



**Emergency
Preparedness,
Response,
and Recovery
Checklist**

EMERGENCY PREPAREDNESS, RESPONSE, AND RECOVERY CHECKLIST

Beyond the Emergency Management Plan

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—From a declaration of the American Bar Association

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I. INTRODUCTION

Health care professionals and organizations are recognized for their central and irreplaceable role in communities, particularly when natural disasters or other emergencies occur. As ordinary citizens may go about their business in the everyday setting, health care providers must prepare routinely for a variety of emergency situations that may impair their ability to care for patients on an ongoing basis.¹

Many state laws and regulations require hospitals and other licensed health care facilities to engage in emergency planning and drilling.² Emergency preparedness, including establishing and maintaining an emergency management plan, also is one of the required seven disciplines of “Management of the Environment of Care” for organizations accredited by The Joint Commission (formerly The Joint Commission on Accreditation of Healthcare Organizations).³ Health care providers experience unexpected crises in different contexts, ranging from events where no essential hospital services are compromised to a disaster that affects all hospital operations on both large and small scales. Emergency events may be externally triggered (e.g., natural disasters; outbreaks of new, deadly diseases; or vicious acts of terrorism) that result in a massive demand on a health care system. Emergencies also may be entirely institution-based (e.g., a small fire in the data center, a burst pipe in the emergency department, or a hospital-wide labor strike). Regardless of whether emergencies are external or internal to the organization, such events may impair health care operations and thereby trigger the implementation of a hospital’s emergency management plan and its Incident Command Structure (ICS) or Hospital Emergency Incident Command System (HEICS)⁴ response.

For example, Tropical Storm Allison created such an emergency situation for the Memorial Hermann Health-care System in June 2001 when downtown Houston, TX and the hospital endured more than twenty inches of rain in a three-day period. The flooding water overwhelmed precautions that had been designed to withstand a 100-year flood; destroyed a pathology laboratory; dispersed medical waste and biohazards; submerged mechanical, electrical, and plumbing systems; damaged communication systems; and required the complete evacuation of the Memorial Hermann Hospital and the Memorial Hermann Children’s Hospital.⁵

And, of course, all Americans remember the heroism and professionalism exhibited by health care workers in the hours and days after the terrorist attacks in Stonycreek Township, PA, New York, NY, and Washington, DC, on September 11, 2001. Or consider the example of the North York General Hospital in Toronto, Canada, which experienced a different emergency situation during May and August of 2003, when an outbreak of Severe Acute Respiratory Syndrome (SARS) occurred in its orthopedic unit.⁶ The hospital ultimately had ninety SARS patients, forty-four of them from the hospital’s staff. North York General closed its doors to any new patients, and had to find ways to treat those patients who already had or who developed SARS. Hospital staff assumed significant personal risk to treat a new type of disease that affected their friends and colleagues. They did so under extraordinarily difficult circumstances that included a workplace quarantine and the intense scrutiny of a frightened media and populace.⁷

Remember also that, in the summer of 2003, large portions of New England and the mid-Atlantic states suffered power

1. The Model State Emergency Health Powers Act addresses a number of issues relating to public health emergencies, including: measures to detect and track potential and existing public health emergencies; declaring a state of public health emergency; special powers of governors and state public health authorities during a state of public health emergency (including control of property and persons); dissemination of information regarding public health emergencies; and planning for such emergencies. See THE CTR. FOR LAW AND THE PUBLIC’S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVERSITIES, CTRS. FOR DISEASE CONTROL AND PREVENTION, THE MODEL STATE EMERGENCY HEALTH POWERS ACT (2001) [HEREINAFTER MODEL STATE EMERGENCY HEALTH POWERS ACT (2001)]; THE DRAFT MODEL STATE EMERGENCY POWERS ACT, GUIDELINES FOR CONSIDERATION BY THE STATES (2001), available at www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. The preamble to the Draft notes that “[b]ecause each state is responsible for safeguarding the health, security, and well-being of its people, state governments must be able to respond rapidly and effectively to potential or actual public health emergencies.” *Id.* at 8. The Model Act therefore “grants specific emergency powers to state governors and public health authorities.” *Id.* Because public health laws vary from state to state, some states may consider enacting only certain portions of the Act.
2. See N.Y. COMP. CODES R. & REGS. tit. 10, § 702.7 (2004) (requiring emergency and disaster preparedness for all medical facilities); see also WASH. ADMIN. CODE § 246-320-405(5) (2004) (establishing conditions for hospital licensure including implementation of a disaster plan “designed to meet both internal and external disasters”).
3. See, e.g., THE JOINT COMMISSION, HOSPITAL ACCREDITATION STANDARDS (HAS) Standards EC4.10, EC4.20 (2004) (providing a detailed checklist of required activities and requiring a hospital to conduct drills regularly to test emergency management). Cf. NATIONAL FIRE PROTECTION ASS’N, STANDARD 1600 ON DISASTER/EMERGENCY MANAGEMENT AND BUSINESS CONTINUITY PROGRAMS §§ 1.1, 1.2 (2013) (establishing a standard common set of criteria for assessing and implementing emergency and disaster management), available at www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=1600 (last visited August 18, 2014).
4. See NORTH CAROLINA HOSP. ASS’N, HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM (1992) (discussing both the Incident Command System and Hospital Emergency Incident Command System disaster response plans).
5. Juanita F. Romans, Tropical Storm Allison: *The Houston Flood of June 9th, 2001*, 6 THE INTERNET JOURNAL OF RESCUE AND DISASTER MEDICINE (2002), at <http://ispub.com/IJRDM/3/1/13010> (last visited August 18, 2014).
6. See Susan Kwolek, *Lessons Learned from SARS: The Story of North York General Hospital*, in AM. HEALTH LAW. ASS’N, SARS: LEGAL AND RISK MANAGEMENT LESSONS LEARNED FROM TORONTO TO ATLANTA TELECONFERENCE (Nov. 13, 2003).
7. *Id.*

outages as a result of a falling tree limb cutting power lines in Ohio. Community members flocked to hospitals across the region for shelter even as the hospitals were operating on emergency generator power, canceling elective procedures, and frequently functioning with compromised computer and other systems. As recently as late summer of 2004, four hurricanes devastated the state of Florida, causing the evacuation of local hospitals.

Accordingly, it is vitally important that health care providers maintain a constant state of emergency preparedness to ensure appropriate response and recovery within the quickest possible timeframe. Such preparedness encompasses four phases: (i) preparation; (ii) mitigation; (iii) response; and (iv) recovery.⁸ Without proper planning, a crisis for the provider may result in unintended consequences involving a potential temporary or permanent business failure, thus adding a crucial community institution to the list of the event's casualties.

The purpose of this *Checklist* is to identify the key legal and operational issues arising in an emergency in order to enhance a health care provider's emergency preparedness⁹ by demonstrating the connection between emergency-planning activities and routine planning, contracting, and operational functions. By considering the following points, a health care provider will be in a better position to promote success for the organization as it confronts unexpected events.

This *Checklist* should not be construed as legal advice, however, and does not purport to encompass all possible legal and other issues that may apply in the event of such an emergency situation; each crisis presents its own unique circumstances. Finally, not every crisis will trigger all of the issues identified in this *Checklist*.

Additionally, public health emergencies have the potential for far-reaching effects on the U.S. population at large, and thus pose unique legal and operational issues for local health systems. A public health emergency, as defined in the Model State Emergency Health Powers Act, is an

“occurrence or imminent threat of a health condition caused by bioterrorism or the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, and poses a high probability of a large number of deaths, serious long-term disabilities, or significant risk of substantial future harm in the affected populations.”¹⁰

The challenges inherent in quickly identifying the disease agent, mode of transmission, and best treatment options significantly affect both the well-being of health care workers *and* the daily operations of health care facilities. This is true particularly in the event that it becomes necessary for the public health authority to assume control of a hospital.

True community-wide emergency preparedness therefore hinges on close coordination and cooperation between public health agencies, health care organizations, and their respective legal counsel. Protecting communities from man-made and naturally occurring threats alike requires legal counsel—for both public health agencies and health care providers—to establish a clear understanding of legal roles and operational responsibilities of each party, well in advance of any public health emergency. This is important particularly to minimize the loss of lives and reduce the potential economic consequences of these events.

To further this goal, the U.S. Centers for Disease Control and Prevention's (CDC's) Public Health Law Program has developed the Community Public Health Legal Preparedness Initiative (Initiative).¹¹ Through intensive, community-based, one-day workshops, this Initiative aims to build vibrant and enduring partnerships between legal counsel for private and public hospitals, as well as with other health care organizations and public health agencies, to enhance the use of law as a tool to advance community health through prevention and health promotion. Resources to facilitate this public health/health care partnership are listed in *Appendices D* and *E* of this *Checklist*.

This *Checklist* is organized to reflect the hierarchy established by the ICS structure, which provides a scalable approach to emergency management. The ICS structure

8. National Fire Protection Ass'n, *supra* note 3, § 5.1.2.

9. For additional information relating to operational issues, please see the following websites: Am. Hosp. Ass'n, *Emergency Readiness*, at www.aha.org/advocacy-issues/emergereadiness/index.shtml (last visited April 18, 2014); Ctrs. for Disease Control and Prevention, *Emergency Preparedness and Response*, at www.bt.cdc.gov (last visited August 18, 2014); Greater New York Hosp. Ass'n (GNYHA), GNYHA Emergency Preparedness Resource Center, at www.gnyha.org/eprc (last visited August 18, 2014); Nat'l Disaster Med. Sys., at www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx (last visited August 18, 2014); RAND Ctr. for Domestic and Int'l Health Security, *What's New*, at www.rand.org/health/centers/healthsecurity/ (last visited August 18, 2014).

10. MODEL STATE EMERGENCY HEALTH POWERS ACT (2001), *supra* note 1.

11. See FIRESCOPE CALIFORNIA, GLOSSARY OF TERMS (ICS 010-1) 11 (1999), available at www.firescope.org/ics-guides-and-terms/ICS%20010-1.pdf [hereinafter GLOSSARY OF TERMS]. For more information about the Community Public Health Legal Preparedness Initiative and the Workshop Director's Guide, please visit www.cdc.gov/phlp/publications/topic/emergency.html (last visited August 18, 2014) or contact the CDC Public Health Law Program at phlawprogram@cdc.gov.

offers a model for the immediate (and hopefully short-term) ad hoc restructuring of an organization around functional (rather than administrative) lines to better meet the demands of a given emergency situation. ICS identifies key roles within an organization, addresses responsibilities for each role, and assigns individuals and resources to those roles based on their availability as needed during an emergency. The ICS structure is scalable, enabling its use in the full range of emergency situations that may disrupt a health care provider's operations. The ICS employs an "Incident Commander" with four "sections" that report to the commander: (i) Operations; (ii) Planning; (iii) Logistics; and (iv) Finance, each with its own "chief."¹²

II. INCIDENT COMMAND

The Incident Commander has overall authority and responsibility for operations during an emergency event.¹³ The Incident Commander's main job is to allocate resources and ensure safety. Any function not otherwise assigned also is the responsibility of the Incident Commander. In addition to the four identified Incident Command System roles, the Incident Commander has direct reports from the Liaison Officer, Public Information Officer (PIO), Communications Officer, Safety/Security Officer,¹⁴ and Recorder/Transcriber.

A. Emergency Management Plan

It is critical for the organization's personnel and medical staff to be familiar with its emergency management plan and ICS. In particular, personnel and medical staff should be aware of the following:

1. What constitutes a disaster that could trigger the implementation of the organization's emergency management plan and how is a disaster declared by the facility?
2. What code is called via the overhead paging system to announce the disaster and trigger implementation of the institution's emergency management plan?
3. Where is the organization's staff to report after an emergency is declared, and how will the organization account for their location? How will staff member locations be recorded (*e.g.*, by sign-in sheet)?

- a. Where is the institution's Command Center primarily located, and under what circumstances might it be moved to an alternate location? Is the Command Center appropriately outfitted, and is it available for immediate use?
 - b. What resources in the Command Center might individual staff contribute as part of planning?
 - i. Are personal contact numbers for relevant staff (*e.g.*, home and cell telephones, personal fax number, e-mail address) available to the Command Center?
 - ii. Are the personal contact numbers of contacts at governmental offices, sister institutions, and important vendors available to the Command Center?
4. Have the organization's operations personnel been briefed with respect to the personal role and skills of individual staff, and how may those individuals assist an Incident Commander coordinating a response to an emergency?
 5. Have personnel and medical staff members been provided with information to enable them to develop family emergency plans, so that they can be confident of their families' safety while they fulfill their obligations to respond during an emergency situation?

B. Command Center

The Command Center is the location from which the response to the emergency will be coordinated. It needs to be located and equipped in such a manner as to facilitate an appropriate response to the disaster, regardless of whether its scope is large or small.

