

2010
HOSPITALS' GUIDE FOR
MASS CASUALTY EVENTS

By



UPDATED

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FOREWORD

This updated, complimentary copy of the *2010 Hospitals' Guide for Mass Casualty Events* ("Guide") brings hospitals the latest, and the most up-to-date information on various state and federal laws and regulations addressing mass casualty issues. This Guide is a result of a collaborative effort between Hall, Render, Killian, Heath & Lyman P.C., the Wisconsin Hospital Association, and the Wisconsin Department of Health Services under a grant from the United States Department of Health and Human Services.

This Guide provides a variety of practical information designed to serve as a resource for Wisconsin hospitals as they prepare for, and consider the legal implications, of providing health care services during a mass casualty event. It includes significant updates in the areas of employment, organization and logistics of emergency response, control of communicable diseases, and compliance. The Guide also addresses important issues, such as altered standards of care and resource allocation during mass casualty events, and builds on the experiences and lessons learned from Hurricane Katrina and the novel H1N1 influenza pandemic of 2009.

Although this Guide provides an overview of issues for your consideration, keep in mind that many legal issues and questions remain unanswered. Future mass casualty events will likely test Wisconsin hospitals' preparedness and response capabilities – essentially putting into practice and operationalizing what has taken years to establish. This Guide is designed to assist hospitals as they prepare and respond to such events; however, it should not be considered legal advice. In addition, because laws, regulations, and rulings change frequently, readers of this Guide should not rely on the currency, applicability, or accuracy of its content without full consultation with legal counsel.

We extend a sincere thank you to Bill Bazan, the Wisconsin Hospital Association's Vice-President – Metro Milwaukee, and Dennis Tomczyk, the Wisconsin Department of Health Services Hospital Preparedness Director, for their commitment to emergency preparedness and providing Wisconsin hospitals with an updated, comprehensive legal resource for addressing the many important issues surrounding mass casualty events. We also wish to thank our Hall Render colleagues for sharing their expertise and for contributing in many ways, including cite checking, drafting, and editing this Guide, in order to provide a roadmap that hospitals can turn to as they prepare for and respond to future mass casualty events.

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CHAPTER ONE

EMPLOYMENT ISSUES

I. WAGES AND HOURS.

A. Introduction.

Section I of Chapter One discusses both federal and Wisconsin wage and hour laws in general and with a specific emphasis on questions relating to circumstances that may arise during a mass casualty event.¹ The major legal areas addressed in this section are: (1) ensuring compliance with minimum wage and overtime laws; (2) properly categorizing workers as exempt or non-exempt; (3) determining whether a joint employment relationship exists; and (4) properly calculating hours worked and deductions from paychecks.

Section I anticipates wage and hour issues that may arise during or after a mass casualty event and provides suggestions on how to avoid wage and hour violations or lessen their burden. The specific issues include: (1) identifying states and cities where minimum wage and/or overtime requirements may be different; (2) identifying those jobs for which it will be necessary to hire additional workers or obtain needed help by other means and classify the jobs into exempt and non-exempt categories; (3) determining whether or not an employer can require employees to work overtime; (4) determining whether a joint employer relationship exists for overtime purposes; and (5) determining how to calculate “hours worked” for out of the ordinary situations such as traveling to alternative treatment sites.

Both federal law and Wisconsin law govern wages and hour issues. Wisconsin laws governing this topic are referred to as Wisconsin wage and hour laws, and the federal laws in this area are collectively referred to as the Fair Labor Standards Act of 1938, 29 U.S.C. § 201 *et seq.* (“FLSA”). The FLSA does not supersede Wisconsin wage and hour law to the extent that Wisconsin law is more stringent. Therefore, employers covered by both laws must comply with state and federal requirements and must establish policies in accordance with whichever standard is more protective of the employee’s rights.

All hospitals within Wisconsin are likely considered employers under the FLSA and Wisconsin wage and hour laws. Under the FLSA, an employer means any person acting directly or indirectly in the interest of an employer in relation to an employee and includes a public agency. 29 U.S.C. § 203(d). Under Wisconsin wage and hour laws, any person that has control or direction over any person employed at any type of labor or that is responsible directly or indirectly for the wages of another is considered an employer. Wis. Admin. Code § DWD 272.01(5)(a). Based on these definitions, a hospital will be considered an employer under both federal and state law, and is obligated to follow the requirements of each with respect to its employees. However, to the extent that any individuals who work or may work for the hospital are volunteers or independent contractors, state and federal laws, rules and regulations regarding wage and hour issues may not apply to those relationships. Section IV of Chapter One will address the different tests to apply in order to determine whether a worker may be

¹ The terms disaster, emergency, and mass casualty event are used interchangeably throughout this Chapter.

considered an independent contractor. An individual will be considered a volunteer under the FLSA if the individual (1) performs hours of service for a public agency for civic, charitable, or humanitarian reasons, without promise, expectation, or receipt of compensation for services rendered; although a volunteer can be paid expenses, reasonable benefits, or a nominal fee to perform such services; (2) offers services freely and without pressure or coercion; and (3) is not otherwise employed by the same public agency to perform the same type of services as those for which the individual proposes to volunteer. 29 C.F.R. § 553.101. For the purposes of Section I of Chapter One, it is important to remember that all of the obligations discussed only apply to those workers who are employees.

B. Minimum Wage Laws.

Both the FLSA and Wisconsin wage and hour laws set forth minimum wage rates and requirements. In instances where the laws do not parallel each other, employers should follow the law that is most favorable to the employee. Although the FLSA exempts some classes of employees from its minimum wage requirements (executives, administrative personnel, teachers, etc.) Wisconsin law generally does not.² 29 U.S.C. § 213(a)(1). Therefore, this is an instance in which Wisconsin law generally governs. Wisconsin's minimum wage requirements apply to all employees whether paid on a time, piece rate, commission or other basis. Wis. Admin. Code § DWD 272.02. The following schedules set forth the respective minimum wages according to federal and Wisconsin laws as of June, 2010.

Federal minimum wage:

- \$7.25 per hour — regular employee.
- \$4.25 per hour — opportunity employee.³
- \$2.13 per hour — tipped employees.

Wisconsin minimum wage:

- \$7.25 per hour — regular employee.
- \$5.90 per hour — opportunity non-tipped employee.
- \$2.33 per hour — non-opportunity tipped employee.
- \$2.13 per hour — opportunity tipped employee.

Probably the greatest challenge related to wage and hour law that may occur during any response to a mass casualty event is determining which minimum wage laws apply if a hospital receives assistance from persons in other states and territories and/or sends its employees to another city or state to work. In those circumstances, the hospital must compare the federal rates with that particular state's rate. It is unlikely that a hospital would need to pay anything other than the Wisconsin minimum wage, unless the federal rate is higher, even if it engages employees from other states to work in Wisconsin. However, if a hospital in Wisconsin sends its employees to work in other states, it most likely must follow the other states' minimum wage

² The Wisconsin Administrative Code does provide for some exemptions, such as house-to-house newspaper salespersons, however, none of them are likely to be applicable during a mass casualty event.

³ Opportunity employees are persons under 20 years of age during their first 90 consecutive days of employment.

rates. For example, the Illinois minimum wage rate is \$8.00 per hour as of July 1, 2009 and will be \$8.25 as of July 1, 2010.⁴

C. Overtime Laws.

Hospitals are also covered by both federal and Wisconsin overtime laws. Generally, employers are required to pay overtime to non-exempt employees,⁵ at a rate of not less than one and one-half times the employee's "regular rate of pay" for all hours worked in excess of 40 hours per week. 29 U.S.C. § 207(a); Wis. Admin. Code § DWD 274.03. The FLSA and the Wisconsin Administrative Code contain a special exemption to the 7-day workweek for employers in the health care industry. Health care employers have the option of utilizing an 80-hour workweek period. Instead of calculating overtime pay on a 7-day, 40-hour workweek, the employer may calculate it on a 14-day, 80-hour workweek. In order to comply with the law, there must be an agreement between the employer and employee to that end before the performance of the work; and, more importantly, if an 80-hour workweek is selected, employees must receive overtime wages for any hours worked in excess of 8 hours per day. 29 C.F.R. § 778.601; Wis. Admin. Code § DWD 274.04(10). Unless the employer has chosen to use an 80-hour workweek, it is not required to pay overtime compensation for hours in excess of 8 per day, or for work on Saturdays and Sundays, holidays, or regular days of rest, as long as an employee's total hours per week do not exceed 40. 29 C.F.R. § 778.102; Wis. Admin. Code § DWD 274.03. Neither federal nor Wisconsin law limits the number of hours over 40 that an employee may work per week. 29 C.F.R. § 778.102.⁶ However, Wisconsin requires that "no person shall be employed or be permitted to work in any place of employment for such periods or period of time during any day, night, or week as shall be dangerous or prejudicial to the life, health, safety or welfare of such person." Wis. Admin. Code § DWD 274.02(1); see also OSHA general duty clause, 29 U.S.C. § 654(a)(1) discussed in Section VI of Chapter One.

Many hospitals may desire to require employees to work mandatory overtime during and/or after a mass casualty event. There is no legal impediment found in the wage and hour laws against a hospital requiring its employees to do so. The hospital must simply pay these individuals according to the standards previously outlined and make sure not to endanger the safety and life of its employees. There may be legal impediments outside wage and hour laws, however, to a hospital's authority to require its employees to work overtime. Examples include employment contracts, collective bargaining agreements, and an employee handbook that arguably acts as a contract. Additionally, there are practical matters that a hospital may have difficulty overcoming during a mass casualty event, such as employees who desire to stay with their families or employees who are simply unable to make it to work because of an obstructed roadway. Therefore, it is always a good idea to forewarn employees of what will be expected of

⁴ Minnesota - \$6.15 (large employer-enterprise with annual receipts of \$625,000 or more); \$5.25 (small employer - enterprise with annual receipts of less than \$625,000); Michigan \$7.40, Indiana \$7.25 and Iowa \$7.25 per hour. Employers should also determine whether cities or counties within the state have their own minimum wage laws/ordinances.

⁵ See Section I(D) of this Chapter for a discussion on whether an individual qualifies as an exempt or non-exempt employee.

⁶ Wisconsin law requires one day of rest in seven for employers operating factories or mercantile establishments in the state of Wisconsin. See Wis. Stat. § 103.85 and Wis. Admin. Code § DWD 275. However, this restriction obviously does not apply to hospitals.

them during a mass casualty event, in order to make it more likely that the hospital will receive the help it needs.

D. Exempt Versus Non-Exempt Employees.

Overtime requirements only apply to those individuals who are non-exempt employees. 29 U.S.C. § 207(j); 29 C.F.R. § 778.601. Both Wisconsin and federal law set forth categories of exempt employees and provide tests to determine whether a certain employee is exempt from the payment of overtime wages. Exempt employees receive a weekly salary which is intended to cover all work done within a certain period, regardless of how little or how much time may be required to complete the work. Various exemptions exist, but those most likely to be applicable to hospitals include executives, administrative and professional employees.

In order to be classified as an exempt employee, the employee must be paid a certain minimum amount and on a “salaried basis.” An employee will be considered to be paid on a “salaried basis” if he or she regularly receives each pay period, on a weekly or less frequent basis, a predetermined amount constituting all or part of the employee’s compensation, which amount is not subject to reduction because of variations in the quality or quantity of the work performed. 29 C.F.R. § 541.602. Subject to some exceptions, the employee must receive his or her full salary for any week in which the employee performs any work without regard to the number of days or hours worked. This policy is also subject to the general rule that an employee need not be paid for any workweek in which the employee performs no work. *Id.*

Once it has been established that the employee is paid on a salaried basis, the employee must also satisfy the criteria for exemption as an executive, administrative, or professional employee. *See* 29 C.F.R. Part 541. There are some significant differences between state and federal law here. Mainly, the FLSA is more restrictive with respect to the minimum salary requirement and Wisconsin is more restrictive with respect to the duties tests. In addition, Wisconsin does not recognize the FLSA exemption for computer employees and highly compensated employees. To assist in analyzing the various standards, below is a chart that discusses the various exemptions.

Executive Employee Exemption

State Rule⁷	Federal Rule⁸	Most Stringent
Monthly Minimum Salary of \$700	Weekly Minimum Salary of \$455	Federal rule
Primary duty of the management of the enterprise or a recognized department or subdivision.	Primary duty of the management of the enterprise or recognized department or subdivision. In some instances, the federal rule would allow someone whose principal duty was the management of the enterprise even though the person might not be primarily engaged as a manager or supervisor.	State rule
Customarily and regularly directs the work of two or more other employees.	Customarily and regularly directs the work of two or more other employees.	Same
Has authority to hire or fire other employees (or recommendations as to fire, hire, promotion or other change of status of other employees are given particular weight).	Has authority to hire or fire other employees (or recommendations as to fire, hire, promotion or other change of status of other employees are given particular weight).	Same
Customarily and regularly exercises discretionary powers.	Customarily and regularly exercises discretionary powers.	Same
Does not devote more than 20% (40% in retail or service establishments) of work time to activities that are not directly and closely related to exempt work.	Usually the position spends more than 50% of work time on exempt work but in some positions the exempt work may be their principal or most important duties but not account for 50% of their work time.	State rule

⁷ Wis. Admin. Code § DWD 274.04(1)(a).

⁸ 29 C.F.R. § 541.100(a).

Administrative Employee Exemption

State Rule⁹	Federal Rule¹⁰	Most Stringent
Monthly Minimum Salary of \$700	Weekly Minimum Salary of \$455	Federal rule
Primary duty of performing office or non-manual work directly related to management policies or general business operations of the employer or the employer's customers.	Primary duty of performing office or non-manual work directly related to management policies or general business operations of the employer or the employer's customers.	Same
Customarily and regularly exercises discretion and independent judgment.	Customarily and regularly exercises discretion and independent judgment.	Same
Other duties include: (a) Regularly and directly assists a proprietor, exempt executive or exempt administrative employee. (b) Performs work along specialized or technical lines requiring special knowledge, experience or training under only general supervision. (c) Executes special assignments and tasks under only general supervision.	N/A	State rule
Does not devote more than 20% (40% in retail or service establishments) of time to activities that are not directly and closely related to exempt work.	With most positions, will devote no more than 50% of time to activities not directly and closely related to the above duties. In some positions, however, the individual may spend more than 50% of their work time on other duties but their principal or most important duties will be those listed above.	State rule

⁹ Wis. Admin. Code § DWD 274.04(1)(b).

¹⁰ 29 C.F.R. § 541.200.

Learned Professional Employee Exemption

State Rule¹¹	Federal Rule¹²	Most Stringent
Monthly Minimum Salary of \$750	Weekly Minimum Salary of \$455	Federal rule
Primary duty of performing work requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study.	Primary duty of performing work requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study but which also may be acquired by alternative means such as an equivalent combination of intellectual instruction and work experience.	State rule
Consistently exercises discretion and judgment.	Includes work that requires the exercise of discretion and independent judgment.	State rule
Performs work that is predominantly intellectual and varied in character that the output produced or result accomplished cannot be standardized in relation to a given period of time.	N/A	State rule
Does not devote more than 20% of time to activities that are not an essential part of and necessarily incident to exempt work.	N/A	State rule

Many hospital employees do not meet the above qualifications and thus, would not fall within one of the exempt categories. The regulations interpreting the FLSA also specifically recognize certain types of employees as non-exempt. For example, under the FLSA regulations, emergency medical technicians, ambulance personnel, rescue workers, hazardous materials workers, and similar workers regardless of rank or pay level, who perform work such as preventing, controlling or extinguishing fire of any type or rescuing fire, crime, or accident victims are considered non-exempt. 29 C.F.R. § 541.3(b)(1). While Wisconsin does not have a similar explicit distinction for these workers, it is likely that those workers individually noted in the FLSA would also be classified as non-exempt under Wisconsin law.

In anticipation of a possible mass casualty event, it is helpful for a hospital to identify those job functions for which it will be necessary to hire additional workers or obtain needed help by other means. One option is for hospitals to acquire help from independent contractors or workers from temporary help agencies because the wage and hour laws do not apply to independent contractors; in many instances, the temporary help agency will be considered the

¹¹ Wis. Admin. Code § DWD 274.04(1)(c).

¹² 29 C.F.R. § 541.300.

primary employer for wage and hour purposes and will, therefore, be responsible for adhering to the wage and hour laws.

With respect to those individuals a hospital reasonably anticipates it may need to hire in order to provide assistance during a mass casualty event, it would be helpful to pre-classify these positions into non-exempt and exempt categories using the parameters set forth in this text. This will aid in the ability to easily determine permissible deductions (as set forth in Section I(E) of Chapter One) and/or basis of pay and overtime requirements. The following chart is an example of categorizations. It is not meant to encompass all the hospital needs. Additionally, because the tests for exemptions do not focus on the title of a particular position, rather the individual job description and the worker's particular experience, each hospital must analyze its own job descriptions individually.

Anticipated Position	Exempt or Non-Exempt	Anticipated Number of Workers
Emergency Room Surgeon ¹³	Exempt	?
Nurses	Non-Exempt	?
Emergency Medical Technicians	Non-Exempt	?
Ambulance Personnel	Non-Exempt	?
Receptionist	Non-Exempt	?

E. Deductions from Paychecks.

An employer is restricted with regard to the deductions it may take from exempt employees' wages without violating the "salaried basis" test. The following list explains an employer's permissible deductions that will not violate the salaried basis test:

1. Deductions when the employee is absent for one or more full days for personal reasons other than sickness or disability. 29 C.F.R. § 541.602(b)(1). If the business remains open during inclement weather and an exempt employee is absent for the full day due to inclement weather, the absence is considered as one for personal reasons. FLSA Opinion Letter – FLSA 2005-41;
2. Deductions when the employee is absent one or more full days due to sickness or disability if the deduction is made in accordance with a bona fide plan, policy, or practice of providing compensation for lost salary occasioned by such sickness or disability. 29 C.F.R. § 541.602(b)(2). Such deductions can also be made before the employee has qualified for the plan and after the employee has exhausted his leave allowance under it;
3. As a penalty imposed in good faith for major safety violations. 29 C.F.R. § 541.602(b)(4);

¹³ While many of these individuals may qualify as independent contractors, a hospital-employed emergency room surgeon would likely be considered an exempt employee under the professional exemption.

4. Deductions from the salary of an exempt employee for an “unpaid disciplinary suspension of one or more full days,” provided the disciplinary suspension is imposed “in good faith for infractions of workplace conduct rules” and “pursuant to a written policy applicable to all employees.” 29 C.F.R. § 541.602(b)(5). Examples of written policies are policies prohibiting sexual harassment, workplace violence or drug and alcohol use/possession;
5. For FMLA leave, including less than full-day amounts;
6. In the initial or terminal week of employment; and
7. From a leave bank for partial day absences.

The following is a list of prohibited deductions:

1. Deductions for personal absences of less than a day. 29 C.F.R. § 541.602(b)(1);
2. Deductions for absences occasioned by the employer or by the operating requirements of the business;¹⁴
3. Deductions for absences caused by jury duty, attendance as a witness or a temporary military leave. 29 C.F.R. § 541.602(b)(3);
4. Deductions for medical absences of less than a full day;
5. Deductions for full day medical absences when there is no bona fide sickness plan or policy; and
6. Other non-permitted salary deductions, such as for register shortages, poor work quality or insufficient quantity of work.

It is extremely important to follow these deduction guidelines because failing to do so may result in the loss of an employee’s exempt status. If that happens, the hospital would be required to pay the employee overtime wages, which are likely to be significant during a mass casualty event. If mistakes occur, depending on their severity, the state and federal agencies might not completely revoke an exempt status. The FLSA regulations provide a “safe harbor” which will protect the exempt status of an employee if the employer inadvertently makes improper deductions. Employers should include a statement in their handbooks directing employees to report any suspected, improper deductions. If a hospital believes a mistake was made during a mass casualty event, it should correct the error. It is also important to contact legal counsel to evaluate the particular factual circumstances.

¹⁴ If an employer closes its business due to inclement weather or other disasters for less than a full workweek, the employer must pay the exempt employees’ full salary. Employers may direct exempt employees to take a vacation day or debit their leave bank, provided the employee receives in payment an amount equal to his or her guaranteed salary. *See* FLSA 2005-41.

F. Joint Employers.

In response to a mass casualty event, an employee may be required to work for more than one employer in a given workweek. This may raise overtime issues for non-exempt employees. In certain instances, all of the non-exempt employee's hours worked for multiple employers during the workweek may be considered hours worked for one employer for the purpose of calculating overtime. In such instances, the employers are jointly and severally liable for the overtime.

In general, a joint employer relationship exists when: (1) there is an agreement between employers to share the employee's services; (2) one employer is acting directly or indirectly in the interest of the other employer; (3) the employers are not completely dissociated and may be deemed to share control, directly or indirectly, because one employer controls, is controlled by, or is under common control with the other employer. *Karr v. Strong Detective Agency, Inc.*, 787 F.2d 1205, 1207 (7th Cir. 1986); 29 C.F.R. § 791.2(b).

Hospitals should be aware that engaging a temporary employee to assist during a mass casualty event may create a joint employer relationship between the hospital and the temporary agency. If the employee works more than 40 hours a week for various employers through the temporary agency, even if the employee works 40 hours or less for the week at the hospital, the hospital and the temporary agency may become jointly liable for overtime compensation. Accordingly, the hospital should pay careful attention when negotiating contracts with temporary agencies, so that its interests are protected.

G. Definition of "Hours Worked."

Given the unpredictability of the work hours and work situations that will arise during a mass casualty event, it is also helpful to review the definition of "hours worked." Generally speaking, "hours worked" are those hours being "suffered" or "permitted" to be worked even if the employer does not specifically authorize the work. 29 C.F.R. § 785.6; Wis. Admin. Code §§ DWD 274.045 and 272.12. If the employer knows or has reason to believe an employee is working, that time must be counted as work time. 29 C.F.R. § 785.11. The employer must exercise its control and ensure that work is not performed if it does not intend to pay for the time worked. 29 C.F.R. § 785.13. One way of addressing this issue is to maintain a policy prohibiting non-exempt employees from working outside their scheduled hours without supervisor approval and then discipline non-exempt employees who violate the policy.

The areas where hospitals may have questions regarding hours worked during a mass casualty event may include the following: (1) waiting or on-call time; (2) meal and rest periods; (3) sleep time; (4) travel time; (5) medical attention; (6) administrative time; and (7) civic and charitable work.

Non-working periods while on duty (waiting times) are generally compensable. 29 C.F.R. § 785.15. The compensability of on-call time depends on the amount of control exercised by the employer over the employee during these times. The focus is on whether the employee has the ability to effectively use the on-call work time for his or her own personal purposes. 29 C.F.R. § 785.17. If the employer requires the employee to remain so close to the

premises that the employee cannot use the time effectively for his or her own purpose, then the on-call time is generally compensable.

Wisconsin law recommends, but does not require, that employers allow each employee at least 30 minutes for each meal period reasonably close to the usual meal period time or near the middle of a shift. Wis. Admin. Code § DWD 272.12(2)(c)(2). Meal periods of more than 30 minutes generally are not compensable provided the employee is completely relieved from duty. 29 C.F.R. §§ 785.18 and 789.19. The employee must be free to leave the premises. The employee is not relieved from duty if he or she is required to perform any duties while eating. Wis. Admin. Code § DWD 272.12(2)(c)(2). In Wisconsin, rest periods which are less than 30 minutes are compensable. Wis. Admin. Code § DWD 272.12(2)(c)(1). Authorized rest periods or breaks of less than 30 consecutive minutes during a shift must be counted as work time for which there shall be no deductions from the employee's wages. *Id.*

Sleep time is compensable if the employee is required to be "on duty" for less than 24 hours. 29 C.F.R. § 785.21. If the employee is on duty for more than 24 hours, the parties can agree to exclude up to 8 hours of sleep time so long as the employee gets at least 5 hours of uninterrupted sleep. 29 C.F.R. § 785.22.

Time spent traveling to and from the employer's job site is generally not compensable. 29 C.F.R. § 785.35. However, travel time is considered "hours worked" in certain circumstances. Common examples include: an emergency call requiring travel away from the regular worksite and involving a substantial distance; travel that keeps an employee away from home overnight; and travel that is all in a day's work, such as travel from jobsite to jobsite during the workday. 29 C.F.R. §§ 785.36-39.

Time spent by employees waiting for, or receiving, medical attention on the premises or at the direction of their employer during normal working hours when the employee is working is also considered time worked under the FLSA. 29 C.F.R. § 785.43. Time visiting a company doctor outside of working hours or time taken from work in order to visit a doctor and obtain treatment for an injury previously received at work is not time worked.

Time spent by employees working for public or charitable purposes at the employer's request, under the employer's direction or control, or while employees are required to be at the work premises is compensable time worked under FLSA. 29 C.F.R. § 785.44. The time is not compensable if the work is undertaken voluntarily, outside of the employee's normal working hours, and is not considered to be the same duties the employee performs during normal work hours.

Time spent by employees performing administrative duties, such as reviewing and/or drafting emails outside of work hours or finishing up paperwork at home which is part of the employee's duties, is compensable time. If the employee's manager or supervisor knows or has reason to know the work is being performed outside of work hours, it must be considered compensable work, even if the employee did not ask permission to perform the work and the time was unscheduled. 29 C.F.R. § 785.12.

These general guidelines should aid a hospital in determining what hours must be reimbursed. For example, an employee's travel from the hospital to an alternative treatment site during the middle of his or her shift counts as hours worked. Additionally, if an employee continues working beyond his or her normal shift, that time must be counted as hours worked. While many hospital employees may volunteer to work extra hours during a mass casualty event, there is no exception to the "hours worked" rule for this type of scenario. An employee cannot waive his or her right to minimum wage or overtime. As a result, the hospital must pay those individuals' wages, and overtime, if applicable.

H. Conclusion.

During a mass casualty event, the hospital will need to make many rapid decisions related to wage and hour issues. Anticipating the categories of workers the hospital will need, sources to obtain those workers, and the rules it must follow related to their reimbursement will make this process work more efficiently during a mass casualty event. The hospital may hire workers, call upon other health providers, and contact temporary help agencies with which it had prior agreements. It needs to record employees' time worked and classify them as exempt or non-exempt. Decisions as to overtime and deductions will also come into play. Presuming the hospital has set up a classification table for its employees, its decisions on these issues should be rather straight forward as long as its actual needs coincide with its anticipated needs.

In the aftermath of a mass casualty event, a hospital should consider conducting an internal audit of any wage and hour issues that arose during the mass casualty event to confirm compliance with the laws. If errors were made, such as employees incorrectly being exempted for overtime purposes, or non-exempt employees not properly being given overtime credit and compensation, the hospital should correct these errors immediately to minimize the potential of costly litigation or the assessment of penalties by state or federal agencies. Wage and hour laws are mainly enforced through administrative agencies, including the Wisconsin Department of Workforce Development and the U.S. Department of Labor. Because many penalties are discretionary, the agencies may be obliged to be more patient with a hospital that underwent a significant overload during a mass casualty event. This is, of course, more likely if the hospital attempted in good faith to anticipate its needs and methods of compliance and immediately corrected any errors made.

II. WORKER'S COMPENSATION.

A. Introduction.

During a mass casualty event, employees may be working longer hours under stressful conditions. Accordingly, the chances of getting injured on the job may significantly increase during a mass casualty event, thereby increasing worker's compensation claims. Hospitals should become familiar with Wisconsin's Worker's Compensation Act ("WCA"), found at Wis. Stat. Ch. 102, to better understand their duties under the WCA. Section II addresses: (1) who is covered by the WCA; (2) what injuries are likely to be covered by the WCA; (3) when the employee is likely to be in the course of his or her employment; and (4) how a substantial increase in worker's compensation claims, which may occur as the result of a mass casualty event, will impact a hospital's experience modification factor.

B. Coverage Under the WCA.

In order for an employee injury to be covered under the WCA, four elements must be established: (1) at the time of the injury, both the employer and employee must be subject to the provisions of the WCA; (2) the employee must sustain an injury; (3) at the time of the injury, the employee must be in the course of employment; and (4) the injury must arise out of employment. Wis. Stat. § 102.03.

1. A Hospital is an Employer Under the WCA.

The WCA statutorily defines covered employers and employees. Almost everyone who employs someone is an employer, and most if not all hospitals will be considered employers having responsibilities under the WCA. *See* Wis. Stat. § 102.04. The WCA provides that the following entities, among others, are employers:

- (a) The state, each county, city, town, village, school district, sewer district, drainage district, family care district and other public or quasi-public corporations therein.
- (b) Any person, except a farmer, who usually employs three or more employees, whether in one or more trades, businesses, or occupations, and whether in one or more locations.
- (c) Any person, except a farmer, usually employing less than three employees, who has paid wages of \$500 or more in any calendar quarter.
- (d) A temporary help agency, for all employees it has placed or leased and for whose services it receives compensation from the leasing employer.
- (e) Any person who has purchased a worker's compensation insurance policy is also considered an employer subject to the WCA's jurisdiction.

Wis. Stat. §§ 102.04(1) and 102.05.

Because presumably all hospitals employ three or more employees, they will be considered employers that are required to provide worker's compensation coverage to their employees under the WCA, unless they are granted an exemption from the duty to provide such coverage from the Worker's Compensation Division. Employers granted an exemption will be required to be self-insured for worker's compensation purposes.

2. Employees Are Covered Workers Under the WCA.

The definition of employee under the WCA includes, in relevant part, the following:

- (a) Every person in the service of the State, or any municipality therein, whether elected or under any appointment, or contract of hire, express or implied. Wis. Stat. § 102.07(1).
- (b) Every person in the service of another under any contract of hire, express or implied, and all helpers, assistants, or employees whether paid by the employer or employee, if employed with the employer's actual or constructive knowledge including minors. This includes anyone "whose employment in the course of any trade, business, profession, or occupation of the employer, however casual, unusual, desultory or isolated the employer's trade, business, profession, or occupation may be." It excludes domestic servants, as well as persons "whose employment is not in the course of a trade, business, profession, or occupation of the employer, unless . . . the employer elects to include them." Wis. Stat. § 102.07(4).
- (c) Members of the National Guard or the state guard when on state active duty, provided that substantial equivalent federal benefits are not available. Wis. Stat. § 102.07(9).
- (d) An employee, volunteer or member of an emergency management unit and member of a regional emergency response team who is acting under a contract under Wis. Stat. § 323.70(2). Wis. Stat. § 102.07(7m).
- (e) A state employee who is on a leave of absence granted under Wis. Stat. § 230.35(3)(e) to provide services to the American Red Cross in a particular disaster is an employee of the state provided one of the following occurs: (i) the American Red Cross specifies in its written request under Wis. Stat. § 230.35(3)(e)2.c. that a unit of government in the state is requesting the assistance of the American Red Cross in a particular disaster and the state employee during a leave of absence provides services related to assisting the unit of government; or (ii) the American Red Cross specifies in its written request under Wis. Stat. § 230.35(3)(e)2.c. that it has been requested to provide assistance outside of the state in a particular disaster, and there exists between the State of Wisconsin and the state in which services are to be provided a mutual aid agreement entered into by the governor, which specifies that the State of Wisconsin and the other state may assist each other in the event of a disaster and which contains provisions addressing worker's

compensation coverage of the other state who provides services in Wisconsin. Wis. Stat. § 102.07(17g).

3. Independent Contractors, Temporary Workers, Loaned Employees and Volunteers are Not Employees Covered Under the WCA.

To the extent a hospital engages workers classified by the WCA as independent contractors, temporary workers, loaned employees and/or volunteers, it is not responsible to provide worker's compensation insurance coverage for these individuals, nor will it be liable for any worker's compensation claim.

(a) Independent Contractors.

A hospital is not responsible for providing worker's compensation coverage to independent contractors. The WCA sets forth a rather rigorous test for determining whether an individual is an independent contractor versus an employee. Under the WCA, an independent contractor is not an employee of an employer for whom the independent contractor performs work or services if the independent contractor meets all of the following conditions:

- (i) Maintains a separate business with his or her own office, equipment, materials and other facilities;
- (ii) Holds or has applied for a federal employer identification number with the Federal Internal Revenue Service ("IRS"), or has filed business or self-employment income tax returns with the Federal IRS based on that work or service in the previous year;
- (iii) Operates under contract to perform specific services or work for specific amounts of money and under which the independent contractor controls the means of performing the services or work;
- (iv) Incurs the main expenses related to the service or work that he or she performs under the contract;
- (v) Is responsible for the satisfactory completion of work or services that he or she contracts to perform and is liable for a failure to complete the work or services;
- (vi) Receives compensation for work or service performed under a contract on a commission or per job or competition bid basis and not on any other basis;
- (vii) May realize a profit or suffer a loss under contracts to perform work or service;

- (viii) Has continuing or recurring business liabilities or obligations; and
- (ix) The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

Wis. Stat. § 102.07(8)(b).

(b) Volunteers.

True volunteers are not employees under the WCA, unless the volunteer work grows out of, and is incidental to, employment. *Begel v. LIRC*, 246 Wis.2d 345, 631 N.W.2d 220 (Ct. App. 2001). While the WCA provides the Wisconsin Department of Workforce Development ("DWD") with the authority to prescribe by rule classes of volunteer workers who may, at the election of the person for whom the service is being performed, be deemed to be employees for the purposes of the WCA, DWD has not set forth rules to that end. Wis. Stat. § 102.07(11). Subject to any future rules DWD may prescribe, workers who neither receive nor expect to receive any kind of compensation for their services are considered volunteers and do not qualify for worker's compensation coverage under the entity's policy for whom they are volunteering. *See United Way of Greater Milwaukee, Inc. v. ILHR*, 105 Wis.2d 447, 313 N.W.2d 858 (Ct. App. 1981); *see also Symanowicz v. Army and Air Force Exchange Service*, 672 F.2d 638 (7th Cir. 1982). Volunteers working for IRS-approved nonprofit organizations are not considered employees if they do not receive more than \$10 per week in cash or things of value. Wis. Stat. § 107.07(11m).

Some hospitals may have lists of prearranged volunteers who are willing to help out upon notice. These types of individuals will not be considered hospital employees covered by the WCA as long as the hospital is not compensating them for their time. *See Klusendorf Chevrolet-Buick, Inc. v. LIRC*, 110 Wis.2d 328, 335, 228 N.W.2d 890 (1982). The hospital should also be aware that compensation need not be in the form of money in order to absolve volunteer status. *Id.* Therefore, a hospital must be extremely careful not to provide its volunteers anything that could be classified as compensation for their services.

Any volunteer firefighters or other municipal and/or city workers volunteering by providing emergency aid will be considered employees of the state, municipality, or emergency group. Most importantly, for the purposes of the hospital's administration, these individuals will not be considered hospital employees, and therefore, the hospital will not be liable for their worker's compensation coverage. The same holds true for the specified American Red Cross workers. In other words, the individuals to whom the hospitals will generally need to both provide worker's compensation coverage and reimburse according to the WCA are those individuals it has directly employed.

Wisconsin laws specifically address worker's compensation coverage for volunteer practitioners who may provide assistance during a mass casualty event. A practitioner who, during a state of emergency and in a geographic area in which the state of emergency applies, provides services for which the practitioner is or has been licensed, certified, registered, or, in the

case of a nurse aide, qualified, is for any claim arising from the provision of services, considered an employee of the state for worker's compensation benefits, provided that the following criteria are met: (1) the services are provided on behalf of a health care facility or mass clinic, or at the request of the Department of Health Services ("DHS") or a local health Department; (2) the health care facility, mass clinic, DHS, or local health department on whose behalf the practitioner provides the services does not compensate the practitioner for the services, except that it may reimburse the practitioner for travel, lodging or meals; (3) the practitioner is registered in the volunteer registry as required in Wis. Stat. § 257.02; and (4) if the practitioner provides the volunteer services at a health care facility or mass clinic, the practitioner registers in writing with the health care facility or mass clinic. Wis. Stat. § 257.03.

(c) Temporary Workers and Loaned Employees.

During mass casualty events, it is not uncommon for hospitals to engage temporary workers to assist in managing the increased workload. Wisconsin Statutes specifically state that the temporary work agency is responsible for providing worker's compensation coverage, not the employer where the temporary worker is placed. "A temporary help agency is the employer of an employee whom the temporary help agency has placed with or leased to another employer that compensates the temporary help agency for the employee's services. A temporary help agency is liable under Wis. Stat. § 102.03 for all compensation payable under this Chapter to that employee." Wis. Stat. § 102.04(2m). The statute also prohibits the temporary help agency from receiving reimbursement from another employer for any payments the temporary help agency is required to make under the WCA.

An important issue to note is that the WCA is the exclusive remedy for an employee against his or her employer with respect to an injury on the job. As such, an employee cannot sue his or her employer in tort for damages resulting from a job-related injury. One of the benefits of hiring an employee from a temporary help agency is that the tort immunity that extends to the agency under the WCA also extends to the employer where the employee is placed. Accordingly, a hospital not only enjoys the benefit of not having to provide WCA coverage, but it cannot be sued in tort for any injuries the temporary worker sustains while performing duties on the hospital's premises.

This same tort immunity benefit extends to loaned employees. To determine whether a worker is a loaned employee for tort immunity purposes, the "loaned employee" test must be applied. See *Bauernfeind v. Zell*, 190 Wis.2d 702, 528 N.W.2d 1 (1995). The "loaned employee" test is as follows:

- (i) Did the employee actually or impliedly consent to work for the borrowing employer?
- (ii) Whose work was the employee performing at the time of injury?
- (iii) Who had the right to control the details of the work being performed?
- (iv) For whose primary benefit was the work being done?

If the responses to these questions demonstrate that an employer had an employment relationship with the employee who was loaned to the employer, then the “loaned employee” defense can be applied to bar liability in tort. For example, if a business provided employees to a hospital in order to respond to a mass casualty event, the employees consented to performing the work for the hospital, the hospital gave the employees instructions regarding their work, and the work was the hospital’s responsibility, the employees would likely be considered loaned employees. In such circumstances, the employer lending the employee would be responsible for providing worker’s compensation insurance, not the hospital, yet the loaned employee would not be able to collect from the hospital for work injuries under the WCA or through a tort claim. Therefore, it is beneficial for a hospital to engage temporary workers or loaned employees to assist during a mass casualty event.

4. Injury.

In order to be entitled to worker’s compensation benefits, an employee must sustain a covered injury, as that term is defined in Wis. Stat. § 102.01(2)(c). A covered injury is “a mental or physical harm to an employee caused by accident or disease, [including] damage to or destruction of artificial members, dental appliances, teeth, hearing aids and eye glasses.” However, some injuries caused by mental stress without trauma are excluded. *See Probst v. LIRC*, 153 Wis.2d 185, 450 N.W.2d 478 (Ct. App. 1989). Because the standard allows recovery unless the non-traumatically caused mental injury resulted from “a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience,” the circumstances surrounding and stressors involved in a mass casualty event may very well be considered beyond the ordinary. *Compare International Harvester v. LIRC*, 116 Wis.2d 298, 341 N.W.2d 721 (Ct. App. 1983) (where the court sustained LIRC’s decision that an individual’s mental condition, resulting from witnessing his friend and co-worker being splashed with molten metal, then catch on fire, burn and die, and then returning to the same job, was compensable), with *Probst v. LIRC*, 153 Wis.2d 185, 450 N.W.2d 478 (Ct. App. 1989) (where the court denied an individual compensation because it found her anxiety attacks resulting from the financial troubles and litigation of her employer were not uncommon to executives).

An injury caused by an “accident” is one in which the cause was of an accidental nature or the effect was the unexpected result of the routine performance of the employee’s duties. *See School Dist. No. 1 v. DIHLR*, 62 Wis.2d 370, 375, 215 N.W.2d 373 (1974). An occupational disease results from exposure to an injurious condition or substance, usually over an appreciable period of time, such as carpal tunnel syndrome as the result of repetitive motion. During a mass casualty event, there will be an increased likelihood that employees may sustain injuries. For example, an employee may be more likely to sustain an injury during a mass casualty event from an exposure to a virus than he or she would be otherwise.

5. In the Course of Employment and Arising Out of Employment.

In order for an injury to be covered under the WCA, the injury must occur while the employee was performing services growing out of, and incidental to, his or her employment. The courts have developed several tests and criteria in order to determine whether work is “in the course of employment.” Mainly, if the individual is doing something requested by the employer,

is on the employer's premises (including a parking lot), or is doing something for the benefit of the employer, the worker will be in the course of employment. Wis. Stat. § 102.03(1)(c)(1).

The injury or disease must also arise out of the employment. Wis. Stat. § 102.03(1)(e). That is, there must be a causal connection between the work activity and the injury. That said, an employee's proclivity to be injured because of a preexisting condition is not a defense to the "arising out of" requirement.

While there is an increased risk of employees sustaining injuries during a mass casualty event, the employer and worker's compensation insurer are only responsible if the injury is causally linked to the worker's job. While enforcing safety policies during a mass casualty event will decrease the risk, a hospital will have to deal with any causation questions after the fact. However, it is important for the hospital to investigate a claim as soon as possible after hearing about an injury and document what it learns.

C. Impact on a Hospital's Experience Modification Factor.

With the exception of employers who are self-insured for worker's compensation purposes, each employer's contribution to the Wisconsin worker's compensation system is determined and collected as a premium they pay for their insurance policy each year. The Wisconsin Compensation Rating Bureau ("WCRB") is licensed under Wis. Stat. Chapter 626 and sets forth all the rules, regulations and procedures relating to the classification of employers, worker's compensation rates, and rating plans. Many factors contribute to the premium amounts each employer pays to its insurance company for worker's compensation coverage. For example, the number of employees it employs, statewide benefit rates, statewide average rates, manual rates that are business and industry specific, and experience ratings will all affect a hospital's worker's compensation premiums. The experience rating uses the historical loss experience of the individual employer as a predictor of future losses to adjust the premium the employer pays. For example, if a hospital's actual past losses are greater than the expected average losses for all employers in the same business, an experience rating surcharge would be applied to the employer's policy and its premium would be increased. Conversely, a hospital would receive a credit if its actual losses are lower than the average expected losses. More information on the WCRB is available at <https://www.wcrb.org/wcrb/wcrbhome.htm>.

Given that a hospital's worker's compensation premium will be determined, in large part, by the number of its actual losses compared to expected average losses, it is natural for a hospital to be concerned about the potential for its premiums to increase substantially after a mass casualty event. However, these concerns have been taken into consideration. A mass casualty event could likely fall into one of two categories: (1) a catastrophic claim, or (2) an injury resulting from a terrorism event. Terrorism events are likely to be specifically excluded from consideration in experience rating. *See* WCRB Circular Letter 2895, April 18, 2002 (any claims directly attributable to the terrorist acts of September 11, 2001 will be excluded from the experience rating calculations). Therefore, no qualifying worker's compensation injuries resulting from acts of terrorism are likely to affect a hospital's experience rating. A catastrophic claim is essentially any accident involving two or more persons. Such an accident will be limited, for the purpose of experience rating, to only twice the maximum amount, even though many more individuals may have suffered compensable injuries.

D. Conclusion.

Delineating between those persons for whom the hospital must carry worker's compensation coverage and those persons for whom it need not is one of the most important employee/non-employee distinctions an employer will need to make, especially in anticipation of a mass casualty event that has the potential for creating many on-the-job injuries. Because the WCA requires the responsible state or local government to cover volunteer firefighters and other regional emergency response team members, hospitals will not be responsible for their coverage. Additionally, hospitals are not required to cover true volunteers.¹⁵ While a mass casualty event is a time where injuries are likely to take place on the job, hospitals should do the best job they can to properly investigate any injuries that occurred to its employees as soon as it reasonably can in order to curtail any potentially fraudulent claims.

III. UNIONIZED FACILITIES.

Section III of Chapter One outlines the basic law governing unionized facilities and sets forth the duties and responsibilities of the employer during a mass casualty event. It also sets forth suggestions for employers to prepare for such a scenario. The most important preparation tool for the hospital employer during a mass casualty event is having a negotiated contract that provides the leeway to engage all of the help it needs and allows it to waive other contractual requirements as necessary during a mass casualty event. The union representative may not agree to all of these types of provisions, but the stronger the contract as to the hospital's rights during a mass casualty event, the better.

A. National Labor Relations Act.

The National Labor Relations Act of 1935, 29 U.S.C. §§ 151-169 ("NLRA"), imposes a variety of legal obligations on employers.¹⁶ Primarily, it provides employees with affirmative rights and freedoms to engage in protected and concerted activity for mutual aid and protection, and to select a bargaining representative of their choice. Employers must recognize the employee's rights.

The National Labor Relations Board ("NLRB") is the government agency set up to enforce the NLRA. A claim filed with the NLRB that an employer, labor organization, or third party has violated the NLRA is an Unfair Labor Practice Charge ("ULP"). A labor organization is any organization, typically a union, that deals with employers concerning grievances, labor disputes, wages, rates of pay, hours of employment, or conditions of employment. A bargaining unit is a group of employees who have a community of interest in their wages, hours and working conditions, and are eligible to be, or are represented by, a union as a group. Managers, supervisors, and confidential employees are excluded and not eligible to be represented by a

¹⁵ Note that, although these individuals are excluded from coverage under the hospital's worker's compensation policy, they are not precluded from filing a personal injury claim in tort against the hospital if they are injured while carrying out their duties.

¹⁶ While the NLRA does not apply to any state or a political subdivision thereof, Wisconsin has provisions similar to those found in the NLRA that are applicable to both state and municipal employers that can be found at Wis. Stat. §§ 111.70-111.77 and 111.80-111.94.

union. Under the NLRA, unions that represent employees are the exclusive representative of those employees for purposes of collective bargaining over wages, hours, and other conditions of employment (“mandatory subjects of bargaining”). On a periodic basis, the employer is legally required to attempt in good faith to negotiate a contract for each bargaining unit, though it is not legally required to agree to any proposal made by the unions.

In 1974, Congress amended the NLRA to establish a new category of employer called “health care institutions.” Additionally, the 1974 amendments added more stringent notice requirements on both the union and health care institution employer related to the termination and modification of collective bargaining agreements. 29 U.S.C. §§ 158-59. Labor organization members striking in violation of these new notice requirements lose any protections as “employees” under the NLRA. Specifically, the notice provision requires either party desiring to terminate or modify a contract to serve written notice of the proposal 90 days prior to the expiration, notify the Federal Mediation and Conciliation Service within 60 days after such notice of the existence of a dispute, and continue in full force and effect, without resorting to strike or lockout, all the terms and conditions of the contract for 90 days following such notice. A labor organization, before engaging in any strike, picketing or other concerted refusal to work at any health care institution, must notify the institution as well as the Federal Mediation and Conciliation Service of its intention 10 days prior to such action. 29 U.S.C. § 158.¹⁷

B. Collective Bargaining Agreements.

The collective bargaining agreement, or union contract (“CBA”), in addition to past practice and state/federal law, determines what rights and responsibilities employers, employees, and unions have. It is, in some senses, the equivalent of an employee handbook or personnel manual in a non-union setting. It is critical for managers/supervisors to read, understand, and abide by each and every provision of a CBA. Failure to do so can result in grievances, breach of contract claims, and unfair labor practice charges being filed against the employer. Most CBAs contain ambiguous terms that can be difficult to interpret. In such cases, an employer should not attempt to resolve the matter on its own, as it may create a binding past practice. Instead, the employer should consider consulting with an attorney and follow these guidelines:

1. Look at the contract as a whole.
2. Give words their ordinary meaning unless it is clear another meaning was intended.
3. Where there is a conflict, specific clauses take precedence over general clauses.
4. Determine what, and how well established, the practice has been with respect to the interpretation and application of the language.
5. Consider any available bargaining history.

¹⁷ Wisconsin law prohibits strikes by public sector employees. *See* Wis. Stat. § 111.70(4)(L).

The following CBA provisions are likely the most important during a mass casualty event: management rights, nondiscrimination, seniority, and scope of job duties.

1. The management rights clause is the most important to the employer. It sets forth the employer's general right to manage employees and business operations. These particular rights are generally limited by state/federal law and by other provisions of the CBA.
2. Nondiscrimination in employment is required. In general, all employees covered by the CBA must be treated in exactly the same way. Special deals or rights are not allowed, unless permitted by the CBA, and adverse treatment because of an employee's participation in the union (or as an officer, etc.) is prohibited. An employee's length of continuous service generally determines the extent to which s/he is entitled to preferential treatment when it comes to promotion and transfer, layoffs and recall, overtime, and shift selection.
3. In general, employees should be assigned job duties that are consistent with the job description for their classification. Some CBAs allow for temporary assignments.

CBAs generally set forth rather strict guidelines employers must adhere to in order to conduct a disciplinary investigation and/or discipline an employee. For example, bargaining unit employees have a statutory right under the NLRA to request and have union representation during an investigatory interview (i.e., a meeting that the employee reasonably believes might result in disciplinary action). Most CBAs have grievance procedures that must be followed in order to resolve disputes regarding discipline or contract interpretation or application. Often, certain steps must be followed within a specific timeline or they are waived.

Because the CBA basically governs the relationship between the hospital and the bargaining unit, hospitals should attempt to include terms in the contract addressing issues such as required mandatory overtime, job transferring, the hospital's ability to subcontract or to hire non-union personnel on a short-term basis, and any other provision it believes will aid it during a mass casualty event. It would also be prudent to include broad language to the effect that the hospital can take whatever steps necessary with respect to acquiring additional personnel and assigning personnel during a mass casualty event.

C. Refusal to Work.

During a mass casualty event, workers may refuse to perform some or all of their duties because they claim the duties are hazardous. Supervisors, managers, and human resource representatives need to be aware of employees' rights under the NLRA before disciplining employees for these actions. Employers are prohibited from interfering with, restraining, or coercing employees in, among other things, the exercise of their right to engage in "concerted activities." 29 U.S.C. § 158(a)(1). Employees have the right to engage in concerted activities for the purpose of mutual aid or protection. 29 U.S.C. § 157. A refusal to work under an alleged hazardous condition is protected by the NLRA if it is determined to be a concerted activity.

29 U.S.C. § 158(a)(1). Generally, the NLRA recognizes and protects concerted activities undertaken to avoid or remedy dangerous working conditions. *See Lenape Prods., Inc.* 283 N.L.R.B. 178 (1987) (employees protesting supervisory indifference to excessive gas fumes and presence of rats in plant); *Consumers Power Co.*, 282 N.L.R.B. 130, 132 (1986) (employee protesting customer violence toward employee). In order to receive protections under the NLRA, employees engaging in concerted activities related to a refusal to work must have:

1. An honest belief of danger;
2. Sincerity in identifying the danger as a cause of the concerted activity; and
3. A reasonable basis for the honest belief.

See Brown & Root, Inc. v. NLRB, 634 F.2d 816 (5th Cir. 1981).

The following factors are irrelevant in determining whether the refusal to work does not afford protection under the NLRB.

1. Whether the danger was perceived to be severe;
2. Whether the refusing employee could have approached the employer or requested an immediate OSHA inspection first; and
3. Whether the refusing employee had available some reasonable alternative to refusing work.

See NLRB v. Washington Aluminum Co., 370 U.S. 9 (1962).

It is important to note that employees who engage in this concerted activity are not entitled to walk off the job if the collective bargaining agreement contains a no strike clause that includes a duty not to strike over safety disputes. *See Irvin H. Whitehouse & Sons Co. v. NLRB*, 659 F.2d 830 (7th Cir. 1981).

During a mass casualty event, the hospital may find that it is constrained by the provisions of a CBA that does not provide it with sufficient flexibility. In those occasions, the hospital should attempt to follow the agreement to the extent possible, thereby minimizing the likelihood of receiving ULP charges or answering grievances.

IV. EMPLOYEE VERSUS INDEPENDENT CONTRACTOR RELATIONSHIP.

A. Introduction.

Whether a worker is classified as an independent contractor or an employee affects the employer's responsibility to comply with certain employment laws, such as wage and hour laws or family and medical leave laws. A worker's status as an independent contractor or an employee may be difficult to ascertain and depends on the particular law at issue, not on the label placed on the worker. No one standard set of criteria defines an independent contractor; rather, different laws set forth their own definitions and qualifications for classifying workers as

independent contractors. In any particular circumstance, some or all of these definitions may have to be applied. While many of the laws contain very similar criteria, the state law tests for worker's compensation and unemployment insurance provide particularly rigorous standards for one to qualify as an independent contractor.

One of the tasks hospitals will need to accomplish during a mass casualty event is to engage far more help than normal, whether by the use of employees, temporary workers, loaned employees, volunteers or independent contractors. One of the things a hospital can do to make this situation flow as smoothly as possible is to be prepared with an administrative plan of action. With respect to the management of the influx of "extra help" during a mass casualty event, hospitals should prepare a comprehensive guide of potential job classifications and denote whether those jobs are likely to be filled by independent contractors or employees under each law discussed throughout Section IV of Chapter One.

Although there will inevitably be room for error because some factors for determining independent contractor status rely on the specific facts and circumstances, a plan of action is a good starting point to prepare for an emergency. The remainder of Section IV discusses the distinctions between how an employer treats independent contractors, as opposed to employees, and sets forth the various tests for identifying independent contractors in order to aid hospitals in making these distinctions.

B. Employer Responsibilities Toward Employees as Opposed to Independent Contractors.

If an individual is classified as an employee rather than an independent contractor, the employer is responsible for complying with various Wisconsin, federal and local employment laws. This paragraph provides a summary of some of the most important requirements, but is not intended to provide an all inclusive comparison. First, the Internal Revenue Code ("IRC") requires employers to make appropriate deductions from an employee's income and income statements. This includes deductions for federal income tax, social security and Medicare taxes, and both state and federal unemployment taxes. The employer is not required to do so for independent contractors. Further, the employer's reporting requirements are different for both independent contractors and employees. Employers must file an IRS Form 1099 for monies given to independent contractors, and IRS Forms W-4 and W-2 for employees. Additionally, the employer is responsible for complying with the WCA, Wisconsin's unemployment insurance laws and Wisconsin wage and hour laws with respect to employees. Moreover, the requirements of federal fair employment statutes, such as Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.* ("Title VII"), the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.* ("ADA"), the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621 *et seq.* ("ADEA"), and the federal Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 ("FMLA"), and similar state statutes, such as the Wisconsin Fair Employment Act, Wis. Stat. §§ 111.31-111.395, apply to the employee/employer relationship but not the independent contractor/employer relationship. It is important to note, however, that a hospital may be subjected to a liability if an independent contractor violates these laws with respect to a hospital employee. For instance, an employee may have a viable claim against the hospital for hostile work environment if a non-employee medical staff member subjects the employee to sexual harassment. One other significant issue is that the doctrine of imputed or vicarious liability

applies to an employee/employer relationship, but not to an independent contractor/employer relationship. Accordingly, the actions, words and/or knowledge of an employee supervisor can be imputed to the employer. The following Section IV(C) addresses federal and state law tests for determining when a worker should be classified as an independent contractor.

C. Independent Contractor Tests.

The following paragraphs set forth various tests to determine whether a worker is an independent contractor. They also discuss the implications of misclassifying a worker.

1. The IRC.

The IRC uses common law factors placed into three categories in order to determine who is an independent contractor. These factors examine the relationship between the worker and the business. The relevant factors are: (1) behavioral control, (2) financial control, and (3) relationship type.

Whether an employer has behavioral control over a worker depends upon whether the business has a right to direct and control how the worker does the task for which the worker is hired. Facts demonstrating behavioral control include the following:

- (a) The type and degree of instructions the employer gives the worker. Consider whether the worker is told:
 - (i) when and where to do the work?
 - (ii) what tools or equipment to use?
 - (iii) what workers to hire or assist with the work?
 - (iv) where to purchase supplies and services?
 - (v) what work must be performed by a specified individual?
 - (vi) what order or sequence to follow?
- (b) Whether there is an evaluation system in place that measures the details of how the work is performed (as opposed to just the end result).
- (c) Training which the employer gives the worker.

The key consideration under the behavioral control factor is whether the employer has retained the right to control the details of a worker's performance. Therefore, the perceived relationship between the parties may not be dispositive, as long as the employer retains the right to control the details of a worker's performance, such as by written contract, even if it chooses not to do so.

Whether an employer has financial control over a worker depends upon whether the employer has a right to control the business aspects of the worker's job. Factors demonstrating financial control include:

- (a) The extent to which the worker has unreimbursed business expenses. Usually independent contractors will have these. Fixed, ongoing costs incurred regardless of whether work is currently being performed are especially important.
- (b) The extent of the worker's investment. Often independent contractors will have investment in facilities, such as an office or tools.
- (c) The extent to which the worker makes his or her services available to the relevant market. Is the worker free to seek out other work opportunities and work for other employers? Does the worker advertise, use a business card, place a listing in the Yellow Pages, and maintain a visible business location?
- (d) How the employer pays the worker. An employee is normally paid a guaranteed wage for a period of time (hourly or otherwise). Whereas, an independent contractor is usually paid a flat fee for the job (with the exclusion of some professionals that get paid hourly).
- (e) The extent to which the worker can realize a profit or loss.

The third factor is the relationship type of the parties. Facts that demonstrate parties' relationship type include the following: written contracts describing the relationship the parties intended to create; whether or not the employer provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay or sick pay; the permanency of the relationship (engaging a worker with an expectation that the relationship will continue indefinitely, rather than for a specific project or period, is considered evidence of an employee/employer relationship); and the extent to which services performed by the worker are a key aspect of the employer's regular business.¹⁸

The consequence for misclassification under the IRC is that the employer may be assessed retroactive taxes plus interest as well as other monetary penalties. However, Section 530 of the IRC provides a safe haven for those employers acting with a reasonable basis for not treating an individual as an employee. The safe haven provision includes specific requirements the employer must meet in order to qualify as having a reasonable basis, such as for example, reasonably relying on judicial precedent or the advice of an attorney.

¹⁸ For additional information regarding the distinction between employees and independent contractors under the IRC, see IRS *Publication 15-A, Employer's Supplemental Tax Guide*, January 2010, which can be found at <http://www.irs.gov/pub/irs-pdf/p15a.pdf>.

2. The FLSA and the FMLA.

Some federal laws administered by the U.S. Department of Labor, including the FLSA and the FMLA, apply the “economic reality test” in order to determine whether a worker is economically dependent on the employer or if the worker is an autonomous business, thus delineating employees from independent contractors. The test consists of six factors, but no one factor is controlling. All factors are weighed in order to decide the economic realities of the situation. The factors are as follows:

- (a) Work investment in equipment or material (what tools are needed and who provides them?).
- (b) Supervision and control (who supervises and controls the work being done, when it is done, and the means versus the end?).
- (c) The opportunity for profit or loss.
- (d) Independent judgment.
- (e) Permanency (is it a consistently recurring job or a one-shot deal?).
- (f) Inter-relatedness of work to employer.

29 C.F.R. § 825.105.

The differences between the employee and independent contractor status under the FLSA and FMLA are significant. Under the FLSA, an employer must comply with all provisions, such as minimum wage, overtime, and hours of work requirements with respect to employees, but not independent contractors. Under the FMLA, the employer is responsible for complying with the entire law with respect to employees. However, with respect to independent contractors, a secondary employer (i.e., the hospital) must only comply with the requirement to accept an employee of an independent contractor coming back from family medical leave, but is not responsible for providing required notices, providing the initial leave and/or maintaining any benefits.

While FLSA-related issues are more likely to create work for a hospital who hires additional employees to cope with a mass casualty event, a hospital may also need to deal with FMLA requests and leaves. Therefore, where the hospital can engage independent contractors or temporary employees to meet its needs during a mass casualty event, its burden under these laws would be significantly lessened.

3. The ADEA and the ADA.

Although the federal discrimination laws are also administered by the U.S. Department of Labor, the Equal Employment Opportunity Commission (“EEOC”) of the U.S. Department of Labor applies a separate, although related, test to determine whether a worker is considered an employee, and therefore protected under statutes such as Title VII, the ADEA and the ADA.

The EEOC considers the following 16-point test in order to determine whether a worker is an independent contractor:

- (a) The employer has the right to control when, where and how the worker performs the job.
- (b) Work does not require high level of skill or expertise.
- (c) Employer furnishes the tools, materials and equipment.
- (d) Work is performed on the employer's premises.
- (e) Continuing relationship between worker and employer.
- (f) Employer has right to assign additional projects to worker.
- (g) Employer sets hours of work and duration of job.
- (h) Worker paid by hour, week, or month rather than agreed cost of performing job.
- (i) Worker does not hire and pay assistance.
- (j) Work performed as part of regular business of employer.
- (k) Employer is in business.
- (l) Worker is not engaged in his/her own distinct occupation or business.
- (m) Employer provides worker with benefits, such as insurance, leave or worker's compensation.
- (n) Worker is considered an employee of the employer for tax purposes (i.e., the employer withholds federal, state, and social security taxes).
- (o) Employer can discharge worker.
- (p) Worker and employer believe they are creating an employer/employee relationship.

See EEOC Guidance, Notice No. 915.002 (12/03/97).

The above list is not exhaustive. Instead, all incidents of the relationship must be assessed with no one factor being determinative. Generally, the determination is based upon the degree of independence of the worker, whether or not the individual puts his or her assets at risk and whether the individual makes his services available to the general public, not exclusively to the employer.

4. The NLRA.

To distinguish between employees and independent contractors, the NLRA specifically excludes “any individual having the status of an independent contractor” from its definition of employee. 29 U.S.C. § 152(3). A ten-factor test, known as the “right to control” test, which comes from the Restatement (Second) of Agency § 220, was cited with approval in *NLRB v. United Ins. Co. of America*, 390 U.S. 254 (1968). It is composed of the following ten factors:

- (a) Extent of control that, by the agreement, the employer may exercise over details of work.
- (b) Whether person is engaged in a distinct occupation or business.
- (c) Kind of occupation with reference to whether, in the locality, the work is usually done under the direction of the employer or by a specialist without supervision.
- (d) Skill required.
- (e) Who supplies instrumentalities, tools in place of work.
- (f) Length of time for which person is employed.
- (g) Method of payment—by time or job.
- (h) Whether the work is part of the employer’s regular business.
- (i) Intent of parties.
- (j) Whether principal is or is not in business.

The most important factor under the NLRA test is the “degree to which the party for who the work is performed retains the right to control the manner in which the details of the work are to be performed.” Specifically, under the NLRA, the distinction between employee and independent contractor affects the employer’s responsibility to bargain with the employee (represented by a union) and its liability for unfair labor practices.

5. Wisconsin State Laws.

There are various Wisconsin state laws that also use specific criteria to identify independent contractors, such as Wisconsin’s wage and hour law, the Wisconsin Fair Employment Act, Wis. Stat. §§ 111.31-111.395, Wis. Stat. § 103.10, and the Wisconsin Employment Peace Act, Wis. Stat. § 111.01 *et seq.* The two most significant Wisconsin statutes dealing with the independent contractor/employee distinction are Wisconsin unemployment insurance laws and the WCA. Instead of setting forth a balancing test, these two laws impose criteria that must be met.

Wisconsin's unemployment insurance laws exempt employers from participation with respect to independent contractors. Under this law, an employee is "any individual who is or has been performing services for pay for an employing unit, whether or not the individual is paid directly by the employing unit . . ." Wis. Stat. § 108.02(12)(a). Conversely, an independent contractor is an individual who either holds or has applied for an employer identification number with the Federal IRS or has filed business or self-employment income tax returns with the Federal Internal Revenue Service based on such services in the previous year, and who meets six (6) or more of the following conditions:

- (a) The individual maintains a separate business with his or her own office, equipment, materials and other facilities.
- (b) The individual operates under contracts to perform specific services for specific amounts of money and under which the individual controls the means and method of performing the services.
- (c) The individual incurs the main expenses related to the services that he or she performs under contract.
- (d) The individual is responsible for the satisfactory completion of the services that he or she contracts to perform and is liable for a failure to satisfactorily complete the services.
- (e) The individual receives compensation for services performed under a contract on a commission or per-job or competitive-bid basis and not on any other basis.
- (f) The individual may realize a profit or suffer a loss under contracts to perform services.
- (g) The individual has recurring business liabilities or obligations.
- (h) The success or failure of the individual's business depends on the relationship of business receipts to expenditures.

Wis. Stat. § 108.02(12)(bm).

The WCA sets forth an even stricter test. See Section II(B)(3)(a) of Chapter One for a detailed list of the criteria that must be met in order for an individual to be considered an independent contractor under the WCA.

The implications of engaging independent contractors instead of forming an employer/employee relationship with respect to unemployment and worker's compensation laws are significant. A hospital may need to bring on additional employees to handle the increased workload or to address a shortage of employees due to illness. After the mass casualty event, a hospital may then downsize its workforce due to reduced need. All those employees terminated

may apply for unemployment benefits. Independent contractors, on the other hand, are not allowed benefits.

The worker's compensation cost-benefit analysis is similar. An employee is entitled to worker's compensation benefits and the independent contractor is not (absent an agreement to the contrary). The greatest risk, however, is the risk of misclassifying an employee as an independent contractor and not providing insurance for that individual. Misclassification that is not covered by a worker's compensation policy can lead to a huge liability on the part of the hospital.

D. Conclusion.

Anticipating the hospital's needs for additional assistance will be crucial for the effective administration and coordination of aid during a mass casualty event. The category of worker the hospital eventually calls upon to assist it will define the hospital's legal responsibilities toward the worker. Quite simply, the hospital will have greater responsibilities toward employees than independent contractors. However, there may be many positions that the hospital will want to fill for which there will be no person available to do the work as an independent contractor. For example, a janitor who does not own his or her own business is unlikely to qualify under any independent contractor test. Therefore, in addition to maximizing opportunities to hire independent contractors, it would also be helpful for a hospital to explore other alternatives such as temporary employment agencies and loaned employees from other facilities. In those situations, a joint employer situation is likely to exist, in which the two employers share responsibilities.

Another benefit of using independent contractors is that after a mass casualty event, the hospital may need to reduce its staff due to reduced needs. While terminated employees may file for unemployment insurance, to the extent the hospital engaged independent contractors, it will not need to deal with that burden.

V. EMPLOYEE BENEFITS.

A. Introduction.

Employers, including hospitals, generally offer their full-time (and sometimes part-time) employees various benefits. The range of benefits offered includes health-related programs such as medical insurance to other less serious benefits such as a free meal at a yearly company picnic. Another way of distinguishing among the benefits employers offer to their employees is determining which benefits the employer is legally required to provide and which benefits it is not. This distinction may be less noteworthy in the case of a union employer or other employer who has a contractual duty to provide its employees with benefits in excess of those required by law.

Anticipating the use of employee benefits prior to a mass casualty event is extremely difficult because some of the benefits, such as FMLA leave, depend upon factors beyond the employee's control such as his or her own health or that of his or her family. It is likely that many of these requests during a mass casualty event will be immediate needs. As a result, the employer's best way to prepare is to have a clear understanding of the laws and to develop

straightforward methods of recordkeeping and administration. For example, newer employees may not be entitled to FMLA leave, and therefore, the hospital will not need to grant leave in the event an employee's family member has been seriously injured. While it may not be the hospital's practice to deny such a request for leave, it is important that it understand its rights.

Hospitals will have more leeway dealing with benefits that are not mandatory, such as vacation benefits and personal time. In order to avoid any notice or compliance issues, it is important to inform employees of the hospital's right to cancel any pre-approved vacation or personal time due to an emergency situation such as a mass casualty event. If the hospital has an employee handbook, it is important to include this type of disclaimer within that handbook.

It is also important to advise employees that they may be called into work in an emergency. While most hospitals already have on-call staff, it may be necessary to expand this list during a mass casualty event, and employees should be warned in advance of such a possibility. Employers should have clear policies allowing this discretion and should have disciplinary procedures established so that the policies may be utilized when employees refuse to cooperate during a mass casualty event.

Section V of Chapter One first discusses those benefits that a hospital employer is required to provide its employees under relevant law that may be difficult to either administer or grant during a mass casualty event. It continues with those benefits the employer may have chosen, but is not legally bound, to provide.

B. Required Benefits.

Some of the benefits that employers are legally required to provide to employees and which may be difficult to administer or grant during a mass casualty event are: family and medical leave, military leave, worker's compensation insurance, leave to vote, and jury duty leave.¹⁹ The following paragraphs provide a general overview of these benefits.

1. Family and Medical Leave.

Both the Wisconsin Family and Medical Leave Act, Wis. Stat. § 103.10, and the federal Family and Medical Leave Act of 1993, 29 U.S.C. §§ 2601-2654 (collectively referred to here as "FMLA"), require employers with 50 or more employees to provide qualifying employees with unpaid family and medical leave. Wisconsin law permits employees who have been employed by an employer for at least the past 12 months and who have worked at least 1,000 hours in those past 12 months to take the following leave time in a calendar year:

- (a) Up to 6 weeks of family leave for the birth or adoption of a child.

¹⁹ At the time of printing of this Manual, the Supreme Court of Wisconsin was gathering information to determine whether the city of Milwaukee's ordinance requiring mandatory sick leave benefit was constitutional. The ordinance, if it is found to be constitutional, would require private-sector employers in the city of Milwaukee to offer paid sick leave to all employees. Workers would earn one hour of sick leave for 30 hours worked, and up to 9 days of sick leave per year, if the Milwaukee ordinance is enacted. Businesses with 10 or fewer employees would be required to provide up to five days a year of paid sick time.

- (b) Up to 2 weeks of family leave to care for a child, spouse, parent, domestic partner²⁰ or domestic partner's parent, suffering from a serious health condition. (Note: child of a domestic partner is not included.)
- (c) Up to 2 weeks of medical leave for the care of the employee's own serious health condition which renders him/her unable to work.

Wis. Stat. § 103.10(1)(c), (3)-(4).

Federal law allows employees who have been employed by an employer for at least 12 total months and who have worked at least 1,250 hours in the past 12 months to take up to 12 weeks of leave in a year for one or more of the following reasons:

- (a) Family leave for the birth, adoption or foster care placement of a child.
- (b) Family leave to care for a child, spouse, or parent suffering from a serious health condition.
- (c) Medical leave for the care of the employee's own serious health condition which renders him/her unable to work.
- (d) Due to a qualifying exigency arising out of an employee's parent's, child's or spouse's active duty or call to active duty.

29 U.S.C. §§ 2611(2)(A) and 2612(a).

Qualifying exigencies include: (1) short-notice deployment, defined as a call/order to active duty seven days prior to date of deployment; (2) military events and activities related to a call to active duty; (3) childcare and school activities (e.g., arrange for alternative childcare, provide childcare on urgent or immediate basis, enroll child in new school or daycare); (4) to make or update financial and legal arrangements to address military member's absence; (5) attend counseling (provided by someone other than a health care provider); (6) rest and recuperation limited to 5 days per leave, to spend with military member on short-term leave; (7) post deployment activities, defined as up to 90 days following termination of active status; and (8) additional activities as agreed to by both employer and employee. 29 C.F.R.

²⁰ In order to be eligible for leave to care for a domestic partner (same-sex or opposite sex) or a domestic partner's parent, an employer may require that the employee certify that the domestic partnership is registered with the Register of Deeds for the county in which the employee and domestic partner reside; or certify that the employee is in an unregistered domestic partnership that satisfies the following requirements:

- The domestic partners are at least 18 years old and otherwise competent to enter into a contract;
- Neither domestic partner is married to, or in a domestic partnership with, another individual;
- They share the same residence;
- They are not blood related in any way that would prohibit marriage under Wisconsin law;
- They consider themselves to be members of their immediate family; and
- They agree to be responsible for each other's basic living expenses.

Wis. Stat. § 40.02(21c)-(21d).

§ 825.126(a). Exigency leave applies to Ready Reserve, Select Reserve, Individual Ready Reserve, National Guard, retired military members of the Regular Armed Forces, retired Reserve, and those serving in the regular Armed Forces.

Qualified employees may also take up to 26 weeks of unpaid leave to care for injured members of the Armed Forces. This is limited to the employee's parent, child, spouse or next of kin. Note that no more than 26 weeks of leave is available for an employee who takes leave to care for an injured service member, as well as leave for other qualifying reasons during the applicable 12-month period. This leave is only available one time in a single 12-month period and is applied on a per-covered-service member, per injury basis. 29 C.F.R. § 825.127(c)(4). Generally, an employer can require the employee to provide at least 30 days' advance notice of the need for leave because of a birth, adoption, or foster care placement, or for planned medical treatments for themselves or family members. 29 U.S.C. § 2612(e); 29 C.F.R. § 825.302. An employer may also request that the employee make reasonable efforts to schedule planned medical treatments so as not to unduly disrupt the employer's operations. 29 U.S.C. § 2612(e).

The employer may require that every employee seeking or needing FMLA leave submit a medical certification form signed by the treating health care provider. 29 U.S.C. § 2613. The employer can require the employee to return the completed certification within 15 days. 29 C.F.R. § 825.305(b). The employer may request recertification in the event of an extended leave. 29 U.S.C. § 2613(e). Both state and federal medical certification forms are available, however, an employer is free to use their own form, provided it meets the state and federal requirements.²¹ See Wisconsin FMLA medical certification form, ERD-10111, and federal FMLA medical certification form, WH-380-E and WH-380-F, all available in Appendix A of this Manual. Employers should become familiar with their rights and obligations related to FMLA notices and certifications prior to a mass casualty event to reduce the risk of violating an employee's FMLA rights.

Under the federal FMLA, an employer is required to provide employees with notice of eligibility and their rights and responsibilities as required by 29 C.F.R. § 825.300(b). This information must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Employers may use the U.S. Department of Labor's Form WH-381, which complies with the regulations and which is available in Appendix B of this Manual.

Federal law also requires employers to inform employees of the amount of leave that will be counted against the employee's federal FMLA entitlement. 29 C.F.R. §§ 825.300(c), 25.301, and 825.305(e). Employers may use the U.S. Department of Labor's Form WH-382, which complies with the regulations for these purposes and which is available in Appendix C of this Manual.

If the leave is due to a qualifying exigency and the employer requests certification of the qualifying exigency (not required but recommended), Form WH-384 can be used. There is also a federal form recommended by the U.S. Department of Labor which employers may use for the

²¹ State requirements can be found at Wis. Stat. § 103.10(7)(b); federal requirements can be found at 29 C.F.R. §§ 825.306-825.308.

certification for serious injury or illness of a covered service member, Form WH-385. Forms WH-384 and WH-385 are available in Appendix D of this Manual.

Although neither the federal nor Wisconsin FMLA require that the employer provide paid leave, they do require that an employee's group health insurance coverage remains in effect with the employer paying its portion during the leave as if the employee were working. Wis. Stat. §§ 103.10(5)(a) and 103.10(9)(b); *see also* 29 U.S.C. § 2614(c).

Upon return from family or medical leave, an employer must reinstate the employee to the position he or she held immediately prior to the leave if the position is vacant. If the position is not vacant, the employee must be placed in an equivalent position. Wis. Stat. § 103.10(9); 29 U.S.C. § 2614(1). An employer may require an individual returning from medical leave to provide it with a certification from his or her health care provider that indicates the individual is able to return to his or her job without restrictions. 29 U.S.C. § 2614(4).

Because employees are required to notify the hospital 30 days prior to, or as soon as practicable before, a foreseeable leave, such as the birth or adoption of a child or a planned medical treatment, hospitals will have sufficient time to plan for that employee's absence if a mass casualty event should occur during the leave. Additionally, hospitals may deny leave to those individuals who do not meet the threshold months and hours requirements explained above. The more difficult scenario is where an employee requests leave or simply takes leave due to an unforeseeable qualifying event. However, neither the federal or Wisconsin FMLA provide an exception for employer hardship.²²

2. Military Leave.

The Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. §§ 4301-4333 ("USERRA"), grants employment and reemployment rights to employees who serve in the uniformed services, as well as prohibits discrimination in employment against such individuals. 38 U.S.C. §§ 4311-4312. Under USERRA, employers must grant leave to employees who are members of the military who are ordered to active duty or training duty for the reserves. Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent for the purpose of determining fitness to perform duty, and a period for which a person is absent for the purpose of performing funeral honors duty. 38 U.S.C. § 4303(13). In order to receive reemployment rights and benefits and other employment benefits, the individual must provide advance notice²³ of his or her service, the cumulative period of the individual's absence, and all previous absences from employment with that employer by reason of service in the uniformed services must not be greater than 5 years.²⁴ 38 U.S.C. § 4312(a)(1)-(2). The employee must also report to work or submit an application for reemployment. 38 U.S.C. §§ 4312(a)(3) and 4312(e). USERRA also provides provisions permitting employers to not reemploy an employee who was on military leave for

²² There is a narrow exception which grants an employer the right to deny the restoration of key employees (salaried employee who are among the highest paid 10% of all the employees) if the restoration would cause "substantial and grievous economic injury" to the operations of the employer. *See* 29 C.F.R. §§ 825.217-218.

reasons such as changed circumstances or undue hardship. 38 U.S.C. § 4312(d). USERRA also requires employers to continue the service member's coverage under a health plan for up to 18 months. 38 U.S.C. § 4317.

In the case of a widespread mass casualty event due to a terrorist attack, it is likely that some of a hospital's employees may be called to active duty. While the employer is given some relief with respect to reemployment if such reemployment causes an undue hardship, USERRA does not provide similar relief with respect to permitting leave. Therefore, a hospital may expect to lose some of its service member employees in the event of a mass casualty event that also requires the deployment of troops.

3. Voting.

If a mass casualty event falls during a political election, the hospital must allow its workers time off from work to vote. Employers must allow up to three consecutive hours while the polls are open, provided the employee requests the time off before the election day. While this does not give an employer much time to make arrangements for coverage, it does allow the employer to choose the time of day that it will allow the time off. Employers are not required to pay for the time off, but an employer cannot otherwise penalize an employee for properly requesting and taking the time off. Wis. Stat. § 6.76.

4. Jury Duty.

An employer must grant an employee an unpaid leave of absence without loss of time in service for the duration of the jury service. Wis. Stat. § 756.255. There is no exception to the employer's duty to provide its employees with jury duty leave. That said, an employee will generally receive a jury duty notification at least a few days prior to his or her required service. This notice will provide the hospital with some time to prepare and find someone to fill the position. Therefore, hospitals should require employees to inform them as soon as possible after receiving notice of the individual's jury duty obligations. Additionally, during preliminary questioning, a judge will normally ask questions in order to determine a worker's ability to serve. At that time, an employee could request to be excused due to his or her desire to continue aiding the hospital during the mass casualty event. The employee should also call the court in order to determine whether the jury selection has been canceled due to the mass casualty event.

5. Worker's Compensation.

An employer must provide Worker's Compensation Insurance for its employees. This topic is covered in detail in Section II of Chapter One.

²³ However, notice need not be provided if giving such notice is precluded by military necessity. 38 U.S.C. § 4312(b).

²⁴ There are several exceptions to the five-year length of absence restriction that mainly focus on the service person being required to continue an initial period of service, or due to factors outside his/her control such as being ordered to active duty as the result of a war. See 38 U.S.C. § 4312(c).

6. Reasonable Accommodation for Individuals with Disabilities.

Both the ADA and the Wisconsin Fair Employment Act (“WFEA”), Wis. Stat. §§ 111.31-111.395, set forth requirements requiring employers to reasonably accommodate qualified individuals with disabilities. The WFEA has been interpreted by the Wisconsin Supreme Court and the Labor and Industry Review Commission to require reasonable accommodations additional to and broader than those that would be required under the ADA. Both the ADA and the WFEA provide exceptions for undue hardship and safety risks to other employees that may be helpful in responding to some requests during a mass casualty event, but these exceptions are not very well defined in Wisconsin law. Because each individual situation must be addressed on its specific facts, it is extremely difficult to anticipate and plan for such requests. However, it is most important that the hospital engage in an interactive process with the employee regarding his or her needs (i.e., meet with the employee to analyze job functions, determine precise job limitations and identify reasonable accommodations, if any) and seek legal advice as soon as possible.

C. Optional Benefits.

In addition to those benefits an employer is required to provide, many employers, including hospitals, offer employees a range of other benefits such as funeral leave, paid time off, holidays, personal time, and health care benefits.²⁵ Those benefits involving the employee’s absence may make it difficult for a hospital to properly function during a mass casualty event. Because these are discretionary benefits, it is a good idea for hospitals to include language in their employee handbooks requiring advance approval for leave and allowing the hospital to revoke approval in the event of a mass casualty event where the employee’s services are needed.

D. Conclusion.

There are certain benefits that a hospital must continue to provide during a mass casualty event and certain benefits it need not. In the case of discretionary benefits that the hospital is not required to provide, it is important that the hospital notify its employees of the hospital’s right to postpone certain benefits, such as vacation, during a mass casualty event.

VI. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION.

A. Introduction.

The Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.* (“OSHAct”), requires the U.S. Secretary of Labor, acting through the Occupational Safety and Health Administration (“OSHA”), to establish safety and health standards for employment that employers must meet. The OSHAct covers all private employers doing business in interstate commerce and having one or more employees. It does not directly apply to the State or a political subdivision of a State. However, Wisconsin has made relevant OSHA standards

²⁵ While the initial offering of health care benefits is discretionary, once an entity decides to offer benefits, it must comply with nondiscrimination and other similar provisions with regard to such benefits.

discussed within Section VI of this Chapter applicable to public employers as well.²⁶ Therefore, the majority of Section VI is relevant to public employers, as well as private ones. An employee for the purposes of the OSHAct includes any individual performing services under the employer's direction and control for compensation. 29 U.S.C. § 652(6); *see also Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323-24 (1992). OSHAct's coverage of "employees" has been interpreted broadly in light of its purpose and the economic realities of the relationship.