1. Has the institution established a formal Command Center?
2. In choosing a location, has the institution considered what types of emergencies to which the institution will need to respond, so that the center is located in an easily accessible location that is close to the response, but not so close as to risk interfering with it?¹⁵

12. By custom in the health care environment, each of these five key roles (*i.e.*, the Incident Commander and her/his four Chiefs) has an assigned color. See NORTH CAROLINA HOSP. ASS'N, *supra* note 4, for an organizational chart showing these four divisions.

13. FIRESCOPE CALIFORNIA, FIELD OPERATIONS GUIDE (ICS 420-1) 5-2 (2010), available at www.usfa.fema.gov/downloads/pdf/publications/field_operations_guide.pdf [hereinafter FIELD OPERATIONS GUIDE].

14. See NORTH CAROLINA HOSP. ASS'N, *supra* note 4.

15. For example, locating a command center in an emergency room that might have to deal with a mass casualty response may risk pulling people into the Emergency Department who will have administrative but not clinical responsibilities and so may inadvertently interfere with the response.

3. Is the Command Center connected with the institution's emergency generators?
4. Is it properly equipped with the following resources?
 - a. Computers, e-mail, the organization's intranet, Internet access, phones, pagers, radios, and other resources in order to fulfill an institution's communication needs?
 - b. Paper, pens, and markers for handwritten communication needs?
 - c. Sufficient information about the institution's resources (and made easily accessible and searchable) to enable the functioning of an Incident Commander who may be unfamiliar with the hospital's major relationships and personnel?
 - d. Easy access to institutional policies, both those needed for routine operations (*e.g.*, Administration Policy and Procedure Manual, Medical Staff Bylaws) and any policies and procedures that have been adopted in anticipation of an emergency? What mechanism ensures that such policies are always kept up to date? For example, does the Command Center have access to compliance policies with respect to the Health Insurance Portability and Accountability Act (HIPAA) that describe how to respond to inquiries seeking information regarding the location and condition of missing persons who may be patients?
5. Can the Command Center be moved if circumstances require such action?
6. Is the Command Center scalable?
 - a. Is it in a single room, or is it in a location that can be expanded?
 - b. Is the location accessible to the senior management team?
 - c. If the Command Center needs to be expanded, has the institution determined an alternate location? Is that alternate location connected to the emergency generator system?
 - d. Is the Command Center (or alternate location) capable of accommodating multiple people who are working multiple phones and computers simultaneously for easy and immediate communication among the ICS officers and Section Chiefs?
 - e. Is it close to, but separate from, a personnel staging area, so that the Incident Commander and the Operations Section Chief may easily assign people awaiting instruction, without having the people crowd into the Command Center?
7. Does the Command Center include easy access to community and affiliate resources, including all necessary contact information?

C. Incident Commander

The Incident Commander is the individual who assumes overall authority for the institution's response to the emergency. In an institution that implements a classic ICS structure, the commander role may be filled by almost anyone in the institution who identifies and announces the emergency until such time as someone in an administrative chain of command superior to that person takes over the role of Incident Commander.¹⁶

In a HEICS system, the role of Incident Commander may be filled by individuals who have pre-assigned roles that will automatically slot into the command structure. For example, the organization's chief operating officer may automatically assume command for a hospital-wide emergency; by contrast, the Chief of Engineering may assume command for responding to a broken pipe that floods the hospital's data center. Regardless of whether the Incident Commander is in the institution's organization chart, she is responsible for the response until relieved or the emergency ends.

1. Does the institution's emergency plan call for the implementation of an ICS or HEICS system?
2. If it is an ICS system, are *all* the potential individuals who may declare a disaster and assume command aware of their potential authority?
 - a. Are they trained in the emergency management plan?
 - b. Do they understand how they may be relieved of responsibility?
3. If an institution uses a HEICS system, are the individuals who may assume command as a result of their roles within the organization aware of their roles and their responsibilities in an emergency? Could the designation of the Incident Commander change, based on the nature of an emergency?

16. A classic incident command response may require an individual who is above the Incident Commander in the organization's standard organization chart to either assume command or become a direct report to the Incident Commander.

4. If the organization uses a HEICS structure (or other modified ICS structure that pre-assigns individuals to roles in the incident command structure), is the structure regularly reviewed when individuals leave (and new individuals join) the organization, and are the assignments updated as needed?
5. Under either an ICS or HEICS of system:
 - a. Does the relevant individual know the location of the Command Center and the potential resources in it;
 - b. Is that individual familiar with the institution's resources to enable her to gather and assign resources as necessary; and
 - c. Does some kind of chart exist that may be populated with names and contacts in order to keep track of the people who are filling the other roles within the command structure?

D. Liaison Officer

The Liaison Officer communicates with external agencies on behalf of the Incident Commander.¹⁷

1. Has the organization identified those external agencies (e.g., fire, rescue, police, and public health authorities) with which it will need to interact in the event of an emergency?
2. Has the organization compiled contact information for each external agency, and is that contact information available in the Command Center? Is it reviewed on a periodic basis before an emergency occurs to ensure that it is current?
3. Does the contact information include as many different means of communication (e.g., cell phone, fax, land-line telephone, radio contact information) as possible?
4. Is the Command Center itself set up to be able to use any and all available means of communication?
5. In planning for an emergency, has the organization established appropriate lines of communication with local response agencies, and has it discussed and coordinated the facility's plans with relevant agencies ahead of time?

E. Public Information Officer

The Public Information Officer (PIO) serves as the contact for media inquiries, and coordinates communication between the organization and the public.¹⁸

1. Does the organization have a designated PIO or media-contact person on call at all times?
2. Does the organization have a policy that all media inquiries must be directed to the PIO or media person on-call?
3. Are the Incident Commander and PIO prepared to make rapid decisions regarding (i) what information to disclose about an organization's particular situation and readiness; (ii) at what times to make such announcements; and (iii) to which media outlets?
4. Has the organization established patient- and family-tracking procedures and mechanisms that will enable the PIO to locate and obtain information on patients who are evaluated and treated during an emergency, as well as to respond appropriately to inquiries?
5. Is the organization equipped with sufficient telephone lines, cell phones, and other resources to communicate quickly and effectively in an emergency situation?
6. Does the Command Center include telephone numbers and other contacts to community media personnel?
7. Has the organization developed HIPAA- and Joint Commission-compliant media-consent forms to enable willing and available patients to speak with the media about the facility's response during an emergency? Do such consent forms include an agreement with the media company as required by the standards of The Joint Commission?
8. Has the organization communicated its essential role in emergency response to the community and its political representatives alike, so that the survival of the facility will be a priority consideration that the community and government will take into account after the disaster?
9. Has the organization communicated to donors and other supporters of the organization the essential role that is played by the facility in community emergency response?

17. GLOSSARY OF TERMS, *supra* note 11, at 12.

18. FIELD OPERATIONS GUIDE, *supra* note 13, at 5–3.

F. Communications Officer

The Communications Officer ensures effective communications between the Command Center and the rest of the organization. Emergency events require rapid and accurate communications. Many audiences are involved in communication before, during, and after an event, including: (i) the Command Center and internal response personnel; (ii) staff of the organization; (iii) patients and their families; (iv) other agencies and organizations that are part of the event response; (v) police, fire, military, and other governmental agencies; (vi) the general public; and (vii) donors and other supporters of the organization.

1. How will the organization determine what information should be conveyed to others? Will everyone receive the same information, or will some receive less information than others?
2. How will the organization accommodate staff's desire and need to know about an emergency event from the standpoint of the safety of family members, while ensuring continued staff availability for patients?
3. In the event that external authorities issue orders or assume direction of the organization's response, how will those developments be communicated?
4. Has the organization prepared "template" messages, and made them available in the Command Center, for use in the event of an emergency, to reduce the time needed to distribute messages to staff?
5. How and to whom will any orders to evacuate any portion of the facility, or to terminate services, be communicated?
6. Are all means of communication tested on a periodic basis to ensure readiness for use during an emergency event?
7. Has the organization established, and is the Command Center capable of issuing, multiple alternative means of communication, including telephone calls, overhead announcements, e-mail, intranet and Internet Web postings, meetings, correspondence, handwritten postings, and "runners" assigned to courier handwritten messages?
8. Does the Command Center include contact information for key internal personnel, including individuals who may be away from the facility when an emergency is declared?

G. Safety/Security Officer

Safety and security are essential to incident-response activities. Panic and "mob action" easily can overwhelm an organization unless order is maintained; further, unsafe conditions may put additional lives in jeopardy.

1. Who is responsible for maintaining order during an emergency?
2. What supplies or equipment are needed to maintain order, and are they readily available?
3. Does the organization have the ability to obtain additional security personnel on short notice in the event of an emergency?
4. Is a designated safety officer on call at all times?
5. How will the Incident Commander ensure the safety of individuals participating in emergency response activities (including, without limitation, those engaged in decontamination, crowd control, search and rescue within damaged buildings, or isolation and quarantine)?
6. To ensure the safety of all personnel, does the emergency-response plan call for regular changes of shift (if personnel are available) to avoid exhaustion and compromised functioning of those in response roles?
7. How will the institution handle community members who may seek shelter in the hospital during an emergency? Is the institution able to designate specific areas for such people? Are these areas away from patient areas, and away from staging and other areas that might interfere with the emergency response? Does the institution have the resources to feed and shelter such people? If not, how would it handle the influx, and where would it send these people? Will it need to contact its local police precinct around this issue?
8. How will the institution handle an influx of individuals seeking relatives who might be unidentified patients?
9. Does the organization have a security plan in place for crowd control and other needed security measures?

H. Recorder/Transcriber

The Recorder/Transcriber maintains records of any actions taken as directed by the Incident Commander, as well as any significant event that may occur during the crisis. The Recorder/Transcriber assures continuous flow of and access to information for Command Center staff.

1. Has the organization provided for a recorder/transcriber in the event of an emergency?
2. How will the records of any incident response be used during debriefing to inform the organization's planning for future readiness?

III. OPERATIONS

The Operations Section Chief reports directly to the Incident Commander, and has responsibility for conducting operations during the emergency.¹⁹ The Operations Section Chief is responsible for whatever services are being provided during the emergency, and frequently oversees a fairly large number of operational leaders responsible for specific areas, such as Decontamination, Emergency Services, Inpatient Services, and the Operating Room.²⁰ Some key issues facing the Operations Section Chief include the following.

A. Isolation and Quarantine

Government authorities may exercise police powers in an emergency situation, including the isolation of infected individuals and quarantine of healthy individuals who may have been exposed to an infectious agent. For a disease listed in federal Executive Order 13295 as communicable and quarantinable, the U.S. government has jurisdiction to apprehend, detain, and conditionally release individuals to stop its interstate spread or international importation, and need not wait for an interstate spread actually to occur before acting.²¹ Thus, it is important for health care providers to coordinate isolation and quarantine measures with federal, state, and local authorities.

1. What are the local, regional, state, and national plans for handling a sudden influx of patients who may require decontamination as a result of having been exposed to chemical, biological, or radiological agents?
2. Does the Incident Commander have the authority to implement decontamination, isolation, or quarantine measures? If not, who does? Who needs to be informed in the event that such measures are implemented?
3. Has the organization engaged in isolation or quarantine planning with local and regional public health officials in order to understand what will be expected or demanded if isolation or quarantine is ordered?
4. Is the organization familiar with the plans of all such authorities, and has it coordinated its emergency planning with these authorities?
5. Do procedures exist to identify incoming patients who may require decontamination or isolation? Are staff members trained in them, and is appropriate equipment available to conduct such procedures? How is the safety of staff ensured in the event a patient requires decontamination or isolation?
6. What plans exist for placing, observing, and caring for individuals subject to isolation or quarantine? Do local officials plan to utilize hospitals or other private facilities for these purposes in an emergency?
7. What legal procedures are required to implement isolation or quarantine of individuals or groups?
8. If a patient is admitted to a hospital, how will isolation and quarantine orders be delivered to the patient during her stay? What constitutes valid orders for isolation or quarantine? Does the organization have a system for receiving and recording any such orders?
9. Is the organization at risk if it implements an isolation or quarantine order issued without a court hearing?
10. Is a court hearing and court order required for the imposition of isolation or quarantine measures? Is an order that is issued without a hearing valid?
11. If a hearing is necessary for a hospital patient who is subject to an isolation or quarantine order, how will the hearing be conducted?
12. Can local, regional, or state agencies provide either legal indemnification or an opinion of counsel regarding the liability of health care providers for cooperating with isolation or quarantine orders?
13. How will facilities be compensated for their additional expenses incurred and revenue lost if they are designated as isolation or quarantine facilities? What documentation will be required to make claims for expenses and lost revenues relating to an isolation or quarantine event?
14. Following an isolation or quarantine event, what entity will compensate facilities for their costs of recovery, and what will be the basis for such compensation? What

19. See NORTH CAROLINA HOSP. ASS'N, *supra* note 4.

20. FIELD OPERATIONS GUIDE, *supra* note 13, at 7–2.

21. 42 U.S.C. § 264 (2004).

documentation will be required to make claims for these costs of recovery?