Section VI of Chapter One outlines the basics of the OSHAct as well as OSHA's Bloodborne Pathogens Standard, Personal Protective Equipment Standard ("PPE Standard") and Standard on Hazardous Waste Operations and Emergency Response ("HAZWOPER"), as such Standards relate to a hospital's responsibilities and planning for a mass casualty event. It also discusses the likelihood of OSHA-issued citations and penalties as the result of violations during a mass casualty event.

B. Overview of OSHA Requirements.

Section 1 of the OSHAct provides that Congress' purpose in enacting the statute was to assure safe and healthful working conditions for working men and women. The "general duty clause" requires that each employer furnish to each employee employment and a place of employment which are free from recognized hazards that are causing, or are likely to cause, death or serious physical harm to the employees. 29 U.S.C. § 654(a)(1). Congress designed this clause and OSHA enforces it to cover serious workplace hazards to which no specific OSHA health or safety standard applies. In order to prove a violation of the general duty clause, OSHA must establish that the employer failed to provide a safe workplace or a safe employment by having failed to eliminate a hazard that either the employer or its industry recognizes and that caused, or was likely to cause, death or serious physical harm to one or more of the employer's employees. *Marshall v. L.E. Myers Co.*, 589 F.2d 270, 271 (7th Cir. 1978). The general duty clause may likely come into play during a mass casualty event where OSHA's specific standards do not cover a particular hazard or risk.

Wisconsin sets forth a similar requirement in its "Safe-Place Statute," Wis. Stat. § 101.11 *et seq.* It requires that an employer: (1) provide its employees a place of employment that is safe for both the employees and frequenters; (2) furnish and use safety devices and safeguards; (3) adopt and use methods and processes reasonably adequate to make the place of employment and the employment itself safe; (4) construct, repair, and maintain the place of employment to ensure that it is safe; and (5) do every other thing reasonably necessary to protect the life, health, safety, and welfare of such employees and frequenters.

OSHA authorizes the U.S. Secretary of Labor to establish standards governing workplace safety and health. 29 U.S.C. § 655(a). In certain circumstances, an employer may petition OSHA for a permanent variance from a safety or health standard where it can show that its current practice achieves the same measure of safety or health. Options also exist to request

²⁶ Wis. Admin. Code §§ Comm 32.15 and 32.50 demonstrate the parts of the OSHAct that Wisconsin enforces with respect to public employers. Among those are requirements related to the Occupational Safety and Health Standards, 29 C.F.R. Part 1910, and Recording and Reporting Occupational Illnesses, 29 C.F.R. Part 1904.

temporary variances from OSHA requirements.²⁷ The standards most likely to affect hospitals are the Bloodborne Pathogens Standard, Personal Protective Equipment Standard and the Standard on Hazardous Waste Operations and Emergency Response (“HAZWOPER”).

In addition to safety and health standards, OSHA sets forth regulations that generally deal with recordkeeping and inspections. The OSHAct also authorizes the U.S. Secretary of Labor to set forth regulations governing recordkeeping and reporting. 29 U.S.C. § 657(c). The regulations require every employer to post at each establishment a poster published by OSHA that explains employees’ rights under the OSHAct. 29 C.F.R. § 1903.2(a)(1). OSHA’s recordkeeping and reporting requirements apply to all employers having more than 10 employees at any time in the prior calendar year. 29 C.F.R. § 1904.1(a)(2). OSHA’s Recording and Reporting Occupational Injuries and Illnesses requirements can be found in 29 C.F.R. Part 1904.²⁸ A general summary of those record-keeping requirements follows:

1. Log of Work-Related Injuries and Illnesses (OSHA “300 Log”). This log is a record of fatalities, non-fatal injuries resulting in lost workdays, or non-fatal injuries not resulting in lost workdays but in transfers to other jobs, termination of employment, medical treatment other than first aid, loss of consciousness, or work motion restriction. The employer must record the following information: date of injury; name of employee;²⁹ job title/description; injury/illness description; fatality or lost workday or job transfer; and change in illness/injury within seven days of receiving the information. A “300 Log” must be maintained for each establishment, but employers with various or changing worksites may maintain the Log at a central location. 29 C.F.R. §§ 1904.7, 1904.29, and 1904.46.
2. Injury and Illness Incident Report (OSHA Form No. 301). This record is a compilation of every employee’s name, address, occupation, and vital statistics. It includes information as to where and how an accident occurred, the extent of injury or illness, and if there was a fatality. It also includes the name and address of the physician or hospital treating the employee. One must be completed for every recordable injury or illness entered on the OSHA 300 Log. *See* 29 C.F.R. § 1904.29. Wisconsin Worker’s Compensation Division Form WKC-12 can serve as an alternative to OSHA Form No. 301.
3. Annual Summary. The annual summary is basically an annual totals report taken from the 300 Log. The employer must post it by February 1 of each year and keep it posted through April 30, a copy must be posted in each establishment in a conspicuous place. *See* 29 C.F.R. § 1904.32.

²⁷ Public employers can also request variances pursuant to Wis. Stat. § 101.055 and Wis. Admin. Code § Comm 32.07.

²⁸ Wisconsin adopted 29 C.F.R. Part 1904 and made it applicable to public employers. *See* Wis. Admin. Code § Comm 32.50.

²⁹ There is an exception to the rule of providing identifying information, such as a name, in the hospital’s 300 Log when an injury or illness constitutes a privacy concern, such as in the case of a needle stick or sharps injury from a contaminated needle or mental illness. *See* 29 C.F.R. § 1904.29(b)(6)-(7).

An employer is not required to keep a separate OSHA 300 Log for each establishment that is not expected to be in operation for more than one year. While an employer still needs to record the applicable information, it can include it in a main log at a central location. *See* 29 C.F.R. § 1904.30. For example, a hospital would not be required to keep a separate 300 Log at an alternative treatment site, although it would need to make sure to include the information on the hospital's normal 300 Log.

The recordkeeping rules apply to all employees on the payroll, whether they are, among others, labor, executive, hourly, salary or part-time employees. A hospital is also responsible for recording the injuries and illnesses of those temporary workers from leasing services, temporary agencies, or personnel supply services that it supervises on a day-to-day basis. However, it is not responsible for the recordkeeping of self-employed individuals that become injured or ill while doing work on the hospital property. *See* 29 C.F.R. § 1904.31.

C. Standards Particularly Applicable to Hospitals in Preparation for a Mass Casualty Event.

1. Bloodborne Pathogens Standard.

OSHA's Bloodborne Pathogens Standard ("BPS") was originally published in 1991 and was amended by the Needlestick Safety and Prevention Act of 2000, Pub. L. No. 106-430. *See* 29 C.F.R. § 1910.1030. The BPS requires employers who have employees with occupational exposure such as hospitals to do the following: (1) complete a written exposure control plan; (2) implement universal precautions; (3) offer Hepatitis B vaccinations; (4) provide post-exposure evaluation, treatment, and counseling; (5) communicate hazards to employees; (6) educate and train employees in infection control; and (7) keep adequate records in accordance with 29 C.F.R. § 1910.20. The BPS applies to all occupational exposure to blood and other potentially infectious materials ("OPIM"), as well as to all occupational exposures to all bloodborne pathogens, not just HIV and Hepatitis B virus. 29 C.F.R. § 1910.1030(a)-(b).

The key provision of the BPS is the written Exposure Control Plan. As part of this Plan, the employer must prepare an exposure determination which lists the job classifications involving different levels of occupational exposure, as well as all tasks and procedures that employees undertake that result in occupational exposure. 29 C.F.R. § 1910.1030(c). Another key provision of the BPS is the requirement of the use of Universal Precautions and engineering and work practice controls to implement Universal Precautions. 29 C.F.R. § 1910.1030(d). Where occupational exposure remains after the institution of these controls, the BPS mandates the use of personal protective equipment ("PPE"). 29 C.F.R. § 1910.1030(d)(3). The equipment is appropriate if it does not permit blood or other OPIM to pass through the employee's clothing or body.

The BPS also requires a written schedule for cleaning, identifying the method of decontamination, and for disposing of contaminated sharps. 29 C.F.R. § 1910.1030(d)(4). It specifically sets forth standards for containers for these items and other regulated waste. Contaminated laundry must also be labeled as biohazard or red-bagged. 29 C.F.R. § 19.1030(d)(4)(iv).

The hospital must make Hepatitis B vaccinations available, at no cost, to all employees who have occupational exposure to blood within ten working days of initial assignment and after receiving required training. 29 C.F.R. § 1910.1030(f). The employee must sign the OSHA approved form if he or she chooses not to be vaccinated. In the event that booster doses are later recommended, the employer must also offer them. 29 C.F.R. § 1910.1030(f)(2)(iv).

In response to an exposure incident, the employer must undertake a confidential medical evaluation documenting the circumstances of the exposure, identifying and testing the source if feasible, and testing the exposed employee's blood with her/his consent. If the employee declines HIV testing, the employee's blood sample must be preserved for 90 days and tested during that time if the employee wishes to do so. The results of the source individual's test must be made available to the exposed person. Otherwise, the results are confidential. Any post-exposure follow-up must be paid by the employer. 29 C.F.R. § 1910.1030(f)(3).

Fluorescent orange or contrasting orange-red biohazard warning labels must be attached to waste containers and other containers containing blood or OPIM. Red bags can be substituted for labeled bags. Contaminated equipment must also be labeled appropriately. 29 C.F.R. § 1910.1030(g).

Additional sections of the BPS involve training and recordkeeping. Detailed and extensive training needs to be provided to employees at the inception of employment and annually thereafter. The employer must also keep records of this training. Records of all employee exposures, as well as a sharps injury log, must be kept up until 30 years after the end of the individual's employment with the employer. 29 C.F.R. § 1910.1030(h).

Because the BPS only applies to "all reasonably anticipated occupational exposures to blood or OPIM," a hospital employee who is not normally assigned to perform a job with occupational exposure, but who aids in an emergency, is not covered by the BPS. This is generally referred to as the Good Samaritan exception.³⁰ Volunteers are also not covered by the BPS.³¹ Note, however, that OSHA interprets the term "volunteer" very broadly and will consider a volunteer as an employee if he or she is reimbursed in any manner such as with discounted service.

Many of these provisions, especially those related to the use of PPE as well as the disposal of sharps and other contaminated objects, may be difficult to comply with during a mass casualty event where the hospital uses alternate treatment sites. However, OSHA has not exempted hospitals from this responsibility. Therefore, hospitals should include the provision of proper PPE as well as disposal containers in its plans for preparing an alternate treatment site.

³⁰ See Standard Interpretation 3/23/2001, *Coverage of the BBP Standard for Good Samaritan Acts and Personal Medical Conditions*, and Standard Interpretation 12/4/1992, *Applicability of Bloodborne Pathogens Standard to Emergency Responders, Decontamination, Housekeeping, and Good Samaritan Acts*.

³¹ See Standard Interpretation 12/4/1992, *Background of Bloodborne Pathogens Standard and Requirements for Emergency Medical Services*.

2. PPE Standard.

While the BPS includes the use of PPE, the PPE Standard is separately set forth at 29 C.F.R. §§ 1910.132-138. The PPE Standard generally requires that protective equipment (including personal protective equipment for the eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers) be provided, used and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of process or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact. 29 C.F.R. § 1910.132(a). It also requires the employer to conduct a hazard assessment of the workplace, to determine what PPE is needed, and to communicate the selection to the necessary employees. The employer is also responsible for training on the use of PPE. 29 C.F.R. § 132(d)-(f).

Because the PPE Standard's focus is on protecting employees rather than maintaining the worksite, it is most likely that its provisions will apply at an alternate treatment site. For this reason, it is important for hospitals to anticipate the needs of an alternative treatment site and plan accordingly. That said, OSHA may in its discretion decline to issue any citation.

As part of an emergency preparedness plan, hospitals need to develop a manner to provide PPE, sharps and biohazard containers as well as decontamination material to alternative treatment sites such as gymnasiums or other areas of patient spill-over. A hospital should also consider identifying potential sources of additional workers that have bloodborne pathogens training from another employer. This will alleviate the hospital's obligation to provide training to additional help during a mass casualty event. Temporary employee agencies might be a good option because the hospital then shares the OSHA obligations with that employer. The temporary agency would usually be responsible for providing general training, vaccinations, and follow-up evaluations following an exposure incident. This avenue saves valuable, and most likely necessary, time in the event of a mass casualty event.

3. HAZWOPER.

HAZWOPER covers emergency response operations for releases of, or substantial threats of releases of, hazardous substances without regard to the location of the hazard. 29 C.F.R. § 1910.120. HAZWOPER applies to all operations that require, or have the potential to require, emergency response operations involving exposure to hazardous substances. HAZWOPER offers a combination of standards and guidelines to protect employees from potential risks, allowing employers the flexibility to develop safety and health programs suitable to their facilities. While all of HAZWOPER's guidelines are too voluminous to discuss in this Manual, the most important section requires employers whose employees engage in emergency response to develop an emergency response plan. 29 C.F.R. § 1910.120(q). This requirement is likely to apply to hospitals because, at the very least, its hospital-based first receivers would be covered. A written plan must be developed and implemented to handle anticipated emergencies prior to the commencement of emergency response operations. 29 C.F.R. § 1910.120(q)(1). The plan must address, at a minimum, the following:

- (a) Pre-emergency planning and coordination with outside parties;

- (b) Personnel roles, lines of authority, training, and communication;
- (c) Emergency recognition and prevention;
- (d) Safe distances and places of refuge;
- (e) Site security and control;
- (f) Evacuation routes and procedures;
- (g) Decontamination;
- (h) Emergency medical treatment and first aid;
- (i) Emergency alerting and response procedures;
- (j) Critique of response and follow-up; and
- (k) PPE and emergency equipment.

29 C.F.R. § 1910.120(q)(2).

Emergency response organizations may use the local emergency response plan or the state emergency response plan or both, as part of their emergency response plan to avoid duplication. 29 C.F.R. § 1910.120(q)(2)(xii). Two resources that can be of great assistance to a hospital in planning compliance procedures are: (1) OSHA Directive CPL 02-02-059 (“OSHA Directive”), which can be found at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=1572&p_table=DIRECTIVES; and (2) *OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substance* (“OSHA Best Practices”), which is available at http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html.

The OSHA Directive provides a comprehensive summary of HAZWOPER. The OSHA Best Practices document compliments the OSHA Directive by setting forth best practices to protect hospital-based first receivers during releases of chemicals, radiological particles, and biological agents that produce victims who may need decontamination prior to administration of medical care. Some of the issues addressed are selecting appropriate PPE and training needs. The Best Practices document provides a thorough overview of a hospital’s responsibilities under HAZWOPER for first receivers of victims from mass casualty events and should be referred to in order to plan for such an event.³²

³² While it is impossible to set forth all of the potentially applicable standards and interpretations in this Manual, it is suggested that hospitals access the following OSHA website for additional guidance regarding preparing for and responding to bioterrorism threats: <http://www.osha.gov/SLTC/bioterrorism/solutions.html>.

D. Citations and Penalties for Violations of OSHA Standards and Record-Keeping and Reporting Violations.

OSHA has the authority to enforce its standards as well as issue notices and penalties for employers in violation of the standards.³³ However, OSHA must issue a citation and notification of a penalty within six months of the occurrence of any violation (i.e., the last day on which one or more employees had access to the alleged zone of danger). Violations may fall into one of three categories: (1) de minimis, (2) non-serious, and (3) serious. De minimis violations are those violations that have “no direct or immediate relationship to safety or health.” *Caterpillar, Inc. v. Herman*, 131 F.3d 666, 668 (7th Cir. 1997). OSHA issues non-serious violations when an accident or occupational illness stemming from a violation likely would not result in serious physical harm or death but likely would have a direct or immediate relationship with employee safety or health. 29 U.S.C. § 666(c). Non-serious violations generally carry either no penalty or a penalty of a nominal amount, although OSHA may issue a penalty of up to \$7,000 per violation. *Id.* Serious violations exist where there is a substantial probability that death or serious physical harm could result from a condition, practice, means, methods, operations or processes. *Id.* There is an exception for an employer that did not, and could not with reasonable diligence, know of the presence of the violation. In cases of non-serious and serious violations, OSHA applies a gravity-based penalty calculation and penalty adjustment factors, such as good faith, employer size, and violation history, that can reduce the penalty by as much as 95%. OSHA must assess a civil penalty of up to \$7,000 for serious violations. OSHA also has special provisions related to repeat offenders and willful violations, in which cases civil penalties can be as great as \$70,000 each. 29 U.S.C. § 666(a). OSHA may also issue citations for an employer’s failure to maintain or accurately maintain a 300 Log. While OSHA may cite an employer for minor inaccuracies, it will likely do so on a non-serious basis and without a penalty.

While the OSHAct does not, per se, include any waivers for an employer’s liability for OSHA violations, OSHA’s authority to issue citations is somewhat discretionary. Therefore, it may consider the unpredictability of incidents that occurred during a mass casualty event. However, whether the hospital reasonably could have and/or should have anticipated a risk or event that resulted in a violation will likely weigh into its decision.

³³ Although Wisconsin adopted many OSHA regulations and standards, it maintained its enforcement authority over public employers. Therefore, the Wisconsin Department of Commerce, not OSHA, is responsible for the regulation of public employers. Contrary to the penalties listed herein, the Department’s authority to issue citations is found in Wis. Stat. § 101.02(12)-(13). Those statutes provide:

(12) Every day during which any person or corporation, or any officer, agent or employee of a person or corporation, fails to observe and comply with any order of the department or to perform any duty specified under this subchapter shall constitute a separate and distinct violation of the order or of the requirements of this subchapter, whichever is applicable.

(13)(a) If any employer, employee, owner, or other person violates this subchapter, or fails or refuses to perform any duty specified under this subchapter, within the time prescribed by the department, for which no penalty has been specifically provided, or fails, neglects or refuses to obey any lawful order given or made by the department, or any judgment or decree made by any court in connection with this subchapter, for each such violation, failure or refusal, such employer, employee, owner or other person shall forfeit and pay into the state treasury a sum of not less than \$10 nor more than \$100 for each such offense.

Therefore, the most the Department can penalize the public employer is \$100 per offense.

E. Employee's Refusal to Perform Work Alleged to be Hazardous.

During a mass casualty event, an employer may be faced with employees who refuse to perform certain duties because they allege that the work is hazardous. The employer should know when it may lawfully discipline employees and when the refusal is protected under the OSHAct.

An employer is prohibited from discriminating against an employee who exercises his/her rights under the OSHAct. 29 U.S.C. § 660(c)(1). The regulations have addressed what constitutes an exercise of the employee's rights as it relates to a refusal to perform work that the employee alleges is hazardous. Specifically, 29 C.F.R. § 1977.12(b) states:

... occasions might arise when an employee is confronted with a choice between not performing assigned tasks or subjecting himself to a serious injury or death arising from a hazardous condition at the workplace. If the employee, with no reasonable alternative, refuses in good faith to expose himself to the dangerous condition, he would be protected against subsequent discrimination. The condition causing the employee's apprehension of death or injury must be of such a nature that a reasonable person, under the circumstances then confronting the employee, would conclude that there is a real danger of death or serious injury and that there is insufficient time, due to the urgency of the situation, to eliminate the danger through resort to regular statutory enforcement channels. In addition, in such circumstances, the employee, where possible, must also have sought from his employer, and been unable to obtain, a correction of the dangerous condition.

Accordingly, hospital supervisors, managers and/or human resource departments must be made aware of this reasonable person standard and apply it to the facts in question to determine whether the employee's refusal to perform the allegedly hazardous duties is a protected activity. If the hospital determines that the refusal is a protected activity, the employee cannot be disciplined for the refusal. The hospital, however, is not required to pay the employee for time not worked. *Whirlpool Corp. v. Marshall*, 445 U.S. 1, 9 (1980).

F. Conclusion.

Some important OSHA requirements applicable to hospitals during a mass casualty event are (1) the BPS; (2) the PPE Standard; and (3) HAZWOPER; as well as the general duty clause. A hospital will need to establish a method for providing proper training of additional workers as well as preparing alternate treatment sites with PPE and containers for contaminated objects. In order to minimize training, the hospital should identify other employers that can provide loaned or temporary employees that will be responsible for training.

VII. PROTECTING EMPLOYEES FROM PANDEMIC INFLUENZA.

In anticipation of flu virus outbreaks, several government agencies have provided guidance to employers on how to decrease the risk of an infected workforce, handle the inevitable onslaught of employee absences, maintain business continuity, and other related

workplace topics. The Center for Disease Control (“CDC”) has published “*Guidance for Businesses and Employers to Plan and Respond to the 2009-2010 Influenza Season.*” Within the specific context of health care employment, OSHA has issued two helpful publications for employers: “*Pandemic Influenza Preparedness and Response Guidance for Health Care Workers and Health Care Employers*” and “*Health Care Workplaces Classified as Very High or High Exposure Risk for Pandemic Influenza, What to Do to Protect Workers.*” All employers’ pandemic flu preparation processes should involve a close review of these instructive publications:

<http://flu.gov/plan/workplaceplanning/guidance.html>
http://www.cdc.gov/H1N1flu/business/toolkit/pdf/business_Toolkit.pdf
http://www.osha.gov/Publications/OSHA_pandemic_health.pdf
<http://www.osha.gov/Publications/exposure-risk-classification-factsheet.html>

During an influenza season, employers will face even greater challenges to maintaining normal business operations. Employers should prepare and test flexible and effective pandemic flu preparation plans. The CDC recommends that employers take the following actions:

1. Review normal seasonal absenteeism rates in order to increase awareness of unusual spikes in those numbers;
2. Engage state and local health departments to confirm channels of communication and methods for dissemination of local outbreak information;
3. Allow sick workers to stay home without fear of losing their jobs;
4. Develop flexible leave policies to allow workers to stay home to care for sick family members or for children if schools are closed;
5. Involve employees in the outbreak planning and preparation process;
6. Identify essential business functions, essential jobs or roles, and other critical elements required to maintain business operations; and
7. Set up authorities, triggers and procedures for activating and terminating the company’s response plan, all during business operations and transferring business knowledge to key employees.

During the course of the H1N1 flu outbreak, several health care employers sought guidance on whether they could require mandatory vaccinations for all of their employees. During the onset of the H1N1 flu outbreak, several hospitals across the country took the position that all of their workers were required to receive the vaccine or face disciplinary action, including termination. In addition, the Health Department of New York mandated that all health care workers be vaccinated against the influenza. As of the time of this publishing, the legal issues surrounding mandatory influenza vaccinations have not been settled. In the State of Washington, the State Nurses Association, which generally supports vaccinations, is suing a local health system over its decision to make the flu shot a condition of employment. Although

the outcome of these lawsuits have not been decided, it is important to note that many states already require that people working in hospitals be immunized against measles, mumps, and rubella. At the very least, employers who are considering making vaccinations a condition of employment should allow for exceptions for religious or medical purposes and also consult with legal counsel.

CHAPTER TWO

INDEPENDENT HEALTH CARE PROFESSIONALS

I. VOLUNTEERS VERSUS INDEPENDENT CONTRACTORS.

A. Volunteers.

1. Lay Volunteers and Volunteer Health Care Professionals.

At the outset, it should be noted that, in a mass casualty³⁴ event, a hospital may require the assistance of both volunteers who are qualified to provide health care services and lay volunteers who lack such qualifications but who could assist more generally with crowd control and other non-health care needs. A hospital should have a plan in place to organize and mobilize both lay volunteers and volunteer health care professionals. Such a plan will reduce the hospital's liability risks and will help to ensure that the services of volunteers are used appropriately and efficiently. A hospital should coordinate with local volunteer groups periodically to develop and improve its plan for involving and utilizing such groups during a mass casualty event.³⁵

When preparing a plan related to the use of volunteers, a hospital should consider the requirements of state and federal rules and regulations. Notably, the Wisconsin Administrative Code requires that every hospital have in place written policies that govern the use of volunteers. The policies should be established by the governing board and must: (a) delineate the scope of volunteer activities; (b) provide that volunteers may assist with patient care only under the direct supervision of appropriate hospital personnel and after appropriate in-service training that is documented; (c) provide that volunteers may not assist with patient care if it involves functions that require performance by licensed practical or registered nurses; and (d) provide that no volunteer under 16 years of age may give direct patient care. Wis. Admin. Code § DHS 124.05(3)(c). Policies should also, however, contemplate the possibility of a waiver of certain state and federal regulatory requirements as permitted under applicable laws. Hospitals should consider including in the volunteer policy a statement that, in the event a waiver is issued, volunteers can be used to the full extent permitted by law.

A hospital should review its volunteer policies and consider whether the policies adequately address the use of volunteers in mass casualty events. As part of its review, the hospital should identify deficiencies in its policies and should make any changes that are

³⁴ The terms disaster, emergency, and mass casualty event are used interchangeably throughout this Chapter.

³⁵ Other resources may include federal volunteers, such as the Medical Reserve Corps ("MRC"). The MRC is a national network of volunteers which establishes teams of local volunteer medical and public health professionals who can provide assistance during times of community need. See <http://www.medicalreservecorps.gov>. Additionally, the National Disaster Medical System's Disaster Medical Assistance Teams ("DMATs") may be a volunteer resource available to hospitals during a mass casualty event. DMATs are composed of professional and para-professional medical personnel, supported by a cadre of logistical and administrative staff, designed to provide medical care during a disaster or other event. See <http://www.dmat.org>. While DMATs typically deploy as an organized team with dedicated assets, other types of federalized volunteers may be available to staff alternative care sites and otherwise assist hospital response efforts.

necessary to address mass casualty event circumstances. A hospital should also consider whether the requirement to supervise volunteers will be workable and how volunteer training may need to be restructured in a mass casualty event.

2. Liability.

In determining the extent to which it will seek or accept the services of volunteers during a mass casualty event, a hospital should consider any available protections from liability. In general, individuals who provide volunteer services to or on behalf of a Wisconsin nonstock corporation are shielded from liability, except in limited circumstances. Volunteers who provide services at the scene of an emergency or accident are also generally shielded from liability in rendering emergency care. In addition, hospitals that grant emergency staff privileges to volunteer health care professionals during a state of emergency related to public health are generally immune from liability for the health care professional's acts. These protections, and their limitations, are discussed in greater detail below and are also addressed in Chapter Seven.

- (a) Limited liability for volunteers providing services to or on behalf of a Wisconsin nonstock corporation without compensation.

Wisconsin law provides that a volunteer providing services to or on behalf of a Wisconsin nonstock corporation is not liable to any person for liabilities arising from any act or omission as a volunteer, unless the person asserting liability proves that the act or omission constitutes: (a) a violation of criminal law, unless the volunteer had reasonable cause to believe that his or her conduct was lawful or had no reasonable cause to believe that his or her conduct was unlawful; (b) willful misconduct; (c) an act or omission within the scope of the volunteer's duties as a director or officer of the corporation; (d) an act or omission for which the volunteer received compensation or anything of substantial value instead of compensation; or (e) negligence in the practice of a profession that requires a credential or other license, registration, certification, permit, or approval, if the volunteer did not have the required credential, license, registration, certification, permit, or approval at the time of the negligent act or omission. Wis. Stat. § 181.0670(2). "Volunteer" is defined as an individual, other than an employee of the corporation, who provides services to or on behalf of the corporation without compensation. Wis. Stat. § 181.0670(1). The law does not distinguish between services provided by a volunteer in a state of emergency or services provided under non-emergency circumstances.

Limited liability protection for volunteers will not be granted in connection with: (a) civil or criminal proceedings brought by or on behalf of any governmental entity; (b) proceedings brought under an express private right of action created by state or federal statute; or (c) claims arising from the negligent operation of a vehicle by a volunteer for which an operator's permit, license, or insurance is required. Wis. Stat. § 181.0670(3). It should also be noted that the Wisconsin laws discussed above grant protection from liability to the volunteer, but not to the organization on whose behalf the volunteer provides services. See Section I(A)(2)(g) of Chapter Two for a discussion of a hospital's potential liability for the acts of its volunteers.

- (b) Civil liability exemption for a person who renders emergency care at the scene of an emergency or accident.

Wisconsin's Good Samaritan Statute provides that any person who renders "emergency care" at the scene of any emergency or accident in good faith is immune from civil liability for his or her acts or omissions in rendering such emergency care. Wis. Stat. § 895.48(1). The purpose of the Good Samaritan Statute is to encourage individuals to provide emergency care to injured persons by granting them immunity for their acts. A person does not receive immunity if he or she is an employee trained in health care or is a health care professional and he or she renders emergency care for compensation within the scope of his or her usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, en route to a hospital or other institution equipped with hospital facilities, or at a physician's office. Wis. Stat. § 895.48(1); *See also* 67 Op. Att'y Gen. Wis. 218 (1978) (discussing the terms "employees trained in health care," "health care professionals," "for compensation," and "scope of usual and customary employment").

Both lay volunteers and volunteer health care professionals that provide emergency care should be entitled to immunity under the Good Samaritan Statute if the hospital itself is considered the scene of an emergency or accident. This immunity will not extend to emergency care provided at a hospital by hospital employees trained in health care or medical staff members who provide emergency care for compensation at a hospital, even if the hospital is considered the scene of the accident or emergency. However, any volunteer health care practitioner would be indemnified if the services are provided during a state of emergency and in a geographic area in which a state of emergency applies. Wis. Stat. § 257.03.

(c) Emergency Volunteer Health Care Practitioners.

Under Wisconsin law, a volunteer practitioner who, during a state of emergency³⁶ provides services for which the practitioner is licensed, certified, registered, or, in the case of a nurse's aide, qualified, is considered a state agent and shall be indemnified for any claim arising from the provision of the services. The services must be performed in a geographic area in which the state of emergency applies. Wis. Stat. § 257.03. Volunteer practitioners will not be considered agents of the state if their acts or omissions involve reckless, wanton, or intentional misconduct. Wis. Stat. § 257.03(3). In addition, the health care facility on whose behalf services are provided is considered a state agent and, therefore, is indemnified for any claims arising from the provision of services. Wis. Stat. § 257.04.

(d) Volunteer Protection Act of 1997.

The federal Volunteer Protection Act of 1997 provides that no volunteer of a nonprofit organization shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity if: (a) the volunteer was acting within the scope of the volunteer's responsibilities in the nonprofit organization at the time of the act or omission; (b) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the activities or practice in the state in which the harm occurred; (c) the harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer;

³⁶ The state of emergency must be declared by the governor, a governing body of any local unit of government or a federal state of emergency. *See* Wis. Stat. §§ 257.01(10); 323.10; 323.11.

and (d) the harm was not caused by the volunteer while operating a motor vehicle for which the state requires the operator to possess an operator's license or maintain insurance. 42 U.S.C. § 14503(a). For these purposes, "nonprofit organization" means any tax-exempt 501(c)(3) organization or any not-for-profit organization, which may or may not have obtained certification as a tax-exempt organization under the Internal Revenue Code, that is organized and conducted for public benefit and operated primarily for charitable, civic, educational, religious, welfare, or health purposes. 42 U.S.C. § 14505(4). "Volunteer" means an individual performing services for a nonprofit organization or a governmental entity who receives \$500 per year or less either as compensation (other than reasonable reimbursement or allowance for expenses actually incurred) or through receipt of any other thing of value in lieu of compensation. 42 U.S.C. § 14505(6).

Protection under the Volunteer Protection Act of 1997 does not affect any civil action brought by a nonprofit organization against any volunteer of the organization. Therefore, a hospital is not prohibited from bringing a claim against one of its volunteers. In addition, this provision does not affect the potential liability of the nonprofit organization itself with respect to harm caused by one of its volunteers. See Chapter Seven for additional information regarding volunteer liability.

(e) Other sources of liability protection for volunteers.

Liability protection may also be available to volunteers who provide services through organized disaster response programs. For example, individuals may qualify as "federalized" volunteers if they provide services as a result of an appointment to an excepted position under Schedule A of the Excepted Service, as discussed in 5 C.F.R. Parts 6 and 213, or otherwise qualify as temporary federal employees under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121 *et seq.* For more information on how an individual is appointed to an excepted position under the Excepted Service, visit http://www.opm.gov/strategic_management_of_human_capital/fhfrf/FLX05010.asp. Disaster response personnel who are members of a DMAT, or a similar National Disaster Medical System Team, are granted liability protection under the Federal Tort Claims Act. Further, responders who deploy pursuant to the Emergency Management Assistance Compact ("EMAC") are treated as state employees and are protected from liability under state law. For more information on Wisconsin's participation in the EMAC, see Section II(E)(3) of this Chapter.

(f) Immunity for a hospital that grants emergency staff privileges.

Under Wisconsin law, a hospital may grant emergency staff privileges³⁷ to a health care provider when the following conditions are met: (a) the health care provider seeks to provide care at the hospital during a state of emergency related to public health;³⁸ (b) the health care provider does not already have privileges at the hospital at the time the emergency is declared; and (c) the health care provider seeking emergency staff privileges has privileges at another hospital. Wis. Stat. § 50.36(3d)(a). Hospitals that grant emergency staff privileges in the above circumstances are immune from liability for the acts or omissions of the health care providers

³⁷ The terms "emergency staff privileges" and "disaster privileges" may be used interchangeably throughout this Chapter.

³⁸ The governor may declare a state of emergency related to public health. See Section I of Chapter Three.

who are granted such emergency staff privileges. Wis. Stat. § 50.36(3d)(b). Unlike the other provisions relating to protection from liability described above, this specific provision in Wisconsin law protects hospitals, rather than the volunteers themselves, from liability due to the acts or omissions of its volunteers.

Since Wis. Stat. § 50.36(3d) applies only when health care providers are granted emergency staff privileges during a state of emergency related to public health declared by the governor, hospitals may want to maximize protection under this statute by granting emergency staff privileges to health care providers only after a state of emergency related to public health has been declared by the governor. Because a hospital may still be held liable for the acts or omissions of health care providers granted emergency staff privileges before the state of emergency is declared, it is prudent that a hospital document the date and time when a health care practitioner is granted emergency staff privileges and the reason the emergency staff privileges are being granted to the health care provider in order to memorialize the hospital's actions in the event a potential liability issue arises at some point in the future.

In planning a response to a mass casualty event, a hospital may desire to first call upon health care providers who already have privileges at the hospital to provide care before calling in volunteers who would need to be granted emergency staff privileges. However, this phased approach may be impractical during an emergency, and a hospital may need to grant emergency staff privileges before a state of emergency related to public health has been declared. Under such circumstances, a hospital may mitigate the risk of being found liable for the acts and omissions of those with emergency staff privileges by appropriately credentialing and privileging such providers and by providing appropriate supervision. See Section II of this Chapter for a detailed discussion of credentialing.

(g) Hospital's liability for acts of volunteers.

Whether during a mass casualty event, or otherwise, a hospital may be found liable for the acts of its volunteers under the doctrine of respondeat superior, which provides that a "master" may be liable for the torts of its "servant." Typically, this doctrine is cited to assert that an employer should be liable for the acts of its employees; however, the doctrine extends to situations in which the servant is not acting as an employee but rather as an unpaid volunteer who performs services for another and who, with respect to his or her physical conduct in the performance of the services, is subject to the other's control or right to control. See *Beul v. ASSE Int'l, Inc.*, 233 F.3d 441, 444-45 (7th Cir. 2000), citing *Heims v. Hanke*, 5 Wis.2d 465, 468 (1958) (overruled on other grounds by *Butzow v. Wausau Mem'l Hosp.*, 187 N.W.2d 349, 353-54 (Wis. 1971)).

A hospital may mitigate the risks of being found liable for the acts and omissions of its volunteers by instituting policies that assign volunteers to appropriate tasks based on their abilities and that also provide for reasonable supervision of its volunteers during an emergency. In addition, working with organized volunteer groups may help ensure that volunteers are adequately organized, trained, and supervised, which may minimize the potential for liability resulting from volunteers' negligent actions.

In planning for disasters, it is important to realize that the demand upon the hospital may so far exceed hospital resources that the ability of hospital employees to supervise volunteers may be strained. “Span of Control” is a concept used in the Incident Command System (“ICS”) to address the number of resources an individual with incident command supervisory responsibilities can effectively oversee. Under ICS theories, a supervisor’s span of control should be limited to three to seven subordinates. Where larger numbers of individuals are required to respond to an emergency, ICS Span of Control guidelines suggest that an organization should accommodate that need through the organization of individuals into multiple branches, divisions, and groups during a mass casualty event. Hospitals should consider using the ICS Span of Control guidelines when establishing policies regarding deployment and supervision of volunteers. More detailed information on the ICS can also be found at http://www.fema.gov/txt/nims/nims_doc2.txt.

3. Wisconsin Hospital Emergency Preparedness Program.

Hospitals can increase access to volunteers during a mass casualty event by participating in the Wisconsin Hospital Emergency Preparedness Program (“WHEPP”). The WHEPP assists hospitals in their response to emergencies and disasters by, among other things, facilitating the deployment of health care professionals to hospitals in need. Hospitals that participate in the WHEPP execute a Wisconsin Mutual Aid Memorandum of Understanding (“MOU”) which indicates that a hospital is willing to assist other hospitals within the state during an emergency. The MOU is a non-binding agreement that indicates that the participating hospital intends to cooperate with other participating hospitals in the state to coordinate response efforts in the event of a disaster. A participating hospital called upon to share staff, supplies and equipment is under no obligation to do so if it would jeopardize its ability to care for its own patients. Under the MOU, hospitals may receive emergency staffing by:

- (a) Entering into an Inter-Facility Staffing Agreement (sample agreements are attached to the MOU which can be obtained through the Wisconsin Division of Public Health, Hospital Preparedness Program); or
- (b) Requesting volunteers through the Wisconsin Emergency Assistance Volunteer Registry Program (“WEAVR”) discussed in Section II(D) of this Chapter, the Emergency Operations Center, or through a request directly to hospitals participating in the WHEPP.

Detailed information regarding the WHEPP can be found at <http://dhs.wisconsin.gov/preparedness/hospital/index.htm>. Other states also have similar programs, which were developed under the federal Emergency System for Advance Registration of Volunteer Health Professionals program and which may provide hospitals with helpful resource information.

B. Independent Contractors.

1. Existing Independent Contractor Relationships.

A hospital should discuss and clarify with existing independent contractors the duties of such individuals or organizations in the event of an emergency situation. Because such individuals and organizations are familiar with the hospital, its operations, and its staff, their assistance in an emergency may be preferable to the assistance of unknown volunteers. In addition, a hospital may consider entering independent contractor relationships with staffing agencies prior to an emergency to ensure that adequate numbers of personnel are available as necessary during a mass casualty event.³⁹ In doing so, however, the hospital should ascertain how many other health care facilities the staffing agency has (or will) contract with for similar services. As hospitals in New Orleans discovered after Hurricane Katrina, many health care facilities rely on just one or two companies to provide the same emergency services to multiple health care facilities, which may substantially limit the actual availability of such services in a mass casualty event.

Hospitals may also wish to consider specifying in medical director and other similar contracts the hospital's expectation that the physician providing such services must be prepared to provide health care services at the hospital in the event of a disaster.

2. Payments to Physicians.

A hospital may desire to pay physicians who do not ordinarily provide services at the hospital for services provided in response to a mass casualty event. Please note that when services are provided in exchange for compensation, the liability protections for volunteers described in Sections I(A)(2)(a)-(e) of Chapter Two do not apply. In addition, a hospital should ensure that any such payments comply with the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b) and the federal physician self-referral statute, 42 U.S.C. § 1395nn(a) (the "Stark Law"), as further discussed below. Because both the Anti-Kickback Statute and the Stark Law require that contracts be in writing, a hospital may wish to enter into written contracts with a panel of independent contractors who may be called upon during a mass casualty event before the mass casualty event occurs, or to have contracts ready to be entered and signed at the time a physician arrives at the hospital to provide services for which he or she will be compensated. If patient care needs make it impossible for a physician to sign a contract before providing care during a mass casualty event, the contract should be signed as soon as possible after the immediate emergency situation is under control, but in any event, before the physician receives any compensation from the hospital. A hospital that desires to pay physicians for care provided during a mass casualty event should develop a policy that addresses the logistics of entering into signed written agreements and that also outlines the circumstances under which such payments will be made, the level of compensation that will be provided, and the means of determining and demonstrating that the compensation paid represents fair market value for the services rendered.

³⁹ Please note that Chapter Two addresses independent health care personnel. However, a hospital should also review its agreements with independent contractors who do not provide health care services to clarify the independent contractors' roles during emergencies. For example, if a hospital contracts with an outside company for nutrition services, such as patient meal services and cafeteria operations, the hospital should ensure that the contract will support the hospital's needs during a mass casualty event.