15. Who, if anyone, is financially responsible for lost wages due to an order of quarantine or isolation? Who is responsible for compensating a health care worker who is sent home by her employer following an exposure? In what way does the answer to this question change if the person is ordered into home quarantine by public health authorities? How does the answer change if the person experienced exposure in a work environment, rather than in a home environment or while traveling abroad?
16. Is it possible for facilities to employ work place quarantine measures? Can an employee be quarantined at home outside of working hours (i.e., permitted to leave the home only to go to work)?
17. Who is financially responsible for the costs of isolation or quarantine in a hospital that occurs pursuant to a public health order? What is the response going to be if a third-party payer determines that care for a particular illness is not covered, or is no longer medically necessary, and refuses to pay?
18. Who is responsible for enforcing isolation and quarantine orders? (For example, if a patient must be physically detained in isolation, who will ensure the patient stays there?)

B. Patient Diversion Issues

In an emergency, the normal flow of patients to and among health care providers almost certainly will be interrupted. See *Appendix A* for a discussion of the applicability of the Emergency Medical Treatment and Active Labor Act (EMTALA)²² in the event of a major public health emergency.

1. How will the determination be made that the organization's emergency-response plan (or the community emergency-response plan) should be implemented (e.g., whether an official declaration is necessary)? Has a threshold number of cases been established to require the triggering of the plan? What occurs if the plan appears to conflict with an organization's own legal or other obligations? What happens if the community has not developed an emergency-response plan? Does the institution have its own plan?
2. Does the organization have in place a full range of transfer agreements to provide for the emergency transfer of patients whose medical conditions are beyond the scope

of its services? If the organization is a tertiary care facility, does it have in place transfer agreements with other community providers under which the tertiary care facility will receive patients in an emergency?

3. Do the organization's transfer agreements with any long term care facilities address the immediate return of hospitalized residents in the event of an emergency situation requiring an evacuation of patients?
4. Do the organization's routine files, as well as its Command Center records, include (in readily accessible locations) the list of such community and affiliate resources, including a description of the potential resources and appropriate contact information, for easy reference by the incident command staff in an emergency?
5. Has the organization planned for partial or complete closure (including partial or complete evacuation) of the facility in the event of an emergency?
6. Does the organization have an established protocol for closure of the facility to incoming patients as the result of an emergency?
7. Has the organization identified all parties who need to receive notice of any closure, including other providers, ambulance companies, agencies responsible for triage and patient allocation in an emergency, first responders, and regulatory or licensing authorities?
8. Is the organization a participant in the National Disaster Medical System (NDMS), under which hospital beds are made available to the Department of Homeland Security for use in the federal medical response to major emergencies and declared disasters? If so, what are the organization's responsibilities within the NDMS program?
9. Is the organization's process for closure or diversion compliant with the organization's obligations under EMTALA, and with state or local rules and orders of public health officials? Will the organization continue to provide for screening examinations and required stabilizing care within its available resources at all times it remains in operation?
10. Has the Centers for Medicare & Medicaid Services (CMS) issued any emergency guidance? What should hospitals do in the interim between the arrival of patients and the issuance of CMS guidance, as this could lead to treatment differences before and subsequent to such an issuance?

22. See generally Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2004).

11. May patients be directed to the organization by a governmental authority, including a public health, police, or military official, overriding the organization's EMTALA duties? If so, is the Command Center equipped to receive documentation of the order or direction? In the alternative, has the Incident Commander created appropriate records of the directions received?
12. What is the institution's threshold response in such situations (e.g., any initial evaluation provided; immediate diversion to designated facility; patients presenting with symptoms covered by emergency-response situation, as well as other symptoms)?
13. Can medical-screening exam procedures be altered due to concerns over contamination (e.g., performed outside)?
14. Will response differ by acuity of circumstances (e.g., mass disaster vs. intermittent flow of affected patients)?
15. How will EMTALA compliance be demonstrated and/or documented in the event that an emergency-response plan is implemented?
16. Does the organization have a contingency plan if a potentially exposed patient presents, but the case must first be evaluated by law enforcement or public health? Does this constitute an "undue delay" under EMTALA?
17. What is the facility's obligation, if a patient is diverted elsewhere, to ensure that patient transfer is effectuated?
18. Have state or local authorities made declarations that will protect the organization in circumstances where an emergency is not "national," and therefore does not trigger protection from sanctions in the regulations?
19. If the facility in question is the designated treatment facility, how are existing patients handled? What happens once capacity is reached? Does the designated facility have a memorandum of understanding (MOU) or mutual-aid agreement with other facilities, or with state or local government?
20. Has there been a presidential declaration of emergency that suspends EMTALA obligations? Will some or all EMTALA obligations be suspended or waived in the event of a local emergency in the absence of a federal or local declaration?²³

C. Patient Tracking and Placement

In a mass-casualty event, organizations may be overwhelmed with a sudden influx of patients. It is essential for facilities to both track and be able to report on these patients.

1. Does the organization have an identified triage area for large numbers of incoming patients?
 - a. Has the organization identified secondary triage site(s) if its original triage site becomes overwhelmed by an influx of patients?
 - b. Is the organization able to staff and supply such site(s)?
 - c. If the organization utilizes secondary sites, might they be separated by purpose (e.g., all patients needing decontamination in one area, those not needing decontamination into another)?
 - d. Are such secondary site(s) separate from staging areas for any human resources and other resources?
 - e. Can the triage zone accommodate decontamination procedures, if needed?
2. Have tracking forms and other tools been made readily available in the emergency department and in the Command Center to permit manual tracking of incoming patients?
3. Does the organization have a method (and the necessary paper forms and supplies) for recording patient medical information when patient volume or other conditions do not permit the use of computerized systems? Does the organization have a plan to record manually gathered information into computer systems when conditions permit?
4. Where will a large number of incoming patients be housed? What portions of the facility can be converted to patient care on short notice?
5. If a large number of incoming patients require isolation due to contamination or infectious disease, where will they be placed? Who will care for them, and what protective equipment, supplies, or facility changes will be needed?
6. Does the organization have an identified area for family members and other concerned individuals to obtain information about patients at the facility? Has it identified needed resources for such individuals, including food and water, as well as emotional and spiritual counselors?

23. To date, CMS has not stated this explicitly, but it is important to note that policy in this area is evolving.

7. Has the organization trained the emergency department and other relevant staff in techniques of triage? Does the organization provide emotional and spiritual support for front-line staff engaged in triage and treatment?

D. Reporting Requirements

Each state has its own requirements for reporting communicable diseases and conditions to either local or state health departments who, in turn, report information to the CDC. Some local jurisdictions also may have communicable-disease reporting requirements. The time and manner of reporting likely will vary among jurisdictions and among diseases. Some state laws on communicable-disease reporting may bestow immunity on some individuals making such reports.

1. Has the organization identified the communicable disease reporting laws for state or local jurisdictions?
2. Are those responsible for making the reports aware of the time frames and procedures for reporting each type of communicable disease? (Particular attention should be paid to those communicable diseases that are identified as “Category A” critical biological agents—anthrax, botulism, plague, smallpox, tularemia, and viral hemorrhagic fevers).
3. Has the organization’s staff been informed of confidentiality requirements whenever reporting of communicable diseases to any government agency is mandated by law?
4. Has the organization assessed the availability of legal immunity for a person making such a report?
5. Has the organization distributed guidelines to personnel and medical staff describing permissible uses and disclosures of protected health information for public health and other reporting purposes under HIPAA?²⁴

E. Personnel Issues

In addition to their role as providers of health care services, health care institutions also are employers. In this context, health care institutions must comply with myriad state and federal laws. In the event of an emergency, institutional personnel of all varieties will be called upon to perform various functions, both within and outside of their typical scope of duties. Preparing for and dealing with the aftermath of a crisis will involve an array of duties not only to the public and individual patients, but to the institution’s employees as well.

Although the laws and regulations discussed in this section apply specifically to the employment relationship between health care institutions and their employees, it is important to note that some providers and other personnel work as independent contractors rather than as employees. Institutions should consider the effects of independent-contractor status with respect to the ability to use certain personnel in the event of an emergency, particularly if such individuals have relationships with more than one institution. Moreover, public sector health care institutions also must bear in mind liability issues that might arise under various civil-rights statutes.²⁵

1. *General Considerations* In developing an emergency management plan, organizations should consider the following personnel-related issues:
 - a. Have the institution’s employees received materials and training on the development of personal emergency plans for themselves and their families? Do employees’ families understand that, in an emergency, their personal emergency plans may need to be initiated without the employees (or with them only calling into a designated contact), as they may be required to stay at the facility and assist in the facility’s response? Do they have enough information about family emergency plans to feel confident that their family will be safe during the emergency so they can focus on their responsibilities?

24. See generally Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 26, 29, and 42 U.S.C.) (establishing guidelines for confidentiality issues). The Department of Health and Human Services has issued a Privacy Rule that provides comprehensive Federal protection for the privacy of health information. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,596 (Dec. 28, 2000) (codified at 45 C.F.R. pts. 160, 164). The Privacy Rule recognizes that various agencies and public officials will need protected health information (PHI) to deal effectively with a bioterrorism threat or emergency. To facilitate the communications that are essential to a quick and effective response to such events, the Privacy Rule permits covered entities to disclose needed information to public officials in a variety of ways. Covered entities may disclose PHI without the individual’s authorization to a public health authority acting as authorized by law in response to a bioterrorism threat or public health emergency. 45 C.F.R. § 164.512(b) (2004). The Privacy Rule also permits a covered entity to disclose PHI to public officials who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism.

25. See generally 42 U.S.C. § 1983 (2004).

- b. Has the institution identified multiple safe staging areas for groups of employees, outside of the primary emergency-response areas, so that they can be assigned as needed? Have the locations of the staging areas been communicated to employees?
 - c. Does the institution have a mechanism that ensures that employees are only released to return home if they are not needed, and if the institution believes that the employee may safely leave the premises? Has the institution developed mechanisms that will enable it to learn of unsafe conditions that would interfere with employees and others exiting the institution (e.g., closed roads, bridges, and mass-transit problems)?
 - d. Has the institution made provision for emergency emotional, spiritual, psychological, and potentially psychiatric support to its employees who are dealing with the personal impact of the emergency? Does it have a plan to employ a triage or other mechanism in such a situation?
 - e. Has the institution anticipated providing some long term, post-response support to its employees in the event of a major disaster? Does it have the internal resources to do so, or would it need to go to another organization or agency? If it needs to go elsewhere, does it know where to go?
 - f. If an independent contractor has any of its employees performing responsibilities onsite at the institution, has that contractor set up a mechanism to locate and safeguard its employees? Do such employees have a central place to gather and sign in?
 - g. Does the institution know who the independent contractor employees are, and where they would gather in an emergency in case it needs to call upon their expertise (e.g., a contractor providing routine on-site staffing and management for an institution's data center)? Does the institution know who to contact at the independent contractor's office to get those individuals resourced appropriately in an emergency?
 - h. Does the independent contractor know what the institution's expectations are with respect to the use of contractor employees in an emergency?
 - i. Has the independent contractor trained or drilled its employees in their responsibilities to the institution in an emergency?
2. *Workers' Compensation.* State workers' compensation laws could be implicated if an employee contracts an illness on the job during the course of a public health emergency. This most likely will occur among first responders, law enforcement, and health care workers. Emotional distress due to fear of exposure generally is compensable under these rules. In an emergency, health care workers may experience injuries while rendering aid during the crisis. Workers' compensation also may be available for such injuries, depending on the activity causing the injury and the worker's job duties during the emergency. Where the injury involves a disease for which a vaccine or medication is available, the application of worker's compensation may depend on whether the person undertakes voluntary vaccinations or medical treatment. Finally, because workers' compensation laws vary significantly among the states, it is necessary to consult the workers' compensation laws of the jurisdiction in question.
- a. Has the organization reviewed workers' compensation statutes and regulations for the appropriate jurisdiction?
 - b. Has the organization identified the potential liability for injuries, medical expenses, retirement benefits, and disability benefits incurred by the participation of employees and volunteers during an emergency?
 - c. Has the organization determined whether other federal or state benefit programs may apply or, alternatively, may bar submission of a claim (e.g., if state laws constitute an exclusive remedy) regarding certain disaster or disaster-preparedness situations?
 - d. Has the applicable jurisdiction(s) established any compensation programs specific for certain activities (e.g., vaccination), and is coverage different for employees as opposed to volunteers?
 - e. Does a "no-fault" compensation program apply?
 - f. Has the organization identified the availability of workers' compensation and/or other forms of financial support for persons unable to return to work because of an isolation/quarantine order?
 - g. How will the organization address any potential legal liability for implementing "working" quarantine policies for essential service personnel?
 - h. If an employee is quarantined, but is asymptomatic, is the employee entitled to compensation for the time spent in quarantine?
 - i. Is the institution prepared for workers' compensation claims, which may be filed months or years after the actual emergency event, claiming that the event and the event response negatively affected employees' physical or psychological health?
3. *Other Compensation and Wage/Hour Issues.* Similar to other employers, health care institutions are subject

to federal regulations that pertain to employee compensation and hours.²⁶ In addition, organizations must comply with specific labor, compensation, and general employment laws relating to health care workers. For example, some states have enacted measures banning mandatory overtime for nurses and other health care professionals.²⁷ Meeting these obligations could present a significant challenge in the face of a major public health emergency, involving a redefinition of the work day, work week, and/or overtime. Some states are considering mandating the continuation of wages if employees are kept from work due to isolation or quarantine (policies that might be considered akin to jury duty). Such measures might enhance compliance by reducing individuals' fears of lost income, and also afford protection for the rest of the workforce.

- a. Would discharging an employee who is absent because she is subject to quarantine be deemed illegal as a public policy violation?
 - b. What is the outcome if extended hours required of health care workers run up against legal limits on the hours that physicians and nurses can work consecutively?
 - c. Will payment be provided for temporary lodging, meals, or other incidental expenses?
 - d. How will payroll and benefits be maintained?
4. *Credentialing Issues, Including Disaster Privileges.* Issues may arise regarding whether a hospital or health care entity may allow outside medical personnel to assist regular staff during an emergency due to existing medical privileges requirements. The Joint Commission requires hospitals to establish a procedure for verifying credentials and granting privileges during and after a disaster,²⁸ and has established procedures for doing so. In addition, at the federal level, the Secretary of the Department of Health and Human Services is required to establish a system for advance registration of health professionals to provide for verification of credentials, licenses, accreditations, and hospital privileges when such professionals volunteer during a public health emergency.²⁹
- a. Has the appropriate state or local jurisdiction adopted regulations regarding the use of disaster privileges during an emergency situation? Do such regulations provide immunity for granting or denying such disaster privileges, or for providing care after being granted such privileges?
 - b. Does the chief executive officer (CEO), medical staff president, or another official have the option to grant disaster privileges pursuant to the standards of The Joint Commission? Does the institution have a document that delegates this responsibility to the Incident Commander as the designee if the designated official is not physically available during the disaster?
 - c. Who has been designated in writing to grant disaster privileges? Has the organization specified such individual's duties, as well as a mechanism to manage the activities of health care practitioners who receive disaster privileges (and to readily identify such individuals)? Will the designated individual treat the verification process as a high priority? Is this position identified in the emergency management plan and/or otherwise accessible to the Incident Commander in an emergency?
 - d. Does the medical staff have a mechanism to initiate the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control?
 - e. Are the organization's disaster and emergency privileging processes consistent with the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need? If not, is an amendment to the medical-staff bylaws contemplated and/or needed?
 - f. Has the appropriate jurisdiction established procedures regarding credentials? Does the appropriate jurisdiction allow an expedited and/or different process for verifying that the person practicing has the proper credentials when in an emergency situation? Are immunity protections associated with the credentialing process available during an emergency?
 - g. Are "request for staff privileges" forms for collecting credentials data available in the Command Center?

26. Please see discussion regarding the Fair Labor Standards Act in Section III(F)(5) of this *Checklist*, which is the text accompanying notes 42-43.

27. See Ann E. Rogers et al., *The Working Hours of Hospital Staff Nurses and Patient Safety*, 23 HEALTH AFF. 202, 203 (2004); ME. REV. STAT. ANN. tit. 26, § 603(5) (2003) (stating that any nurse "who is mandated to work more than 12 consecutive hours" in the event of an unforeseen emergent circumstance "must be allowed as least 10 consecutive hours of off-duty time immediately following the worked overtime"); see also OR. REV. STAT. § 441.166 (2003); N.J. STAT. ANN. § 34:11-56a34 (2004).

28. THE JOINT COMMISSION, *supra* note 3, at Standard MS 4.10.

29. Public Health Security and Bioterrorism Response Act of 2002, Pub. L. No. 107-188, § 107, 116 Stat. 594, 608 (codified as amended at 42 U.S.C. § 247d-7b).

5. *Use of Licensed Professionals Outside Their Scope of Practice.* The use of licensed professionals outside their normal scopes of practice, or using non-licensed professionals to perform tasks that would typically require a license, may raise legal issues. Some states may have statutes that specifically authorize such practices, or allow certain licensed professionals (e.g., physicians) to delegate certain tasks to others while providing supervision. Additionally, emergency-management statutes or other public health emergency preparedness laws may allow the governor of a state (or another designated individual, e.g., a state agency director) to suspend certain statutes to authorize such activities during a crisis.
 - a. Do the appropriate local and state jurisdictions allow for medical staff to delegate their authority during an emergency situation? If so, to what extent?
 - b. Does legal authority exist to suspend professional-licensure requirements during a major disaster? If so, who has that authority? Does the institution know how that decision would be communicated to it during an emergency?

6. *Use of Licensed Professionals from Other States.* Issues may arise relating to using licensed professionals from other states to assist in responding to an emergency. The National Emergency Management Association has published a model law, entitled *The Emergency Management Assistance Compact (EMAC)*,³⁰ most states have entered into this compact. Article V of *EMAC* provides that

. . .whenever (i) any person holds a license, certificate, or other permit issued by any *EMAC*-participating state evidencing qualifications for professional, mechanical, or other skills, and (ii) when such assistance is requested by the receiving party state, such person shall be deemed to be licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster.³¹

It also is possible that state professional regulatory and/or emergency management statutes address these issues.

- a. Has the organization's state adopted *EMAC* or other measures that address the use of licensed professionals from other jurisdictions during an emergency?
- b. Does the organization know what limitations and conditions the governor of the state may prescribe when issuing an order pursuant to *EMAC* or other statutory provisions? Do *EMAC* or other state statutory provisions confer immunity on licensed professionals from other jurisdictions in an emergency?
- c. Does the organization know if licensed medical personnel employed by federal agencies are permitted to assist during an emergency, and is their ability to practice in an emergency contingent upon the state's licensure requirements?

F. Statutory and Regulatory Considerations

As part of their emergency management planning, organizations should evaluate the implications of the following laws and regulations.

1. *Occupational Safety and Health Act (OSHA)*.³² OSHA applies to most private sector employers. It is enforced by the Occupational Safety and Health Administration (OSHA) within the U.S. Department of Labor (DOL).³³ The Act contains a "General Duty Clause" requiring employers to furnish a place of employment free from recognized hazards likely to cause death or serious physical harm. OSHA sets workplace standards for safety and various toxic/chemical exposures.
 - a. Does the emergency present a hazardous working condition triggering OSHA obligations and attendant employee protections? (In some circumstances, employees are permitted to refuse to work in the face of real danger of death or injury.)
 - b. Has OSHA promulgated guidelines for diseases, toxic or chemical exposures, or similar health hazards involved in the emergency?³⁴ Are any such guidelines being contemplated?

30. See Emergency Mgmt. Assistance Compact (EMAC), EMAC Emergency Management Assistance Model Legislation, at www.emacweb.org/index.php/learnaboutemac/emac-legislation (last visited August 19, 2014).

31. *Id.* at art. V. It should be noted that Article VI of EMAC provides that "Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes; and no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or gross recklessness." *Id.* at art. VI.

32. Occupational Health and Safety Act of 1970, 29 U.S.C. § 651 (2004).

33. For a further discussion of the Occupational Health and Safety Administration, see Occupational Health and Safety Admin., U.S. Dep't of Labor, at www.osha.gov (last visited August 19, 2014).

34. See OCCUPATIONAL HEALTH AND SAFETY ADMIN., U.S. DEP'T OF LABOR, INFORMATION REGARDING SEVERE ACUTE RESPIRATORY SYNDROME (SARS) (establishing guidelines for health care workers, laboratories, and airlines dealing with SARS), at www.osha.gov/dep/sars/index.html (last visited August 19, 2014).

2. *Family and Medical Leave Act (FMLA)*.³⁵ The FMLA requires employers with fifty or more employees to allow eligible employees to take up to twelve weeks of unpaid leave in a twelve month period for a serious health condition (among other reasons).³⁶ A “serious health condition” is defined as an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.³⁷ Some states have analogous provisions, some of which are more generous than the federal law.
 - a. Does FMLA cover an employee who is an asymptomatic patient subject to quarantine or isolation?
 - b. Does FMLA cover an employee’s family member who is an asymptomatic patient subject to quarantine or isolation?
 - c. Would a major emergency requiring the participation of all available personnel potentially excuse noncompliance with FMLA, except for those employees with absolute medical needs?
3. *Americans with Disabilities Act (ADA)*.³⁸ The ADA creates a variety of duties applicable to employers with regard to disabled employees. It prohibits discrimination against individuals with disabilities who are otherwise qualified for a job, and it limits pre-employment inquiries. A “disability” is defined as “a physical or mental impairment that substantially limits one or more of the major life activities of such individual.”³⁹ The ADA applies to employers with fifteen or more employees and is enforced by the federal Equal Employment Opportunity Commission (EEOC).⁴⁰ Health care organizations and others must consider the following issues in an emergency, given the nature of an institution’s physically impaired employees for whom it might previously have provided an ADA accommodation.
 - a. Do the individuals need any special considerations in ensuring that they:
 - Are located properly at the beginning of an emergency;
 - Can go to (or be brought to) a staging area for contribution to the response;
 - Contribute to the response, and not somehow get in the way of it; and
 - Can safely return to their offices (and responsibilities), and/or home, after the response?
 - b. Would it constitute disability discrimination to fire an employee kept out of work due to quarantine or isolation? Does such a decision depend on the employee’s disease condition?
 - c. Do any of the organization’s employees have a disability that will require special assistance in the event of an evacuation? Is the organization’s evacuation plan consistent with the needs and special requirements of each of its employees and medical staff members?
 - d. An employer may reject a job applicant with a disability or terminate an employee with a disability, for safety reasons if the person poses a direct threat (*i.e.*, a significant risk of substantial harm to self or others) without violating the ADA. This might cover an adverse employment decision with regard to an employee subject to isolation or quarantine due to exposure and the risk of infection. Could a bona fide emergency convert an accommodation that normally is a reasonable one into an undue hardship?
 - e. What should be the organization’s response where employee absenteeism mounts due to the stress of a particular emergency situation, and employees claim that they are suffering from post-traumatic stress disorder? Can such employees’ essential job functions be accommodated at home?
4. *National Labor Relations Act (NLRA)*.⁴¹ The NLRA provides legal protection for employees engaging in “protected concerted” activity, and governs the relationship among unions, employees, and employers. The NLRA is enforced by the National Labor Relations Board (NLRB), and governs most private sector employers.
 - a. Has the organization addressed special emergency circumstances (*e.g.*, overtime, lost wages, work rules, duty to bargain, grievances) ahead of time in existing collective bargaining agreements? If not, will such issues be addressed during the next renewal of collective bargaining agreements?

35. Family Medical Leave Act, 29 U.S.C. §§ 2601–2654 (2004).

36. *Id.* §§ 2611–2612.

37. *Id.* § 2611.

38. Americans with Disabilities Act, 42 U.S.C. § 12101 (2004).

39. *Id.* § 12102.

40. *Id.* § 12111.

41. National Labor Relations Act, 29 U.S.C. §§ 151–169 (2004).

- b. What is the role of union stewards in an emergency situation?
5. *Fair Labor Standards Act* (FLSA).⁴² This federal statute establishes minimum wage, maximum hour, and overtime requirements. It requires that all non-exempt employees working over forty hours a week receive overtime pay at a rate of one and one half times the regular rate. Hospitals and other health care institutions are covered employers under the FLSA. The FLSA is enforced by the Wage and Hour Division within the Employment Standards Administration of the DOL.
- a. Does time spent in mandatory quarantine count toward the calculation of compensable hours worked?
 - b. In the event of a major emergency requiring all available personnel to work extended hours, could the good-faith provisions of the Portal to Portal Act⁴³ excuse noncompliance with economically burdensome overtime requirements (particularly where much of the emergency services provided might well be without any reimbursement or payment)?

IV. PLANNING

The Planning Section Chief anticipates the course of events over the relevant time horizon, and makes plans to ensure continued smooth operation of the facility.⁴⁴ At the initiation of an emergency, the Planning Section Chief assesses staffing needs, calls in off-duty staff, arranges for transportation of those who need it, establishes a labor pool, and other related tasks. Once a longer period becomes the relevant planning horizon, the Planning Section Chief shifts from a focus on the “next several hours” to an emphasis on “the next several days” as emergency operations commence and stabilize. Eventually, the Planning Section Chief prepares for the demobilization or “standing down” of the organization from the emergency. But planning activities go well beyond the activities of a Section Chief during an emergency. Planning is the heart of good emergency response, and it is found in all activities engaged in by the organization for its daily operations. Emergency planning wedds the knowledge that an emergency will occur with the routine management activities the institution conducts.

42. 29 U.S.C. § 201 (2004).

43. See 29 U.S.C. § 251 (2004).

44. FIELD OPERATIONS GUIDE, *supra* note 13, at 8–3.

A. Corporate Governance

It is important that an appropriate chain of succession is established in the event key players are unavailable during an emergency situation.