(a) The Anti-Kickback Statute.

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce referrals for which payment may be made under a federal health care program. The type of remuneration covered by the Anti-Kickback Statute includes the transfer of anything of value, in cash or in kind, directly or indirectly, covertly or overtly. 42 U.S.C. § 1320a-7b(b).

The Anti-Kickback Statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain the referrals of services or to induce further referrals. *United States v. Kats*, 871 F.2d 105, 108 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68, 69 (3d Cir. 1985). Any determination of whether the requisite intent to violate the statute is present would involve an analysis of all objective facts and circumstances surrounding the arrangement(s) under scrutiny. Violation of the Anti-Kickback Statute constitutes a felony punishable by fine, imprisonment, or both. Additionally, violation of the statute may lead to exclusion from federal health care programs and imposition of civil monetary penalties.

Any time a hospital engages in a financial relationship with a physician or an independent practitioner, or otherwise provides a physician or an independent practitioner with remuneration of any kind, it should be mindful of the Anti-Kickback Statute. The Anti-Kickback Statute includes several safe harbors that protect certain arrangements that might otherwise technically violate the Anti-Kickback Statute. If an arrangement meets all of the conditions of the safe harbor, it will be protected from prosecution. Although the safe harbors only protect arrangements that precisely meet all of the specific conditions set forth in the safe harbor, an arrangement that fails to meet a safe harbor is not necessarily a violation of the Anti-Kickback Statute. Rather, it means that the arrangement must be evaluated to determine if the parties have the requisite intent to knowingly and willfully induce or encourage referrals based on the facts and circumstances surrounding the arrangement. Payments made to physicians or independent practitioners for services provided during a mass casualty event are not likely to be motivated by an intent to induce referrals from them; rather, such payments are most likely motivated by a desire to ensure adequate staffing to provide necessary patient care during a mass casualty event. Therefore, it is unlikely that such payments would be found to violate the Anti-Kickback Statute.

In determining whether to compensate physicians and other independent practitioners who provide services during a disaster, it may be appropriate to evaluate whether or not the practitioner will be able to bill directly for such services, or whether that individual is otherwise being compensated in some manner for those services. In some cases, waivers of payment requirements have been granted to hospitals who provide care to disaster victims, but no similar waivers have been granted to physicians or other independent practitioners (for example, after the Haiti earthquake). If the physician or independent practitioner is otherwise compensated for their services, payment by the hospital may be less critical. Where, however, the physician or independent practitioner is not otherwise compensated, reasonable payment by the hospital for services necessary to properly care for patients is likely permissible.

One Anti-Kickback Statute safe harbor that may apply when contracting with physicians or independent practitioners to provide services in an emergency is the personal services safe harbor. For protection under this safe harbor, a hospital should structure arrangements with

physicians and independent practitioners so that as many of the following seven standards are met as possible:

- (i) There is a written agreement signed by the parties;
- (ii) The agreement covers and specifies all of the services provided for the term of the agreement;
- (iii) If the agreement provides for services on a periodic, rather than full-time basis, the agreement specifies the schedule of such intervals, their precise length, and the exact charge for such intervals;
- (iv) The term of the agreement is for at least one year;
- (v) The compensation paid is set in advance, is consistent with fair market value, and does not take into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made under a federal health care program;
- (vi) The services performed under the agreement do not violate state or federal law; and
- (vii) The services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

42 C.F.R. § 1001.952(d). Even if a personal services agreement does not meet all of these safe harbor requirements, it is not necessarily a violation of the Anti-Kickback Statute. Rather, the agreement must be evaluated to determine whether it is intended to knowingly and willfully induce or encourage referrals.

(b) The Stark Law.

The Stark Law generally prohibits a physician from making a referral for designated health services payable under the Medicare program to an entity with whom the physician (or an immediate family member of such physician) has a financial relationship unless an exception applies. 42 U.S.C. § 1395nn(a). For Stark Law purposes, a “financial relationship” includes an ownership or investment interest, or a “compensation arrangement,” which is defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity. 42 U.S.C. § 1395nn(h)(1)(A). “Remuneration” means any remuneration given to a physician, directly or indirectly, overtly or covertly, in cash or in kind. “Designated health services” include, among other items, inpatient and outpatient hospital services, radiology services, durable medical equipment and supplies, home health services, and physical and occupational therapy services. 42 C.F.R. § 411.351. Violations of the Stark Law may result in the denial of payments for designated health services provided or billed in violation

of the Stark Law, civil monetary penalties of up to \$15,000 for each prohibited referral, and exclusions from federal health care programs. 42 U.S.C. § 1395nn(g)(1)-(3).

Unlike the Anti-Kickback Statute, which has an intent element, the Stark Law is a so-called “strict liability” statute. As a result, if a financial relationship exists between a physician and an entity, the physician is prohibited from making referrals to the entity for designated health services payable by the Medicare program. Like the Anti-Kickback Statute, however, the Stark Law contains several exceptions that exclude certain common arrangements from its general prohibition. Arrangements must fit squarely within an exception in order to be deemed to comply with the Stark Law. Exceptions that may be useful when structuring arrangements with physicians to provide services in the event of an emergency are the personal service arrangements exception and the fair market value compensation exception.

The Stark Law exception for personal service arrangements requires that:

- (i) The arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement;
- (ii) The arrangement covers all of the services to be provided by the physician to the entity;
- (iii) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement;
- (iv) The term of the arrangement is for at least one year;
- (v) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and does not take into account the volume or value of referrals or other business generated between the parties; and
- (vi) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or any other activity that violates any state or federal law.

42 C.F.R. § 411.357(d).

Alternatively, an independent contractor arrangement with a physician could be structured to fit within the Stark Law exception for fair market value compensation. To meet this exception, the independent contractor relationship must meet the following requirements:

- (i) The parties enter into a signed, written agreement that covers only identifiable items or services, all of which are specified in the agreement;

- (ii) The agreement specifies a timeframe for the arrangement, which can be for any period of time and contain a termination clause, provided the parties enter into only one arrangement for the same items or services during the course of a year;
- (iii) The compensation to be provided is specified in the agreement, set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals generated by the referring physician;
- (iv) The arrangement is commercially reasonable and furthers the legitimate business purposes of the parties;
- (v) The arrangement does not violate the Anti-Kickback Statute or any federal or state law or regulation governing billing or claims submission; and
- (vi) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates a state or federal law.

42 C.F.R. § 411.357(l).

While there is no specific “disaster” Stark Law exception, penalties under the Stark Law may be waived by the Secretary of the Department of Health and Human Services (“Secretary”) for entities in a disaster zone, if a disaster has been declared by the President of the United States, or a public health emergency has been declared by the Secretary. 42 U.S.C. § 1320b-5 (Section 1135 of the Social Security Act, therefore often referred to as a “Section 1135 Waiver”). The Secretary’s Section 1135 Waiver authority is relatively broad, and includes the ability to waive Medicare Conditions of Participation, licensure requirements, and sanctions related to certain violations of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (“EMTALA”) and the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d *et seq.* (“HIPAA”). Section 1135 Waivers were issued as a result of Hurricane Katrina and the novel H1N1 influenza pandemic of 2009. For a sample Section 1135 Waiver see http://www.flu.gov/professional/federal/h1n1_1135waiver_10272009.html.

3. Liability for Independent Contractors.

A hospital is immune from liability for the acts and omissions of a health care provider who has been granted emergency staff privileges during a state of emergency declared by the governor, as described in Section I(A)(2)(f) above. The hospital’s immunity would apply even where the health care provider is an independent contractor of the hospital rather than a volunteer. However, the liability protections provided to volunteers described in Sections I(A)(2)(a)-(e) above do not apply to an independent contractor who receives compensation for his or her services.

II. CREDENTIALING.

A. Wisconsin Law.

1. Generally.

Wisconsin law generally requires that only qualified individuals be permitted to exercise privileges in a hospital. Wisconsin's Administrative Code provides that a hospital's medical staff is responsible to the governing body of the hospital for the quality of all medical care provided to patients in the hospital. Wis. Admin. Code § DHS 124.12(2)(a). Temporary staff privileges may be granted for a limited period of time if the individual is otherwise properly qualified for membership on the medical staff. Wis. Admin. Code § DHS 124.12(4)(c)(4). Evaluation criteria, including individual character, competence, training, experience and judgment should be considered before granting such privileges. *Id.*

2. Emergency Staff Privileges.

As discussed in Section I(A)(2)(f) above, Wis. Stat. § 50.36(3d) permits a hospital to grant emergency staff privileges to a health care provider to whom all of the following apply: (1) the health care provider seeks to provide care at the hospital during a state of emergency related to public health declared by the governor; (2) the health care provider does not have staff privileges at the hospital at the time the state of emergency is declared; and (3) the health care provider has staff privileges at another hospital. As described in Section I(A)(2)(f) of this Chapter, a hospital that grants emergency staff privileges under this provision has immunity from civil liability for acts or omissions by a health care provider who is granted emergency staff privileges. Wis. Stat. § 50.36(3d)(b).

B. Medicare Conditions of Participation for Hospitals.

The Medicare Conditions of Participation, not unlike the Wisconsin Administrative Code requirements, generally provide that a hospital's medical staff is responsible for the quality of medical care provided to its patients. In addition, the medical staff must examine the credentials of individuals who may be permitted to provide care in the hospital. *See* 42 C.F.R. § 482.22. As discussed in Section I(B)(2)(b) of this Chapter, the Secretary may waive Conditions of Participation under a Section 1135 Waiver if a disaster has been declared by the President of the United States, or if a public health emergency has been declared by the Secretary. 42 U.S.C. § 1320b-5.

C. The Joint Commission.

The Joint Commission requires a hospital to have an emergency operations plan that comprehensively describes its approach to emergencies in the hospital or community. Joint Commission Standard EM.02.01.01. Part of a hospital's approach to emergencies should include the granting of disaster privileges to volunteer licensed independent practitioners (e.g., physicians, podiatrists, or dentists) and the assignment of disaster responsibilities to other volunteer practitioners (e.g., physician assistants, advanced practice nurses, etc.) who are not independent, but are otherwise required by law to have a license, certification or registration. *See* Joint Commission Standards EM.02.02.13 and EM.02.02.15. Although the Joint

Commission authorizes streamlined credentialing and privileging, it also requires that safeguards be in place to ensure that volunteer practitioners are competent to provide safe and adequate care, treatment or services. For Joint Commission accredited hospitals, we recommend that the hospitals review their emergency operations plan, medical staff bylaws and related hospital policies to ensure accreditation standards are met.⁴⁰

The relevant Elements of Performance related to Joint Commission Standard EM.02.02.13 addressing volunteer licensed independent practitioners (e.g., physicians, podiatrists, and dentists) require the following:

1. The hospital grants disaster privileges to volunteer licensed independent practitioners only when the emergency operations plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.
2. The medical staff identifies in its bylaws those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.
3. The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners.
4. The medical staff describes in writing how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges, for example, by direct observation or mentoring.
5. Before being considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains from the volunteer licensed independent practitioner a valid government-issued photo identification, for example, a driver's license or passport, and at least one of the following:
 - (a) A current picture identification card from a health care organization that clearly identifies professional designation;
 - (b) A current license to practice;
 - (c) Primary source verification of licensure;
 - (d) Identification indicating that the individual is a member of a DMAT, the Medical Reserve Corps, the Emergency System for

⁴⁰ The Joint Commission Standards also address the granting of disaster privileges to independent practitioners in disaster situations. Importantly, these standards are more restrictive than the process contemplated by Wis. Stat. § 50.36, which allows hospitals to grant privileges to a broad category of health care providers in certain emergency situations. Hospitals accredited by the Joint Commission are encouraged to consult legal counsel for advice on how best to address this conflict.

Advance Registration of Volunteer Health Professionals, or another recognized state or federal response organization;

- (e) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances; or
- (f) Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

The relevant Elements of Performance related to Joint Commission Standard EM.02.02.15 (addressing other volunteer practitioners such as physician assistants or advanced practice nurses) require the following:

1. The hospital assigns disaster responsibilities to other volunteer practitioners only when the emergency operations plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.
2. The hospital identifies, in writing, those individuals responsible for assigning disaster responsibilities to the other volunteer practitioners.
3. The hospital determines how it will distinguish other volunteer practitioners from its staff.
4. The hospital describes, in writing, how it will oversee the performance of other volunteer practitioners who have been assigned disaster responsibilities, for example, through direct observation or mentoring.
5. Before a volunteer practitioner is considered eligible to function in this situation, the hospital obtains his or her valid government-issued photo identification, for example, a driver's license or passport, and one of the following:
 - (a) A current picture identification card from a health care organization that clearly identifies professional designation;
 - (b) A current license, certification, or registration;
 - (c) Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice);
 - (d) Identification indicating that the individual is a member of a DMAT, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or another recognized state or federal response organization or group;

- (e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
- (f) Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.

The Joint Commission further provides that during a disaster the hospital must oversee the performance of all volunteers. Based on its oversight of each volunteer, the hospital must determine within 72 hours after the volunteer's arrival whether assigned disaster privileges and/or responsibilities should continue. Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) should occur as soon as the disaster is under control or within 72 hours from the time the volunteer practitioners presents him or herself to the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours due to extraordinary circumstances, the hospital should complete the primary source verification as soon as possible and also document all of the following:

1. Reason(s) that primary source verification could not be performed within 72 hours of the volunteer's arrival;
2. Evidence of the volunteer's demonstrated ability to continue to provide adequate care, treatment, or services; and
3. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

The Wisconsin Disaster Credentialing system, explained in Section II(D) below, may be used to verify primary source information for practitioners. For sample medical staff bylaw provisions addressing disaster privileging, see Appendix E.

D. WEAVR and Wisconsin Disaster Credentialing.

Wisconsin maintains a health professional volunteer registry and a database that stores information regarding each volunteer's identity, licensing, credentialing, accreditation, and privileging in hospitals and other medical facilities. Wisconsin's database is managed by the WEAVR and the Wisconsin Disaster Credentialing ("WDC") systems. WEAVR may be accessed online at <http://dhs.wisconsin.gov/preparedness/WEAVR>. WEAVR provides health professionals with an easy way to indicate their interest in volunteer service during an emergency. In addition, WEAVR securely houses all volunteer information in a central location. Each volunteer health professional enters in to the WEAVR system their contact information and information about expertise, including degree, licensure, certification, and specific skills. WEAVR requires that all health practitioners interested in providing volunteer services keep their contact and expertise information current. In the event that a hospital's other volunteer resources are insufficient, or if certain volunteers need relief, WEAVR volunteers can be called on to provide additional assistance.

WDC is a secure web-based system that allows a hospital to quickly perform primary source verification for a physician, allied health professional, or other licensed health care worker. WDC is connected to and displays real-time information from other online credentialing sources such as the Wisconsin Department of Regulation and Licensing, other states' licensing agencies, the Office of Inspector General's exclusions database, the National Practitioner Data Bank, and the American Board of Medical Specialties. WDC provides hospitals with information collected in one location, eliminating the hospital's need to check multiple online databases when performing primary source verification. In addition, hospitals may choose to participate in WDC by voluntarily providing additional information to WDC regarding a practitioner's current medical staff status and other information, which will be available to hospitals using WDC for purposes of disaster credentialing. Hospitals may obtain additional information about WDC by contacting the Wisconsin Division of Public Health.

E. Credentialing for Categories of Practitioners.

This Section discusses the credentialing for various categories of practitioners. It is important to note that, depending on the scope of the emergency and the state and federal waivers issued, greater flexibility may be available to hospitals confronted with credentialing issues.

1. Members of Medical Staff at Hospital Where Additional Practitioners Are Needed.

The first group of practitioners who will be available to assist in an emergency are those medical staff members who are already present at the hospital. Medical staff bylaws may stipulate that in an emergency any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, or services necessary as a life-saving measure or to prevent serious harm, regardless of his or her medical staff status or clinical privileges, provided that the services provided are within the scope of the individual's license. *See* Rationale for Joint Commission Standard MS.06.01.13. Including such a provision in the medical staff bylaws may help the hospital deal with the initial stages of an emergency by providing care through current medical staff members. To take full advantage of a provision regarding emergency privileges, a hospital may wish to implement a system to alert medical staff members of all categories to come to the hospital in the event of an emergency. These individuals can provide care within the scope of their individual professional licenses until additional emergency health care providers have been called to the hospital and granted disaster privileges.

2. In-State Practitioners Who Are Members of Other Hospitals' Medical Staff.

Members of other hospitals' medical staffs may be granted disaster privileges in accordance with the hospital's disaster privileges provisions in its medical staff bylaws. A hospital's disaster privileging policy may provide that such practitioners be granted privileges upon meeting state law requirements for emergency staff privileges, as discussed in Section II(A)(2)(f) above, as well as applicable Joint Commission Standards, where appropriate.

3. Out-of-State Practitioners, EMAC Members, and Retired Practitioners.

In general, licensed health care providers may practice only in those states in which they are licensed. For example, Wisconsin law provides that no person may practice medicine and surgery, or attempt to do so, or make a representation that he or she is authorized to do so, without a license to practice medicine and surgery granted by the Wisconsin Medical Examining Board. Wis. Stat. § 448.03(1). A physician who violates this section may be fined not more than \$25,000 or imprisoned for not more than 9 months or both. Wis. Stat. § 448.09(1m). A hospital must ensure that it does not permit out-of-state practitioners or others who are not licensed in Wisconsin to provide care that requires a Wisconsin license, unless a state of emergency has been declared by the governor and he or she waives the requirement that a practitioner hold a valid Wisconsin license to practice.⁴¹ The Wisconsin Administrative Code requires that a hospital governing body ensure that those with medical staff privileges be qualified both legally and professionally for the positions to which they are appointed. Wis. Admin. Code § DHS 124.12(4)(a)(2). While an out-of-state practitioner may be qualified professionally to provide services, failure to be licensed in Wisconsin renders the practitioner legally unqualified. A hospital that permits an unlicensed practitioner to provide services in the hospital could be held liable for negligent credentialing. *See Johnson v. Misericordia Cmty. Hosp.*, 97 Wis.2d 521, *aff'd*, 99 Wis.2d 708 (1981). As a result, hospitals should not permit out-of-state practitioners or others who are not licensed in Wisconsin to provide care that requires a Wisconsin license, unless a state of emergency has been declared by the governor and the licensure requirement has been waived.

Wisconsin is a party to the EMAC, which has been entered into by all 50 states and which provides an exception to the general rule that practitioners licensed in other states may not provide health care services in Wisconsin. *See* Wis. Stat. § 323.80. Under the EMAC, whenever any person holds a license, certificate, or other permit issued by any party state evidencing the meeting of qualifications for professional, mechanical or other skills, and when that person's assistance is requested by the receiving state (i.e., Wisconsin), that person is deemed to be licensed, certified, or permitted by the receiving state (i.e., Wisconsin) to render aid involving such skill to meet a declared emergency. Wis. Stat. § 323.80(5). The governor may limit or condition this deemed status. Therefore, when the governor has declared a state of emergency and requests assistance from other states that are parties to the EMAC, a hospital may permit out-of-state health care practitioners to provide health care services within their scope of licensure, and may grant disaster privileges within their scope of licensure, subject to any specific conditions or limitations imposed by the governor. Note, however, that the EMAC provisions only apply when one state requests assistance from another state, and the responding health care provider responds as part of an organized EMAC response. Volunteer health care providers who self-deploy are not covered by EMAC; however, the services of these providers may be used under other legal authority.

As is the case with out-of-state practitioners, hospitals should take special care to ensure that retired practitioners still hold a valid license to practice medicine before allowing them to

⁴¹ Out-of-state practitioners who are not licensed to practice in Wisconsin may receive indemnification as emergency volunteer health care practitioners as specified in Wis. Stat. § 257.03 and further discussed in Section I(A)(2)(c) of this Chapter.

join the medical staff during an emergency. Hospitals should not grant privileges to individuals who are not properly licensed, absent appropriate waivers as discussed above.⁴²

4. Nurses and Other Licensed Health Care Professionals.

In general, only the categories of practitioners who would be granted clinical privileges in a non-emergency situation may be granted privileges to assist in a disaster. Such individuals should be permitted to provide care only within the applicable scope of licensure and should be assigned a supervisor.

For registered nurses and other licensed health care professionals who are not permitted to practice independently in a hospital under Wisconsin law, a hospital should develop a policy that sets forth procedures for identification and verification of licensure. It is important to remember that, depending on the circumstances, waiver of licensure may have been granted, and scope of practice may be modified to respond to the disaster. However, hospitals should have a clear and straightforward process for determining whether, and when, such expansions of practice are permitted.

5. Non-Licensed Health Care Professionals.

As discussed above, a hospital may not permit non-licensed health care professionals to provide medical care that, by law, must be provided by a licensed individual. A hospital should review its use of non-licensed health care professionals under normal circumstances and consider whether their tasks should change during a mass casualty event.

F. Preparedness.

In order to ensure that adequate numbers of practitioners are available to provide services in emergency situations, it is extremely important to develop a comprehensive plan for credentialing and assigning duties to volunteer health care professionals. A hospital should develop an application form for disaster privileges so that a record of the disaster privileging process is kept for each individual who requests disaster privileges. The form should be brief, but at a minimum should require the individual's name and contact information, date of birth, the type of professional license held and the states of licensure, the individual's specialty or area of expertise, the types of identification presented, and the applicant's signature. A hospital may also wish to require a practitioner to list the health care facilities or organizations where he or she provides services and/or holds privileges. The application form should also include the effective date of the disaster privileges granted, the scope of the privileges granted, the title and signature of the person granting the privileges, and the name of the individual who will supervise the practitioner with disaster privileges. Finally, the form should include an area to indicate when the disaster privileges are terminated and the title and signature of the individual who terminates the disaster privileges.

⁴² Individuals who at any time within the previous ten (10) years, but who do not currently hold a license to practice, may receive indemnification as emergency volunteer health care practitioners as specified in Wis. Stat. § 257.03 and further discussed in Section I(A)(2)(c) of this Chapter.

It is important that a hospital keep detailed records of the disaster privileges granted. As explained above, a hospital's protection from liability for acts or omissions of a practitioner granted disaster privileges is available only during a state of emergency relating to public health. Thus, it is imperative that a hospital know which practitioners were granted disaster privileges and when such privileges were granted and terminated. When a formal granting of privileges is not required, the hospital should document the scope of practice and level of supervision granted to volunteer health care providers.

A hospital must also be able to easily identify those practitioners to whom the hospital has granted disaster privileges. The hospital should be sure that disaster privilege identification badges or some other form of identification is available for distribution when disaster privileges are granted. The badges should be easily identifiable by color, size, and labeling and clearly indicate that the individual has disaster privileges. All of the forms and other materials necessary for disaster privileging should be kept together in places that will be easily accessible in the event of an emergency. Hospitals may wish to maintain disaster privileging materials in more than one location in their facilities in the event that certain areas of such facilities are not accessible during a mass casualty event. A hospital may also wish to develop a brief orientation program for those who are granted disaster privileges, although it may not be feasible to provide even a brief orientation during a mass casualty event due to urgent patient care needs.

It is critical that a hospital develop a disaster privileging process before a mass casualty event occurs. Credentialing and privileging providers efficiently during a mass casualty event is necessary to ensure that patients receive care promptly. When drafting bylaws, policies and procedures related to disaster privileging, a hospital must ensure that the procedures outlined are realistic and can be followed during a mass casualty event. Those who are likely to assist in disaster privileging should participate in mock exercises to become familiar with the procedures and to determine whether the procedures are likely to be workable during a mass casualty event.

III. INSURANCE.

Individuals providing volunteer services to a hospital during an emergency are provided with protection from civil liability arising from their actions or omissions as volunteers under the provisions described in Sections I(A)(2)(a)-(e) of this Chapter. Keep in mind that hospitals are offered far less protection from liability in the event of an emergency; a hospital is only protected from liability arising from acts or omissions of practitioners granted disaster privileges during a state of emergency related to public health declared by the governor. A hospital's immunity from liability does not extend to the acts and omissions of practitioners when a state of emergency has not been declared or to the acts and omissions of lay volunteers or health care workers who are not granted disaster privileges. Therefore, it is important that a hospital evaluate the risks with respect to liability stemming from services provided by volunteer non-licensed health care professionals and licensed health care professionals prior to the occurrence of a declared emergency and review its insurance policies to determine whether it is adequately insured against those risks.

It will also be important to record accurately the challenges faced by the hospital in responding to the disaster during, or as soon as possible after, initial response to the disaster. Contemporaneous documentation regarding resources and demands will help demonstrate that

the actions taken by the hospital in preparing for and responding to the emergency were reasonable.

IV. BILLING.

A. Billing Medicare and Medicaid for Services Provided by Volunteer or Independent Contractor Practitioners.

In general, there are no relevant federal or state law provisions that prohibit a hospital from billing Medicare or Medicaid for services provided by participating health care professionals who receive no compensation for their services. The same requirements apply to billing for services provided by volunteers as billing for services provided by individuals who are compensated for their services. An entity enrolled in the Medicare program may submit a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished (whether on or off the premises of the entity submitting the bill). *Medicare Claims Processing Manual (CMS Pub. 100-04)*, Chapter 1, § 30.2.7. This provision does not require that the contractual arrangement between the physician and the facility be in writing, but if a hospital will bill for a physician's services, the hospital must ensure that the physician does not also bill for the same services. It is important to remember that Section 1135 Waivers may waive or modify certain billing requirements which would otherwise prevent a hospital from billing for such services.

Likewise, under the Wisconsin Medicaid program, payment may be made to a hospital if a service was provided in the hospital and a contractual agreement exists between the participating provider and the hospital under which the hospital prepares and submits the claim for reimbursement for the service provided by the individual provider. Wis. Admin. Code § DHS 106.03(5)(a)(2). The hospital must apply for and receive certification from the Wisconsin Department of Health Services to submit claims and receive payment on behalf of the provider performing the services. Wis. Admin. Code § DHS 106.03(5)(b).

B. Billing Private Payors for Services Provided by Volunteer Health Care Professionals.

A hospital should review private payor contracts to determine whether it will be reimbursed for services provided by volunteer health care professionals. A hospital may wish to negotiate with private payors for coverage for services provided in whole or in part by volunteer health care professionals during a state of emergency if the contracts do not provide for such coverage.

CHAPTER THREE

ORGANIZATION AND LOGISTICS OF EMERGENCY RESPONSE

I. OVERVIEW.

The overwhelming numbers of casualties caused by a mass casualty event⁴³ could easily place severe strain on a hospital's logistics system. With a strained logistics system, a hospital's response to a mass casualty event could be seriously undermined. Even the best equipped and staffed hospital could be made entirely ineffectual if it were unable to mobilize its personnel, equipment, and medication as necessary in a mass casualty situation. Accordingly, a hospital should consider how its response to a mass casualty event can be coordinated with the efforts of local, state, and federal governments, and with the efforts of other health care providers.

Existing health care systems consist of a patchwork of hospitals, outpatient clinics, ancillary care organizations, and private physicians. Together, these organizations have significant resources that can be employed in response to a major emergency incident. However, utilizing these resources effectively requires substantial coordination. Since government plays a significant role in coordinating response efforts, including those of health care providers during mass casualty events, it is critical that hospital administrators understand how their facility's response fits into the government's overarching emergency response strategy.

This Chapter presents an overview of the organizational framework established under federal and state law to facilitate the response to a mass casualty event. Although primary responsibility for disaster response is local, the federal government has established standards intended to support and integrate local, state, and federal disaster response. This Chapter begins with a discussion of the National Response Framework and the National Incident Management System, which are resources that the federal government has developed to encourage a coordinated response to emergency incidents at all levels. It then discusses various state laws that govern the declaration of a state of emergency, and the provisions that direct the preparation and execution of state and local emergency response plans.

II. FEDERAL EMERGENCY MANAGEMENT SYSTEMS.

A. The National Response Framework.

Following the September 11th attacks, the federal government created the Department of Homeland Security to assist in responding to security and other threats facing the United States. In 2004, in an effort to provide common response principles and a unified planning structure in response to large-scale emergency events, the Department of Homeland Security developed the National Response Plan ("NRP"), which has now been superseded by the National Response Framework ("Framework"). Like the NRP, the Framework is a comprehensive guide that addresses how the nation responds to emergency incidents at all levels. *See National Response Framework*, U.S. Dept. of Homeland Security (January 2008) and available at <http://purl.access.gpo.gov/GPO/LPS91897>. The Framework also includes supplemental

⁴³ The terms disaster, emergency, and mass casualty event are used interchangeably throughout this Chapter.

resources, including Annexes,⁴⁴ which provide additional detail for individuals involved in emergency management and response. These Annexes provide functional, operational, and incident specific guidance that can be applied to nearly every type of emergency incident. It is important to recognize that the Framework is not intended to provide a comprehensive plan for disaster response; rather, it provides guiding principles to support the development of an integrated and effective response in the event of an emergency, however large or small. *Id.* at 2.

The Framework specifies how federal agencies will coordinate with state and local governments and the private sector in their response to emergency incidents. *Id.* at 1. An effective disaster response requires layered, mutually supporting capabilities and personal preparedness by individuals and entities. As the disaster becomes more complex, the importance of integration becomes more critical. For that reason, the Framework provides that each governmental level plays a role in developing the capabilities needed to respond to emergency incidents, including developing plans, conducting assessments and exercises, providing and directing resources and capabilities, and gathering lessons learned. *Id.* at 4. These activities require that local, state, and federal governments and private entities be aware of their respective roles and responsibilities, assist each other in achieving shared goals, and understand how they fit within, and are supported by, the Framework. *Id.* at 6. The Framework directs organizations to define key leadership, build response capabilities, and impose the discipline necessary to plan and operate effectively. *Id.* at 5.

A core premise of the Framework is that there is a sovereign responsibility at the local level to respond to a mass casualty event. As a result, local police, fire departments, emergency medical services, public health and medical providers, and private businesses each have a responsibility to organize and integrate their capabilities to respond to an emergency event at the local level. *Id.* Under the Framework, private sector entities are called upon to provide key response services and equipment (donated or compensated) during a mass casualty event, either through local public-private emergency plans or in response to governmental and nongovernmental initiatives. *Id.* at 20. The role of the state government is to supplement the local response and to coordinate resources and capabilities from throughout the state and from other states.⁴⁵ *Id.* at 6. When an incident or emergency occurs that requires resources beyond what the local and state government can support, the federal government may step in to provide the required resources under the mechanisms of the Framework.

B. The National Incident Management System.

The command and management structures of the Framework are based on the National Incident Management System (“NIMS”). *Id.* at 47. NIMS provides a nationwide standard management template that enables all levels of government and the private sector to work together under a unified command structure. Much of NIMS is built upon the Incident

⁴⁴ Emergency Support Functions Annexes cover functions such as Communications, Emergency Management, and Public Health and Medical Services. Support Annexes describe how various governmental and non-governmental entities will coordinate and execute common functional processes. Incident Annexes address the type of incident involved.

⁴⁵ Throughout the Framework, discussion of authorities and roles of states is also intended to incorporate U.S. territories, possessions and tribal nations. The unique rights of tribal governments and associated tribal rights should be considered when responding to a mass casualty event.

Command System, which is a command system developed by local, state and federal wildland fire agencies in the 1970s. *Id.* at 48.

III. EMERGENCY MANAGEMENT UNDER WISCONSIN LAW.

A. Powers of State and Local Government.

Wisconsin law gives the governor broad powers to respond to mass casualty events. The governor may issue an executive order declaring a state of emergency when he or she determines that an “emergency resulting from a disaster or the imminent threat of disaster” or a public health emergency exists. Wis. Stat. § 323.10. Wisconsin law defines a “disaster” as a severe or prolonged, natural or human-caused, occurrence that threatens or negatively impacts life, health, property, infrastructure, the environment, the security of this state or a portion of this state, or critical systems, including computer, telecommunications, or agricultural systems. Wis. Stat. § 323.02(6). A “public health” emergency is defined as the occurrence or imminent threat of an illness or health condition that: (a) is believed to be caused by bioterrorism or a novel or previously controlled or eradicated biological agent; and (b) poses either a high probability of a large number of deaths or serious or long-term disabilities among humans, or a high probability of widespread exposure to a biological, chemical, or radiological agent that creates a significant risk of substantial future harm to a large number of people. Wis. Stat. § 323.02(16).

When a state of emergency is declared, Wisconsin law grants extensive powers to the governor to take action. Among such powers, the governor may issue orders as he or she deems necessary for the security of persons or property. Wis. Stat. § 323.12(4). Such orders could include, among other things, declaring priority of emergency management contracts over other contracts, allocating state resources, and even the taking, use or destruction of private property. *Id.* In certain circumstances, the governor may also suspend the application of an administrative rule if strict compliance with the rule would prevent, hinder, or delay a response to the disaster. *Id.*

A local government unit may also declare, by ordinance or resolution, a local state of emergency within the limits of its jurisdiction. Wis. Stat. § 323.11. Wisconsin law authorizes local governments to declare a state of emergency “whenever conditions arise by reason of a riot or civil commotion, a disaster, or an imminent threat of a disaster, that impairs transportation, food or fuel supplies, medical care, fire, health, or police protection, or other critical systems of the local unit of government.” *Id.* The period of the local state of emergency must be limited to the period the emergency conditions exist. *Id.*

The response to the novel H1N1 influenza virus of 2009 provides an example of the exercise of the governor’s powers during a declared disaster. The governor of Wisconsin exercised his authority under Wisconsin emergency management laws in April 2009, when the United States government declared a public health emergency related to the presence of the H1N1 influenza. On April 30, 2009, the governor issued Executive Order 280, declaring that a state of public health emergency existed in the state. Among other things, the order designated DHS as the lead agency, directed the Department of Health Services (“DHS”) to take all necessary and appropriate measures to prevent and respond to incidence of H1N1 influenza in the state, directed DHS to take any measures it deemed necessary and appropriate to make

antiviral treatments available to persons within the state, and suspended the provisions of any administrative rule in which it was determined by DHS that compliance with the rule would prevent, hinder, or delay necessary actions to respond to the emergency and increase the health threat. Emergency procedures remained in place for several months.

B. Wisconsin Emergency Response Plan.

The declaration of a state of emergency triggers the execution of various emergency management plans at local and, if appropriate, state levels. The state-level management plan is the Wisconsin Emergency Response Plan (“WERP”). Wis. Stat. § 323.13(1)(b); *see also State of Wisconsin Emergency Response Plan*, Wisconsin Emergency Management (February 2005), and available at <http://emergencymanagement.wi.gov/docview.asp?docid=2841>. Local governmental units are also directed to develop local emergency response plans, which must be consistent with the WERP. Wis. Stat. § 323.14(1)(b). Primary responsibility for implementing the applicable emergency response plan lies with the head of emergency management for the applicable level of government. Wis. Stat. § 323.15(1)(a).

The WERP is developed through a collaborative effort directed by the adjutant general and the Department of Military Affairs (“DMA”). The WERP incorporates the advice of designated supporting state agencies, including DHS, the Department of Transportation, the Department of Natural Resources and the Department of Agriculture, Trade and Consumer Protection. The WERP directs every aspect of the state’s incident response and governs the activities of applicable state agencies. In most types of emergencies, the Wisconsin Emergency Management (“WEM”) division of the DMA acts as the lead agency and coordinates each state agency’s response. However, if the emergency is related to public health, the governor may designate DHS as the lead agency. Wis. Stat. § 323.10. In this role, DHS will function as the public health authority for the duration of the emergency and be responsible for coordinating the medical response at the state level. Wis. Stat. §§ 323.10 and 250.042(1). As the lead agency, DHS is granted additional powers, including the power to purchase and distribute immunizing agents, antibiotics and other medical supplies. Wis. Stat. § 250.04(2). Other state agencies continue to be coordinated by WEM, and would provide logistical, law enforcement, and other support. The entire state government response, both medical and non-medical, would be directed from the State Emergency Operations Center (“State EOC”) (as further discussed below), which may be located in Madison, in the affected region, or at another location, depending on the situation. *See State of Wisconsin Emergency Response Plan* at 3.

The WERP conforms with the provisions of the Framework and NIMS to ensure there is a coordinated and effective response when federal agencies and assets are involved. *Id.* at 1. Consequently, the WERP incorporates many of the concepts set forth in the Framework. Notably, the WERP utilizes Emergency Support Functions (“ESFs”) to identify primary and support agencies necessary for incident response at the local and state level. *Id.* at 3. Local/county resources are grouped into ESFs, with each ESF headed by a county agency and additional county agencies designated as support agencies based on their resources. Each ESF has a corresponding state level ESF with which it must coordinate for the purpose of responding under the WERP. *Id.* at 6.

During a mass casualty event, ESFs are critical to coordinating functional capabilities and resources provided by state agencies and private sector organizations. Once triggered, the ESFs serve as the primary operational level method for providing assistance in critical functional areas. *Id.* The ESFs most relevant to hospitals are ESF #5 (Mass Care, Housing, and Human Services) and ESF #8 (Public Health and Medical Services), which are designated as the primary responsibility of DHS. *Id.* at 41. The 15 ESFs and their primary and supporting agencies are listed on Figure 1 at the end of this Chapter.

C. Local Emergency Operations Plans.

As noted above, although the declaration of a state of emergency mobilizes significant state resources, local governments still have both the right to declare a local state of emergency and the primary responsibility under the WERP for providing the response “on the ground.” *Id.* at 6. Coordinated through the State EOC, the state’s response is designed to support and supplement local efforts, not to replace them. Because local governments have the primary responsibility to respond to disasters and public health emergencies, Wisconsin law requires that local governments develop emergency management plans that are compatible with the WERP. Wis. Stat. § 323.14(1)(b). These local plans govern the deployment of government resources, and the resources of non-governmental organizations, including hospitals. If local governments fail to develop, adopt or implement their emergency management plan, the adjutant general may refuse to authorize grants, funds, or items of equipment requested by local government. Wis. Stat. § 323.13(1)(dm).

Typically, the primary location for coordinating the state’s emergency response is the State EOC. *Wisconsin Emergency Response Plan* at 2. The primary location for the State EOC is at 2400 Wright Street, Madison, WI, although the State EOC can be activated at other locations, depending on the emergency. The primary State EOC facility has communications and support capabilities available 24 hours a day. The contact number for the State EOC is 1-800-943-0003. The State EOC is a centralized command center for emergency operations, and depending on the type and scope of emergency, several secondary emergency operation centers (each, an “EOC”) may also be established. The EOCs consolidate command by ensuring that senior personnel from each component of the response are present and able to communicate and coordinate response efforts. By consolidating command at the EOCs, response to the disaster is coordinated and decisions related to disaster operations take into account the differing concerns of responding agencies. If possible, the local emergency response plan is directed by a local EOC, which is set up and staffed by local emergency management personnel who then coordinate with the State EOC. Often, hospitals will also establish a hospital-level EOC, which is staffed by appropriate management personnel and serves as the main command center for the hospital’s response.

D. Incident Command System.

Direction and organization of response efforts during a mass casualty event will follow the mandatory command structure known as the Incident Command System (“ICS”). Wis. Stat. § 323.13(c). The ICS provides a standardized management structure that permits divergent entities to coordinate their response efforts. ICS is designed to define, direct, and manage the roles, responsibilities, and operations of all of the agencies involved in a multi-jurisdictional or

multi-agency emergency response, and is one component of the NIMS. ICS establishes a standard command structure, using common terminology and defined roles and responsibilities. By using common structures and terminology, communication between responders and coordination of efforts is enhanced. An individual is identified as the incident commander (“Incident Commander”), and that individual has the responsibility of coordinating the response efforts at that level of response. If an emergency response requires integrated action from several different agencies or entities, a “Unified Command” may be established, in which senior personnel from each responding agency or entity participate in and support the actions directed by the Incident Commander. ICS also supports a coordinated response by establishing incident response objectives, and by managing the response to meet the identified objectives.

Using the ICS, the local Incident Commander at the local EOC directs the execution of the local emergency response plan. If the disaster has triggered a state declaration of emergency, the local Incident Commander will work with the State Incident Commander at the State EOC to coordinate state assistance. *Wisconsin Emergency Response Plan* at 13. Meanwhile, the State EOC, staffed by representatives from WEM, DHS and other applicable state agencies, would direct the mobilization of state agency resources and would work with federal agencies such as the Federal Emergency Management Agency (“FEMA”), the Centers for Disease Control (“CDC”), and the U.S. Department of Health and Human Services (“DHHS”) to coordinate a federal response, if necessary. *Id.* Figure 2, at the end of this Chapter, shows a diagram of a model ICS command structure that could be implemented to integrate local and state government entities in response to a mass casualty event.

The ICS arose from experience in the fire service, where it was noted that a coordinated response to major incidents such as wildfires was severely hampered by communication failures and lack of an integrated command architecture. However, ICS has been criticized by some as not including certain roles which are central in health care provider incident response. The Hospital Incident Command System (“HICS”) has been developed and adopted by many health care providers to incorporate the unique situations that may be faced by hospitals. HICS is consistent with both NIMS and ICS, and can easily be integrated into the community-based ICS. Information about HICS can be found at <http://www.emsa.ca.gov/HICS/default.asp>.

IV. ROLE OF HOSPITALS.

Hospitals have key responsibilities to support the local, state, and national response under the Framework. The Joint Commission requires that accredited hospitals implement and test disaster response plans. Joint Commission Standards EM.02.01.01 and EM.03.01.01. The Framework anticipates that hospitals and private sector entities will prepare contingency plans and coordinate periodically with local, state, and federal governments to ensure that their plans are consistent with each other and the Framework. *National Response Framework* at 6. Hospitals, too, are required to have emergency operations plans (“EOPs”) which describe the hospital’s disaster response framework and the integration of the hospital’s EOP with the community emergency management plan. Joint Commission Standard EM.02.01.01. Further, the Medicare Conditions of Participation require that hospitals must develop and test comprehensive emergency plans to ensure that safety and well being of patients are protected during emergency situations. *Medicare State Operations Manual* (“SOM”), Appendix A, Tag A-0701 (interpreting 42 C.F.R. § 482.41(a)).

Hospitals should also ensure they are properly integrated into the appropriate ESFs by local and state agencies. Hospitals that offer emergency services are required by Wisconsin law to coordinate their services with their local emergency management plans. Wis. Admin. Code § DHS 124.24(2)(a)(4). Further, the local emergency management plans are required by law to be consistent with the WERP. Wis. Stat. § 323.14(1)(b). Hospitals need to be integrated into the community command structure that governs all aspects of the response to a disaster or public health emergency, and must be prepared to operate within that framework. Failure to do so could result in the revocation of a hospital's regulatory approval by DHS. Wis. Admin. Code § DHS 124.03(6).

Hospitals should review their local emergency management plans and understand their roles and responsibilities under those plans so that effective standard operating procedures can be developed. The Joint Commission requires that accredited hospitals activate their emergency management plan twice a year at each site included in the plan. Joint Commission Standard EM.03.01.03. For each hospital that offers emergency services, at least one of the two emergency response exercises should include an influx of simulated patients, and one of the exercises must be part of a community-wide exercise. *Id.* Further, it is important that hospitals are aware of each plan's logistics. For example, local response plans may coordinate the establishment and operation of various treatment and triage centers, each of which would need to be staffed and equipped by the hospital. Additionally, transportation of equipment, personnel and patients to and from these centers would be another aspect of the local response plan. Determining beforehand who will be responsible for logistical tasks should be a priority of any disaster planning.

In order to help hospitals coordinate a response with local medical care centers and government agencies in the event of a mass casualty event, the Department of Defense has published various reports titled *Modular Emergency Medical System (MEMS)* (Revised 2002), *Concept of Operations for the Neighborhood Emergency Help Center* (2001), and *Concept of Operations for the Acute Care Center* (2003). These reports are the products of a multi-agency working group that included representatives from major academic medical centers, government, military, public health, and emergency management institutions and agencies. Hospital emergency planners can use these reports when contributing to the local emergency management plan.⁴⁶ Additional resources are also available from the American Hospital Association and the American Health Lawyers Association.

Hospitals should also coordinate with local, state, and federal officials regarding the incorporation of the CDC's Strategic National Stockpile ("SNS") program into their local emergency management plans. A detailed discussion of the SNS program is available at <http://www.bt.cdc.gov/Stockpile/>. The SNS has large quantities of medicine and medical supplies stored at strategically located, secure warehouses ready for immediate deployment following a mass casualty event. If there is an incident severe enough to cause local medical supplies to be depleted, state and federal authorities may approve deployment of SNS. Hospital

⁴⁶ Requests for copies of these reports can be made to James Church, U.S. Army Soldier and Biological Chemical Command ("SBCCOM"), Biological Weapons Improved Response Program, by phone at (410) 436-5686 or e-mail james.church@sbccom.apgea.army.mil.

emergency planners are strongly encouraged to ensure capacity is developed in the local emergency management plan to request, receive, stage, and dispense SNS program medicine and medical supplies.

V. SUMMARY AND CONCLUSION.

As discussed above, a hospital must develop an emergency operations plan and consider how its response to a mass casualty event can be coordinated with the efforts of local, state, and federal governments and other health care providers. The Framework provides the overarching structure of incident response at all levels. At the state level, the declaration of a state of emergency triggers the activation of the WERP, which governs all aspects of a state's response. Local emergency response plans are required to be consistent with the WERP and, accordingly, must incorporate the command and management structures of the ICS and the ESF. Hospitals that offer emergency services are required by law to coordinate their services with their respective local response plans. Although the specifics of local emergency plans will vary, all involve some degree of partnering with local officials in order to facilitate a coordinated response at both the local and state levels.

FIGURE 1

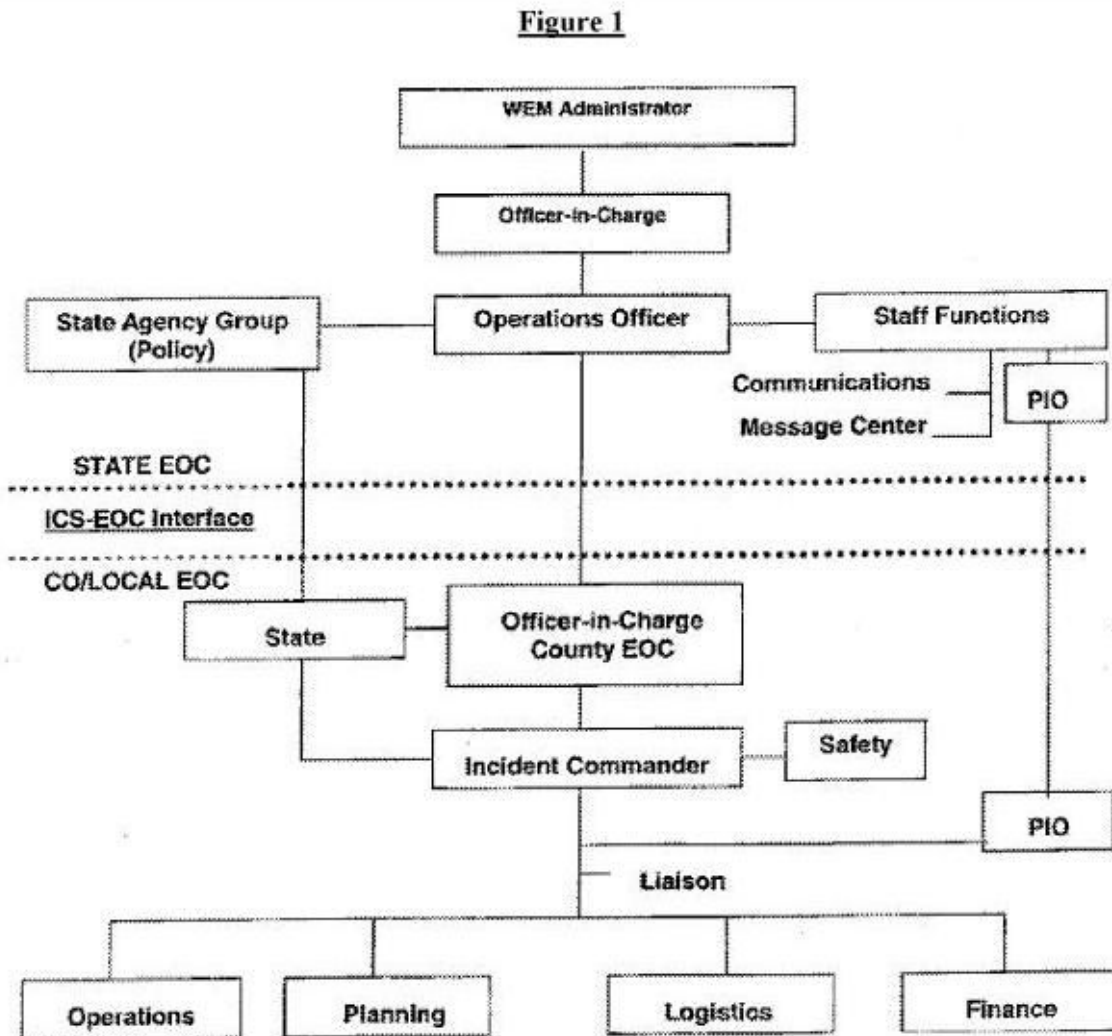
February 2005

**ATTACHMENT 5
EMERGENCY SUPPORT FUNCTIONS
PARTICIPATING AGENCY RESPONSIBILITIES MATRIX**

STATE AGENCIES	1 - TRANSPORTATION	2 - COMMUNICATIONS	3 - PUBLIC WORKS & ENGINEERING	4 - FIREFIGHTING	5 - EMERGENCY MANAGEMENT	6 - MASS CARE, HOUSING & HUMAN SERVICES	7 - RESOURCE SUPPORT	8 - PUBLIC HEALTH & MEDICAL SERVICES	9 - URBAN SEARCH & RESCUE	10 - OIL & HAZARDOUS MATERIALS	11 - AGRICULTURE & NATURAL RESOURCES	12 - ENERGY	13 - PUBLIC SAFETY & SECURITY	14 - LONG-TERM RECOVERY & MITIGATION	15 - EXTERNAL AFFAIRS			
Wisconsin Emergency Management	S	P	P	S	P	S	P	S	P	JP	S	S	P	P	P			
Department of Agriculture, Trade & Consumer Protection		S			S	S	S	S		S	P	S	S	S	S			
Department of Health & Family Services		S			S	P	S	P	S		S			S	S			
Department of Military Affairs	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S			
Department of Natural Resources		S	S	P	S		S	S	S	JP	S		S	S	S			
Department of Transportation	P	S	S		S	S	S		S	S	S	S	S	S	S			
Department of Administration	S	S	S			S	S							S				
Department of Commerce			S											S				
Department of Corrections													S					
Department of Justice		S			S								S					
Department of Public Instruction						S												
Department of Workforce Development						S								S				
Public Service Commission			S									P						
State Capitol Police		S											S					
State Lab of Hygiene											S							
UW Extension							S	S			S							
UW System Police													S					
Veterinary Diagnostics Lab											S							
American Red Cross						S		S			S							
Civil Air Patrol					S				S									
Educational Communications Board		S																
National Weather Service		S																
RACES		S																
Salvation Army						S												
US Coast Guard													S					

LEGEND: P= Primary Responsibilities S=Supporting Responsibilities JP=Joint Primary Responsibilities

FIGURE 2



CHAPTER FOUR

ALTERNATIVE TREATMENT SITES

At times, the scope or nature of a disaster⁴⁷ may require that treatment be offered outside of standard health care facilities. Depending on the nature and size of the emergency, alternative treatment sites may range from tents to schools or factories. When delivering care at alternative treatment sites, many issues may arise, such as liability, reimbursement, and operational issues.

Wisconsin law currently allows for a government-approved temporary takeover of facilities such as hotels, schools, churches, and large indoor areas during an emergency. The governor may proclaim a state of emergency for the entire state or any portion of the state if he or she determines that an emergency resulting from “a disaster or the imminent threat from disaster” exists. Wis. Stat. § 323.10. The governor may “declare priority of emergency management contracts over other contracts, allocate materials and facilities in his or her discretion, and take, use and destroy, in the name of the state, private property for emergency management purposes.” Wis. Stat. § 323.12(4)(a). Although a hospital on its own cannot take over a facility and turn the facility into an alternative treatment site, it can accomplish the same result through a declaration from the governor.

In addition, federal agencies may, at the direction of the President of the United States, provide essential assistance to meet immediate threats to life and property that result from a major disaster, including lending or donating federal equipment, supplies, facilities, personnel, and other resources for use or distribution by local governments. 42 U.S.C. § 5170b(a)(1). Federal agencies may also provide temporary facilities for schools or for other essential community services. 42 U.S.C. § 5170b(a)(3)(D). The governor of Wisconsin must request from the President a declaration that a major disaster exists. 42 U.S.C. § 5170. A major disaster means “any natural catastrophe . . . 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 [Title 42 Chapter 68 of the United States Code] 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.” 42 U.S.C. § 5122(2). Based on the above, if an emergency event is severe enough to constitute a major disaster, a federal facility may be given to the local governmental unit in the hospital’s region for use as the hospital’s alternative treatment site.

Effective emergency planning requires that potential alternative treatment sites be evaluated before an emergency occurs. Hospitals should be familiar with facilities in the area that might be used to provide care in a disaster. Creativity and flexibility are key; while a school gymnasium may provide a large area for care, a dental school may be a preferred site due to the presence of medical gases. Hospitals should participate in community-based emergency planning, and consider entering into contracts with nearby facilities for the use of their space and other resources in an emergency.

⁴⁷ The terms disaster, emergency, and mass casualty event are used interchangeably throughout this Chapter.

I. LIABILITY ISSUES.

A. Prevention.

Generally, the liability issues facing an alternative treatment site are the same as those facing a hospital, with the caveat that the alternative facility is not normally used for hospital purposes. Of course, there may not be much a hospital can do to prevent having to use an alternative treatment site. The alternative treatment site may be necessary if the hospital is overwhelmed with patients due to a mass casualty event, or if due to the nature of the emergency, it is important to segregate or sequester patients, or to divert non-critical patients to neighborhood-based facilities. Use of an alternative treatment site may also be necessary if the hospital is in some way contaminated or damaged such that it cannot accept patients at its facility. In the latter situation, the best recommendation for each hospital in terms of preventing the need for an alternative treatment site is to ensure that the hospital's facilities meet federal and Wisconsin standards for hospitals and comply with architectural and building requirements, so as to limit or prevent contamination or damage in the first place. To prevent liability risks related to the use of an alternative treatment site, the hospital should aim, to the best of its ability, to use alternative treatment sites that conform as closely as possible to the requirements mandated for hospital facilities. While this may be challenging, since few building types are regulated as much as hospitals, facilities such as dental schools or ambulatory surgery centers may be better equipped, and present lower liability risks, for use in emergency situations than non-health care facilities such as schools or gymnasiums.

Hospitals are considered easy targets for bioterrorist attacks, due to the fact that hospitals traditionally have limited physical security, multiple entrances and exits, and free ingress and egress of non-employees. Therefore, hospitals should recognize that the hospital or an alternative treatment site, itself, may be the target of a bioterrorist attack. The hospital should assess the physical security needs of its building and any alternative treatment sites in order to determine the characteristics that may make it a potential target for a bioterrorist. *Guidance for Protecting Building Environments from Airborne Chemical, Biological, or Radiological Attacks*, Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, May 2002 at 7. The hospital should take steps to prevent access to outdoor air intakes and other areas that might allow unauthorized access to the HVAC, elevator, water, and other such systems that could be used to carry out a bioterrorist attack. *Id.* at 8-12. With increasing reliance on computerized systems, improved computer security and hardening against cyber attacks is also advisable.

B. Preparedness.

Generally, one of the most important steps in developing a disaster protocol (including use of alternative treatment sites) is for the hospital to define its "surge capacity," or its "ability to expand care capabilities in response to a sudden or more prolonged demand." *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, Joint Commission on Accreditation of Healthcare Organizations, March 2003 at 19. A hospital's surge capacity takes into consideration potential patient beds, available space where patients can be triaged, managed, vaccinated, and decontaminated, as well as available personnel, medications, equipment, and supplies. *Id.* Depending on the situation, a

hospital may be able to address surge capacity issues by making internal changes to increase its own inpatient bed capacities in order to treat patients injured in a mass casualty event. However, some situations may require the hospital to consider using either alternative health care facilities (*e.g.*, nursing homes, physician clinics, etc.) or non-health care facilities (*e.g.*, hotels, armories, auditoriums, etc.) to address surge capacity needs. In many emergencies, an increase in the hospital's own inpatient bed capacity is preferable to having to resort to use of alternative treatment sites. The Wisconsin Hospital Emergency Preparedness Plan ("WHEPP") provides specific guidance on increasing inpatient bed capacity during mass casualty events. For instance, in its disaster protocol, a hospital should include methods for assessing the acuity level of patients to determine whether any currently hospitalized patients are eligible for early discharge, or whether any inpatients can be moved from critical care areas to general inpatient beds which require less resources. WHEPP, Op 7, available at http://dhs.wisconsin.gov/preparedness/pdf_files/WHEPPv3_08272004.pdf. In considering whether hospitalized patients may be eligible for early discharge, hospitals should consider the impact that an emergency may have on a patient's ability to leave the hospital. For instance, ambulances may not be available to transport bed-bound patients, and family members may be unable to reach the hospital due to interruptions in the transportation or communications systems. When addressing methods of increasing inpatient bed capacity, the WHEPP also indicates that, among other things, hospitals should have protocols that prioritize necessary admissions, convert private rooms into rooms that can house multiple patients, and open closed patient areas and convert them to active patient care areas. *See* WHEPP, Checklist of Increasing Inpatient Bed Capacity, Ck-Op-7.

Despite a hospital's best efforts to increase its own inpatient bed capacity after a mass casualty event, there may be circumstances in which increasing inpatient bed capacity at the hospital is insufficient to meet the demand for care or in which the hospital may not be able to use its facilities at all. Further, in certain types of emergencies, particularly public health emergencies, the response plan may preferentially direct certain patients to alternative treatment sites. To the extent it can, a hospital should work with state and local government, including emergency management and public health personnel, to prepare for the use of an alternative treatment site in the event of a mass casualty event. These preparations should be implemented in conjunction with the hospital's emergency operations plan,⁴⁸ required by Joint Commission Standard EM.02.01.01 which requires a hospital to develop an emergency operations plan that is designed to coordinate the hospital's communications, resources and assets, safety and security, staff responsibilities, utilities, and patient and clinical support activities during an emergency. Importantly, Joint Commission Standard EM.02.01.01 Elements of Performance 3 and 7 require not only that the hospital's emergency operations plan identify the hospital's capabilities and establish response procedures when the hospital cannot be supported by the local community in the event of an emergency, but also that the emergency operations plan identify alternative treatment sites that meet the needs of the hospital's patients during such emergencies.

Hospitals can attempt to designate, and possibly enter contractual arrangements with, schools, hotels, churches, convention centers, or other facilities to serve as alternative treatment sites. In 2007, the Agency for Healthcare Research and Quality ("AHRQ") published a planning

⁴⁸ While the Joint Commission uses the term "emergency operations plan," we use the term "disaster protocol" interchangeably throughout the remainder of this Chapter.

guide that included discussion on issues surrounding the use of non-health care facilities as alternative treatment sites. In assessing whether a facility may be appropriate to use as an alternative treatment site, the AHRQ points out that the hospital must consider, among other things, the specific medical functions and treatment objectives that the facility would need to accomplish. For instance, one type of facility may better serve as a primary triage point, while another may have capabilities allowing it to be used as an ambulatory care clinic or low-acuity patient care site. *See Mass Medical Care with Scarce Resources: A Community Planning Guide*, Agency for Healthcare Research and Quality, February 2007, Chapter 6 (addressing the use of alternative treatment sites). The AHRQ also provides an online tool for assessing the appropriateness of an alternative treatment site at http://www.ahrq.gov/research/altsites/altmatrix1_final.htm.

It may be beneficial to have multiple facilities serve as alternative treatment sites, not only because different facilities have different treatment capabilities, but also due to the unpredictable nature of a mass casualty event, wherein the hospital may not be able to make use of a particular site due to contamination or structural damage at that location. Hospitals may want to consider making Wisconsin Emergency Management a third party to such contracts. Although this is not required by Wisconsin law or regulation, Wisconsin Emergency Management coordinates with state and federal agencies to provide disaster response and has a legitimate interest in the success of the agreement. Wisconsin Emergency Management may also be able to provide valuable insight into arrangements of this type. *See* Wisconsin Emergency Management website, available at <http://emergencymanagement.wi.gov/>. We recommend that these agreements explicitly grant the hospital immunity from liability for the use of the property of the alternative treatment site during a designated emergency. *See Public Health Emergency Legal Preparedness Checklist, Civil Legal Liability and Public Health Emergencies*, Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, December 2004 at 8.

Any arrangements with prospective alternative treatment sites should include provisions addressing when the hospital may access the facility. The hospital should attempt to obtain use of the space in the event of a mass casualty event at any time after it becomes apparent that the hospital will reach its capacity of patients, may be damaged or contaminated, or whenever activation of alternative treatment sites is otherwise indicated. At the very least, the hospital should secure the use of the site pursuant to the governor's declaration of a state of emergency for the hospital's region. The hospital should also, if possible, obtain use of the alternative treatment site during disaster drills, which is helpful in evaluating the likely success of the hospital's emergency operations plan regarding use of the alternative treatment site. Any agreement regarding use of an alternative treatment site should state that, at the designated time when the hospital uses the space as an alternative treatment site, the hospital has the authority to make decisions regarding the use of the space and is in charge of supervising the employees and volunteers brought or provided to the alternative treatment site.

In addition, depending on its location and its proximity to other hospitals, each hospital may want to coordinate with other local hospitals when entering into agreements with facilities that may be able to serve as alternative treatment sites. Such agreements would have to specify the responsibilities of each hospital, and the authority given to each. *See Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness*

Systems, Joint Commission on Accreditation of Healthcare Organizations, March 2003, at 8. If the hospital chooses to coordinate with other area hospitals in contracting with a facility, the hospitals may want to enter into an independent emergency collaboration agreement that designates the authority of each hospital and the services each will provide, subject to any diminished capacity due to the mass casualty event. Such an agreement would also aid the hospitals if each has not entered into an agreement with a facility and the hospitals need to share an alternative treatment site upon the declaration of an emergency.

The hospital should share its alternative treatment site plans with Wisconsin Emergency Management and the governor's office, and should develop a relationship whereby the hospital can directly contact the individuals advising the governor regarding designation of a state of emergency and the taking of private land in an emergency to communicate any need for an alternative treatment site. The hospital should designate a liaison between the hospital and the alternative treatment site and between the hospital and the Wisconsin governmental entities.

The hospital should also prepare its staff, or designated staff members, for the provision of care outside of the hospital's main facilities. The hospital should institute any necessary training, and should develop a plan wherein staff report to prearranged locations in the event of a mass casualty event, in conjunction with the hospital's emergency operations plan, as detailed above.

For additional information on the organization and logistics involved when coordinating local response to a mass casualty event, see Chapter Three of this Manual.

C. Response.

The hospital's response to a mass casualty event that necessitates the use of an alternative treatment site will require coordination between governmental entities, other local hospitals, and alternative treatment sites. If the hospital has not contracted with a facility to use the facility's site as an alternative treatment location, the hospital may have to wait until the governor declares a state of emergency for the region, or designates space for emergency management purposes and allows the hospital to use such space.

To the extent possible, the hospital should plan to follow its routine patient placement and infection control practices at the alternative treatment site. However, if the number of patients overwhelms routine triage and isolation strategies, a hospital must employ more practical alternatives. Such alternatives may include grouping patients who present with similar symptoms into a designated section of the alternative treatment site. *See Interim Bioterrorism Readiness Planning Suggestions*, Association for Professionals in Infection Control and Epidemiology, Inc. ("APIC"), Bioterrorism Working Group, April 2002 at 5. These areas should be chosen in advance by hospital staff and should be based on "patient arrival sites, patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and capacity to safely hold potentially large numbers of patients." *Id.*

Once operating the alternative treatment site, the hospital should endeavor to prevent the transmission of disease or infection, particularly when an emergency situation is the result of a public health or bioterrorism event. The hospital should make use of whatever environmental

controls are available at the alternative site and should ensure that the ventilation system is functioning appropriately. If possible, the hospital should work with facility staff to compartmentalize the ventilation system to reduce the spread of disease. The hospital should also work to manage any smoke, dust, or fumes and attempt to eliminate these hazards from the area where patients are treated. The hospital must instruct staff and volunteers at the alternative treatment site to adhere to proper sanitation when working with patients, as well as adhere to the careful disposal of biohazards and waste.

At the alternative treatment site, the hospital must take care in the procedures it implements when receiving and using antibiotics, supplies, and other related items. If the alternative treatment site is sent any pharmaceuticals, vaccines, antidotes, or other medical supplies necessary to treat patients injured in a mass casualty event, hospital staff must ensure that these supplies are properly stored and properly used. To the extent possible, hospital policies and procedures on the storage and distribution of medication should be instituted at the alternative treatment site during its use.

As part of its response, the hospital should, to the extent possible, work to ensure the security of the alternative treatment site and its patients. The hospital should take steps reasonably necessary to protect them from the spread of communicable diseases and the cause of the bioterrorism event, if applicable, taking into consideration all of the measures discussed in Chapter Five of this Manual, including quarantine. The hospital also should institute procedures ensuring that the patients are protected from their relatives and the public, both for their own security and health and for the health of the visitors. The hospital should designate certain employees to manage the intake of patients and the flow of visitors at the alternative treatment site. Especially in a time of panic, such as that which may be caused by a mass casualty event, hospital personnel or volunteers must be assigned to deal with frantic relatives or members of the general public who are in a state of fear or confusion after the mass casualty event but do not need to be admitted as patients. Volunteers who have received appropriate training before the disaster can be invaluable in assisting with worried or panic-stricken individuals.

The hospital must also consider the possibility that it may be treating, or be asked to treat, the person or persons responsible for the mass casualty event. To respond to this scenario, the hospital should work with local law enforcement to ensure that there is appropriate security staff at the alternative treatment site. In addition, if the person is known to be the cause of the mass casualty event, that person may be at risk of attack and should be guarded and isolated to the extent possible. Hospitals should immediately contact Wisconsin Emergency Management, the FBI, and/or local law enforcement to request assistance in providing appropriate security as necessary.

As any mass casualty event could later be investigated as a criminal matter, the hospital should attempt to preserve any evidence it finds at the alternative treatment site that may have caused, or may be related to the cause of, the mass casualty event. The hospital should ensure that the policies developed in connection with law enforcement are carried out at the alternative treatment site. The hospital should make sure the alternative treatment site has a supply of plastic bags, pens, and ties to secure the bags. Anything that may be potential evidence, such as any traces of a substance that may have caused a biological incident, should be labeled with the date of collection, location and means of collection, and other details that may provide important

information to those later investigating the mass casualty event. If evidence is transmitted from the alternative facility to the FBI or local law enforcement, the hospital should document who received it, where it was taken, and when it was transmitted.

Initially, during the mass casualty event, the hospital will need to communicate to the public the conversion of the space from its usual use to that of an alternative treatment site. Public notice scripts should be developed, to the extent possible, during the emergency planning process, to notify the community of the use of the alternative treatment site. Hospitals should consider coordinating such communications through the local Incident Command System, which will help ensure that the information provided by the hospital is clear, consistent, and understandable to the public. *Interim Bioterrorism Readiness Planning Suggestions*, APIC, Bioterrorism Working Group, April 2002 at 9. For more information on the Incident Command System, see Section III(D) of Chapter Three. In communicating with the public, the use of neutral terms during a mass casualty event is encouraged to prevent inflaming public emotion and to prevent increased anxiety and fear. For instance, hospitals should avoid using words such as “weapons of mass destruction” or “weapons of mass effect” that may create panic among the public. *Hospital Preparedness for Mass Casualties*, Final Report, American Hospital Association, August 2000 at 29. Hospital employees can notify the local media that patients can be brought directly to the alternative treatment site and can also put this information on the main page of its website and on any automatic phone message.

D. Recovery.

Following a mass casualty event, the hospital should work to restore the full functions of its facility, if necessary, and should work to end operations at the alternative treatment site and resume normal operations.

II. BILLING/CODING/REIMBURSEMENT.

A. Preparedness.

In connection with the drafting and implementation of its emergency operations plan for the Joint Commission, discussed above, the hospital should coordinate with the Centers for Medicare & Medicaid Services (“CMS”), the State of Wisconsin, and private insurance payors regarding reimbursement concerns relating to services performed at an alternative treatment site. In particular, the hospital should review any existing contracts it has with private payors to determine specific coverage limits. The hospital should also try to work with its private payors to try to add alternative treatment sites to the definition of the hospital “facility” so that services covered at alternative treatment sites in emergency situations will be covered by the private payors.

B. Response.

As discussed further in Sections II(B), III, and IV of Chapter Six of this Manual, Medicare and Medicaid have various conditions for participation and requirements related to billing and coding, such as electronic claims submission and medical record documentation requirements. To the extent possible, hospitals and individuals providing services at any alternative treatment site should try to comply with as many of these requirements as possible

when providing services as a result of a mass casualty event. To the extent this is not possible, both federal and state law provide ways for hospitals to seek a waiver or variance (commonly referred to as a “Section 1135 Waiver”) from regulatory requirements as discussed in applicable sections of Chapter Six.

Note that the governor of Wisconsin, during a state of emergency, can also issue orders as he or she deems necessary for the security of persons and property, or suspend the provisions of any Wisconsin administrative rule if the strict compliance with that rule would prevent, hinder, or delay necessary actions to respond to a declared emergency. Wis. Stat. § 323.12(4)(b), (d).

C. Recovery.

If the hospital is not a participating provider in the Medicare program, it may still be reimbursed under Medicare if it provides emergency services and it meets the Medicare requirements for a hospital, as stated in 42 U.S.C. § 1395x, and the services constitute emergency services under 42 C.F.R. § 424.101. Although the hospitals providing emergency services in response to a mass casualty event would arguably meet these requirements, and although the services provided in a mass casualty event would likely be deemed emergency services, the regulations are silent as to whether these services can be provided at an alternative treatment site. Medicare does not specifically reference services provided at alternative treatment sites.

If a provider is not certified by Medicaid and provides emergency services to a Wisconsin Medicaid recipient, the provider may be able to receive Medicaid reimbursement if the services rendered are otherwise covered services and: (a) the provider submits to the fiscal agent a provider data form and a claim for reimbursement of emergency services on forms prescribed by the Wisconsin Department of Health Services (“DHS”); (b) the provider submits to DHS a statement in writing on DHS’s form explaining the nature of the emergency, including a description of the recipient’s condition, cause of emergency, if known, diagnosis and extent of injuries, the services that were provided and when, and the reason that the recipient could not receive services from a certified provider; and (c) the provider possesses all licenses and other entitlements required under Wisconsin and federal statutes, rules, and regulations, and is qualified to provide all services for which a claim is submitted. Wis. Admin. Code § DHS 105.03(1). Again, it is likely the services provided by the hospital and its staff meet these requirements, but the Wisconsin Medicaid regulations are silent as to services performed at alternative treatment sites.

When two or more hospitals utilize the same alternative treatment site, reimbursement can be divided according to which hospital provides the services to be reimbursed. Hospitals may also be able to receive payment for services rendered by volunteers. See Section IV of Chapter Two for more information on billing for volunteer services.

If services provided at an alternative treatment site do not fall into Medicare’s or Medicaid’s covered services, CMS may still provide reimbursement by making an exception for services rendered as a result of the mass casualty event. For example, during Tropical Storm Allison in 2001, CMS allowed a transplant hospital to perform transplants at other non-certified

facilities within their hospital chain. CMS issued a national coverage decision to such effect within 24 hours and a final rule in the Federal Register. CMS also instructed Medicare carriers and fiscal intermediaries to be flexible in responding to providers' requests for extensions for medical record production, cost report submissions, and other reporting and documentation requirements. Medicare contractors also were prepared to assist area providers in reconstructing any billing and payment records destroyed by flooding. CMS also worked closely with the sending and receiving hospitals, consultants, and the Texas Department of Health in responding to certification issues related to patients being treated in alternative treatment locations. CMS waived all notice requirements for changing bed status and approved certain remote locations. <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=398>.

III. LICENSURE/ACCREDITATION.

Absent a change of Wisconsin law, an alternative treatment site is not likely to be licensed or accredited as a hospital or similar entity, primarily because the main use of the alternative treatment site is likely to be other than for the provision of health services. As a general matter, we recommend that the hospital operate the alternative treatment site in a way that conforms as closely as possible to the standards required for licensed and accredited hospitals.

A. Preparedness.

When analyzing possible alternative treatment sites prior to any mass casualty event, hospitals should focus on facilities which meet or at least come close to conforming to the physical environment standards for hospitals, as articulated in the Wisconsin Administrative Code. Specifically, a hospital should look for an alternative treatment site that has the following characteristics: (1) thresholds that are easily crossed by equipment on wheels; (2) provisions for emergency fuel and water; (3) an emergency lighting system; (4) diagnostic and therapeutic facilities, supplies and equipment sufficient to permit an acceptable level of patient care; (5) walls and ceilings that are smooth, washable and in good repair; (6) floor materials that are easy to clean and have wear and moisture resistance appropriate for the location; (7) electrical cords that are in good repair; and (8) carpeting with a flame-spread rating of 75 or less or a critical radiant flux of more than .45 watts per square centimeter, noncombustible acoustical tile, and wastebaskets. Wis. Admin. Code § DHS 124.36.

B. Recovery.

As noted in Section II(B) of this Chapter, the governor of Wisconsin, during a state of emergency, can suspend the provisions of any administrative rule if the strict compliance with that rule would prevent, hinder, or delay necessary actions to respond to a declared emergency. Wis. Stat. § 323.12(4)(b), (d). To the extent the governor fails to suspend state licensure/accreditation requirements in a declared emergency, a hospital may also ask DHS to grant a waiver or variance from any of its regulations, as indicated in Section II(B) of this Chapter, and as specifically discussed in Section IV(A) of Chapter Six of this Manual. If necessary, the hospital should request such a waiver or variance as soon as practicable after it knows it will be using an alternative treatment site.

IV. COMMUNICATION SYSTEMS.

A. Preparedness.

As the hospital may be in a position where it needs to communicate immediately and often with any alternative treatment sites, the use of technology may be vital to operations during a mass casualty event. The hospital should consider whether an alternative treatment site will have up-to-date telephone, internet, or videoconference capabilities, as well as any necessary technology to back these systems up in case of a power failure, that will allow it to communicate with the main hospital facility at times when the alternative treatment site is in use. To the extent possible, backup communications systems should be identified in advance. The Joint Commission recommends using two-way radios, dedicated communications channels, wireless personal digital assistants, cell phones, satellite phones, pagers, and designated web sites to communicate during an emergency. *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, Joint Commission on Accreditation of Healthcare Organizations, March 2003 at 31. The hospital, if it looks at different sites to contract for an alternative treatment site, should evaluate these capabilities. Further, if the hospital utilizes an electronic medical record (“EMR”) system, the hospital should consider whether this system can be accessed outside of the hospital facility, such as from an alternative treatment site. If the hospital’s EMR system is not accessible, the hospital should consider how medical information will be recorded when services are rendered at an alternative treatment site. See Section IV of Chapter Six for more information on medical record documentation requirements during an emergency.

If a hospital provides emergency services and a physician is unable to reach a patient within 15 minutes, Wisconsin law requires that the physician provide specific instructions to the emergency staff on duty if emergency measures are necessary. Wis. Admin. Code § DHS 124.24(2)(c)(3). Such instructions may be in the form of protocols approved by the medical staff or standing orders. *Id.* Use of approved protocols or standing orders will allow greater latitude for the hospital if physicians are not able to reach the hospital or alternative treatment site due to the mass casualty event. Physicians can take advantage of the multiple communication devices discussed above to remain in contact with patients at either the hospital or at the alternative treatment site if the mass casualty event prevents them from attending to the patients in person.

B. Response.

To the extent an alternative treatment site is not set up with telephone, internet, or videoconference capabilities, the hospital may be able to transport two-way radios, cell phones, pagers, or other portable communications devices already in use at the hospital to the alternative treatment site to increase methods of communication between the facilities and to more efficiently serve patients affected by the mass casualty event. The hospital should use its electronic resources as much as possible to coordinate between the hospital and the alternative treatment site. This can provide for up-to-the-minute information exchange and prevent additional exposure that may be a risk of face-to-face contact.

CHAPTER FIVE

LEGAL ISSUES RELATING TO CONTROL OF COMMUNICABLE DISEASES

I. COMMUNICABLE DISEASES.

While the threat of many communicable diseases has diminished due to the development of antibiotics and other medical treatments, communicable diseases continue to present a threat to public health. New and emerging diseases, such as Severe Acute Respiratory Syndrome (“SARS”), can quickly spread and create localized epidemics as scientists attempt to isolate and identify the pathogen, while well-known illnesses, such as influenza, can mutate and avoid acquired immunity, as was seen in the novel H1N1 pandemic in 2009. Interventions to limit the spread of, and to treat, communicable diseases that threaten public health include quarantine (the sequestering of individuals who have likely been exposed, but are currently asymptomatic) and isolation (the sequestering of individuals who are symptomatic and known to be contagious), as well as mandatory vaccination. Hospitals, of course, play a critical role in the control of communicable diseases. This Chapter reviews the legal issues presented by the most common public health interventions in communicable disease treatment and containment.

A. General Legal Issues Regarding the Response of State and Local Government to Communicable Diseases.⁴⁹

1. Police Power.

At the state level, the primary legal authority to respond to an emergency is based on the inherent authority of the state, often referred to as the “police power.” The police power grants states the authority to enact laws and regulations that protect the health, safety, and welfare of citizens, including laws and regulations related to the isolation, quarantine, and vaccination of individuals who have, or who are suspected of having, a communicable disease. Because this authority rests with each state, each state is responsible for isolation, quarantine, and other public health activities within its borders. States conduct their public health activities in accordance with their respective state statutes and regulations. Only if the state is unable or unwilling to take effective action to control the spread of communicable diseases will federal agencies step in.

State and local laws and regulations regarding communicable diseases vary widely. State public health statutes have frequently evolved over time as lawmakers have responded to varying disease threats such as tuberculosis, polio, malaria, and HIV/AIDS. Recently, some states have codified extensive revisions to statutes related to the enforcement of these public health measures, while other states rely on older statutory provisions. Wisconsin’s laws are explained below.

2. Due Process and Individual Rights.

Public health laws generally grant broad powers to state and local public health officials to implement measures necessary to protect public health, including the use of quarantine and isolation. Since many of these measures can infringe on individual liberty interests, actions of

⁴⁹ The terms infectious diseases, and communicable diseases are used interchangeably throughout this Chapter.

public health officials have the potential to be challenged on the grounds that the actions unconstitutionally deny equal protection or due process rights. Consequently, many states provide due process protections in their public health laws. For example, Wisconsin law requires that a public health official that petitions a court to order an individual to comply with a quarantine directive must ensure that the petition is supported by clear and convincing evidence that the individual has been given the directive in writing, has had the opportunity to seek counsel, and that the remedy is the least restrictive alternative that would serve to protect the public's health. Wis. Admin. Code § DHS 145.06(5), (6). However, during a state of emergency related to public health, the governor may suspend the provisions of any administrative rule if strict compliance with the rule would prevent, hinder, or delay necessary actions to respond to the disaster.⁵⁰ Wis. Stat. § 323.12(4)(d). The decision to suspend the provisions of any administrative rule could limit, and possibly eliminate, the availability of certain statutory or regulatory rights which are intended to preserve constitutional due process rights.

In general, case law upholds the exercise of broad powers by a state when reasonably necessary to protect public health. For example, in 1905, the U.S. Supreme Court upheld a state's compulsory smallpox vaccination statute, provided that the statute extended an exception to compulsory vaccination for individuals who are medically unfit for vaccination. *Jacobson v. Massachusetts*, 197 U.S. 11, 37-38 (1905). Similarly, a California appellate court upheld a quarantine order issued by a health officer to a man with active tuberculosis where the health officer reasonably believed that the man posed a threat to public health. *Application of Halko*, 246 Cal. App. 2d 553 (1966). In 1995, a New York court upheld an order issued by the city health commissioner requiring the forcible detention in a hospital of a person with active, infectious tuberculosis. *City of New York v. Antoinette R*, 165 Misc. 2d 1014, 630 N.Y.S.2d (1995). Precedents established by these cases, and others, suggest that a state's exercise of broad public health powers in the event of an emergency would be upheld by a court where the challenged measures are reasonably necessary to protect the public's health.

B. Model State Emergency Health Powers Act.

Following the September 11th terrorist attacks and the subsequent anthrax exposures, the Centers for Disease Control and Prevention ("CDC") commissioned the Center for Law and the Public's Health to develop the Model State Emergency Health Powers Act of 2001 ("MSEHPA"), with the goal of providing a modern illustration of a public health law for controlling infectious diseases during emergencies that balances public health needs and individual rights. In general, the MSEHPA:

1. Sets a threshold definition of what constitutes a "public health emergency;"
2. Requires the development of a comprehensive public health emergency response plan that includes: coordination of services; procurement of necessary materials and supplies; housing, feeding, and caring for affected populations; and the administration of vaccines and treatment;

⁵⁰ The terms disaster, emergency, and mass casualty event are used interchangeably throughout this Chapter.