1. Has the organization established a chain of command?
2. Has a process been established that ensures continuous command-and-control functions at all times and by appropriate individuals?
3. Are documentation requirements established for an individual who asserts command responsibilities during an emergency?
4. Is it clear within the emergency management plan and other documents how an incident commander is identified? Is the incident commander’s authority with respect to the administrative commander (*e.g.*, the CEO) identified in the documentation, and understood by those who might assume incident command and/or maintain administrative authority over the institution?
5. Has the organization’s board of directors ratified the chain of command, and is documentation to that effect on file in the Command Center?
6. Are senior leaders trained in their expected emergency response roles, as well as in alternative roles they may be expected or required to assume during an event?
7. Has the organization drilled for the activation of the Command Center during evening, night, and weekend shifts?
8. Have specific departments drilled in their potential responsibilities? In addition to emergency department drills, has the senior management team drilled together? Have other departments (*e.g.*, finance, human resources) been included in the drills?

B. Hazard Vulnerability Analysis

It is important for each organization to conduct a Hazard Vulnerability Analysis (HVA). In an HVA, the organization identifies the foreseeable risks it faces, classifies them as “high” or “low” likelihood, and assesses their potential effect on the organization. What results is a prioritization of emergencies to plan for, enabling the organization to devote its attention to the high-likelihood, high-effect risks.

1. Who is charged with the preparation of the HVA (*e.g.*, a member of senior management, the facilities department, a committee)?
2. If the charged individual is not a member of senior management, have members of the senior management team provided their input?
3. Where is the HVA located? Has a copy been included in the institution's emergency management manual?
4. Does the organization's senior management understand the major issues identified as part of the analysis, and do these issues inform the facility's documentation and contracting processes?
5. Does the HVA include the possibility of responding to terrorism and the so-called "CNBC" (*i.e.*, concussive, nuclear, biological, and chemical) events, as well as the differing effects each might have on the ability of the facility to respond?
6. Is the organization located in a potential terrorist target area? If so, does the organization need to stockpile certain mission-critical supplies, and is it keeping track of its incurred expenses in doing so?
7. Does the HVA and the institution's other emergency plans contemplate whether and how the emergency could limit access to (and from) the institution for patients, employees, and vendors?
 - a. Are critical roads and transit points subject to their own risks (*e.g.*, earthquakes), or are they targets for terrorist attacks?
 - b. Do such ingress/egress thoroughfares run by locations that may need to limit their own access in an emergency and beyond (*e.g.*, past police headquarters or governmental buildings)?
 - c. Does the organization understand how long a threatened closure may last (*e.g.*, during the emergency; during the cleanup; permanently)?
 - d. Based on the length of possible closure, how might the closure affect both the response to the emergency and the eventual recovery from it?
8. Have the institution's vendors been apprised of the possible limitations of access to the facility, and can they contribute to any necessary workaround strategy to ensure the delivery of supplies and equipment to the facility?

C. Community Support, Affiliation, and Transfer Agreements

Health care providers often are parties to myriad community support, affiliation, or transfer agreements. Such agreements can be a source of support during a crisis situation.

1. Does the facility participate in community or industry organizations that may provide support, or to which the facility may need to contribute, during an emergency in the community? Is the contact information for these organizations readily accessible to the Command Center?
2. Is the facility part of a larger health care system upon whose resources it can call (or to whose resources the facility may need to contribute) in an emergency?
 - a. Are such potential emergency contributions (*i.e.*, resources of system members to other system members) described in any document or other agreement? For instance, in an emergency, will other facilities assist the organization by sending staff, supplies, and/or equipment?
 - b. If the facility generally is a stand-alone facility, can agreements be implemented with other community providers (perhaps even with potential competitors) for emergency assistance?
 - c. How will these contributions be compensated?
3. Is the institution part of a regional association that can coordinate resources and response among facilities?
 - a. Will the communication lines with any such association be clear, even in an emergency?
 - b. Is the institution confident that the association will address the institution's unique concerns relating to its patient population, location, and available resources?
4. Does the organization have mutual assistance pacts with other facilities that may be able to supply needed personnel, supplies, or equipment? Are such mutual assistance agreements specific to the organization (*e.g.*, does a pediatric hospital have access to pediatric ventilators in an emergency)?

D. Vendor Agreements

The institution's "mission-critical"⁴⁵ vendor agreements should provide for the vendor's assistance in planning for and responding to an emergency.

45. Mission critical items are not limited to clinical issues such as medical supplies. Mission critical items may include food service agreements, software agreements for billing applications, and other items important to the organization's operation.

1. As part of the contracting process, has the institution discussed with its potential vendors the outcome of its HVA?
2. Is the vendor aware of the potential risks that are of particular concern to the institution?
3. Have contract discussions addressed any expectations between the parties about vendor response and/or assistance in an emergency?
4. Has the organization sought and included input from the vendor(s) in developing the institution's disaster recovery plans?
5. Does the institution have the leverage to demand a priority response in an emergency? Should it attempt to negotiate such a priority anyway?
6. Have any expectations been discussed with respect to compensation for additional emergency services and/or goods? (The parties may decide legitimately to leave the agreement silent on this point, or may go into depth about this issue.)
7. Does the vendor understand that the institution expects that the vendor will show up in an emergency and that the parties will discuss the compensation after the disaster, but that the consideration will not reflect a mark-up in the negotiated consideration purely because of the emergency?
 - a. Could access to the institution be interrupted, disrupting the flow of services and/or goods to the institution in a disaster?
 - b. Will the institution have access to alternative suppliers of services and/or goods (e.g., food)?
8. Is the contract clear that a disaster at the institution's location will not necessarily relieve the vendor of its obligations?
9. Does a disaster experienced by the *vendor* at its location relieve the vendor of all contractual obligations, or would it instead trigger the vendor's obligation to implement its own disaster recovery plan in addition to the disaster-recovery plan of the institution?
10. If a disaster interferes with the provision of the underlying services for a certain period of time (e.g., notwithstanding an involved disaster-recovery plan, the institution's software applications are unable to process its data for thirty days after the disaster), may the institution terminate the underlying agreement?

E. Documentation

Documentation of a health care institution's operational, financial, and administrative activities is important for many purposes. Nevertheless, documentation in patient charts, for example, may be less complete than usual when providers are responding to an emergency situation. This may pose a legal vulnerability for health care providers. During an emergency situation, documentation also may be particularly important for insurance reimbursement and grant purposes if grants are made available based on what was done (and adequately documented) during the emergency. If documentation is insufficient, then an organization can lose track of patients, symptoms and diagnoses, and loved ones because the organization is not following its usual systems.

1. Is a triage tagging system in place that determines the triage classification of each person who is evaluated and treated in the emergency department?
2. Does the organization have a system of documentation sufficient for tracking of patients and communication with health care providers?
3. Is the documentation in the chart sufficient to demonstrate that the standard of care was met, as well as to enable continuity of care?
4. If the institution relies on a computer registration system that may be unavailable during portions of an emergency event, can the institution print out blank screens (*i.e.*, template information entry screens providing the prompts for information that can be manually recorded on hard copy) prior to or during the emergency, so that demographic, insurance, and other information elements usually captured by the computer system electronically can still be captured (if only by hand) and then back-loaded into the computer system once the crisis has passed? Similarly, if the organization's information technology (IT) system fails temporarily, is a process in place to document critical entries in a patient's medical record by hand, and ultimately to transfer them to the electronic system when it is again functional?
5. Does the system of the documentation in place during emergencies meet requirements for insurance reimbursement, subsequent loans, funding from the Federal Emergency Management Agency (FEMA), payer funding, and/or other emergency funding?
6. Is the documentation sufficient to comply with reporting obligations to licensing agencies?

7. How will the organization's payroll records accurately capture the significant overtime provided in an emergency?
8. Are any supplies that are given out to the community or government authorities appropriately documented for subsequent reimbursement?
9. Do any state-statutory immunity provisions apply to recordkeeping during an emergency?
10. Have disaster funds been secured by proper declarations from the President, the governor, the Secretary of Agriculture, and/or the Secretary of Commerce as appropriate? (See Section VI (D), Declaration of an Emergency or Major Disaster, and Securing Disaster Funds).

F. Physical Plant and Facilities

It is important for a health care organization to assess any potential vulnerabilities with its physical plant and facilities, as well as to take appropriate measures to ensure the continuation of utilities, IT systems, communications, and other services necessary to maintain its operations.

1. If an IT system is judged to be mission-critical, is it on the electrical backup systems? Are the computers that need to access the system also on the backup systems?
2. What are the institution's emergency power capabilities? Are there any issues in accessing the emergency power if a mass blackout is caused for any reason?
3. Can the institution access portable generators? Might the placement of a portable emergency generator cause any street and/or zoning issues? Have the organization's personnel been trained in the proper operation of emergency generators?
4. Has the organization assessed potential vulnerabilities relating to the physical location of individual departments (e.g., placement of a data center in a basement location that may be subject to flooding)?

G. Civil Liability

When designing an emergency preparedness plan for a health care institution, it is likely that questions or concerns will be raised regarding the potential civil liability of health care entities or personnel who respond to an emergency. It is possible that state statutory immunity provisions may apply to such situations. Immunity provisions may be found

in state "Good Samaritan," emergency-management, or other statutes.

1. Does the appropriate jurisdiction(s) provide exemption from civil liability for emergency care as provided in a Good Samaritan act, emergency management laws, or other statutes?
2. Has the organization's medical staff and allied health practitioners been apprised of the applicable statutes and of their liabilities and immunities during an emergency situation?

V. LOGISTICS

The Logistics Section Chief arranges for the needed support to operations, including delivery of food and other supplies; assessment and safe use of the facility, if in question (e.g., following an earthquake or explosion); and for the equipment of rooms and alternate care sites if evacuation or relocation becomes necessary.⁴⁶

A. Personnel

In an emergency situation, some staff will need to remain on duty in order to maintain the continued functioning of the organization and provide patient care, while others may need to be released or evacuated. Plans should be in place to mobilize needed personnel while effectively moving non-essential staff away from the institution.

1. Who is responsible for notification of an emergency situation to the organization's employees and members of its medical staff? How is such notification carried out?
2. Are staging areas assigned for specific groups of employees?
3. Do the relevant employees know where those staging areas are?
4. How are the staging areas for off-campus locations (e.g., clinics, physicians, and back offices) coordinated?
5. How will the institution ensure that adequate personnel will be deployed, but not so many that the institution becomes overrun dealing with personnel instead of patients?
6. How is the information about available personnel at these off-campus locations communicated to the Incident Commander?

46. FIELD OPERATIONS GUIDE, *supra* note 13, at 9–3.

7. What occurs if one of the off-campus locations has its own demand for additional personnel to respond to the crisis? Does the institution's management plan contemplate a response from multiple locations?
8. Have issues of food and rest been contemplated in choosing the staging areas?
9. Is the institution prepared to provide places of rest for employees who are unable to return home (e.g., cots, physician examination tables, unoccupied beds and administrative offices, local motel rooms)?
10. Are these places of rest separate from patient care areas?
11. If employees will need to overstay their shift, is adequate food available onsite to feed them? If not, will the facility's usual food suppliers be able to access the institution in an emergency, or will the hospital need to seek alternate suppliers (e.g., local restaurant(s))?
12. How will the institution handle employees' need to contact their families?
13. Do the employees have family emergency plans in place?
14. How will the institution handle employees who need/demand to leave in order to safeguard their own families?
15. What occurs if certain employees demand to leave, but it may be unsafe to do so? How will the institution obtain information about the surrounding streets? How will it convey that information to its employees?
16. How will adequate staffing during the crisis be ensured? Does the organization have an emergency or contingency staffing plan in the event that personnel either are unable or unwilling to report to work? Is the organization aware of state-specific laws and regulations affecting personnel overtime or extended shifts?⁴⁷
17. How will the institution communicate to those of its employees who were not at the facility at the start of the crisis that they should or should not try to report to the facility?
18. How will the institution handle bringing personnel to the facility if the usual means of access is interfered with by the event (e.g., a blizzard or flood)?
19. How will the organization ensure the availability of contract or leased health care practitioners (who may have relationships with other institutions) during the emergency situation? Does the independent contractor or employee leasing agreement(s) contemplate alternative staffing arrangements in the event of an emergency? Do such agreements clearly delineate what duties the organization can require of contracted or leased employees during an emergency situation?
20. How will documentation of employee and contract health care practitioner overtime be documented, and how will such personnel records be protected?
21. How will the institution account for an employee who could not get to work and/or was not needed to respond (e.g., will the time away from the individual count as paid time off, or will her wages be docked)? What labor agreements may influence the thinking around this issue, and what do they say about it?
22. How will the institution demobilize its employees from their response?
23. Will some or all employees need to be debriefed in the aftermath of the emergency event?
24. Is an evacuation plan in place? Does the evacuation plan involve movement to particular sites? What assumption of liability does the institution assume when effecting such an evacuation?

B. Information Technology Infrastructure and Software Applications

An organization's agreements relating to IT infrastructure and software applications should take into account emergency response needs.