3. Authorizes the collection of data and records and access to communications to facilitate the early detection of a health emergency;
4. Vests the power to declare a public health emergency in the governor, subject to legislative and judicial checks and balances;
5. Authorizes officials to care for and treat ill or exposed persons, separate affected individuals from the population at large to prevent further transmission, collect specimens, and to seek the assistance of in-state and out-of-state private sector health care workers during an emergency;
6. Requires public health authorities to inform the population of public health threats in a manner calculated to be accessible to, and understandable by, all segments of the population;
7. Authorizes the governor to allocate state finances as needed during an emergency and protects some state and private actors from future legal causes of action; and
8. Grants state and local public health officials the authority to seize and use private property to care for patients, destroy dangerous or contaminated materials, and implement safe handling procedures for the disposal of human remains or infectious wastes.

The Wisconsin Legislature has implemented numerous statutory provisions modeled after provisions in the MSEHPA, including the following:

1. A provision creating a 23-member Public Health Council in the Wisconsin Department of Health Services (“DHS”), which must include representatives of health care consumers, health care providers, health professions educators, local health departments and boards, public safety agencies, and the Public Health Advisory Committee established by the DHS Secretary. The Council is required to advise DHS, the governor, the legislature, and the public on progress in implementing the DHS 10-year public health plan and on the coordination of responses to public health emergencies. Wis. Stat. §§ 15.197(13) and 250.07(lm).
2. A provision requiring the state to reimburse local health departments for all of their expenses which are incurred in quarantining a person outside of his or her home during a declared state of emergency related to public health and which are not reimbursed from federal funds. Wis. Stat. §§ 20.435(1)(c), 20.465(3)(e), and 252.06(10)(c).
3. A provision establishing a statewide system of mutual aid for emergency management programs, emergency medical services (“EMS”) programs, fire departments, and local health departments. Upon the request of a county, city, village, or town, or a person acting under an Incident

Command System (“ICS”),⁵¹ the personnel of any emergency management program, EMS program, fire department, or local health department may assist the requester within the requester’s jurisdiction, without regard to any other jurisdictional provision. The entity employing the personnel acting in response to a request for assistance is responsible for the personnel-related costs incurred in providing the assistance. Wis. Stat. §§ 66.0312, 66.03125, and 66.0314.

4. A provision requiring that an ICS be used by all emergency response agencies, including local health departments, in responding to, managing, and coordinating multi-agency or multi-jurisdiction incidents when a state or local emergency declaration has been made or in any other emergency situation. This provision also requires the adjutant general, in developing statewide emergency training and exercise programs, to provide training to officers and employees of local health departments and to elected and appointed local government officials in use of the ICS in managing emergencies. Wis. Stat. §§ 250.042(1), 323.02(9), 323.02(14), 323.13(1)(b)-(d), and 323.15(1)(a).⁵²
5. A provision amending the law that provides an exemption from liability for a person who provides equipment or services during a state of emergency declared by the governor for the death of, or injury to any person, or damage to any property, caused by his or her actions. Previously, this exemption from liability applied if the person provided the equipment or services under the direction of the governor, the adjutant general, or the head of emergency management services in any county, town, or municipality. This exemption from liability also applies if the person provides the equipment or services under the direction of DHS if DHS is designated by the governor as the lead state agency to address a public health emergency or at the direction of a local health department that is acting as an agent of DHS. Wis. Stat. § 323.45; *see also* Section II of Chapter Seven.
6. A provision designating as a state agent any health care provider who performs voluntary, unpaid health care services during a public health emergency for worker’s compensation purposes. Wis. Stat. § 257.03.

⁵¹ “Incident Command System” is defined as a functional management system established to control, direct, and manage the roles, responsibilities, and operations of all of the agencies involved in a multi-jurisdictional or multi-agency emergency response. Wis. Stat. § 323.02(9).

⁵² For more information on the use of the ICS *see* Section I of Chapter Three.

C. Powers and Duties of State and Local Authorities.

1. General Powers and Duties of DHS Relating to the Control of Communicable Diseases.

The Wisconsin Statutes provide DHS with broad powers to implement measures to protect public health. In particular, pursuant to Wis. Stat. § 252.02, DHS may, as it deems necessary to address communicable disease threats:

- (a) Establish systems of disease surveillance and inspection to ascertain the presence of any communicable disease;
- (b) In an emergency, provide medical aid and temporary hospital accommodations to those sick with a communicable disease;
- (c) Close schools and forbid public gatherings in schools, churches, and other places to control outbreaks and epidemics;
- (d) Establish and enforce rules or issue orders: to prevent the introduction of any communicable disease into the state; to control and suppress communicable disease; to quarantine and disinfect people, locations, and things infected or suspected of being infected by a communicable disease; and to provide for the sanitary care of public and other buildings; and
- (e) Authorize and implement all emergency measures necessary to control communicable diseases.

In exercising these powers and carrying out these duties, DHS may communicate necessary information directly to hospitals or through local public health officials, the Wisconsin Health Alert Network (<http://www.han.wisc.edu>), or mass media.

2. General Powers and Duties of Local Public Health Authorities Relating to the Control of Communicable Diseases.

Upon the appearance of any communicable disease in his or her territory, a local health officer must promptly take all measures necessary to prevent, suppress, and control the communicable disease, including forbidding public gatherings when necessary to control outbreaks or epidemics. Wis. Stat. § 252.03(1), (2). If local authorities fail to enforce the communicable disease statutes and rules, DHS may take charge, and the county or municipality is responsible for expenses incurred by DHS. Wis. Stat. § 252.03(3).

DHS or a local health officer acting on behalf of DHS may require the isolation of a patient or an individual who refuses compulsory vaccination in a state of emergency, quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures as may be necessary. Wis. Stat. § 252.06(1).

Wisconsin law also provides that no person who is knowingly infected with a communicable disease may willfully violate the recommendations of the local health officer or subject others to danger of contracting the disease. In addition, no person may knowingly and willfully take, aid in taking or advising, or cause to be taken a person who is infected or is suspected of being infected with a communicable disease into any public place or conveyance where the infected person would expose any other person to danger of contracting the disease. Wis. Stat. § 252.19. The penalties for violating these provisions include imprisonment for not more than 30 days or a fine of not more than \$500.00 or both. Wis. Stat. § 252.25.

The term “communicable disease” is defined in Wis. Admin. Code § DHS 145.03(4) as a “disease or condition listed in Appendix A of this chapter.” The diseases or conditions in Appendix A of Wis. Admin. Code § DHS 145 include, but are not limited to, anthrax, botulism, measles, rabies, rubella, smallpox, and tuberculosis. Appendix A of Wis. Admin. Code § DHS 145 is included as Appendix F of this Manual and is discussed in more detail in Section I(D) of this Chapter. Wis. Admin. Code § DHS 145 also defines “other disease or condition having the potential to affect the health of other persons” as a “disease that can be transmitted from one person to another but that is not listed in Appendix A.” Consequently, a hospital must ensure that it properly advises those infected with such a disease so that others are not exposed to the danger of contracting the disease.

A hospital will likely be in compliance with Wis. Stat. § 252.19 if it complies with discharge planning and safe discharge requirements under federal and Wisconsin law. The federal discharge planning requirements are located in the Medicare Conditions of Participation for Hospitals at 42 C.F.R. § 482.43 and Wisconsin discharge planning requirements are set forth in Wis. Admin. Code § DHS 124.05(2)(j). A hospital’s duty to provide for a safe discharge for inpatients includes a duty to provide necessary medical information to the patient and family members involved. Although fulfilling this duty may be difficult during an emergency situation, failure to provide the necessary medical information could contribute to the spread of a communicable disease. If a hospital is concerned it may not meet this duty for patients with communicable diseases in the event of an emergency, it should discuss such concerns with local public health officials and coordinate with such officials to ensure adequate information is disseminated and the public is protected from transmission of the communicable disease. Please note, if a hospital fulfills its communicable disease reporting requirements, as discussed in Section I(D) below, public health officials will likely be involved in discharge planning for communicable disease patients, as appropriate.

In a public health emergency, the ability of a hospital to fully comply with Wis. Stat. § 252.19 may be reduced, as community emergency operations plans are triggered which transfer patients to alternate care sites, often using improvised transportation services. In this case, however, the hospital should implement all reasonable safeguards, such as issuance of masks to patients with respiratory disease, to minimize the risk of a spread of the communicable disease.

D. Communicable Disease Reporting Requirements.

Certain health care providers, including physicians, nurses, and physician assistants, are required to report known or suspected cases of communicable diseases to local public health officials or the state epidemiologist. Wis. Stat. § 252.05; Wis. Admin. Code

§ DHS 145.04(1)(a). Each health care facility must ensure that required reports are made to the local health official, or if required, to the state epidemiologist. If the health care facility has an organized program of infection control, the person in charge of the infection control program must ensure that diseases are reported as required to avoid unnecessary duplication. Wis. Admin. Code § DHS 145.04(1)(c).

Reports must include the name and address of the person reporting and of the attending physician; the diagnosed or suspected disease; the ill or affected individual's name, address, phone number, date of birth or age, race and ethnicity, sex, county of residence, date of onset of the disease, and name of parent or guardian if a minor; and other facts that the state health department or local health officer may require for the purposes of surveillance, control, and prevention of communicable disease.⁵³ Wis. Admin. Code § DHS 145.04(2).

Communicable diseases of urgent public health importance, listed in Category I of Appendix A of Wis. Admin. Code § DHS 145, must be immediately reported to the local health officer by telephone or fax upon identification of a case or suspected case. If the local health officer is unavailable, the report must be made immediately to the state epidemiologist. Communicable diseases included in Category I include anthrax, food-borne or waterborne outbreaks, smallpox, and tuberculosis, among others. Following an immediate report of a Category I communicable disease, and within 24 hours, an Acute and Communicable Diseases Case Report (DHS Form F-44151) must be mailed to the address provided on the form or the data must be entered into the Wisconsin Electronic Disease Surveillance System.

Diseases listed in Category II of Appendix A of Wis. Admin. Code § 145 must be reported to the local health officer within 72 hours of the identification of a case or of a suspected case. The disease is required to be reported either through an Acute and Communicable Disease Case Report (DHS Form F-44151), by other means, or by entering the data into the Wisconsin Electronic Disease Surveillance System. Category II diseases include, among others, cryptosporidiosis, hepatitis B and C, Lyme disease, tetanus, varicella (chicken pox), and suspected outbreaks of other acute or occupationally-related diseases. Diseases listed in Category III of Appendix A of Wis. Admin. Code § 145, which include AIDS and HIV, must be reported to the state epidemiologist within 72 hours after identification of a case or suspected case on an AIDS Case Report form (DOH Form 4264) or a Wisconsin HIV Infection Confidential Case Report form (DOH Form 4338) or by other means. Some of the diseases in each category may also require follow-up reports on specific forms. All DHS forms referenced above are available at <http://dhs.wisconsin.gov/forms/F-4.asp>.

Submission of the required reports not only ensures that a hospital is in compliance with Wisconsin law, but also triggers the involvement of public health officials. These officials will help a hospital handle the public health aspects of communicable disease control.

⁵³ Please note that it is permissible to disclose this information pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as HIPAA permits disclosures of protected health information as required by law. 45 C.F.R. § 164.512(a), (f). For more information on HIPAA, see Chapter Six.

II. VACCINATION.

A. Wisconsin Law.

Under Wisconsin law, the governor may issue an executive order declaring a state of emergency related to public health for the state or any portion of the state and may designate DHS as the lead state agency to respond to the emergency if the governor determines that a public health emergency exists, as defined in the statute. Wis. Stat. § 323.10. During a public health emergency, DHS may be granted the power to order any individual to receive a vaccination unless the vaccination is reasonably likely to lead to serious harm to the individual or unless the individual refuses to obtain the vaccination for reasons of religion or conscience. Wis. Stat. § 252.041(1)(a). Also, DHS may isolate or quarantine individuals who refuse to obtain a vaccination. Wis. Stat. § 252.041(1)(b). DHS has the foregoing powers only if the governor declares a state of emergency related to public health and designates DHS as the lead state agency.

The governor of Wisconsin exercised his authority under these provisions in April 2009 when the federal government declared a public health emergency related to the presence of the novel H1N1 influenza. On April 30, 2009, the governor issued Executive Order No. 280, declaring that a state of public health emergency existed for Wisconsin. Among other things, the order designated DHS as the lead agency, directed DHS to take all necessary and appropriate measures to prevent and respond to an incidence of novel H1N1 influenza in Wisconsin, directed DHS to take any measures it deemed necessary and appropriate to make antiviral treatments available to persons within the state, and suspended the provisions of any administrative rule in which it was determined by DHS that compliance with the rule would prevent, hinder, or delay necessary actions to respond to the emergency and increase the health threat. It is possible that the governor would issue similar executive orders in the event of other emergencies where the risk of spreading communicable diseases is present.

B. Federal Law.

1. The Project Bioshield Act of 2004.

The Project Bioshield Act of 2004, Pub. L. No. 108-276 (“Project Bioshield Act”), was signed into law by President Bush in July 2004. The Project Bioshield Act allows the U.S. Department of Health and Human Services (“DHHS”), under certain conditions, to authorize the temporary emergency use of certain medical products, such as vaccines, that have not yet received Food and Drug Administration (“FDA”) approval. 42 U.S.C. § 247d-6b(c). The Project Bioshield Act also facilitated the creation of a government market for the development of new countermeasures related to threats from chemical, biological, radiological, and nuclear agents by authorizing the appropriation of \$5.6 billion from 2004 through 2013 to purchase vaccines, drugs, therapies, and diagnostic tools, including countermeasures, that still required additional development. 6 U.S.C. § 321(j). Despite the considerable financial incentives included in the Project Bioshield Act, manufacturers of medical products were reluctant to enter the biodefense market out of fear of liability related to the use of products rushed to the market during an emergency. Consequently, Congress enacted other laws to further encourage the

development of countermeasures, including the Public Readiness and Emergency Preparedness Act discussed below.

2. Public Readiness and Emergency Preparedness Act.

To address lingering concerns from manufacturers after passage of the Project Bioshield Act, Congress passed the Public Readiness and Emergency Preparedness Act (“PREP Act”) as part of the 2006 Defense Appropriations Act, Pub. L. 109-148 (amending the Public Health Services Act codified at 42 U.S.C. § 247d-6d). Under the PREP Act, the Secretary of DHHS is authorized to issue a declaration that provides immunity to covered persons from tort liability, excluding willful misconduct, for claims of loss related to the administration or use of countermeasures. 42 U.S.C. § 247d-6d(a)(1), (b)(1).

Among other things, each declaration issued under the PREP Act is required to identify: the covered countermeasures; the categories of diseases, health conditions, or threats to health for which the Secretary recommends the administration or use of the countermeasure; the time period for the protection; and the persons covered by the declaration. 42 U.S.C. § 247d-6d(b)(2). The PREP Act provides broad definitions of both “covered person” and “covered countermeasure.” A “covered person” may, at the Secretary’s discretion, include qualified persons who prescribe, administer, or dispense countermeasures (*i.e.*, health care and other providers). 42 U.S.C. § 247d-6d(i)(2). A “covered countermeasure” means a qualified pandemic or epidemic product, a security countermeasure, or an unapproved drug, biological product, or device used under an Emergency Use Authorization (“EUA”) (discussed in Section II(B)(3) of this Chapter) in accordance with the Federal Food, Drug and Cosmetic Act. 42 U.S.C. § 247d-6d(i)(1).

The first PREP Act declaration was issued in early January 2007, to limit liability for the administration of the H5N1 influenza vaccine. Since then, declarations have been issued covering countermeasures against other strains of influenza, including novel H1N1, anthrax, botulism, smallpox, and acute radiation syndrome. PREP Act declarations are available at <http://www.hhs.gov/disasters/discussion/planners/prepact/index.html>.

3. Emergency Use Authorizations.

Under Section 564 of the Federal Food, Drug, and Cosmetic Act (codified at 21 U.S.C. § 360bbb-3 and amended by the Project Bioshield Act), the FDA Commissioner may, during the time specified in an emergency declaration,⁵⁴ authorize the introduction into interstate commerce of a drug, device, or biological product intended for use in an actual or potential emergency. An EUA may be used to authorize the emergency use of a product not approved for use by the FDA or the use of an FDA-approved product for an otherwise unapproved use. 21 U.S.C. § 360bbb-3(1)(2).

In order for an EUA to be issued, the Secretary of DHHS must declare an emergency based on one of the following grounds: (1) The Secretary of the Department of Homeland Security determines that there is a domestic emergency, or a significant potential for a domestic emergency, involving a heightened risk of attack with a specified biological, chemical,

⁵⁴ Please note, a declaration for purposes of EUA is not synonymous with a declaration under the PREP Act.

radiological, or nuclear agent or agents; (2) a determination by the Secretary of Defense that there is a military emergency, or a significant potential for a military emergency, involving a heightened risk to United States military forces of an attack with a specified biological, chemical, radiological, or nuclear agent or agents; or (3) a determination by the Secretary of DHHS that a public health emergency under section 319 of the Public Health Service Act (“PHS Act”) exists that affects, or has the significant potential to affect, national security, and that involves a specified biological, chemical, radiological, or nuclear agent or agents, or a specified disease or condition that may be attributable to such agent or agents. 21 U.S.C. § 360bbb-3(b).

Both the emergency declaration, including any renewal, and the EUA, including the termination or revocation of an EAU, must be published in advance in the Federal Register. 21 U.S.C. § 360bbb-3(b)(4), (h)(1). During 2009, in response to the novel H1N1 influenza, several EUAs were put into effect related to the use of certain antiviral agents and diagnostic medical devices. 74 Fed. Reg. 38636-38648 (Aug. 4, 2009). More information about the EUAs related to novel H1N1 influenza can be found at <http://www.cdc.gov/h1n1flu/eua/>.

4. The Homeland Security Act of 2002.

The Homeland Security Act of 2002, Pub. L. No. 107-296 (codified at 42 U.S.C. § 233(p)) (“Homeland Security Act”), provides protection from liability for health care entities, vaccine manufacturers, and certain individuals who implement smallpox countermeasures. More specifically, Section 304 of the Homeland Security Act provides an exclusive remedy against the United States for injury or death attributable to smallpox countermeasures, including vaccines. 42 U.S.C. § 233(p)(3)(B). Under this provision, no claim for death or injury attributable to a smallpox countermeasure may be brought against a health care entity or qualified person who administers smallpox countermeasures.

The protections of Section 304 of the Homeland Security Act apply only when the Secretary of DHHS has issued a declaration concluding that an actual or potential bioterrorist incident or other actual or potential public health emergency makes advisable the administration of certain smallpox countermeasures to one or more categories of individuals. Further, the Homeland Security Act provides protection from liability with respect to claims arising out of the administration of a smallpox countermeasure to an individual only if: (1) the countermeasure was administered by a qualified person during the effective period of a declaration by the DHHS Secretary; and (2) the individual was within a category of individuals covered by the declaration or the qualified person administering the countermeasure had reasonable grounds to believe that such individual was within such a category. 42 U.S.C. § 233(p)(2)(B). The terms “covered countermeasure,” “covered person,” “qualified person,” and “arising out of administration of a covered countermeasure,” are defined in 42 U.S.C. § 233(p)(7).

The protections of Section 304 of the Homeland Security Act were activated in January 2003, when the DHHS Secretary issued a declaration regarding the administration of smallpox countermeasures for a term of one year. 72 Fed. Reg. 4013-4014. The declaration, which was later extended and amended, listed the following smallpox countermeasures to be administered: (1) vaccinia (smallpox) vaccines, including the Dryvax vaccine; (2) cidofivir and derivatives thereof; and (3) vaccinia immune globulin (VIG). In addition, the DHHS Secretary advised in the declaration that the covered countermeasures be administered to: (1) health care workers

who may be called upon to monitor or treat any persons who are either covered by the declaration or are deemed to be individuals to whom a covered countermeasure has already been administered by a qualified person pursuant to the declaration; (2) any person who is a member of a smallpox response team identified by state or local government entities or DHHS; (3) public safety personnel, including but not limited to, law enforcement officers, firefighters, security, and emergency medical personnel who may be called upon to assist the smallpox response teams referred to in (2); and (4) personnel associated with certain federal government facilities abroad.

III. QUARANTINE AND ISOLATION.

A. Federal Law.

1. Interstate and Foreign Quarantine.

Under federal law, the DHHS Secretary is generally authorized to make and enforce regulations to prevent the introduction, transmission, and spread of communicable disease from foreign countries into the United States and within the United States. 42 U.S.C. §§ 264 and 266. An individual may be isolated or quarantined for the purpose of preventing the introduction, transmission, and spread of certain communicable diseases specified in an Executive Order of the President. 42 U.S.C. § 264(b). The current list of communicable diseases which may warrant isolation or quarantine includes cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers (*e.g.*, Lassa, Marburg and Ebola), severe acute respiratory syndrome (“SARS”), and influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic. 42 C.F.R. § 70.6; Executive Order 13295, April 4, 2003 (amended by Executive Order 13375, April 1, 2005.) Anyone who is incubating or infected with cholera, plague, smallpox, typhus, or yellow fever must receive a written permit from the Surgeon General or his/her authorized representative prior to engaging in interstate travel. 42 C.F.R. § 70.5. Penalties for violating federal quarantine regulations include a fine of not more than \$1,000, imprisonment for not more than one year, or both. 42 U.S.C. § 271.

In addition, the DHHS Secretary is authorized to assist states and local governments in preventing and suppressing communicable diseases and in enforcing state and local quarantine and other health regulations. 42 U.S.C. § 243(a). Also, the director of the CDC is allowed to take reasonable measures to prevent the spread of disease between states if intrastate efforts are insufficient. 42 C.F.R. § 70.2. The CDC typically works closely with state and local health departments when it becomes involved in intrastate public health activities. One example of the CDC’s cooperation with states when intrastate efforts may not have been sufficient was during the 2003 SARS outbreaks in Asia. During these outbreaks, the CDC worked with state and local public health agencies to investigate possible SARS cases. Because federal public health officials currently work with state and local health officials, individuals with whom the hospital is already familiar would likely be working alongside CDC officials.

Despite DHHS’ broad powers to prevent the spread of the communicable diseases listed in the President’s Executive Order, the DHHS and the CDC generally defer to state and local health authorities in the primary use of their separate quarantine powers. In an unusual step, in 2007, the CDC issued an isolation order against an individual thought to have extremely drug-

resistant tuberculosis who apparently defied a no-travel order. This case excited significant media attention, due at least in part to the unclear and contradictory information provided to the patient regarding whether he could or could not travel using public transportation.

2. The Stafford Act.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, *et seq.* (“Stafford Act”), provides another avenue through which the federal government may be involved in implementing quarantine measures. In the event of the declaration of an emergency under the Stafford Act, the Federal Emergency Management Agency and its coordinating agencies (such as the CDC) can be called upon to implement health and safety measures, presumably including quarantine. Quarantine under the Stafford Act must be implemented under the same statutory standards as those set forth in Title 42 of the United States Code, described in Section III(A)(1) above.

3. Treatment and Care Provided by the United States Public Health Service.

Any person detained in accordance with federal quarantine law may be treated and cared for by the United States Public Health Service (“Public Health Service”). 42 U.S.C. § 249(a). Such persons may also receive care and treatment from public or private medical or hospital facilities at the expense of the Public Health Service when authorized by the officer in charge of the applicable CDC quarantine station. 42 U.S.C. § 249(c). CDC quarantine stations typically have contracts with certain hospitals to serve as quarantine facilities for CDC-imposed quarantine. The Chicago CDC quarantine station has jurisdiction over cases arising in Wisconsin. While no specific guidelines are provided as to the conditions for reimbursement, a hospital should keep documentation of any care authorized to be provided at the expense of the Public Health Service and should ensure that the documentation supports the medical necessity of the treatment of the patient’s condition. Additional information regarding quarantine and isolation authority can be found in the Congressional Research Service Report for Congress, *The 2009 Influenza A(H1N1) Outbreak: Selected Legal Issues*, May 6, 2009, and available at http://assets.opencrs.com/rpts/R40560_20090506.pdf.

B. Wisconsin Law.

1. Permitted Scope of Quarantine and Isolation Restrictions.

If deemed necessary by DHS or a local health officer for a particular communicable disease, all persons except the local health officer, his or her representative, attending physicians and nurses, members of the clergy, members of the immediate family, and any other person having a special written permit from the local health officer, are forbidden to be in direct contact with a patient infected with a communicable disease. Wis. Stat. § 252.06(4)(a). If DHS has been declared the public health authority by the governor in response to an emergency, no person, other than a person authorized by DHS or its agent, may enter an isolation or quarantine premises. Wis. Stat. § 252.06(4)(b)(1). Violation of this restriction is punishable by a fine of up to \$10,000 or imprisonment for up to 9 months, or both. Wis. Stat. § 252.06(4)(b)(2). In addition, any person who violates the restriction may themselves be subject to isolation or quarantine. Wis. Stat. § 252.06(4)(b)(3).

A local health officer may employ as many persons as necessary to execute his or her orders and to properly guard any place if quarantine or other restrictions on communicable disease are violated or an intent to violate is manifested. These people must be sworn in as quarantine guards, shall have police powers, and may use all necessary means to enforce state laws and orders and rules of DHS and local health officers with regard to the prevention and control of communicable diseases. Wis. Stat. § 252.06(5).

When the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer may remove the person to such place, provided that removal does not endanger the person's health. Wis. Stat. § 252.06(6)(a). The local health officer may remove a person confined to jail, a state prison, a mental health institute, or other public place of detention to a hospital or other place of safety if that person has a disease that the local health officer or the institution's director of health deems dangerous to the other residents of the facility or the neighborhood. Wis. Stat. § 252.06(6)(b).

Wisconsin Admin. Code § DHS 145 sets forth more specific powers of state or local officers when imposing isolation and quarantine. These powers apply only when an individual has a communicable disease listed in Appendix A of Wis. Admin. Code § DHS 145 or any other infectious disease that a chief medical officer of the state deems a threat to the citizens of the state. If the state health officer, a local health officer, a chief medical officer, or other DHS official knows or suspects that the individual has a contagious medical condition that poses a threat to others, the official may direct that person to comply with any of the following, as appropriate:

- (a) Participate in a designated program of education or counseling;
- (b) Participate in a defined program of treatment for the known or suspected condition;
- (c) Undergo examination and tests necessary to identify a disease, monitor its status, or evaluate the effects of treatment;
- (d) Notify or appear before designated health officials for verification of status, testing, or direct observation of treatment;
- (e) Cease any conduct or employment that constitutes a threat to others;
- (f) Reside part-time or full-time in an isolated or segregated setting that decreases the danger of transmission of the communicable disease; and
- (g) Be placed in an appropriate institutional treatment facility until the person becomes noninfectious.

Wis. Admin. Code § DHS 145.06(4).

As noted above, the foregoing measures may be imposed only on persons who are known or suspected to have a contagious medical condition that poses a threat to others. The following criteria are used to determine whether a person who has been medically diagnosed with a communicable disease listed in Appendix A of Wis. Admin. Code § DHS 145 poses a threat to others:

- (a) Whether the person exhibits a behavior that has been demonstrated epidemiologically to transmit the disease to others or that evidences a careless disregard to the transmission of the disease to others;
- (b) Whether the person has engaged in past behavior that evidences a substantial likelihood that he or she will transmit the disease to others or statements of the person that are credible indicators of the person's intent to transmit the disease to others;
- (c) Whether the person refuses to complete a medically directed regimen of examination and treatment necessary to render the disease non-contagious;
- (d) Whether the person demonstrates inability to complete a medically directed regimen of examination and treatment necessary to render the disease non-contagious as evidenced by: (1) diminished capacity due to mood-altering chemicals, including alcohol; (2) a diagnosis as having significantly below average intellectual functioning; (3) an organic disorder of the brain or a psychiatric disorder of thought, mood, perception, orientation, or memory; or (4) being a minor or having a court-appointed guardian following a court's determination that the person is incompetent;
- (e) Whether the person has misrepresented substantial facts regarding his or her medical history or behavior that can be demonstrated epidemiologically to increase the threat of transmission of disease; and
- (f) Whether the person has engaged in any other willful act or pattern of acts or omission or course of conduct that can be demonstrated epidemiologically to increase the threat of transmission of disease.

Wis. Admin. Code § DHS 145.06(2).

Note that, in order to be considered a threat to others, a person merely suspected of harboring a contagious medical condition (as opposed to being diagnosed with the condition) must exhibit one or more of the factors noted above, as well as demonstrate one of the following without medical evidence that refutes the factor:

- (a) That the person has been linked epidemiologically to exposure to a known case of communicable disease;

- (b) That the person has clinical laboratory findings indicative of a communicable disease; or
- (c) That the person exhibits symptoms that are medically consistent with the presence of a communicable disease.

Wis. Admin. Code § DHS 145.06(3).

Note that the foregoing provisions fail to take into account new and emerging diseases. Often, the method of transmission of a new disease may be unclear, and therefore, there may be insufficient epidemiological evidence regarding the risk of transmission to meet the requirements.

With regard to real and physical property, the state health officer, a local health officer, a chief medical officer, or other DHS official may direct persons who own or supervise real or physical property that presents a threat of transmission of any communicable disease listed in Appendix A of Wis. Admin. Code § DHS 145 to do what is reasonable and necessary to abate the threat of transmission. Wis. Admin. Code § DHS 145.06(6). Persons failing or refusing to comply with a directive are subject to the penalties set forth in Section III(B)(1) above.

2. Quarantine or Isolation in a Hospital.

There are several avenues through which DHS may quarantine or isolate individuals in a hospital. Under Wis. Stat. § 252.06(6), the local health officer may remove a person to a separate place to be quarantined when the officer deems it necessary. Although the statute does not explicitly state which types of places could be used for quarantine, presumably such a place would include a hospital. In the context of a public health emergency, it is unlikely that a hospital would be used for quarantine since the hospital will need to prioritize those patients who are infected and require treatment. However, it is possible that a public health officer would ask a hospital to quarantine an individual if there is no public health emergency and other interventions, such as careful monitoring for the onset of symptoms, are indicated.

DHS also has broad powers which allow local health officers to send a person with a communicable disease to a hospital or other health facility for isolation, and many patients with serious communicable diseases may require hospital care regardless of whether isolation or quarantine is imposed. For example, the local health officer or director of health at a jail, state prison, mental health institute or other public place of detention may order in writing the removal of a person with a disease that is dangerous to the health of other residents or the neighborhood to a hospital at which the person is to be provided for and securely kept. Wis. Stat. § 252.06(6)(b). State and local health officials may also place a person with a communicable disease who poses a threat to others in isolation at an appropriate institutional treatment facility until the person becomes noninfectious. Wis. Admin. Code § DHS 145.06(4)(g). It is advisable to consult with your local health department to discuss the possibility of quarantine and isolation at your facility and the circumstances under which the health department may plan to use your facility for these purposes.

3. Penalties for Violation.

If a person fails to comply with a quarantine or isolation directive described above, the public health official who issued the directive may petition a court to order the person to comply. As discussed in Section I(A)(2) of Chapter Five, the petitioner must ensure that: (1) the petition is supported by clear and convincing evidence of the allegation of failure to comply with the directive; (2) the respondent has been given the directive in writing, including evidence that supports the allegation, and has been afforded the opportunity to seek counsel; and (3) the remedy proposed is the least restrictive on the respondent that would serve to correct the situation and protect the public's health. Wis. Admin. Code § DHS 145.06(5), (6).

Despite the procedures set forth above, DHS retains the statutory power to authorize and implement all emergency measures necessary to control communicable diseases. Wis. Stat. § 252.02. Therefore, in the event of an emergency where there is not time to petition for a court order, DHS may instruct public health officials to enforce directives without petitioning for a court order. In addition, during a state of emergency related to public health, the governor may suspend the provisions of any administrative rule, such as Wis. Admin. Code § DHS 145.06(6) described above, if strict compliance with the rule would prevent, hinder, or delay necessary actions to respond to the emergency and would increase the health threat to the population. Wis. Stat. § 323.12(4)(d).

4. Payment of Expenses Associated with Isolation or Quarantine.

A hospital is not expected to bear all of the costs of implementing and maintaining isolation at its facility. Wisconsin law provides that expenses for necessary medical care, food, and other articles needed for the care of the infected person shall be charged against the infected person or whoever is liable for the person's support. Wis. Stat. § 252.06(10)(a). The county or municipality in which a person with a communicable disease resides is liable for the following costs, unless the costs are payable by a third party payor or any benefit system: (1) the expense of employing quarantine guards; (2) the expense of maintaining quarantine and enforcing isolation of the quarantined area; (3) the expense of conducting examinations and tests for disease carriers made under the direction of the local health officer; and (4) the expense of care provided to a dependent person who is eligible for assistance in a county that administers a relief block grant program. Wis. Stat. § 252.06(10)(b). All expenses incurred by a local health department, or by an entity designated as a local health department by a federally recognized American Indian tribe or band, in quarantining a person outside his or her home during a state of emergency related to public health declared by the governor and not reimbursed from federal funds (such as federal emergency funds) shall be paid for from state appropriations. Wis. Stat. § 252.06(10)(c).

IV. PREVENTION, PREPAREDNESS, RESPONSE, AND RECOVERY.

Communicable diseases raise a host of clinical and public health issues for hospitals, while the legal issues surrounding communicable diseases often affect state and local public health authorities more than the hospitals and providers themselves. While actions necessary to prevent, prepare for, respond to, and recover from communicable disease cases or an outbreak are primarily clinical, rather than legal in nature, many issues related to communicable diseases

may be mitigated by ensuring compliance with state and federal regulations regarding communicable disease reporting and infection control. For example, by complying with Wisconsin communicable disease reporting requirements, a hospital ensures that public health officials are appropriately informed and can assist the hospital in responding appropriately.

Aside from maintaining compliance, one of the best ways for a hospital to prepare for a mass casualty event involving communicable diseases is to develop and maintain good relationships with local and state public health officials. These officials will likely become heavily involved in any mass casualty event, especially one in which one or more communicable diseases threaten public health. Public health officials can provide clinical and public health guidance to hospitals in planning for and responding to communicable diseases. In addition, the CDC's website, <http://www.cdc.gov>, provides extensive clinical and public health information with regard to communicable diseases. A hospital may also desire to consult infectious disease physicians in developing and revising clinical policies related to control of communicable diseases in the hospital.

CHAPTER SIX

COMPLIANCE ISSUES

I. CONFIDENTIALITY OF PATIENT HEALTH INFORMATION.

A. Overview and Definitions.

Confidentiality of patient health information in Wisconsin is governed by Chapter 146 of the Wisconsin Statutes, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and its implementing regulations at 45 C.F.R. Parts 160 to 164 (collectively, “HIPAA”), and other applicable laws, including the Health Information Technology and related provisions of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (“HITECH”). In general, neither state nor federal law provide broad waivers that would exempt hospitals from compliance with confidentiality requirements during an emergency⁵⁵ situation. However, some requirements of state and federal law are relaxed under emergency circumstances.

Generally, state confidentiality laws that are contrary to federal confidentiality laws are preempted, meaning that the federal requirements will apply. 45 C.F.R. § 160.203. For these purposes, “contrary” means that an entity subject to federal confidentiality requirements would find it impossible to comply with both state and federal requirements, or that state law stands as an obstacle to accomplishing the full purposes and objectives of the federal requirements. 45 C.F.R. § 160.202. An exception to the general rule of preemption is made for state laws that are contrary to, but more stringent than, federal confidentiality requirements. In this regard, Wisconsin confidentiality laws that restrict the use or disclosure of patient health information more than federal confidentiality laws are generally not preempted.

The determination of whether Wisconsin law is preempted by federal law can be complicated. One must consider the Wisconsin Statutes, as well as HIPAA and HITECH, to decide which rules are more stringent. While a full analysis of preemption issues is beyond the scope of this Manual, our aim is to assist hospitals in making such decisions by providing a summary of relevant Wisconsin Statutes and HIPAA or HITECH provisions that may be applicable during emergencies. For assistance in deciding whether Wisconsin law is preempted by federal law in specific circumstances, you are advised to consult your attorney.

Please note that Section I(A) of Chapter Six is intended to give a general overview of confidentiality provisions in Wisconsin and federal law in the context of mass casualty events but does not offer an exhaustive review of the topic of confidentiality. In particular, please note that additional laws apply to the disclosure of HIV test results⁵⁶ and records of patients treated for mental illness, developmental disability, and drug or alcohol abuse.⁵⁷ Because it is assumed

⁵⁵ The terms disaster, emergency and mass casualty event are used interchangeably throughout this Chapter.

⁵⁶ Disclosure of HIV test results is governed by Chapter 252 of the Wisconsin Statutes.

⁵⁷ Records of patients treated for the primary purpose of mental illness, developmental disability, and/or substance abuse are governed by Chapter 51 of the Wisconsin Statutes and the federal Alcohol, Drug Abuse, and Mental Health Administration Organization Act of 1992 (42 U.S.C. § 290dd-2) and implementing regulations (42 C.F.R. § 2.1 *et seq.*).

that, in a mass casualty event, most of the questions that arise regarding confidentiality will not involve these issues, they are not addressed in this Manual.

1. Wisconsin Law.

Generally, health care providers are perceived to be the owners of patient health care records because of the providers' obligations to maintain records on behalf of their patients. However, patients are entitled to fairly broad access to their health care records and have great latitude in directing where the health care records go, or how the records are used. As such, health care providers have significant responsibilities related to the safeguarding of confidential information contained in the patient's health care records.

The confidentiality of patient health care records is primarily governed by Section 146.82 of the Wisconsin Statutes. For purposes of Wisconsin law, "patient health care records" are defined by Wis. Stat. § 146.81(4) as all records related to the health of a patient prepared by or under the supervision of a health care provider, and all records made by an ambulance service provider, an emergency medical technician, or a first responder in administering emergency care procedures to and handling and transporting sick, disabled, or injured individuals.

The general rule under Wis. Stat. § 146.82 is that all patient health care records must remain confidential unless the release of such records is permitted under the statute or is permitted pursuant to the informed consent of the patient or of a person authorized by the patient. The following are deemed by statute to be "persons authorized by the patient": the parent or legal guardian of a minor child; the guardian of an incompetent patient; any person authorized in writing by the patient; a health care agent designated as an incapacitated patient's health care power of attorney; and the personal representative, spouse, or domestic partner of a deceased patient. Wis. Stat. § 146.81(5). If no spouse or domestic partner survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family. *Id.* With respect to minor patients, according to Wis. Stat. §§ 146.835 and 767.24(7), a parent, regardless of whether the parent has legal custody of the child, has a right of access to the minor patient's health care records unless: (1) a court has ordered otherwise; or (2) the parent has been denied periods of physical placement with the child.

Wis. Stat. § 146.81(2) specifies that "informed consent" means written consent which includes the following: (1) the name of the patient whose record is being disclosed; (2) the type of information to be disclosed; (3) the types of health care providers making the disclosure; (4) the purpose of the disclosure, such as whether the disclosure is for further medical care, for an application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation determination, for a legal investigation, or for other specified purposes; (5) the individual, agency, or organization to which disclosure may be made; (6) the signature of the patient or the person authorized by the patient, and if signed by the person authorized by the patient, the relationship of that person to the patient or the authority of the person; (7) the date on which the consent is signed; and (8) the time period during which the consent is effective.

2. Federal Law.

Federal confidentiality requirements under HIPAA and HITECH apply only to “covered entities,” including health plans, health care clearinghouses, and health care providers that electronically transmit health information in certain transactions. Under 45 C.F.R. § 160.103, a “health care provider” is defined as a provider of medical or other health services and any other person or entity that furnishes, bills, or is paid for health care in the normal course of business.

HIPAA and HITECH protect the confidentiality of protected health information (“PHI”), which is defined as individually identifiable health information that is transmitted electronically, maintained electronically, or transmitted or maintained in any other form or medium, whether paper, electronic, or oral. PHI does not include education records or certain other records subject to the Family Education Rights and Privacy Act, 20 U.S.C. § 1232g, or employment records held by a covered entity in its role as an employer. Health information is considered to be individually identifiable under 45 C.F.R. § 160.103 if it: (1) is created or received by a health care provider, health plan, or health care clearinghouse; (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and (3) identifies the relevant individual or for which there is a reasonable basis to believe it could be used to identify the relevant individual.

B. Circumstances Under Which Records Must Be Released.

The Wisconsin Statutes require that reports be made to public authorities in the circumstances set forth below, among others, regardless of whether the patient has consented to the release of such information. Under HIPAA, a covered entity may use or disclose PHI to the extent such use or disclosure is required by law; therefore, disclosure in the circumstances below is permissible under federal law.