1. Do the institution's software licenses specifically authorize the regular backup of relevant software and the data, as well as the loading of the software in test, backup, and disaster recovery environments to protect the applications and data?
2. What, if any, redundancy is built into the institution's IT infrastructure?
3. Has the choice of the location of the institution's data center taken into account issues such as the age of the building's underlying infrastructure, access to emergency generator power, access to air conditioning, and related concerns, as well as the criticality of the applications to be run out of the center?

47. Note that state laws may limit mandatory overtime. See, e.g., Wash. Rev. Code § 49.28.140 (2004). State laws may also limit nurse-to-patient staffing ratios. See, e.g., CAL. HEALTH & SAFETY CODE § 1276.4 (2004); SEE ALSO ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME), COMMON PROGRAM REQUIREMENTS § VI (2003), available at www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf.

4. Will the IT emergency plan be effective in a “minor” disaster (e.g., a cut power line or datacenter flood) that is not primarily or initially an institution-wide issue?
5. Does the institution have in place disaster recovery sites and plans for its software applications?
 - a. Are its software applications and data backed up on a regular basis?
 - b. If the organization’s software applications generally are run on-site, is its disaster recovery site located off-site (or vice versa)?
 - c. Have the advantages and disadvantages of the locations of the organization’s primary software operations and disaster recovery sites been taken into account in the various contracting processes?
 - d. If the institution’s software applications are run in a Web-based or remote computing mode, is the vendor’s disaster recovery plan accessible to the institution, and has the institution reviewed that plan?
 - e. Based upon the review of the remote vendor’s disaster plan, is it necessary for the organization to separately contract for a disaster recovery site for that application, or can the primary agreement be considered to include a disaster recovery component?
 - f. If the institution is relying upon the disaster recovery plans of the remote vendor, will the institution be notified of any changes to that plan?
 - g. Does the institution have the negotiating leverage necessary to require its consent to any changes in the vendor’s disaster recovery plan? Does the institution have the expertise to exercise effectively its consent over a remote vendor’s disaster recovery plan, or is it better to rely on the vendor’s expertise in the particular instance?
- b. Does the facility’s emergency plan currently address maintaining continuity of IT services and recovery of IT services?
- c. For IT services provided in-house (if any), what type of backup systems does the facility have in place (e.g., redundant or “fail over” systems, personnel, skill sets; off-site data storage; off-site backup operations)?
- d. Has the facility identified potential failures in its IT operations?
- e. Has the facility developed detailed procedures for mitigating each of the potential failures?
- f. What plans does the facility have in place for ensuring that necessary IT personnel are available during and following emergencies?
- g. Has the facility established plans for communicating with key IT personnel (including vendor personnel) in case of an emergency, and for ensuring that they can communicate with each other?
- h. Has the facility tested its emergency plans and mitigation procedures at least annually?
- i. Have the vendor’s personnel participated in the emergency planning, mitigation procedures, and drills?

C. Developing Emergency Plans for IT Services

In preparing for emergencies, an organization’s goal should be to maintain continuity of critical IT services during and following the emergency and to have in place a disaster recovery plan that allows IT services to be re-established as quickly as possible.

1. What are the organization’s critical IT services?
 - a. How long can the organization afford to be without such IT services from the perspective of safety, cost, and other relevant considerations? In other words, what is the organization’s risk threshold for various IT functions?
2. For outsourced IT services, what additional issues require consideration by health care organizations?
 - a. What IT issues can/will the facility handle in the event of an emergency?
 - b. What issues does the organization expect its IT vendor(s) to handle?
 - c. Do the facility’s IT vendor(s) have emergency plans in place?
 - d. Do these plans specifically ensure that the facility’s IT services will be maintained during an emergency?
 - e. Has the facility coordinated its emergency IT plans with those of its vendor(s)?
 - f. Are the IT vendor’s emergency plans addressed in the contract between the facility and the vendor?
 - g. Has the facility established plans for communicating and coordinating with its IT vendor(s) in the event of an emergency?
 - h. Are these communication and coordination plans incorporated into the contract between the facility and the vendor?

D. Mitigation of ISP Failure

A specific element for consideration in relation to the facility's emergency IT planning is how to maintain Internet Service Provider (ISP) service during and following an emergency.

1. Does the facility maintain two separate ISP relationships in the event that one ISP fails? Does the organization prefer to have the second ISP arranged as a back-up service (in which case it will only be activated if the primary ISP fails), or does the facility wish to maintain two fully functioning ISPs at all times?
2. Does the organization maintain a service level agreement with its ISP provider(s) that guarantees immediate service if the facility experiences problems with the ISP? Does the agreement include a provision specifying the service that the organization expects to receive during and following an emergency?
2. How serious is the effect of having the facility's IT services unavailable?
3. Has the facility conducted a business analysis regarding the effects of losing its IT services, or is loss of IT services included in the HVA?
4. How much is the facility willing to spend to ensure that the continuity of IT services is maintained (*e.g.*, on a real-time basis; on a delayed response basis)?
5. Does the facility's IT vendor(s) maintain hot or cold sites that will be used to protect the facility's IT services?
6. Would it be less expensive to contract with an IT vendor to provide the facility with hot site or cold site backup, as opposed to contracting for the backup system directly?

E. Maintaining a Hot or Cold Site

The organization will need to decide whether to maintain a "hot site" for some or all IT services (either directly or through an IT vendor). A hot site is a physical location to which the facility can move its data operations and communications in the event of an emergency. The hot site will be configured to the facility's specifications, with computers, printers, Internet services, and work stations for staff. The hot site maintains the same data as is maintained at the facility, either through regular backups or through real-time synchronization. In case of an emergency, a hot site will allow the facility to restore operations within hours or days, depending on the level of service purchased.

A cold site, by contrast, generally does not allow for immediate restoration of data operations and communications. A cold site usually consists of pre-arranged contracts for the lease of computers, equipment, and space in an emergency, as well as off-site storage of data tapes. Although a cold site is a less expensive option, it will take more time for that site to become fully operational. The choice of whether to maintain a hot site, cold site, or some combination of the two, will depend on the facility's need to immediately restore data operations and communications in an emergency. Conducting a business analysis or HVA can help determine the facility's capacity to handle "down-time" in its data operations and communications and guide the selection of backup services and facilities.

1. For how long can the facility afford to be without its IT services?

VI. FINANCE

The Finance Section Chief makes arrangements to ensure the organization's continued financial health, from recording the cost of emergency response to arranging credit for needed supplies and coordinating financial arrangements for emergency operations, such as costs associated with relocating patients from an evacuated building.

A. Cash Flow

Regardless of whether they are operated on a for profit or nonprofit basis, health care institutions depend upon regular cash flow to remain operational. The majority of income for most health care institutions comes from patient insurance reimbursement (either private or government-sponsored). An emergency may interrupt the usual revenue cycle, either due to loss of the institution's computer system or a more general local or regional event. Accordingly, the continued financial operations of a hospital are dependent primarily on an ability to document and bill for services provided during an emergency in a manner that closely approximates the documentation that is used for usual operations.

1. Does the institution's emergency management planning establish how to conduct billing when the computer system (or other infrastructure components) is compromised? Can personnel print out blank screens from the computer system, complete them by hand, and then backload the data entry once the crisis passes?
2. If full documentation for billing purposes is not available, are methods for recordkeeping sufficient to retroactively establish services rendered, either (i) for

purposes of billing third-party payers who would accept billing based on such records and/or (ii) claims under business interruption insurance policies and/or governmental grant programs?

3. Are potential recordkeeping methods varied to enable a confirmation of services through multiple records?
4. To the extent that the institution needs to provide goods and supplies to other responders, has the institution determined how it will keep track of what has been provided, and at what cost, in order to obtain subsequent reimbursement from the party who received the goods or services (or from some other source)? Are the tools necessary to track such outgoing items (including, but not limited to, a pen and paper) available to the Logistics Section Chief during a response?

B. Patient Insurance Coverage

Health care organizations should review third-party payer agreements, as well as examine what other funding sources may exist to cover treatment rendered to patients during an emergency situation.

1. Do private health insurance policies provide for coverage for treatment mandated by public health authorities (e.g., in the case of isolation)?
 - a. Is such treatment covered by a private payer, Medicaid, Medicare, or the Federal Employees Health Benefits Program (FEHBP)?
 - b. Can a determination of medical necessity by a public health authority trump a determination to the contrary by a private payer?
 - c. Are prior authorization/precertification requirements waived in the event of a major disaster or emergency?
 - d. Do payer agreements contain a *force majeure* clause that references epidemics or other public health emergencies as excluded events?
 - e. Are Medicare Disproportionate Share (DSH) payments⁴⁸ or other similar funds available to cover the costs of this treatment if private-payer coverage falls short?
 - f. Can institutions address these issues in provider agreements with health plans?
2. What other funding sources are available to the institution?
 - a. Is business interruption insurance available?

- b. Does the county or state have funds to compensate an institution if private coverage is insufficient?
- c. Are federal funds available for any of the following:
 - Bioterrorism preparedness appropriations (and, if received, can the organization set aside these funds for cash flow interruption in an emergency);
 - New CMS funds appropriated in the Medicare Modernization Act for hospitals to aid hospitals providing uncompensated care; and/or
 - Post-event appropriations?
- d. Can the institution create a new funding stream through patient surcharges or other mechanisms?
- e. Are Red Cross funds available?
- f. If the institution is designated as an isolation or quarantine facility, are there plans (on a federal and/or state level) to provide compensation to facilities if revenues are adversely affected?

C. Institutional Insurance Coverage

Managing risk is an important part of ensuring continued viability and protection in the event of an unexpected occurrence for any business, including the provision of health care (or additional information on terrorism and natural disaster risk management, see *Appendix B*). Insurance plays a vital role in the management of risk by providing a mechanism for spreading that risk. Insurance allows businesses to accept what would otherwise be unacceptable risk.

1. Does the organization review its insurance coverage on a periodic basis?
 - a. What is the current level of coverage? What coverage is available? What are the institution's deductibles?
 - b. Is the organization subject to minimum coverage requirements for the different types of insurance?
 - c. How should the institution determine appropriate coverage levels? What resources/tools are available to aid assessment of risk/vulnerability?
 - d. What causes of loss are covered by the institution's policy? Are distinctions made between differing causes of loss (e.g., natural disaster vs. terrorism vs. naturally occurring bio-incident)? Must the emergency be publicly declared in order to make a claim under the insurance, or may other crises that trigger an interruption of one or more operations generate a claim?

48. See 42 C.F.R. §§ 412.106, 447.272(c)(2) (2004).

- e. Does the institution have a copy of the policy in an easily accessible location? Can the Finance Section Chief locate a copy in an emergency?
 - f. When was the institution's policy last reviewed? Does the institution have a policy in place for how often its coverage is reviewed?
 - g. What documentation is required to file a claim?
 - h. Have appropriate steps been taken to identify and protect vital records (*e.g.*, are copies of important records kept off-site, or in a safe place where they may be accessed easily following an emergency)? Are vital insurance records stored in a fireproof cabinet?
2. What property insurance is available?
 - a. What method will be used to value the insured property?
 - b. How does the institution's insurer evaluate preventive/mitigating action?
 - Does the policy allow for reduced premiums if preventative measures are taken?
 - Does the policy require mitigation of known risks?
 - c. Are recent improvements or additions insured? Must the organization notify the insurer to cover such improvements?
 - d. What costs are covered (*e.g.*, repair to pre-disaster condition; rebuilding; relocation costs)? Have sub-limits that may apply in an emergency been established (*e.g.*, flood or earthquake limits)? Are these limits adequate for recovery from a catastrophe, or will additional resources be required?
 3. What liability insurance coverage is available?
 - a. Could the institution be held liable to third parties for contributing to loss by failing to take appropriate protective measures or for negligence (*e.g.*, failure to take appropriate measures to prevent the spread of infection within the facility; failure to provide adequate evacuation routes)?
- b. What are the limits to the institution's liability coverage? If the limits are determined on a per-occurrence basis, how is an "occurrence" defined in the policy?
 - c. Should the institution consider an umbrella policy (*i.e.*, excess liability insurance) to protect it in the event of a large catastrophic loss?
4. What business interruption insurance is available?
 - a. How will the organization's lost business income be measured? What documentation is required to establish a loss?
 - b. Does the organization's policy specify a time period for coverage or is it covered until operations resume?
 - c. Is the organization covered if the business loss is not a result of insurable peril such as a fire?
 - *E.g.*, Loss of business income as a result of evacuation in response to civil authority in the event of a bio-terrorist attack?
 - *E.g.*, Loss of business income due to supplier interruption?
 - d. What costs are covered?
 - *E.g.*, Premium prices paid in order to maintain minimal operations or facilitate recovery; salaries; other operating expenses?
 - *E.g.*, workers' compensation; health and life insurance costs?

D. Declaration of an Emergency or Major Disaster, and Securing Disaster Funds

Large scale emergencies⁴⁹ and major disasters⁵⁰ are declared by the President of the United States, upon request from the governor(s) of the affected state(s), and must "be based on a finding that the [emergency or major] disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary."⁵¹ Less serious disasters can be declared by the Small Business Administration (SBA), which coordinates disaster assistance for

49. An "Emergency" for purposes of obtaining federal funding, is defined as "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States." 42 U.S.C. § 5122(1) (2004).

50. For purposes of obtaining federal funding, a major disaster is defined as "any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this chapter to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby." *Id.* § 5122(2).

51. *Id.* § 5170.

businesses.⁵² Business can apply for several types of disaster assistance loans (including pre-disaster mitigation loans), depending on the nature of the disaster and the amount of damage suffered.⁵³ Disaster assistance for individuals is coordinated through FEMA.⁵⁴

1. Has the President of the United States declared an emergency or major disaster, triggering federal response mechanisms (including SBA and FEMA)?
 2. Has the SBA declared a disaster, triggering the SBA disaster loan program?
 3. Is the organization located in the declared emergency or disaster area? If yes, is it located in a declared county or an adjacent county? (This may affect the type of SBA loan for which the business is eligible.)
 4. What type of assistance does the organization seek from state and federal agencies?
 - a. Is short term aid (e.g., supplies, personnel, debris removal, technical assistance) required? (This type of assistance is coordinated through FEMA.)
 - b. Are long term loans necessary? (Loans are coordinated through the SBA.)
 - c. Are federal equipment, supplies, facilities, personnel, and other resources indicated?
 - d. Is technical and advisory assistance to state or local governments needed?
 - e. Are medicine, food, and consumables needed? Will additional relief be required from disaster assistance organizations?
 - f. Are debris or wreckage removal; search and rescue; emergency medical care; emergency shelter; provision of food, water, and other essential needs; temporary facilities for schools and essential community services; demolition of unsafe structures; dissemination of public information; or technical advice necessary?
 - g. Are other hazard mitigation efforts warranted?
 - h. Are repair, restoration, and/or replacement of damaged facilities indicated?
 - i. Is establishment of temporary emergency communications systems desirable?
5. Is the institution considered a large or small business by federal standards? Large businesses are eligible for SBA Physical Disaster Business Loans,⁵⁵ but not Economic Injury Disaster Loans or Pre-Disaster Mitigation Loans.⁵⁶ Small businesses are eligible for all three types of loans.⁵⁷
 6. Is the institution eligible for loans from other sources that can be used for disaster assistance? If yes, then the business may not be eligible for SBA disaster assistance loans.⁵⁸ For additional information on securing federal disaster funds, see *Appendix C*.

52. See U.S. Small Business Admin., at Disaster Preparedness and Recovery Plan at www.sba.gov/sites/default/files/articles/FINAL%202014%20SBA%20Disaster%20Preparedness%20Plan.pdf [hereinafter Disaster Preparedness and Recovery Plan].

53. See 15 U.S.C. § 636(b) (2004).

54. See *id.* § 636(b)(1)(C); Disaster Preparedness and Recovery Plan, *supra* note 52.

55. U.S. Small Business Admin., Physical Disaster Business Loans, at www.sba.gov/content/business-physical-disaster-loans (last visited August 19, 2014) [hereinafter Physical Disaster Business Loans]; see also 13 C.F.R. § 123.200(a) (2004).

56. 13 C.F.R. § 121.302 (2004).

57. *Id.* § 123.200(a); see Physical Disaster Business Loans, *supra* note 55; U.S. Small Business Admin., Economic Injury Disaster Loans For Small Businesses, at www.sba.gov/content/economic-injury-disaster-loans (last visited August 19, 2014) [hereinafter Economic Injury Disaster Loans For Small Businesses]; U.S. Small Business Admin., Disaster Loan Program, at www.sba.gov/content/disaster-loan-program (last visited August 19, 2014) [hereinafter Disaster Loan Program].

58. 13 C.F.R. §§ 123.101(c), 123.201(a) (2004).

VII. RECOVERY: ENDING EMERGENCY OPERATIONS

This *Checklist* should provide legal counsel with the necessary tools to assist health care providers in preparing for an emergency and in facilitating the return of the organization from emergency operations to normal status as quickly as possible. The Planning Section Chief will spend considerable time planning for the transition back to routine activities, including demobilization of any additional resources implemented during the crisis. This recovery constitutes the fourth and final stage of emergency preparedness. The Recovery phase includes: implementing any necessary repairs; granting furloughs to staff who responded to the emergency; returning patients to previously closed units; submitting applications for available emergency relief funding; and similar steps. It is important to ensure that the organization has adequate staffing and resources to resume its ongoing operations.

Finally, debriefing from the emergency is an important step to obtain input with regard to “lessons learned” for use in the event of future crises. Administrative and clinical personnel alike should participate in debriefing the event, and the information gathered during debriefing and those gleaned from the records kept in the Command Center

should form the basis for the next round of preparation and mitigation—the first two phases of emergency planning. In this way, successfully concluding the response to (and recovery from) an emergency creates the opportunity for further improvement in readiness in anticipation of the unknown but inevitable next emergency.

* The authors wish to express their sincere appreciation to Lori L. Buchsbaum, and Tisha Bai for their assistance in preparing this publication. Additionally, the authors wish to thank Lori H. Spencer for her perspective on certain public health law issues, and Karl Dean Hendrick for his assistance in reviewing the footnotes to ensure all citations contained in this publication are accurate and authorities cited correctly.

VIII. SELECTED RESOURCES

1. MARK A. ROTHSTEIN, ET AL., INST. FOR BIOETHICS, HEALTH POL'Y AND LAW, UNIV. OF LOUISVILLE SCH. OF MED., QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS, A REPORT TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION (Nov. 2003).
2. LAWRENCE GOSTIN, GEORGETOWN UNIV. LAW CENTER, THE MODEL STATE EMERGENCY HEALTH POWERS ACT: PUBLIC HEALTH AND CIVIL LIBERTIES IN A TIME OF TERRORISM (2002 Working Paper Series In Public Law And Legal Theory And Law And Economics, Working Paper No. 346504, 2003).
3. GAO REPORT TO CONGRESSIONAL COMMITTEES, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORIST RESPONSE, GAO-03-924 (Aug. 2003).
4. THE JOINT COMMISSION, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR CREATING AND SUSTAINING COMMUNITY-WIDE EMERGENCY PREPAREDNESS SYSTEMS (2003).
5. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION, PUBLIC HEALTH GUIDANCE FOR COMMUNITY-LEVEL PREPAREDNESS AND RESPONSE TO SEVERE ACUTE RESPIRATORY SYNDROME, Supplement A Command and Control (Jan. 8, 2004).
6. EMERGENCY MANAGEMENT INSTITUTE, U.S. FIRE ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY, NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS), AN INTRODUCTION, at <http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-700.a> (Last visited August 19, 2014); North Carolina Hospital Association, Hospital Emergency Incident Command System, at <https://web.archive.org/web/20080820005729/http://www.ncha.org/public/docs/bioterrorism/HE-ICS.pdf>.
7. NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 1600 STANDARD ON DISASTER/EMERGENCY MANAGEMENT AND BUSINESS CONTINUITY PROGRAMS (2004) at www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=1600. (Last visited August 19, 2014).

Appendix A

APPLICATION OF EMTALA DURING A MAJOR PUBLIC HEALTH EMERGENCY

Certain events have raised questions regarding whether a provider's obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA)⁵⁹ might be modified or waived in the event of a major public health emergency.⁶⁰ On November 8, 2001, the Centers for Medicare & Medicaid Services (CMS) issued an informal policy statement in response to hospitals' inquiries regarding the extent of their EMTALA obligations following the fall 2001 anthrax incidents.⁶¹ Up to that point, administrative and case law involving EMTALA had not contemplated public health emergencies. The statute itself contains no suggestion that its obligations would vary in the face of a community-wide emergency; nevertheless, when such events began to seem more likely, concerns and questions arose.⁶² Although it reiterated to some extent the continued application of EMTALA's obligations, the 2001 CMS letter suggested that there was an exception to the stabilization requirement if a community response plan is in place.⁶³ Moreover, the letter indicated that a hospital's initial screening obligation might be limited if a community-response plan designated certain facilities to handle particular categories of patients in a bioterrorism situation and if the hospital in question is not such a designated facility.⁶⁴

The Public Health Security and Bioterrorism Preparedness and Response Act of 2002⁶⁵ articulated a more formal policy regarding EMTALA obligations in an emergency situation. The legislation authorized the Secretary of the Department of Health and Human Services (DHHS) to waive sanctions for EMTALA violations when the violation comes from an inappropriate transfer of an unstable patient in public health emergency circumstances (as defined by a presidential declaration). This potential limitation on EMTALA obligations during a public health emergency is more circumscribed than what the 2001 CMS letter suggested, as it does not indicate a reduction in the screening obligation (nor does it eliminate private individuals' right of action). The final EMTALA rule promulgated on September 9, 2003,⁶⁶ also addressed public health emergency situations. Similar to the 2001 CMS letter and the 2002 Public Health Security and Bioterrorism Preparedness and Response Act, this final rule did not answer definitely the question regarding the extent of EMTALA obligations in a crisis situation. The preamble to the rule references the 2001 CMS letter, and notes that the final rule adds a public health emergency provision to the EMTALA regulations.⁶⁷ The new provision states that "sanctions under EMTALA for an inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area. . . . In the event of such an emergency, CMS would issue appropriate guidance to hospitals."⁶⁸

59. Emergency Medical Labor and Active Treatment Act, 42 U.S.C. § 1395dd (2004).

60. Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. Med. & Ethics 590, 591 (2003).

61. Letter from Director, Survey and Certification Group, Ctrs. for Medicare and Medicaid Servs., to Regional Administrators, State Survey Agencies (Nov. 8, 2001) (Question and Answer Relating to Bioterrorism and the Emergency Medical Treatment and Labor Act), *available at* www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMS053467.html (last visited August 20, 2014) [hereinafter Letter to Regional Administrators].

62. New indications that hospitals are not adequately prepared for bioterrorism or similar incidents have heightened such concerns. *See* THE JOINT COMMISSION, HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR CREATING AND SUSTAINING COMMUNITY-WIDE EMERGENCY PREPAREDNESS SYSTEMS, *available at* www.jointcommission.org/assets/1/18/emergency_preparedness.pdf; U.S. GENERAL ACCOUNTING OFFICE, HOSPITAL PREPAREDNESS: MOST URBAN HOSPITALS HAVE EMERGENCY PLANS BUT LACK CERTAIN CAPACITIES FOR BIOTERRORISM RESPONSE, GAO-03-924, at 1 (Aug. 2003), *available at* www.gao.gov/new.items/d03924.pdf.

63. Letter to Regional Administrators, *supra* note 61.

64. *Id.*

65. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified as amended in scattered sections of 7, 21, 29, 38, 42, 47 U.S.C.).

66. Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53,222 (Sept. 9, 2003) (codified at 42 C.F.R. pts. 413, 482, 489).

67. *Id.* at 53,257.

68. *Id.*

CMS Interpretive Guidelines issued to State Survey Agency Directors on May 13, 2004,⁶⁹ seemed to restate the position taken in the 2001 CMS letter. Referencing the new regulatory provision implemented with the 2003 final rule,⁷⁰ the guidelines state that, in the event of a national emergency or crisis, if state or local governments have implemented community response plans designating certain facilities to handle particular categories of patients, then hospitals in the area that are not designated facilities must still provide a medical screening exam, but may then transfer patients in those categories to a designated facility without triggering EMTALA sanctions.⁷¹ The Project Bioshield Act of 2004, signed into law on July 21 of that year, contains a brief provision relating to EMTALA's screening obligations, allowing the DHHS Secretary to waive standard EMTALA requirements and allow for "the direction or relocation of an individual to receive medical screening in an alternate location pursuant to an appropriate State emergency preparedness plan."⁷²

69. Letter from Director, Survey and Certification Group, Ctrs. for Medicare and Medicaid Servs., to State Survey Agency Directors (May 13, 2004) (Revised Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines), *available at* www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter04-34.pdf [hereinafter Letter to State Survey Agency Directors].

70. 42 C.F.R. § 489.24(a)(2) (2004).

71. Letter to State Survey Agency Directors, *supra* note 69, at 31.

72. Project Bioshield Act of 2004, Pub. L. No. 108-276 § 8, 118 Stat. 835, 864 (codified as amended at 42 U.S.C. § 1320b-5).

Appendix B

RISK MANAGEMENT CONSIDERATIONS

Terrorism Risk Management

Individuals and businesses typically purchase insurance coverage from direct insurers. Direct insurers write the policies, collect the premiums, and pay claims to the insured. Reinsurers, on the other hand, provide some protection from exposure for direct insurers by acting as insurance for the direct insurers. Following the attacks on September 11, 2001, the majority of the property and liability loss was passed on to reinsurers. As a result, reinsurers began excluding terrorism risk from their policies, which led direct insurers to begin taking similar actions. Currently, state insurance regulators *require* direct insurers to offer terrorism risk insurance. Reinsurers, who are not regulated by state insurance commissioners, however, are not required to provide reinsurance for terrorism risk, creating a major weakness in the support structure of the insurance industry.