1. Communicable Diseases.

Wis. Stat. § 252.05 provides that certain communicable diseases, including tuberculosis, Acquired Immune Deficiency Syndrome (“AIDS”), and sexually transmitted diseases, must be reported to the local health officer. This report should include the name, sex, age, and residence of the person, the communicable disease, and any other facts that the local health officer or the Wisconsin Department of Health Services (“DHS”) requires. The reporting obligation applies to any health care provider identified in Wis. Stat. § 146.81(1), other than ambulance service providers, emergency medical technicians, or first responders.

2. Deaths.

Wis. Stat. § 979.01 requires that certain deaths be reported to the sheriff, police chief, medical examiner, or coroner of the county in which the death occurred. The reporting obligation applies to, among others, physicians, authorities of hospitals, and other persons with knowledge of the death. Deaths that must be reported include, but are not limited to, the following: (1) all deaths in which there are unexplained, unusual, or suspicious circumstances; (2) all homicides; (3) all suicides; (4) all deaths due to poisoning; and (5) all deaths following accidents, whether the injury is or is not the primary cause of death.

3. Gunshot and Suspicious Wounds.

Gunshot wounds and any other wound, including second or third degree burns to at least 5% of the patient's body, or, due to the inhalation of superheated air, swelling of the patient's larynx or a burn to the patient's upper respiratory tract, that are reasonably believed to have occurred as a result of a crime must be reported pursuant to Wis. Stat. § 255.40. The report must include the patient's name and the type of wound involved and must be made as soon as reasonably possible to the local police department or county sheriff's office for the area where the treatment is rendered. Reporting is not required where the patient is accompanied by a law enforcement officer at the time treatment is rendered, where the patient's name and type of wound or burn injury have been previously reported, or where the wound is a gunshot wound which appears to have occurred at least thirty (30) days prior to treatment. The reporting obligation applies to any person licensed under Wis. Stat. §§ 441, 448 or 455, including, but not limited to, physicians, nurses, and psychologists.

4. Certain Crimes.

Wisconsin's "Good Samaritan" statute states: "Any person who knows that a crime is being committed and that a victim is exposed to bodily harm shall summon law enforcement officers or other assistance or shall provide assistance to the victim." Wis. Stat. § 940.34(2)(a). A person is not required to summon or render aid if others are doing so, or if compliance would place in danger the person attempting to comply. If a crime occurs on a hospital's premises that threatens a victim with bodily harm, the statute would apply and the health care providers and other hospital staff witnessing the crime would be required to comply.

5. Duty to Protect.

There is a non-statutory exception to the rule requiring confidentiality for information obtained during the provision of health care, based on a 1998 decision of the Wisconsin Supreme Court in the case of *Schuster v. Altenberg*, 424 N.W.2d 159 (1988). *See also State v. Agacki*, 595 N.W.2d 31 (1999) (upholding the "duty to warn" exception to the physician-patient privilege established in *Schuster*). This exception applies where disclosure is necessary to protect the patient or the community from imminent and substantial danger. This "duty to warn" requires a health care provider to warn third parties, or to institute proceedings for the detention or commitment of a dangerous patient, if the provider has reasonable cause to believe that the patient is dangerous and if warning a third party or detention is necessary to protect the patient or the public. *Schuster*, 424 N.W.2d at 166; *Agacki*, 595 N.W.2d at 38.

C. Circumstances When Records May Be Released Without Consent.

1. Wisconsin Law.

Wis. Stat. § 146.82 authorizes the release of patient health care records without the informed consent of the patient or person authorized by the patient in certain circumstances, which include, but are not limited to, the following, which may be particularly applicable in a mass casualty event:

- (a) To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to emergency medical services personnel, including, but not limited to, medical staff members, employees, or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if: (1) the person is rendering assistance to the patient; (2) the person is being consulted regarding the health of the patient; (3) the life or health of the patient appears to be in danger and the information contained in the patient's health care records may aid the person in rendering assistance; or (4) the person prepares or stores records, for the purposes of the preparation or storage of those records;
- (b) To the extent that records are needed for billing, collection, or payment of claims;
- (c) Under a lawful order of a court of record. (Note: A "lawful court order" is different from a subpoena signed by a judge. However, in cases where a judge (rather than an attorney) has signed a subpoena requiring record production, the health care provider may determine that the records should be released without requiring the court to enter an order to that effect.);
- (d) In response to a written request by any federal or state governmental agency to perform a legally authorized function, including, but not limited to, management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification;
- (e) Following the death of a patient, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death; and
- (f) For purposes of health care operations.⁵⁸

⁵⁸ HIPAA's definition of "health care operations" is incorporated by reference into the Wisconsin Statutes. *See* Wis. Stat. § 146.82(1). *See* Section I(C)(2) of this Chapter for the HIPAA definition of "health care operations."

2. Federal Law.

HIPAA authorizes the use or disclosure of PHI without informed consent in limited circumstances. While the below list is not exhaustive, it includes circumstances when the use or disclosure of PHI may be permitted without informed consent that may be particularly applicable in a mass casualty event:

- (a) As required by law;⁵⁹
- (b) For public health activities and purposes, to:
 - (i) a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; or
 - (ii) to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation.
- (c) For judicial and administrative proceedings, including in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order;
- (d) For law enforcement purposes, including the following:
 - (i) for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, a covered entity can disclose limited PHI to a law enforcement official in response to the official's request for such information;

⁵⁹ "Required by law" means a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. "Required by law" includes, but is not limited to, court orders and court ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits. 45 C.F.R. § 164.103.

- (ii) in limited circumstances, in response to a law enforcement official's request for information about an individual who is or is suspected to be a victim of a crime;
 - (iii) to law enforcement officials for the purpose of alerting them of the death of the individual if the covered entity has a suspicion that the death may have resulted from criminal conduct;
 - (iv) to law enforcement officials if the covered entity believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the premises of the covered entity; and
 - (v) to law enforcement officials if a covered entity is providing emergency health care in response to a medical emergency not on the premises of the health care provider, if such disclosure appears necessary to alert law enforcement to the commission and nature of a crime, the location of such crime or of the victims of such crime, and the identity, description, and location of the perpetrator of such crime.
- (e) Information about decedents may be disclosed to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties authorized by law;
- (f) A covered entity may, consistent with applicable laws and standards of ethical conduct, use or disclose PHI if the covered entity, in good faith, believes the use or disclosure:
 - (i) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of a threat; or
 - (ii) is necessary for law enforcement authorities to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim or where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody.
- (g) A covered entity may disclose PHI to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act of 1947, 50 U.S.C. § 401 *et seq.*, and implementing authority.

45 C.F.R. § 164.512.

HIPAA also provides that covered entities may use or disclose PHI to carry out treatment, payment, or health care operations, except in cases where Wisconsin law is more stringent.

“Treatment” means:

1. The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party;
2. Consultation between health care providers relating to a patient; or
3. The referral of a patient for health care from one health care provider to another.

45 C.F.R. § 164.501.

“Payment” includes the activities of a health care provider to obtain reimbursement for the provision of health care, including determinations of eligibility or coverage, billing, claims management, collection activities, review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges, and utilization review activities, including precertification and preauthorization of services. *Id.*

“Health care operations” include, but are not limited to:

1. Quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines and related functions that do not primarily aim to obtain generalized knowledge;
2. Population-based activities relating to improving health or reducing health care costs;
3. Protocol development;
4. Case management;
5. Care coordination;
6. Training, accreditation, certification, licensing, credentialing, or other related activities;
7. Underwriting and other insurance related activities;
8. Medical review and auditing functions, including fraud and abuse detection and compliance programs;

9. Conducting or arranging for medical review, legal services, and auditing functions; and
10. Business management and general administrative activities. *Id.*

Under HITECH when a covered entity uses or discloses PHI, or requests PHI from another covered entity, it must, to the extent practicable, limit the amount of PHI it uses, discloses, or requests to a limited data set, or if needed, to the minimum necessary to accomplish the purpose for the use, disclosure, or request.⁶⁰ As defined in 45 C.F.R. § 164.514(e), a “limited data set” is PHI that excludes direct identifiers of the individual or the relatives, employers, or household members of the individual. Direct identifiers include: names; postal address information other than town or city, state, and zip code; telephone numbers; fax numbers; electronic mail addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; vehicle identifiers and serial numbers (including license plate numbers); device identifiers or serial numbers; URL’s; Internet Protocols (IP) address numbers; biometric identifiers (including finger and voice prints); and full face photographic images and any comparable images.

Note that the minimum necessary standards do not apply to: disclosures to or requests by a provider for treatment; uses or disclosures made to the individual; uses or disclosures pursuant to an authorization; disclosures to DHHS in connection with its enforcement of HIPAA; uses or disclosures required by law; or uses or disclosures that are required for compliance with applicable HIPAA requirements. 45 C.F.R. § 164.502(b).

D. Public or Non-Confidential Information.

1. Wisconsin Law.

Wisconsin Statutes do not expressly permit a patient’s condition to be disclosed to those who inquire about the patient without the patient’s informed consent. Nevertheless, Wis. Stat. § 146.82(4) does permit a health care provider to disclose PHI to any of the following individuals, if the patient is incapacitated, or if an emergency makes it impractical to obtain an agreement from the patient, and the health care provider determines, in the exercise of his or her professional judgment, that release of the information is in the best interest of the patient:

- (a) A member of the patient’s immediate family or another relative or close personal friend, provided that the information released is directly relevant to the individual’s involvement in the patient’s care; or

⁶⁰ Under HITECH, the Secretary of the Department of Health and Human Services (“DHHS”) is required to issue guidance on what constitutes “minimum necessary” no later than August 17, 2010. At such time, the requirement to use a limited data set, or if needed, the minimum necessary to accomplish the intended purpose will be replaced and all uses, disclosures, and requests of PHI will have to comply with new minimum necessary guidance issued by the Secretary.

- (b) As necessary to identify, locate, or notify a patient's family member that is responsible for the care of the patient, concerning the patient's location, general condition, or death.

2. Federal Law.

HIPAA permits a health care provider to disclose a patient's name, location in the facility, and "condition described in general terms that does not communicate specific medical information about the individual" without the patient's written authorization provided that either:

- (a) The facility has informed the individual of the information that may be included in a facility directory and to whom the information may be disclosed, and the individual has not expressed any objection. Facilities might comply with this requirement by incorporating language into the admissions documents provided to patients explaining that such disclosures may occur. If no objection is expressed, disclosure is then permissible under HIPAA; or
- (b) The individual cannot practicably be afforded the opportunity to object to the disclosure due to incapacity or an emergency treatment circumstance, and disclosure is consistent with any prior expressed preference of the individual that is known to the facility and in the individual's best interest, as determined by a health care provider in the exercise of professional judgment. The facility must inform the individual and provide an opportunity to object to any such disclosure as soon as practicable.

45 C.F.R. § 164.510(a).

In addition, a covered entity may use or disclose PHI to assist in notifying (including identifying or locating) a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. In particular, during a disaster, a covered entity may use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for the purpose of coordinating with such entities the uses or disclosures permitted to assist in notifying a family member, personal representative, or another person responsible for the care of the individual of the individual's location, general condition, or death. A covered entity must ask for the individual's agreement to such disclosures or give the individual an opportunity to object to the extent that doing so would not interfere with the ability to respond to emergency circumstances. 45 C.F.R. § 164.510(b).

E. Redress for Violations of Laws Related to Confidentiality of Health Care Records.

1. Redress Under Wisconsin Law.

Damages. Pursuant to Wis. Stat. § 146.84, any person or entity who violates a patient's right to confidentiality or a patient's right to access to medical records in a manner that is knowing and willful shall be liable to any person injured as a result of the violation for actual damages, exemplary damages of up to \$25,000, and costs and reasonable actual attorney fees. Likewise, any person or entity who negligently violates a patient's right to confidentiality or a patient's right to access to medical records shall be liable for actual damages, exemplary damages of up to \$1,000, and costs and reasonable actual attorney fees. A custodian of records incurs no liability for the release of patient health care records pursuant to statutory guidelines when acting in good faith.

Injunctive Relief. In addition to damages, Wis. Stat. § 146.84(1)(c) permits an individual to bring an action to enjoin a violation of Wisconsin law relating to confidentiality of patient health care records or patient access to such records, or to compel compliance.

Penalties. In addition, Wis. Stat. § 146.84(2) provides that whoever: (1) requests or obtains confidential information from patient health care records under false pretenses; (2) discloses confidential information with knowledge that the disclosure is unlawful and not reasonably necessary to protect another from harm; or (3) intentionally falsifies or conceals or destroys a patient health care record, may be fined up to \$25,000 or imprisoned not more than 9 months, or both. Whoever negligently discloses confidential information may also be subject to forfeiture of up to \$1,000 per violation. Finally, whoever intentionally discloses confidential information, knowing that the information is confidential, and discloses the confidential information for pecuniary gain, may be fined up to \$100,000 or imprisoned not more than 3 years and 6 months, or both.

2. Redress Under Federal Law.

General Penalty. A tiered penalty structure is applied for violations of HIPAA and HITECH. Under 42 U.S.C. § 1320d-5, the following penalties may apply, depending on the person's perceived culpability for the violation:

- (a) \$100 per violation, with an annual cap of \$25,000, for violations where the person did not know (and by exercising reasonable diligence would not have known) that such person committed a violation;
- (b) \$1,000 per violation, with an annual cap of \$100,000, for violations due to reasonable cause and not to willful neglect;
- (c) \$10,000 per violation, with an annual cap of \$250,000, for violations due to willful neglect that are corrected within thirty (30) days of the date the person knows (or should have known) that the violation occurred; and
- (d) \$50,000 per violation, with an annual cap of \$1,500,000 for violations due to willful neglect that are not corrected within the thirty (30) day period.

Penalty for Knowing Violation. A person who knowingly and wrongfully uses, obtains or discloses PHI will be fined not more than \$50,000, imprisoned not more than 1 year, or both. If the offense is committed under false pretenses, the violator will be fined not more than \$100,000, imprisoned not more than 5 years, or both. If the offense is committed with intent to sell, transfer, or use PHI for commercial advantage, pecuniary gain, or malicious harm, the violator will be fined not more than \$250,000, imprisoned not more than 10 years, or both. 42 U.S.C. § 1320d-6.

Waiver of Sanctions and Penalties. Pursuant to 42 U.S.C. § 1320b-5(b)(7), in the event of a disaster or emergency declared by the President of the United States and a public health emergency declared by the DHHS Secretary, the DHHS Secretary is authorized to waive sanctions and penalties (commonly referred to as a “Section 1135 Waiver”) for covered entities in the emergency area that arise from noncompliance with the following HIPAA requirements:

1. The requirement to obtain a patient’s agreement to speak with family and friends (45 C.F.R. § 164.510);
2. The requirement to honor a request to opt out of the facility directory (*Id.*);
3. The requirement to distribute a Notice of Privacy Practices (45 C.F.R. § 164.520);
4. The requirement to allow a patient to request confidential communications (45 C.F.R. § 164.522); and
5. The requirement to allow a patient to request privacy restrictions (*Id.*).

Actions taken by a covered entity pursuant to a Section 1135 Waiver of the above requirements must not discriminate among individuals on the basis of their source of payment or their ability to pay. In addition, a Section 1135 Waiver of a covered entity’s noncompliance with the above requirements is limited to a 72-hour period beginning upon implementation of the hospital’s disaster protocol. Following the end of the 72-hour period, a covered entity must comply with the above requirements for any patient still under the covered entity’s care. 42 U.S.C. § 1320b-5(b)(7).

F. Prevention and Preparedness.

To prevent noncompliance with state and federal confidentiality laws during an emergency situation, a hospital should review its current confidentiality policies and consider how they will become more difficult to follow in an emergency. A hospital may desire to develop a policy addressing confidentiality of patient records during emergencies that incorporates the provisions described above that apply specifically during emergencies or disasters. The policy could become effective automatically upon implementation of a hospital’s disaster protocol or at the discretion of the hospital’s privacy officer or other hospital administrator. Staff training for emergencies should include training with regard to confidentiality of patient records, as appropriate. In addition, a hospital may determine that training with regard to confidentiality procedures be provided for volunteer practitioners, if feasible.

Whether any disclosure is permissible under state or federal law will depend on the circumstances of the request, including the identity of the requester, the information being requested, and the purpose of the request. By way of illustration, below we provide several examples of requests that might be made of a hospital in a mass casualty event.

Example 1: The American Red Cross asks Hospital A for a list of all inpatients and their dates of birth, in order to assist family members of missing persons in locating those persons. Hospital A, as part of its disaster protocol, has routinely informed each patient that it may disclose the patient's name and other requested PHI in response to a request for information from a disaster relief agency, and Hospital A has maintained a record of those patients who objected to any such disclosure and those who did not. Wisconsin law permits Hospital A to disclose PHI as necessary to identify, locate, or notify a patient's immediate family members or another person that is responsible for the care of the patient concerning the patient's location, general condition, or death, provided that the patient is incapacitated, or an emergency makes it impractical to obtain an agreement from the patient and the health care provider determines that release of the information is in the best interest of the patient. Federal law permits Hospital A to disclose the requested PHI for each patient who did not object to the disclosure to a disaster relief agency, or for any patient who is not present or cannot be afforded the opportunity to object due to incapacity or an emergency treatment circumstance and for whom Hospital A determines, in the exercise of professional judgment, that disclosure is in the patient's best interest.

Example 2: Wisconsin Emergency Management submits a written request to Hospital B for a list of all current patients who may have been affected by a recent mass casualty event, their dates of birth, and their current condition in order to carry out the State of Wisconsin's disaster management protocols. Hospital B may disclose the requested information. The disclosure is required under Wisconsin law as a disclosure in response to a written request by a state governmental agency to perform a legally authorized function and is permitted under HIPAA as a disclosure that is required by law.

Example 3: A family member of Patient Doe asks Hospital C if Patient Doe is currently a patient of the hospital. If Patient Doe is not a current patient of Hospital C, Hospital C may inform the family member that Patient Doe is not a patient. Neither Wisconsin law nor HIPAA would prohibit a hospital from disclosing that a particular person is not a patient.

Example 4: The Milwaukee Public Health Department asks Hospital D for a list of all patients who have been diagnosed with smallpox, including each such patient's sex, age, and residence. Hospital D may disclose the requested information. Wisconsin law requires the disclosure pursuant to the communicable disease reporting requirements of Chapter 252 of the Wisconsin Statutes, and HIPAA permits the disclosure as a disclosure that is required by law.

A hospital may have concerns that withholding information from certain entities or individuals for conformity with Wisconsin or federal law may not be appropriate under some circumstances. Although disclosure is permitted under Wisconsin and federal law only as outlined in applicable statutes and regulations, it is understandable that the hospital may believe the ethical obligation to ensure that individuals receive appropriate care and are advised of the status of their family members in mass casualty events outweighs the risk associated with making a disclosure inconsistent with Wisconsin and federal law. With regard to disclosures that

may be determined by the hospital to be ethically justified but inconsistent with state or federal law, we recommend that applicable hospital policies indicate that when there are questions or concerns about the hospital's privacy policy or its implementation in specific situations, the Privacy Officer, or the hospital's risk management department, should be consulted before making a disclosure. The Privacy Officer or risk management department can then contact and obtain assistance from legal counsel as needed to determine whether disclosure is appropriate in the given circumstances.

G. Response and Recovery.

In response to an emergency, a hospital should follow its policies and procedures as closely as possible. Should the emergency require activation of a hospital's disaster protocol for confidentiality of patient records, hospital administration should clearly communicate to health care providers and others when such policy is in effect and when the hospital returns to following standard policies. Upon the end of the emergency, a hospital should evaluate its compliance with confidentiality laws during the emergency and revise applicable policies as appropriate.

II. EMTALA.

A. Overview of EMTALA.

A hospital that participates in Medicare is required to comply with the federal Emergency Medical Treatment and Active Labor Act of 1985, 42 U.S.C. § 1395dd, and its implementing regulations, 42 C.F.R. § 489.24 ("EMTALA"). EMTALA requires a Medicare participating hospital that has an emergency department to provide an appropriate medical screening examination within the capability of the hospital's emergency department (including any ancillary services routinely available to the emergency department) to any individual who comes to the emergency department and requests an examination or treatment for a medical condition. 42 U.S.C. § 1395dd(a). If the hospital determines that the individual has an emergency medical condition, the hospital must: (a) provide emergency services to stabilize the medical condition within the capabilities of the staff and facilities available at the hospital; or (b) transfer the individual to another medical facility.⁶¹ 42 U.S.C. § 1395dd(b). If a hospital is unable to stabilize an individual within its capabilities, an appropriate transfer should be implemented.

⁶¹ An emergency medical condition is (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part; or (b) with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) that transfer may pose a threat to the health or safety of the woman or her unborn child. 42 C.F.R. § 489.24(b).

A hospital may transfer an individual with an emergency medical condition only if the transfer is an appropriate transfer and one of the following occurs: (1) the patient requests a transfer in writing after being informed of the risks of transfer; (2) a physician has signed a certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient or, in the case of a woman in labor, to the woman or the unborn child, from effecting the transfer; or (3) if a physician is not physically present in the emergency department at the time a patient is transferred, a qualified medical person has signed the above-described certification after a physician, in consultation with the qualified medical person, has agreed with the certification and subsequently countersigns the certification. 42 C.F.R. § 489.24(e).

Medicare State Operations Manual (“SOM”), Appendix V, Tag A-2407/C-2407. If the individual’s condition requires immediate medical stabilizing treatment and the hospital is not able to attend to the individual because the emergency department is operating beyond its capacity⁶², then the hospital should transfer the individual to a hospital that has the capability and capacity to treat the individual’s emergency medical condition. *Id.*

EMTALA applies to any individual who comes to an emergency department, regardless of whether the individual is eligible for Medicare benefits and regardless of the individual’s ability to pay. 42 C.F.R. § 489.24(a). Consequently, any individual who “comes to the emergency department,” as that phrase is defined in the regulations, and requests or requires it, must receive an appropriate medical screening examination to determine whether an emergency medical condition exists. Such an examination must consist of the same services that would be provided to any other patient presenting with the same signs and symptoms, regardless of the individual’s ability to pay. The screening examination must be sufficient to determine, with reasonable clinical confidence, whether an emergency medical condition does or does not exist. SOM, Appendix V, Tag A-2406/C-2406; 68 Fed. Reg. 53221, 53234 (September 9, 2003). The medical screening examination is an ongoing process that may begin, but typically does not end, with processing a patient through a standard triage protocol. While a standard triage protocol may be used to assess an individual’s presenting signs and symptoms at the time of arrival in order to prioritize when the individual will be seen by a physician or other qualified medical personnel, application of such a protocol alone is generally not sufficient to satisfy EMTALA’s medical screening examination requirement. SOM, Appendix V, Tag A-2406/C-2406; 68 Fed. Reg. 53221, 53236. However, an individual’s statement that he or she is not seeking emergency care, together with brief questioning by qualified medical personnel, can be sufficient to satisfy a hospital’s EMTALA obligations in any case in which a request for medical care clearly does not involve an emergency medical condition. 68 Fed. Reg. 53221, 53234.

If it is determined that the patient does not have an emergency medical condition, EMTALA does not obligate a hospital to provide any further screening or treatment to the patient. *Id.* Accordingly, if a hospital finds, through the required medical screening examination, that a patient does not have an emergency medical condition, EMTALA would permit the hospital to refuse to further treat the patient. Likewise, the hospital would not be required to treat the patient if he or she were to present for a non-emergent, elective procedure.

B. Exceptions/Waivers.

Sanctions for an inappropriate transfer or for directing or relocating an individual to receive a medical screening examination at an alternate location do not apply to a hospital with a dedicated emergency department if: (1) the hospital is located in an emergency area during an emergency period; (2) the transfer is necessitated by the circumstances of the declared

⁶² The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital’s premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits. If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits. SOM, Appendix V, Tag A-2407/C-2407.

emergency, or the direction or relocation to an alternate location is pursuant to an appropriate state emergency preparedness or pandemic preparedness plan; (3) the hospital does not discriminate based on the individual's source of payment or ability to pay; and (4) there has been a determination by the DHHS Secretary that a Section 1135 Waiver of sanctions is necessary. 42 U.S.C. § 1320b-5(b)(3); 42 C.F.R. § 489.24(a)(2)(i). For these purposes, an "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exists an emergency or disaster declared by the President of the United States and a public health emergency declared by the DHHS Secretary. 42 U.S.C. § 1320b-5(g)(1). Note that a Section 1135 Waiver of sanctions is limited to a 72-hour period beginning upon the implementation of a hospital's disaster protocol, unless the declared public health emergency relates to a pandemic infectious disease, in which case the waiver will continue in effect until the termination of the declared public health emergency. 42 C.F.R. § 489.24(a)(2)(ii).

CMS' interpretive guidelines indicate that the CMS Central Office will inform the Regional Offices when the DHHS Secretary is permitting a Section 1135 EMTALA waiver, and whether the waiver will be applied retroactively. The Regional Office will then issue an advisory notice that, for a limited period of time during the emergency period, hospitals with dedicated emergency departments in the emergency area will not be subject to sanctions for inappropriate transfers, or for directing or relocating individuals to receive medical screening examinations at alternate locations. The Regional Office will remind hospitals that, in order for the Section 1135 Waiver to apply, the hospital must activate its disaster protocol and the State must have activated an emergency preparedness or pandemic preparedness plan in the emergency area. Any hospital that activates its disaster protocol and utilizes a Section 1135 EMTALA waiver must notify the local surveying agency that it has done so. The surveying agency will then advise the CMS Regional Office as to which hospitals are utilizing the Section 1135 EMTALA waiver. SOM, Appendix V, Tag A-2406/C-2406.

Please note that the law and guidelines discussed above do not specifically address the use of alternative treatment sites, such as schools and convention centers, in emergency areas during emergency periods. However, the DHHS Secretary may waive standard EMTALA requirements and allow for the direction or relocation of an individual to receive a medical screening examination at an "alternate location" pursuant to an appropriate State emergency preparedness or pandemic preparedness plan. The use of the term "alternate location" leaves open the possibility that the DHHS Secretary may permit a hospital to use alternative treatment sites in meeting its EMTALA requirements, provided that the use of alternative treatment sites is as directed in the State's emergency or pandemic preparedness plans. Hospitals may also wish to request that CMS provide additional guidance on this issue during declared emergency events.

Hospitals can also proactively seek a Section 1135 EMTALA waiver from CMS during emergency periods. While there is no prescribed form or elements required when requesting such a waiver, the Washington State Attorney General's Office, in a November 2009 presentation addressing "Hospital Compliance with Regulatory Obligations During Surge Capacity Operations," suggested that that all waiver requests: (1) specify the legal requirement that the hospital wants to be waived; (2) describe the procedure or operation that prompts the request; and (3) describe how the hospital's request fits the waiver purpose and safely increases flexible access to care while decreasing administrative burden. The Washington State Attorney General's Office then provided an example Section 1135 EMTALA waiver request used by a

hospital seeking to preserve bed capacity for burn and complex multi-system trauma patients by seeking a waiver to allow the hospital to transfer patients who may be unstable, prior to stabilization, in order to preserve such capacity. A copy of the presentation provided by the Washington State Attorney General's Office is available in Appendix G of this Manual.

C. Prevention.

In order to prevent violations of EMTALA in the event of an emergency, it is important to keep in mind that a hospital's EMTALA obligations do not cease under all emergency circumstances. Importantly, the waiver of sanctions for inappropriate transfers, or for directing or relocating an individual to receive a medical screening examination at an alternate location, applies only when all of the requirements specified in Section II(B) of Chapter Six are met. Therefore, in local mass casualty events, in smaller emergencies that may not be declared and even in larger emergencies before the emergency declaration is made, EMTALA rules remain in full force and effect.

D. Preparedness.

Perhaps the most important step a hospital can take to prepare to comply with EMTALA during an emergency is to participate in state and local emergency response planning. Following state and local emergency response plans in the event of an emergency will offer a hospital protection from sanctions for inappropriate transfers when the hospital is included in the area declared a disaster or public health emergency area. In addition, following a state emergency preparedness plan will permit a hospital to direct individuals elsewhere in accordance with the plan to receive a medical screening examination. Once state and local emergency response plans are developed, applicable elements of such plans should be incorporated into a hospital's internal disaster protocol, as appropriate. In addition, a hospital should review its transfer agreements and determine whether any changes are necessary. If a hospital is overwhelmed when an emergency has not been declared and community response plans have not been activated, it may transfer patients under EMTALA when it does not have the capability or capacity to provide the treatment necessary to stabilize the patient's emergency medical condition or the capability or capacity to admit the individual. SOM, Appendix V, Tag A-2407/C-2407. Having transfer agreements with other hospitals in place will facilitate such transfers.

E. Response and Recovery.

A hospital must comply with all of EMTALA's requirements until a disaster or emergency has been declared by the President and DHHS Secretary, at which time the hospital may transfer patients in accordance with a state or local community response plan and/or redirect patients to different locations for medical screening examinations in accordance with a state emergency preparedness plan. In addition, a hospital should take notice of any additional guidelines issued by CMS to explain the impact of the EMTALA regulations.

Once either the emergency period declared by the President or the public health emergency period declared by the DHHS Secretary ends, the waivers of EMTALA requirements described above no longer apply, and a hospital must comply with all EMTALA requirements.

Following the emergency, the hospital's policies related to EMTALA should be reviewed to determine whether any changes are necessary.

III. REIMBURSEMENT/BILLING/CODING.

A. Medicare.

A full discussion of reimbursement, billing, and coding requirements applicable to hospitals for payment under Medicare is beyond the scope of this Manual. Section III(A) of Chapter Six focuses on waivers that may apply to reimbursement, billing, and coding requirements in the event of an emergency or disaster situation.

1. Administrative Relief from Medical Review in the Presence of a Disaster.

Medicare contractors (including fiscal intermediaries, carriers, Part A/B Medicare Administrative Contractors, or Durable Medical Equipment Medicare Administrative Contractors) may, at their discretion, conduct medical review of services provided to Medicare beneficiaries to ensure that the contractors pay the right amount for covered and correctly coded services rendered to eligible beneficiaries. Medicare contractors may perform medical review for any claims appropriately submitted to them, including acute inpatient prospective payment system hospital and long-term care hospital claims. *CMS Program Integrity Manual* ("PIM"), Chapter 1, § 1.3.5.

In the event of a disaster, Medicare contractors performing medical review are instructed by CMS to anticipate both an increased demand for emergency and other health care services and a corresponding disruption to normal health care delivery systems and networks. CMS directs contractors to ensure Medicare beneficiaries that they will have access to the emergency or urgent care they need. In addition, contractors are to communicate to providers that their first responsibility, as in any emergency, is to provide the needed emergency or urgent service and treatment and to provide assurance that the contractors will work with providers to ensure that they receive payment for all covered services. CMS provides contractors with some administrative flexibility to accomplish these tasks in the event of a disaster. PIM, Chapter 3, § 3.2.2.

For the purposes of the applicable PIM provisions, "disaster" is defined as any natural or man-made catastrophe (such as a tornado, snowstorm, terrorist attack, bombing, fire, flood, or explosion) that causes damage of sufficient severity and magnitude to: (1) partially or completely destroy medical records and associated documentation that may be requested by the contractor in the course of a Medicare medical review audit; (2) interrupt normal mail service; or (3) otherwise significantly limit the provider's daily operations. The fact that a provider is located in an area designated as a disaster by the Federal Emergency Management Agency is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise the retrieval of medical documentation. PIM, Chapter 3, § 3.2.2(A). As a practical matter, it should also be noted that a surge in patient volume alone does not constitute a "disaster."

In the event of a disaster, contractors may grant temporary administrative relief to any affected providers for up to six (6) months or more with good cause. The types of administrative relief that may be granted are described below. Such administrative relief is to be granted to affected providers on a case-by-case basis provided that: (1) contractors make every effort to be responsive to providers who are victims of the disaster and whose medical record documentation may be partially or completely destroyed; and (2) providers must maintain and, upon contractor request, submit verification that a disaster has occurred and that medical record loss resulted from this disaster to a point where administrative relief from medical review requirements is necessary to allow the provider sufficient time to obtain duplicates of lost records or to reconstruct partially destroyed records. Verification of the disaster and the resultant damage may include, but is not limited to: (1) copies of claims filed by the provider with its insurance and liability companies; (2) copies of police reports filed to report the damage; (3) copies of claims submitted to the Federal Emergency Management Agency for financial assistance; (4) copies of tax reports filed to report losses; or (5) photographs of the damage. PIM, Chapter 3, § 3.2.2(B).

When a provider that has been selected for complex pre- or post-pay review is directly affected by a disaster, the contractor may shift the time period of the claims being reviewed to a later time period. Additional documentation requests should be stopped for providers who have been directly affected for at least sixty (60) days. These claims should not be denied as non-covered and may be tagged for later post-pay review. Contractors may allow up to an additional six (6) months beyond the original due date for submission of requested records and extensions beyond six (6) months may be granted with good cause. In the case of complete destruction of medical records, contractors must accept reproduced copies of medical records from backup records in lieu of original documents. Where no backup records exist, contractors must accept an attestation that no medical records exist and consider the services covered and correctly coded. In the case of partial destruction, providers must reconstruct the records as best they can with whatever original records can be salvaged and should note on the face sheet of each reconstructed medical record: "This record was reconstructed because of disaster." Contractors must also extend deadlines for submission of documentation by providers that are indirectly affected by a disaster, such as by interruption of mail service. PIM, Chapter 3, § 3.2.2(C).

2. Electronic Claims Submission.

Except in certain circumstances, an initial Medicare claim may be paid only if submitted as an electronic claim for processing by the Medicare fiscal intermediary or carrier that serves the provider of services. 42 C.F.R. § 424.32(d)(2). The DHHS Secretary may waive this requirement as appropriate in unusual circumstances. Unusual circumstances are deemed to exist when there is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim and on demonstration, satisfactory to the Secretary, of other extraordinary circumstances precluding submission of electronic claims. 42 C.F.R. § 424.32(d)(4). Therefore, in the event of an emergency that damages a hospital's computer system or disrupts connectivity of that system necessary to transmit electronic claims, the DHHS Secretary may waive the requirement that Medicare claims be submitted electronically.

3. Other Relief.

Despite the lack of specific written guidelines for such relief, it is likely that CMS would make reasonable accommodations for hospitals and other providers in the event of a disaster with regard to reimbursement, billing, and coding. In the past, such accommodations have been made on a case-by-case basis depending on the type and severity of the disaster. For example, following damage in Louisiana due to Hurricane Katrina in 2005, CMS issued a Section 1135 Waiver of the normal burden of documentation and established a presumption of eligibility for services rendered to Medicare and Medicaid beneficiaries after many beneficiaries were evacuated to neighboring states where receiving hospitals and nursing homes had no health care records, information on current health status, or any verification of an individual's status as a Medicare or Medicaid beneficiary. CMS also agreed to reimburse facilities for providing dialysis to patients with kidney failure in alternative settings and waived normal licensing requirements for doctors, nurses, and other health care providers assisting in relief efforts provided that the provider was licensed in his or her home state. *CMS Actions to Help Beneficiaries, Providers in Katrina Stricken Areas*, September 6, 2005. In the event of an emergency, a hospital should remain in contact with CMS officials and representatives of Medicare contractors to discuss possible accommodations for the hospital's situation.

B. Wisconsin Medicaid.

1. Documentation Requirements for Reimbursement.

The Wisconsin Medicaid program requires extensive documentation of each recipient's medical information, services provided, and pertinent financial information. Wis. Admin. Code § DHS 106.02(9). Services covered by Medicaid are not reimbursable unless the documentation and medical recordkeeping requirements are met. Wis. Admin. Code § DHS 106.02(9)(f). Applicable regulations do not contain provisions that would permit waiver of these requirements in the event of an emergency. Hospitals may wish to contact Wisconsin Medicaid officials to discuss how the documentation requirements would apply in the event of a disaster disrupts customary recordkeeping activities or destroys existing documentation.

2. Reimbursement for Emergency Services.

To maximize the likelihood of receiving reimbursement for services provided to Medicaid recipients, such services should be furnished by providers who are certified as Medicaid providers. However, in an emergency, arranging for Medicaid-certified providers to treat Medicaid recipients may not be feasible, especially where many of the providers are volunteers and a hospital may not know whether they participate in the Medicaid program. The Wisconsin Medicaid program will reimburse in-state and out-of-state providers who are not Medicaid-certified for covered services furnished to Medicaid recipients, provided that:

- (a) The provider submits to the Medicaid fiscal agent a provider data form and a claim for reimbursement of emergency services on the appropriate forms;
- (b) The provider submits to the DHS a statement in writing on the appropriate form explaining the nature of the emergency, including

a description of the recipient's condition, cause of the emergency, if known, diagnosis and extent of the injuries, the services that were provided and when, and the reason that the recipient could not receive the services from a certified provider; and

- (c) The provider possess all licenses and other entitlements required under state and federal statutes, rules, and regulations and is qualified to provide all services for which a claim is submitted.

Wis. Admin. Code § DHS 105.03(1). Wisconsin Medicaid will not reimburse non-certified providers for any non-emergency services provided. Wis. Admin. Code § DHS 105.03(2).

C. Private Payors.

Private payors may each have their own policies for reimbursement and billing in the event of an emergency. Hospitals should consult with private payors for guidance on these issues.

D. Prevention, Preparedness, Response, and Recovery.

A hospital may prevent significant problems with reimbursement, billing, and coding in an emergency situation by developing back-up procedures when standard procedures cannot be followed. See Sections IV(B)(2) and IV(C) of Chapter Six regarding HIPAA Security Rule and Joint Commission requirements related to data back-up systems and continuity of information management systems. Consultation with CMS, Medicare contractors, Wisconsin Medicaid officials, and private payors may be helpful to determine whether documentation produced by back-up systems will be sufficient to receive reimbursement.

Once back-up procedures are developed, hospital staff should be trained to use such procedures as appropriate so that the procedures may be implemented smoothly in the event of an emergency. As soon as the immediate emergency situation is under control, hospital officials should contact appropriate representatives of CMS, Medicare contractors, Wisconsin Medicaid, and private payors to discuss the impact of the emergency situation on documentation required for reimbursement and billing. When normal hospital operations have resumed, the back-up procedures should be reviewed to determine whether any changes are needed.

IV. MEDICAL RECORDS/DOCUMENTATION.

A. Wisconsin Law.

As a condition of licensure, Wisconsin law requires that all hospitals maintain a medical record for every patient admitted for care in the hospital. Wis. Admin. Code § DHS 124.14(1). The record must contain certain information, including accurate patient identification data, a health history, statements regarding physical examinations, consultation reports, progress notes by physicians and other health care workers, a definitive final diagnosis, and a discharge summary. Wis. Admin. Code § DHS 124.14(3)(a). In addition, all records of discharged patients must be completed within thirty (30) days of discharge. Wis. Admin. Code § DHS 124.14(3)(c). While Wisconsin law does not specifically exempt a health care provider from

these requirements in emergency situations, Wis. Admin. Code § DHS 124.04 does permit hospitals to ask DHS for a waiver or variance from hospital requirements, including those related to medical record maintenance and documentation. DHS may grant a waiver or variance if DHS finds that the waiver or variance will not adversely affect the health, safety, or welfare of any patient, and: (1) that strict enforcement of the requirement would result in unreasonable hardship on the hospital or patient; or (2) an alternative to the requirement would be in the interests of better care or management. Wis. Admin. Code § DHS 124.04(2).

Of course, it is ideal to seek a waiver or variance from hospital requirements before failing to comply with, or implementing alternative methods to comply with, a hospital requirement. However, this may not be possible in an emergency situation. As such, to the extent that an emergency situation results in medical records that contain less information than required or that remain incomplete more than thirty (30) days beyond discharge, a hospital should document that these circumstances are due to an emergency and also document the steps the hospital took to complete the medical records as fully and as quickly as possible. The hospital may then explain the situation to DHS and request that a waiver or variance from the requirements be applied retroactively during the emergency period. In addition, it may be appropriate for the Wisconsin legislature to address this issue and to provide hospitals with additional statutory guidance applicable to emergency situations.

B. Federal Law.

1. General Requirements for Medical Record Services.

Federal Medicare Conditions of Participation for hospitals contain requirements for medical records that are similar to the requirements set forth in Wisconsin law. A medical record must be maintained for each inpatient and outpatient of the hospital. 42 C.F.R. § 482.24(b). The record must document evidence of a physical examination and medical history, the admitting diagnosis, results of consultative evaluations, documentation of complications, properly executed informed consent forms, practitioners' orders, nursing notes, a discharge summary, and the final diagnosis. 42 C.F.R. § 482.24(c)(2). All patient medical record entries must be legible, complete, dated, timed, and authenticated promptly by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. 42 C.F.R. § 482.24(c)(1).