In late 2002, the Terrorism Risk Insurance Act⁷³ (TRIA) was enacted. The act's enumerated purposes are "to address market disruptions, ensure the continued widespread availability and affordability of commercial property and casualty insurance for terrorism risk, and to allow for a transition period for the private markets to stabilize and build capacity while preserving State insurance regulation and consumer protections."⁷⁴ The Act's "make available" provision found in § 103(c) requires all entities that meet the act's definition of insurer to "make available" in their "property and casualty insurance policies, coverage for insured losses resulting from an act of terrorism."⁷⁵ This coverage cannot differ materially in form from coverage applicable to losses arising from other events.

The Terrorism Risk Insurance Program places the federal government in the role of reinsurer.⁷⁶ However, several limitations apply. Under the act, the federal government only reimburses insurers for a portion of their "insured losses"⁷⁷ resulting from certified "acts of terrorism."⁷⁸ The "act of terrorism" must meet specific requirements including commission "by individual(s) on behalf of any foreign person or foreign interest, as part of an effort to coerce the U.S. civilian population or to influence the policy or affect the conduct of the U.S."⁷⁹ Thus, acts of domestic terrorism are excluded.

Although the act's definition of "insured loss" does not exclude losses from nuclear, biological, or chemical perils, losses resulting from certified acts of terrorism involving those perils are only covered "if the coverage for those perils is provided in the primary or excess property and casualty policy issued by [the institution's] insurer."⁸⁰ The act does not prohibit an insurer from excluding coverage for nuclear, biological, or chemical perils if the same exclusions are also applied to losses arising from events other than acts or terrorism, and if the exclusion is permitted by state law.⁸¹ Although TRIA temporarily⁸² ensures the availability of some coverage for losses due to terrorism, the act is not comprehensive even in the limited terrorism-risk insurance arena.

73. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, 116 Stat. 2322 (codified in scattered sections of 12, 15, 28 U.S.C.).

74. *Id.* § 101(b), 116 Stat. at 2323.

75. *Id.* § 103(c), 116 Stat. at 2327.

76. The Federal "reinsurance" is 90% of covered losses that exceed an insurer's deductible. This share is subject to an annual industry aggregate limit of \$100 billion. The insurer's deductible is based on an insurance company's earned premiums from the previous calendar year. *Id.* § 103(e)(1)(A), 116 Stat. at 2328.

77. The Act defines "insured loss" as any loss resulting from an "act of terrorism." Terrorism Risk Act of 2002 § 102(5), 116 Stat. at 2325.

78. Under the Act, the "act of terrorism" must be certified as such by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General. 31 C.F.R. § 50.5(b) (2004).

79. Additionally, the act must "be a violent act or an act that is dangerous to human life, property, or infrastructure;" must occur in the United States or abroad in the case of air carriers, vessels, or missions; and must result in damages in excess of \$5 million. *Id.* An act cannot be certified if it occurs in the course of a "war declared by Congress" (except for workers' compensation coverage). *Id.*

80. Interpretive Letter from Jeffrey S. Bragg Executive Director of Terrorism Risk Insurance Program, to Mr. D. (Mar. 24, 2004), *available at* <https://web.archive.org/web/20090110143720/http://treasury.gov/offices/domestic-finance/financial-institution/terrorism-insurance/pdf/redactedci.pdf>.

81. *Id.*

82. See Terrorist Risk Insurance Reauthorization Act, Pub. L. No. 110-160, §108, 121 Stat. 1839. (stating that the Terrorism Risk Insurance Act of 2002 will terminate in December 2014).

Natural Disaster Risk Management

Historically, disasters not related to terrorism have been the primary cause of public health emergencies. Natural disasters (e.g., earthquakes, floods, hurricanes, and tornadoes) may have a devastating effect on businesses. According to the Insurance Information Institute, more than 30% of businesses never re-open following closure due to hurricane, tornado, flood, or other disaster.⁸³ Commercial property insurance and business interruption insurance typically will provide the two main sources of protection for the institution in the event of a natural disaster. Property insurance will cover the cost of damage repairs, while business interruption insurance will cover the loss of business income.

Two types of business interruption coverage are available: named perils and all-risk policies. The former provides protection only for specifically named perils, while the latter provides coverage for all perils *except* those specifically excluded. The two types of insurance generally are purchased as a package, and the same perils will be covered under both policies. It is important to note that two common exceptions to property insurance are earthquake and flood damage. Coverage for these events typically can be added for additional fees. In fact, in certain areas, flood insurance may even be required.⁸⁴ Ensuring adequate insurance coverage is an important means to survival following disaster.

83. Press Release, Insurance Information Institute, Can Your Business Survive a Natural Disaster? Advance Planning, Proper Insurance are Essential (Apr. 13, 2004), available at www.iii.org/press-release/can-your-business-survive-natural-disasteradvance-planning-proper-insurance-are (last visited August 20, 2014).

84. Flood insurance is underwritten by the National Flood Insurance Program, which is managed by the Mitigation Division of the Federal Emergency Management Agency. In areas deemed by the National Flood Insurance Program to be at high risk for flooding, flood insurance is a prerequisite to obtaining secured financing to buy, build, or improve structures. See Fed. Emergency Mgmt. Agency, Flood Hazard Mapping, Insurance Professionals and Lenders, at www.fema.gov/plan/prevent/fhm/index.shtml (last visited August 20, 2014); Fed. Emergency Mgmt. Agency, Mitigation Division, at www.fema.gov/government/mitigation.shtml (last visited August 20, 2014); NAT'L FLOOD INSURANCE PROGRAM, PROGRAM DESCRIPTION, MANDATORY FLOOD INSURANCE PURCHASE REQUIREMENT 29 (Aug. 1, 2002), available at www.fema.gov/media-library-data/20130726-1447-20490-2156/nfipdescrip_1_.pdf.

Appendix C

SECURING DISASTER FUNDING

Disaster assistance for businesses is coordinated through the Small Business Administration (SBA).⁸⁵ In order to qualify, the business must be in a declared disaster area.⁸⁶ Two types of disaster declarations activate SBA disaster assistance efforts: Presidential Declaration and SBA Declaration.⁸⁷ A Presidential Declaration is made when damages are significant. In the case of a Presidential Declaration, “SBA offers physical and economic injury loans in the declared counties and economic injury (EI) loans only in contiguous counties. . . . If the damages are less extensive, the Governor can ask for a SBA declaration.”⁸⁸ Two types of SBA declarations may be made: Physical Disaster Declaration and Economic Injury Declaration. The SBA makes three types of disaster assistance loans to business,⁸⁹ and individual assistance is coordinated through FEMA.

1. *Physical Disaster Business Loans.* These loans cover uninsured physical damages.⁹⁰ Any business located in a declared disaster area that incurred damage during the disaster may apply for a loan to help repair or replace damaged property (e.g., real property, machinery, equipment, fixtures, inventory, and leaseholds) to its pre-disaster condition.
2. *Economic Injury Disaster Loans.* These loans are provided to small businesses located in a declared disaster area that suffer substantial economic injury, regardless of *physical* damage.⁹¹ “Small businesses and small agricultural cooperatives that have suffered substantial economic injury resulting from a physical disaster or an agricultural production disaster designated by the Secretary of Agriculture may be eligible for the SBA’s Economic Injury Disaster Loan Program. Substantial economic injury is the inability of a business to meet its obligations as they mature and to pay its ordinary and necessary operating expenses.”⁹²
3. *Pre-Disaster Mitigation Loans.* These low-interest, fixed-rate loans are made to small businesses for mitigation measures to protect business property from damage that may be caused by future disasters.⁹³ “A mitigation measure is something done for the purpose of protecting real and personal property against disaster-related damage. Examples of mitigation measures include retaining walls, sea walls, grading and contouring land, elevating flood-prone structures, relocating utilities, and retrofitting structures against high winds, earthquakes, floods, wildfires, or other disasters.”⁹⁴ The Pre-Disaster Mitigation Loan program is a pilot program designed to support FEMA’s Pre-Disaster Mitigation Program. Loans are made available to businesses which propose mitigation measures that conform to the priorities and goals of the community in which the business is located (as defined by FEMA).

85. See U.S. Small Business Admin., About Small Business Administration, at www.sba.gov/aboutsba/index.html (last visited August 20, 2014).

86. See 13 C.F.R. §§ 123.2-123.3 (2004); Understanding How Disaster Declarations Are Made, *supra* note 52.

87. See 13 C.F.R. § 123.3; Understanding How Disaster Declarations Are Made, *supra* note 52.

88. Understanding How Disaster Declarations Are Made, *supra* note 52.

89. 13 C.F.R. § 123.5 (2004).

90. See *id.* §§ 123.200-123.204; Physical Disaster Business Loans, *supra* note 55.

91. See www.sba.gov/content/economic-injury-disaster-loans (last visited August 20, 2014); 13 C.F.R. 123.300-123.303.

92. Economic Injury Disaster Loans For Small Businesses, *supra* note 57.

93. See 13 C.F.R. § 123.400; Pre-Disaster Mitigation Loan Program, *supra* note 57.

94. Pre-Disaster Mitigation Loan Program, *supra* note 57.

4. *Individual Disaster Assistance.*⁹⁵ Disaster assistance for individuals is coordinated through FEMA. Individuals apply for most assistance directly through FEMA. To apply for SBA loans, individuals who are homeowners or renters must first register with FEMA to obtain a FEMA Registration ID number. FEMA generally establishes local Disaster Recovery Centers to coordinate assistance. After an application for assistance is received, the damaged property is inspected to verify the loss.⁹⁶ The deadline for most individual assistance programs is sixty days following the president's declaration of a major disaster.⁹⁷ Affected individuals may apply for disaster aid consisting of:
- Disaster housing;⁹⁸
 - Funding for housing repairs and replacement of damaged items needed to make homes habitable;⁹⁹
 - Disaster grants to cover necessary expenses not covered by insurance and other aid programs, including replacement of personal property, transportation, medical care, dental care, and funeral expenses;¹⁰⁰
 - Low-interest disaster loans for repair or replacement of homes, automobiles, clothing, or other damages to personal property (loans are administered through the Small Business Administration);¹⁰¹
 - Crisis counseling;¹⁰²
 - Disaster-related unemployment assistance;¹⁰³
 - Legal aid and assistance with income tax, Social Security, and veteran's benefits;¹⁰⁴ and
 - Hazard mitigation.¹⁰⁵

95. See Fed. Emergency Mgmt. Agency, Individual Assistance Programs, at www.fema.gov/individual-assistance-program-tools (last visited August 20, 2014).

96. See FED. EMERGENCY MGMT. AGENCY, HELP AFTER A DISASTER 4 (July 2008), at www.fema.gov/help-after-disaster (last visited August 20, 2014).

97. Fed. Emergency Mgmt. Agency, Region IV, Ten Days Remain for Disaster Aid, Oct. 16, 1998, at https://web.archive.org/web/20030204215216/http://www.fema.gov/regions/iv/1998/r4_095.shtm (last visited August 20, 2014).

98. See 42 U.S.C. § 5174(b) (2004).

99. *Id.* § 5174(c).

100. *Id.* § 5174(e).

101. Fed. Emergency Mgmt. Agency, *supra* note 95.

102. 42 U.S.C. § 5183 (2004).

103. *Id.* § 5177(a).

104. See Fed. Emergency Mgmt. Agency, *supra* note 95.

105. *Id.*

Appendix D

DIRECTORIES OF STATE AND TERRITORIAL PUBLIC HEALTH DIRECTORS, STATE PUBLIC HEALTH LEGAL COUNSEL, AND CDC EMERGENCY-PREPAREDNESS CONTACTS

1. Directory of State and Territorial Public Health Directors, *updated version available at www.astho.org/Directory/* (last visited August 20, 2014).
2. Directory of State Public Health Legal Counsel, *updated version available at www.cdc.gov/php/contact/counsels_map.html* (last visited August 20, 2014).
3. Emergency Preparedness Contacts: Centers for Disease Control and Prevention, *updated information available at www.cdc.gov/nceh/emergency/default.htm* (last visited August 20, 2014).

Appendix E

SELECTED PUBLIC HEALTH EMERGENCY-PREPAREDNESS STANDARDS AND PLANS

1. Smallpox Response Plan and Guidelines (V3.0), Executive Summary and Sections A-F, *full and updated version available at www.bt.cdc.gov/agent/smallpox/response-Plan/index.asp* (last visited August 20, 2014).
2. Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (V2/3), Supplement C: Preparedness and Response in Health care Facilities, *full and updated version available at www.cdc.gov/sars/guidance/* (last visited August 20, 2014).
3. Pandemic Influenza Preparedness Plan, Executive Summary, *full and updated version available at www.flu.gov/planning-preparedness/federal/hhspandemicinfluenzaplan.pdf*.

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