Note that, just as the Secretary of DHHS may issue a Section 1135 Waiver for EMTALA violations as detailed in Sections II(B) of Chapter Six, the Secretary of DHHS may also issue a Section 1135 Waiver related to violations of the Medicare Conditions of Participation for hospitals located in emergency areas during an emergency period. 42 U.S.C. § 1320b-5(b)(1). CMS, however, has failed to provide specific guidance, through regulation or otherwise, regarding how such a waiver is granted. As such, it is recommended that any hospital wishing to receive a Section 1135 Waiver from the Medicare Conditions of Participation contact the local surveying agency or the CMS Regional Office to determine how to proceed. To the extent that a hospital is unable to make such contact, or in the event an emergency situation prevents compliance with the medical record requirements, it is recommended that the hospital document that the circumstances are due to the emergency and then take appropriate steps to complete the medical records as fully and as quickly as possible.

2. HIPAA and the Security Rule.

As of April 20, 2005, health care providers who are covered entities under HIPAA and who maintain or transmit electronic PHI (“ePHI”) must comply with applicable security rules contained in 45 C.F.R. § 164, Subpart C (the “Security Rule”).⁶³ As part of the administrative safeguards that must be in place to protect ePHI under the Security Rule, a provider must establish and implement policies and procedures for responding to an emergency or other occurrence that damages systems that contain ePHI, including, but not limited to, having data back-up and disaster recovery plans. 45 C.F.R. § 164.308(a)(7)(ii). Providers must also establish, and implement as needed, procedures to enable continuation of critical provider processes for protecting the security of ePHI while the provider is operating in emergency mode. 45 C.F.R. § 164.308(a)(7)(ii)(C). As part of the required technical safeguards that must be in place to protect access to ePHI, a provider covered by the Security Rule must establish, and implement as needed, procedures for obtaining necessary ePHI during an emergency. 45 C.F.R. § 164.312(a)(2)(ii).

C. The Joint Commission.

Joint Commission Standard IM.01.01.03 requires that a hospital plan for continuity of its information management processes. The overall purpose of the information continuity process is to return the hospital to normal operations as soon as possible after scheduled or unscheduled interruptions, with minimal down time and no data loss. In this regard, Element of Performance 1 for Joint Commission Standard IM.01.01.03 requires that a hospital have a written plan for managing interruptions to its information processes, whether information is paper-based, electronic, or a mix of paper-based and electronic. Elements of Performance 2 through 4 require that this written plan address the following: (1) scheduled and unscheduled interruptions of electronic information systems; (2) training for staff and licensed independent practitioners on alternative procedures to follow when electronic information systems are unavailable; and (3) backup of electronic information systems. Elements of Performance 5 and 6 require that the hospital test the effectiveness of, and implement, its plan for managing interruptions to information processes in order to maintain access to information necessary for patient care, treatment, and services. A hospital’s actions taken to comply with Joint Commission Standard IM.01.01.03, as well as other Joint Commission Standards related to emergency management, should help greatly in its preparations for an emergency situation.

⁶³ If you are unsure whether the Security Rule applies to your facility, consult legal counsel.

CHAPTER SEVEN

LIABILITY ISSUES

A hospital may be liable in a number of ways when it prepares for, responds to, or recovers from a mass casualty event. It is crucial for hospitals to not only understand the concept of standard of care, but also to understand how a mass casualty event might alter existing standards of care and a hospital's ability to allocate precious resources. Emergency situations may also result in a shifting of liability from private entities, such as hospitals, to the government. Although the issue of liability in a mass casualty event is still evolving, hospitals are advised to undertake advance planning to ensure that they can effectively provide care to patients during an emergency.

I. STANDARD OF CARE IN A MASS CASUALTY EVENT.

A. Overview.

As means of prevention, hospitals should always attempt to deliver medical services in conformance with the general standard of care and hold their employees accountable for doing the same. The general standard of care for medical professionals is whether the medical professional failed under the circumstances of each case to exercise the degree of skill and knowledge that is usually exercised in similar cases by other members of the medical profession. *Malpractice Testimony*, 37 A.L.R.3d 420, 432. The standard of care required of medical professionals is expressed in the standard jury instructions addressing medical negligence, Wis JI-Civil 1023 Medical Negligence and Wis JI-Civil 1023.7 Professional Negligence: Registered Nurses and Licensed Technicians Performing Skilled Services⁶⁴ and which is available in Appendix H of this Manual. The Wisconsin Supreme Court recommended changes to the medical negligence jury instruction in *Nowatske v. Osterloh*, 198 Wis. 2d 419, 543 N.W.2d 25 (1996). The court in *Nowatske* said “the standard of care applicable to physicians in this state cannot be conclusively established either by a reflection of what the majority of practitioners do or by a sum of the customs which those practitioners follow. It must instead be established by a determination of what it is reasonable to expect of a professional given the state of medical knowledge at the time of the treatment in issue.” *Id.* at 438-39. As a result, the duty of any physician, nurse, or licensed technician performing skilled services is to use the degree of care, skill, and judgment which reasonable physicians, nurses, or licensed technicians would exercise.

Although Wisconsin law does not cite to another standard of care applicable to emergency or mass casualty situations in particular, the standard of care stated in the medical negligence jury instructions takes into consideration the circumstances under which the practitioner acts. Inherent in the definition, the standard reflects that a medical practitioner is “required to use the degree of care, skill, and judgment which reasonable” doctors or specialists

⁶⁴Wisconsin law recognizes a distinction between the provision of skilled medical care and routine hospital care. In circumstances where a nurse or hospital employee performs custodial, housekeeping, or routine duties, then an ordinary standard of care would apply. *Payne v. Milwaukee Sanitarium Found., Inc.*, 81 Wis. 2d 264, 260 N.W.2d 386 (1977). Ordinary care is defined as “the care which a reasonable person would use in similar circumstances.” Wis JI-Civil 1385 Negligence: Hospital: Duty of Employees: Performance of Routine Custodial Care not Requiring Expert Testimony.

“would exercise in *the same or similar circumstances[.]*” Wis JI Civil 1023 (emphasis added). A mass casualty event is likely to have a drastic effect on these circumstances. In addition, if a hospital is forced to treat patients out of an alternative treatment facility, although not specifically provided for by Wisconsin law or judicial opinions, this would also be a circumstance that arguably would be considered when analyzing the standard of care. Therefore, practitioners treating patients at an alternative treatment facility will not actually be practicing below the standard of care; rather, the standard of care will reflect the extenuating circumstances and should be viewed accordingly. Regardless, even if a hospital is prepared for a mass casualty event, the precise circumstances of the event should still be taken into consideration when determining the hospital’s, and the practitioners’, standard of care.

If the hospital is a Medicare provider, it also must conform to the Medicare Conditions of Participation. The Conditions of Participation require that the hospital’s governing board ensure that all Medicare patients are under the care of either (1) a doctor of medicine or osteopathy; (2) a doctor of dental surgery or dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; (5) a chiropractor; or (6) a clinical psychologist. 42 C.F.R. § 482.12(c). Medicare patients must be admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State of Wisconsin to admit patients to a hospital. *Id.* In addition, a doctor of medicine or osteopathy must be on duty or on call at all times, and a doctor of medicine or osteopathy must be responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization, and which is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, optometry, chiropractor, or clinical psychologist. *Id.*

Hospitals must also meet certain standards with regard to the environment of care for their facilities. For hospitals participating in the Medicare program, the Medicare Conditions of Participation require the hospital to provide a sanitary environment in order to avoid both the sources and transmission of infections and communicable diseases. 42 C.F.R. § 482.42.

In addition, when providing care, the hospital remains bound by standards of the Emergency Medical Treatment and Active Labor Act of 1985, 42 U.S.C. § 1395dd and its implementing regulations, 42 C.F.R. § 489.24 (“EMTALA”), as further discussed in Chapter Six. Under EMTALA, a hospital is required to complete an appropriate medical screening examination within the capability of the hospital’s emergency department to any individual who comes to the emergency department and requests an examination or treatment for a medical condition. 42 U.S.C. § 1395dd(a). If the hospital determines that the individual has an emergency medical condition, the hospital must: (a) provide emergency services to stabilize the medical condition within the capabilities of the staff and facilities available at the hospital; or (b) transfer the individual to another medical facility. 42 U.S.C. § 1395dd(b). EMTALA also places certain requirements on the hospital’s ability to transfer an individual with an unstable emergency medical condition. 42 U.S.C. § 1395dd(c). The requirements of EMTALA may be suspended or relaxed when a national emergency is declared by the Department of Health and Human Services (“DHHS”) Secretary. For more information, see Chapter Six.

B. Altered Standards of Care.

The possibility that a mass casualty event could compromise the ability of local and regional hospitals to deliver medical services within the current established standards of care is a critical issue that hospitals need to consider and address in their emergency preparedness plans. This important issue was addressed in August 2004 at a meeting convened by the Agency for Healthcare Research and Quality (“AHRQ”) and the Office of the Assistant Secretary for Public Health Emergency Preparedness (“OASPHEP”). One of the main purposes of this meeting was to “[e]xamine how current standards of care might need to be altered in response to a mass casualty event in order to save as many lives as possible.” *Altered Standards of Care in Mass Casualty Events*, AHRQ Publication No. 05-0043, April 2005 at 1. One of the key findings that emerged from the discussion was that “changes in the usual standards of health and medical care in the affected locality or region will be required to achieve the goal of saving the most lives in a mass casualty event.” *Id.* at 2. The meeting also generated five guiding principles for developing altered standards of care to respond to a mass casualty event. *Id.* at 16-18. These principles include the following:

1. In planning for a mass casualty event, the aim should be to keep the health care system functioning and to deliver acceptable quality care to preserve as many lives as possible.
2. Planning a health and medical response to a mass casualty event must be comprehensive, community-based and coordinated at the regional level.
3. There must be an adequate legal framework for providing health and medical care in a mass casualty event.
4. The rights of individuals must be protected to the extent possible and reasonable under the circumstances.
5. Clear communication with the public is essential before, during, and after a mass casualty event.

In September 2009, the Institute of Medicine’s (“IOM”) Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations released *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*.⁶⁵ This committee was charged with establishing a framework for planning and implementing, but not for establishing and defining, specific standards of care that should apply in disaster situations and under scarce resource conditions. The committee’s recommendations include: (1) developing consistent state crisis standards of care protocols; (2) seeking community and provider engagement; (3) adhering to ethical norms during crisis standards of care; (4) providing necessary legal protections for health care providers and institutions implementing crisis standards of care; (5) ensuring consistency in crisis standards of care implementation; and (6) ensuring intrastate and interstate consistency among neighboring jurisdictions. Clearly, hospitals need to prepare for situations in which standards of care would change due to a shortage of critical resources. We encourage all

⁶⁵ For more information on this publication, go to <http://www.iom.edu/disasterstandards>.

hospitals to work with their local, state, and federal officials to develop more definitive guidance in order to ensure that patients receive the best possible care in a mass casualty event while protecting hospitals and providers from liability during such an event.

While the threat of liability may increase during a mass casualty event due to the implementation of altered standards of care, the immunity provisions triggered by a declaration of emergency under the Emergency Management laws found in Chapter 323 of the Wisconsin Statutes currently do not extend to entities such as hospitals. The issue of liability protections for health care workers during an emergency was raised by the Wisconsin Hospital Association (“WHA”) in a letter to Secretary Timberlake of the Wisconsin Department of Health Services (“DHS”) as hospitals were preparing for a potential flu outbreak in the fall of 2009. In its response to the WHA’s inquiry, DHS did not provide any definitive guidance as to how it would prospectively respond in an emergency and stated that “only the legislature may assume civil liability on behalf of the state.” See Appendix I of this Manual for copies of the WHA and DHS letters. Hospitals need to encourage the members of the State legislature to address this important issue. Nevertheless, hospitals should be proactive in their approach to limit their liability by developing preparedness plans, practicing their plans, and adequately documenting their decisions.

C. Surge Capacity.

Surge capacity is a hospital’s ability to expand quickly beyond normal services to meet an increased demand for medical care during large-scale public health and other emergencies. A mass casualty event, either natural or man-made, will place a huge burden on hospitals in four key areas: space, staffing, systems, and supply requirements. The Wisconsin Hospital Emergency Preparedness Plan (“WHEPP”) addresses a number of these issues as they relate to increasing bed capacity during an emergency. A WHEPP checklist containing twenty-five items is designed to assist hospitals in responding to a mass casualty event that results in a surge situation and should be considered prior to a mass casualty event occurring. See http://dhs.wisconsin.gov/preparedness/pdf_files/WHEPPv3_08272004.pdf.

In addition to Wisconsin resources, AHRQ has also developed a range of tools to assist hospitals in their emergency preparedness activities involving surge capacity. See <http://www.ahrq.gov/prep/fieldemprep/>. These resources include the Hospital Surge Model to assist hospitals in determining the resources needed to treat casualties arising from a variety of biological (anthrax, smallpox, pandemic flu), chemical (chlorine, sulfur mustard), nuclear, or radiologic attacks. AHRQ is also examining strategies to alleviate incoming surge at hospitals, such as the use of alternative care sites like community health centers, nursing homes and schools. A site audit tool was developed and used during Hurricane Katarina to allow teams to assess the use appropriateness of a facility and the status of affected facilities during a mass casualty event. See <http://www.ahrq.gov/research/health/>.

The Joint Commission is also actively involved in issues involving surge capacity. The Joint Commission offers guidance to hospitals for increasing surge capacity through the establishment of temporary surge hospitals. See *Surge Hospitals: Providing Safe Care in Emergencies*, The Joint Commission on Accreditation of Healthcare Organizations, 2006, located at http://www.jointcommission.org/PublicPolicy/surge_hospitals.htm. This publication

provides valuable information to health care planners about surge hospitals based on real life experiences including case studies of Hurricane Katrina and Hurricane Rita. This publication also discusses the various types of surge hospitals, as well as planning for and operating surge hospitals. Key issues involving staffing and supplies are addressed, as are issues involving standard of care versus sufficiency of care. *Id.* at 9-10.

D. Resource Allocation.

Hospitals make decisions about how best to allocate available financial and operational resources almost every day. However, in a mass casualty event, these routine decisions take on a whole new meaning. While hospitals are obligated to plan for, and to be able to handle, unexpected and significant surges of patients, a mass casualty event may be so significant in its scope or duration that it exhausts a hospital's resources. A hospital without sufficient resources to care for its patients raises not only operational and financial concerns, but also ethical ones. When presented with an excess of patients and limited resources, hospitals may be forced to make difficult decisions about how patients receive care.

While no amount of planning can address every contingency, a hospital must be prepared to address those circumstances when patient demand exceeds available resources. Importantly, the State of Wisconsin convened a State Expert Panel on the Ethics of Disaster Preparedness (the "Panel") which produced a series of materials that a hospital can use to begin this dialogue with its administrators, vendors, and health care providers. State Expert Panel on Disaster Preparedness, *Ethics of Disaster Preparedness Brochure Series*, available at <http://pandemic.wisconsin.gov/category.asp?linkcatid=2845&linkid=903&locid=106>. While these difficult decisions would only be made in extenuating circumstances, ethical and comprehensive preparation is key when facing a mass casualty event. As such, the Panel believes that hospitals have a responsibility to develop guidelines for the allocation of limited resources, and recommends that those guidelines meet the following criteria:

1. Be consistent with the ethics principles and procedural values identified by the Panel;
2. Be applied consistently across the state;
3. Be based on evidence-based practices to the extent possible, and reflect current best practices for the triage of critical care patients;
4. Be tiered so that, as the number of patients increases and resources are further depleted, these criteria can become more stringent;
5. Allocate resources to save as many lives as possible;
6. Have the consensus of health care providers, especially those involved in the response to the disaster, through open review and discussion and an opportunity for comment; and
7. Have the consensus of the general public through open review and discussion and an opportunity for comment.

State Expert Panel on Disaster Preparedness, *Guidelines for the Triage of Patients*, available at <http://pandemic.wisconsin.gov/docview.asp?docid=14450&locid=106> and which is available in Appendix J of this Manual.

Of course, in order for a hospital to develop guidelines that comply with the above criteria, a number of systems and processes must first be in place. To ensure that hospitals have the necessary support, the Panel has outlined the steps that hospitals must take in order to appropriately implement these guidelines. First, the Panel directs hospitals to establish a multi-disciplinary clinical review committee to educate and engage providers, evaluate current resources, and to develop, and be prepared to implement, ethical and equitable triage policies. *Id.* Importantly, this committee has the primary responsibility for much of the development and oversight of the hospital's response and preparation related to mass casualty events as described further below.

The Panel also recommends that hospitals, with the input of their clinical review committee, develop resource preservation and allocation protocols that can be evaluated and approved before a crisis occurs. *Id.* Generally, the Panel expects that hospital leadership will engage not only the medical staff, but nursing and other appropriate departments as well, to evaluate the hospital's options for the conservation, and if necessary, the rationing of resources. State Expert Panel on Disaster Preparedness, *Ethical Responsibilities of Health Care Leadership*, available at <http://pandemic.wisconsin.gov/docview.asp?docid=14451&locid=106> and which is available in Appendix K of this Manual. To assist hospitals in this difficult area, the Panel has already published protocols that have been reviewed and approved by experts in the field. As of the date of this writing, information on oxygen conservation strategies, as well as pediatric and adult ventilator guidelines, are available through Wisconsin's pandemic preparedness website at <http://www.pandemic.wisconsin.gov>.

While these protocols are expected to evolve, and additional materials are currently under development, other resources are available to assist hospitals as they examine the difficult issues surrounding resource allocation. For example, the Minnesota Healthcare System Preparedness Program has published a series of strategies for addressing scarce resources in a number of common patient care situations. Minnesota Department of Health, *Patient Care Strategies for Scarce Resource Situations*, available at <http://www.health.state.mn.us/oep/healthcare/scarcestrategies.html>. The Minnesota recommendations are generally based on a strategy of preparation, following by substitution, conservation and adaptation of existing resources. If demand still exceeds available resources after these interventions are employed, the Minnesota model then recommends re-use, if applicable and to the extent possible through proper sterilization or disinfection, followed by re-allocation in extreme circumstances. *Id.* While the "Minnesota Model" regarding ventilator allocation decisions has been reviewed and modified slightly for use in Wisconsin, the work of other experts in this area provides a useful starting point for hospitals that are just beginning to think about these issues.

Though the development of these types of protocols may be something that few hospitals have experience with, some of the Panel's other recommendations may be a bit more familiar. For example, the Panel directs hospitals to implement a process for prioritizing admissions and limiting elective or other types of outpatient procedures, and to ensure that there is a sufficient

amount of personal protective equipment available to address a surge in infectious patients. *See Guidelines for the Triage of Patients*. Education of providers, staff, and the community regarding these issues and ongoing quality review of any materials that are developed, are also priorities, as is the continued availability of palliative care when appropriate. *Id.* Collaboration with other health care organizations to facilitate shared resources is also recommended, as mass casualty events take a number of different forms, and could have a variable impact across the state. *Id.*

Finally, hospitals should also consider proactive measures, such as drafting policies and procedures, and possibly bylaws, to address the ethical issues involved when a Public Health Emergency strains necessary and crucial resources. It is no longer inconceivable that extraordinary resource allocation needs may result in a shift in clinical decision-making away from the ethics of the everyday clinical practice of protecting individual well-being and autonomy, toward public health ethics and the promotion of the greater common good. Hospital leaders should consider involving the medical staff, Chief of Staff, and Ethics Committee in discussions about clinical decision-making and the possible need to arbitrate disputes when there is disagreement with an individual physician's decision-making during a declared Public Health Emergency. Anticipating these types of difficult issues and beginning a dialogue is a first step in the process. These issues are multi-faceted and involve numerous legal issues that are beyond the scope of this Manual. We recommend that you consult with legal counsel for more detailed information.

E. Recommendations.

Our recommendations for preparations and response with regard to the standard of care in a mass casualty event are that each hospital work to ensure that its staff, contractors, and volunteers conform to the highest standard of patient care at all times and in all circumstances. To do so, hospitals must ensure that all personnel are properly trained. Once the hospital has its emergency preparedness plan in place to respond to mass casualty events, it should distribute the plan to all employees and contractors. The hospital should also conduct emergency drills to ensure that all personnel are aware of their rules and functions with respect to the emergency plan. The hospital should also review the results of any emergency drill and update its emergency preparedness plan, applicable policies and procedures, and ongoing education and training, as may be necessary.

After a mass casualty event, the hospital should compile as much information as it can in order to adequately and accurately present the circumstances under which physicians, nurses, and other health care professionals performed services, whether at the hospital or at an alternative treatment site. Although some claims may be brought against the hospital following such an event, other claims may be time barred, as any cause of action in Wisconsin for personal injury or wrongful death must be brought within three years after the cause of action accrues. Wis. Stat. § 893.54. Documentation of the circumstances of any alleged claim will help provide the hospital with a firm legal basis from which to defend any such allegations.

Hospitals should also keep in mind the importance of working with government leaders to enact legislation that will assist hospitals and health care providers in the event of a mass casualty situation. Processes will need to be in place to allow for waiver or suspension of rules

and regulations to allow health care providers to take the necessary, and oftentimes difficult, steps to provide treatment in the event a mass casualty occurs and strains hospital resources at every level.

II. LIABILITY SHIFTED TO GOVERNMENT/LIABILITY PROTECTIONS.

In emergency situations, such as mass casualty events, liability may shift to the government for certain actions taken by private entities such as hospitals. Further, the government may offer protection to entities, including hospitals, for performing certain services in times of crisis. However, this shift in liability is not absolute. As Georgetown and Johns Hopkins' Center for Law and the Public Health points out, "unless private sector entities have been conferred sovereign immunity as a government contractor, they will have considerably less civil liability protection than responders and public health agencies." *Public Health Emergency Legal Preparedness Checklist, Civil Legal Liability and Public Health Emergencies*, the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, December 2004 at 16.

A. Government Employees.

Wisconsin's tort claims act states that, in general, "no action may be brought or maintained against any . . . governmental subdivision or agency thereof nor against any officer, official, agent or employee of the . . . subdivision or agency thereof . . . for acts done in their official capacity or in the course of their agency or employment" unless the actions meet certain requirements. Wis. Stat. § 893.80(1). If, within 120 days of the event giving rise to the claim, written notice of the circumstances of the claim is served on the governmental person or entity, and a claim stating the relief sought is presented to the clerk or secretary of the entity and the claim is disallowed, then action may be brought. *Id.* Failure of the appropriate body to disallow a claim within 120 days of written notice of the claim is a disallowance. Wis. Stat. § 893.80(1g). For claims for medical malpractice, the time period is 180 days after discovery of the injury or the date on which the injury should have been discovered. Wis. Stat. § 893.80(1m). However, no suit may be brought against any governmental subdivision or any agency thereof for the intentional torts of its officers, agents, officials, or employees, nor may a suit be brought against such subdivision or agency or against its officers, officials, agents, or employees "for acts done in the exercise of legislative, quasi-legislative, judicial, or quasi-judicial functions." Wis. Stat. § 893.80(4).

In addition, "no civil action or civil proceeding may be brought against any state officer, employee, or agent for or on account of any act growing out of or committed in the course of the discharge of the officer's, employee's or agent's duties . . . unless within 120 days of the event causing the injury, damage or death giving rise to the civil action or civil proceeding, the claimant" serves written notice of the claim upon the attorney general. Wis. Stat. § 893.82(3). For medical malpractice, the time period is extended to 180 days. Wis. Stat. § 893.82(5m). The amount recoverable by any person or entity bringing a civil action or proceeding against a state officer, employee, or agent, which includes a volunteer health care provider, may not exceed \$250,000, and no punitive damages may be allowed or recoverable. Wis. Stat. § 893.82(6). In the event of a mass casualty event, the hospital may receive support and assistance from governmental employees, as directed by the Wisconsin government.

Further, in an emergency, the President of the United States may direct any federal agency to use its resources, including personnel, equipment, supplies, facilities, and managerial, technical, and advisory services, in support of state and local emergency assistance efforts to save lives, protect property and public health and safety, and lessen or avert the threat of a catastrophe. 42 U.S.C. § 5192(a)(1). The President may also provide emergency assistance through federal agencies. 42 U.S.C. § 5192(a)(4). Whenever such federal assistance is provided, “the President may also provide assistance with respect to efforts to save lives, protect property and public health and safety, and lessen or avert the threat of a catastrophe.” 42 U.S.C. § 5192(b). An emergency means “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). Requests to the President to declare an emergency must be made by the governor of the affected state. 42 U.S.C. § 5191(a). The situation must be “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.” *Id.* The governor must first take action under the state emergency plan and then must provide information describing the state and local efforts and resources which have been, or will be, used to handle the emergency and define the type and extent of federal aid requested. *Id.* If the event is an act for which the government has primary responsibility, such as when it threatens national security, the President can declare an emergency. 42 U.S.C. § 5191(b).

Similarly, in responding to a mass casualty event, a hospital may not always be liable for equipment damaged in the process. For example, any losses arising from damage to, or destruction of, government-owned equipment utilized in any authorized emergency management activity will be borne by the owner of the equipment. Wis. Stat. § 323.43. Further, the hospital will not be liable for the death or injury to any person or damage to any property caused by its actions (excepting those that are reckless, wanton, or intentional misconduct) if it provides services or equipment under the following circumstances: (1) under the direction of the Wisconsin governor, the adjutant general, the head of emergency management services in any county, town, municipality, or federally recognized American Indian tribe or band in Wisconsin, DHS (if DHS is designated by the governor to act in an emergency), or a local health department acting when acting as an agent of DHS during a state of emergency declared by the governor, or (2) in response to enemy action, a disaster, or a federally declared state of emergency or during a state of emergency declared by the governor. Wis. Stat. § 323.45(1).

B. Volunteers.

Generally, emergency volunteer health care practitioners, and the health care facilities on whose behalf services are provided, will be indemnified under Wis. Stat. §§ 257.03 and 257.04. Section 257.03 provides that a practitioner who provides services during a state of emergency and in a geographic area in which the state of emergency applies, is deemed a state agent for any claim arising out of the provision of the services for which the individual is or has been licensed, certified, or registered and would be indemnified pursuant to Wis. Stat. §§ 165.25(6),⁶⁶

⁶⁶ This subsection grants authority to the attorney general to appear for agents of the state for any act growing out of or committed in the lawful course of the agent’s duties.

893.82(3)⁶⁷ and 895.46.⁶⁸ As a state agent, the amount recoverable by any person or entity bringing a civil action or proceeding against the practitioner is capped at \$250,000, with no punitive damages, as specified in Wis. Stat. § 893.82(6). The same liability and indemnity protections are extended to health care facilities on whose behalf services under Wis. Stat. § 257.03 are provided. Wis. Stat. § 257.04. However, practitioners will not be considered agents of the state if their acts or omissions involve reckless, wanton, or intentional misconduct. Wis. Stat. § 257.03(3).

Additionally, the Volunteer Health Care Provider Program provides for indemnification of volunteer health care providers who provide health care services at schools primarily to low income persons who are uninsured and who are not recipients of Medicaid or Medicare. *See* Wis. Stat. § 146.89. Under this statute, volunteer health care providers who submit an application associating themselves with a nonprofit agency to the State of Wisconsin and provide services under this statute are deemed state agents of the Department of Health Services for purposes of liability and indemnification protection found in Wis. Stat. §§ 165.25(6), 893.82(3) and 895.46. Hospitals may wish to encourage their employees who wish to be volunteer health care providers under this program, to submit such an application.

If a volunteer is volunteering at a nonprofit hospital or on behalf of a government entity, under the federal Volunteer Protection Act of 1997, 42 U.S.C. §§ 14501-14505, the volunteer will not be liable for harm caused by an act or omission of the volunteer if: (1) the volunteer was acting within the scope of his or her responsibilities at the time of the act or omission; (2) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the activities or practice in Wisconsin; (3) the harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer; and (4) the harm was not caused by the volunteer operating a motor vehicle, vessel, aircraft, or other vehicle for which Wisconsin requires a license or the maintenance of insurance. 42 U.S.C. § 14503. This law does not affect the liability of a nonprofit organization or a governmental agency for harm caused to any person, so the hospital itself may still be liable. *Id.* For additional information on a hospital's liability for volunteers, see Chapter Two.

⁶⁷ This subsection provides that no civil actions or proceedings may be brought against a state agent unless the claimant serves a written notice of the claim upon the attorney within 120 days of the event causing the injury, damage, or death.

⁶⁸ This section authorizes the reimbursement of any judgments.

C. Emergency Employees.

In response to a mass casualty event, hospitals may not be liable under the multi-state Emergency Management Assistance Compact (“EMAC”) for the actions of agents that perform services in conjunction with the hospital. Officers and agents of a party state rendering aid in Wisconsin shall be considered agents of Wisconsin for tort liability and immunity purposes. Party states and officers or employees of party states rendering aid in Wisconsin shall not be liable on account of any act or omission performed in good faith on the part of those forces while so engaged in Wisconsin, or on account of the maintenance or use of any equipment or supplies in connection with the rendering of aid in Wisconsin. Wis. Stat. § 323.80(6). Thus, these individuals would be considered agents of the party state and not of the hospital.

In addition, certain persons rendering emergency care at the hospital or an alternative treatment site may be deemed to be Good Samaritans and thus not held liable for acts or omissions in rendering care. Wisconsin law states that persons who render emergency care at the scene of any emergency or accident in good faith shall be immune from civil liability for their acts or omissions in rendering such emergency care. Wis. Stat. § 895.48(1). However, this immunity does not extend when employees trained in health care or health care professionals render emergency care both for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, en route to a hospital or other institution equipped with hospital facilities, or at a physician’s office. *Id.* This limitation may remove a number of hospital employees from the Good Samaritan protection.

D. Protections for Nonprofit Hospitals.

Nonprofit hospitals may also receive liability protection. The President of the United States may make contributions to “a person that owns or operates a private nonprofit facility damaged or destroyed by a major disaster for the repair, restoration, reconstruction, or replacement of the facility and for associated expenses incurred by the person.” 42 U.S.C. § 5172(a)(1)(B). To receive such contributions, the facility must provide critical services, as defined by the President, in the event of a major disaster. 42 U.S.C. § 5172(a)(3)(A). Critical services include emergency medical care. 42 U.S.C. § 5172(a)(3)(B). Associated expenses may include the base and overtime wages for employees and extra hires of the owner or operator of a private nonprofit facility that perform eligible work, plus fringe benefits on these wages to the extent that such benefits were being paid before the disaster. 42 U.S.C. § 5172(a)(2)(C). Applicants for such assistance must ensure that “such types and extent of insurance will be obtained and maintained as may be reasonably available, adequate, and necessary, to protect against future loss to such property.” 42 U.S.C. § 5154(a)(1). The facility cannot be required to obtain “greater types and extent of insurance than” those certified to the President as reasonable by the “appropriate State insurance commissioner responsible for regulation of such insurance.” 42 U.S.C. § 5154(a)(2). The relevant event would have to be classified as a major disaster, which means “any natural catastrophe . . . 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 Title 42, Chapter 68 of the United States Code 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.” 42 U.S.C. § 5122(2). Depending on the circumstances, a mass casualty event may or may not be classified as a major disaster.

Volunteers providing services to or on behalf of a Wisconsin nonstock corporation are provided limited liability protections under Wis. Stat. § 181.0670. See Section I(A)(2) of Chapter Two for a discussion of the limited liability for volunteers providing services without compensation.

CHAPTER EIGHT

INSURANCE

An analysis of a hospital's insurance coverage is vital to prepare for a mass casualty event. Proper insurance protection may be able to help limit any losses the hospital may suffer. Hospitals must first analyze all of their insurance policies and specifically take note of any limitations or exclusions that may be relevant to coverage of a mass casualty event. Two important parts to the insurance policy are the insuring agreement and the exclusions. Gene Rappe, *The Role of Insurance in the Battle Against Terrorism*, 12 DePaul Bus. L. J. 351, 359 (Spring 2000). These provisions determine what types of events are covered, the nature of the property covered, and what property or events are excluded. *Id.* Given their possibly broad nature and scope, policy endorsements should be reviewed carefully when reviewing the coverage available under any insurance policy.

Hospitals must then weigh the benefits and costs of obtaining additional coverage or endorsements to existing policies to ensure greater coverage that may cover losses in mass casualty situations. Rappe, 12 DePaul Bus. L. J. at 360. If the hospital determines that the risk of the loss exceeds the cost of the coverage, the hospital should work with its insurers to obtain the appropriate additional coverage.

I. LIABILITY INSURANCE.

As a matter of general principle, liability insurance policies typically fall into two different categories: "occurrence" and "claims made" policies. "Occurrence" policies provide coverage for claims that occur during the term of the policy regardless of when a claim is made or a lawsuit is brought. In other words, the policy in effect when the claim occurred is the policy that covers the damages resulting from the covered loss. "Claims made" policies provide coverage only for claims first made against the insured during its policy period. A claim made after the policy expires is not covered by that policy unless the claim is made during an extended reporting period provided in the policy or added by an endorsement.

In general, liability insurance policies promise to reimburse the hospital for covered losses, and also promise to pay for an attorney to defend the hospital in a lawsuit alleging claims potentially covered by the policy. The insurance company's duty to defend depends on the allegations of the complaint. If any of the allegations of a complaint give rise to the potential for coverage under the policy, the insurance company must defend the entire suit. The duty to defend is construed broadly in favor of the hospital as the policyholder.

Each hospital must review its current liability insurance coverage to determine what type of coverage it has. The foundation for most commercial liability insurance is commercial general liability ("CGL") insurance. Subject to the policy's exclusions and conditions, this insurance covers a wide range of liability loss exposures faced by most hospitals. The CGL coverage form contains an exclusion that eliminates coverage for injury arising out of providing or failing to provide professional health care services. As a result, a professional liability policy is needed to cover physicians and other allied medical professionals. Obtaining professional liability insurance and general liability insurance from the same insurance company is generally

recommended as a way to avoid situations in which two different insurers might both deny coverage for an occurrence that falls within a “gray area” between the two distinct policies. The hospital must also determine any coverage exclusions or limitations and any coverage ceilings. The hospital should discuss any coverage shortfalls with legal counsel and its insurance broker to determine whether it has adequate protection should it need to respond to a mass casualty event.

The hospital should also review the insurance coverage on all alternative treatment sites that it may be required to utilize, including any limitations or exclusions and any coverage ceilings. The hospital should attempt to work with its insurer to insure services provided both at the hospital facility and at any alternative treatment sites.

If the hospital’s insurance company agrees to defend the hospital subject to a reservation of the insurance company’s rights, the hospital should check with its own independent counsel to discuss the merits of the insurance company’s coverage position and the consequences of a conflict of interest between the hospital and the insurance company. The hospital may also be entitled to choose its own defense attorney under these circumstances and seek reimbursement from the insurance company for any attorneys’ fees and defense costs involved.

If the insurance company wrongfully refuses to defend the hospital, the insurance company can be precluded from denying coverage for the claim. If the insurance company wrongfully refuses to defend or does not seek a prompt court determination as to whether it owes a duty to defend, the insurance company will be estopped from later disputing its obligation to provide coverage to the hospital. The hospital may be entitled to recover attorneys’ fees, other costs paid to defend a lawsuit, and also the entire amount of any settlement or judgment.

II. PROPERTY INSURANCE.

The hospital should initially ensure that its property insurance is up-to-date. The hospital should also determine what type of policy it has and determine the policy’s exclusions and limitations, as well as its deductibles and policy limits. The hospital should pay particular attention to any war or terrorism exclusions and determine if the risks related to any of these exclusions are too great. The hospital should also attempt to determine if any property insurance coverage exists on any alternative treatment sites that it may use in the event of a mass casualty event. If such coverage exists, the hospital should check for any exclusions, limitations, and coverage ceilings. The hospital should try to work with the property owner and insurer of the alternative treatment site to have the hospital’s uses of the site added to its property insurance coverage.

Property policies consist of a few general categories: commercial policies covering buildings, building contents, and loss of income; inland marine policies that cover moveable property owned by a business; and automobile policies that cover automobiles owned by a business. Rappe, 12 DePaul Bus. L. J. at 360. Commercial property policies, while not identical, are all similar. *Id.* at 360-61. Many are broadly worded policies called “all risk” policies. *Id.* at 362. These cover a large variety of perils and include various exclusions. *Id.* If it has an all risk policy, and has a claim due to a mass casualty event, the hospital will assert that a covered loss was sustained, and the insurer has the burden of proof to demonstrate that the loss falls under an exclusion. *Id.* This is the prevailing legal view. *Id.* at 363.

Even under the comprehensive all risk policies where it would seem that claims from mass casualty events would be covered, several common exclusions often prevent such coverage. These exclusions include electrical damage, pollution, nuclear events, and war. *Id.* at 363. The first, the electrical damage exclusion, often states that the insurer will not compensate the hospital for loss or damage caused by or resulting from artificially generated electric currents that disturb electrical devices, appliances, or wires. *Id.* at 364. This exclusion could apply to destruction caused by a nuclear bomb. *Id.*

The pollution exclusion often states that the insurer will not pay claims for loss or damage caused by or resulting from the discharge or escape of pollutants, a term defined in the policy, unless the discharge or escape itself caused the loss. *Id.* This may apply to damage caused by biological toxins or nerve agents. *Id.* The nuclear exclusion often states that the insurer will not cover losses caused by nuclear radiation or radioactive contamination. *Id.* at 365. Damage caused by radiological weapons may be excluded under the nuclear exclusion. *Id.* Finally, the war exclusion often states that hospital claims incurred by war, warlike action by military forces, insurrection, rebellion, revolution, or action taken by a government in defending against these actions are not covered. *Id.* The insurer may also include terrorism under this exclusion. *Id.* at 366.

If need be, depending on the results of the hospital's analysis of its property insurance coverage, the hospital may choose to try to renegotiate its policy to remove harmful or potentially harmful exclusions. If it is not included in the hospital's policy, the hospital may want to consider adding a provision for terrorism coverage. Damage claims from acts of terrorism are not likely to be denied due to any "war" exclusions in the policy, as such exclusions are not usually broad enough to extend to acts of terrorism. Scholar Andrew Neuwelt cites a *Los Angeles Times* report that states "as presently written, the standard war exclusion does not explicitly extend to acts of terrorism." *The Impact of September 11 on Terrorism Insurance*, 9 ILSA J. Int'l & Comp. L. 473, 478 (Spring 2003). However, the hospital may have a stricter provision than the norm, or a policy that specifically precludes recovery for acts of terrorism.

Under the federal Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, 15 U.S.C. § 6701 ("TRIA"), the government compels U.S. insurance companies to offer insurance for terrorism for sale to the public. Under TRIA, acts of terror are determined exclusively by the U.S. Secretary of the Treasury after consultation with the U.S. Secretary of State and the U.S. Attorney General. Pub. L. No. 107-297, § 102(1)(A). The federal government will provide coverage once damages exceed a certain amount. Pub. L. No. 107-297, § 102(1)(B)(ii). Although terrorism insurance coverage governed by TRIA may be beneficial to the hospital, the hospital should note that the definition of terrorism is limited to acts performed on behalf of foreign interests. Pub. L. No. 107-297, § 102(1). This may be a problem if the hospital faces damages from an event caused by an act of domestic terrorism. In addition, TRIA does not require coverage for attacks by biological agents. If the hospital purchases terrorism insurance, the hospital must ensure that the coverage provides sufficient security for all of the hospital's risks, including structural and property damage, as well as the loss of the contents of the buildings.

Following a mass casualty event, the hospital should contact its legal counsel to assess its policies and coverage and assist the hospital with its claims. The hospital should send notice of

any insurance claims to its agent and to its insurance company at the address identified in the policy, following all applicable notice requirements. It is recommended that the hospital scan these policies into a computerized system that is accessible in case of a mass casualty event that destroys paper records.

If the insurance company denies a claim or reserves its right to deny coverage upon completing a claims investigation, the hospital should consult with its legal counsel to review the claims determination. If filing a lawsuit is necessary, and the hospital prevails in such a suit, the hospital may be able to recover reasonable attorneys' fees from its insurance company. If the insurance company acts in bad faith and has no reasonable basis for its coverage denial, the hospital may have a claim for punitive damages against the insurance company as well. Finally, the hospital may also consider filing a complaint with the Wisconsin Office of the Insurance Commissioner.

III. BUSINESS INTERRUPTION INSURANCE.

The hospital initially should check to see if it has business interruption or continued business interruption insurance. If it does have such coverage, the hospital should determine what the policy limits are and, in terms of time and coverage, what is covered. Finally, the hospital should review the exclusions. Examples of exclusions the hospital should look for are exclusions for claims based on electrical damage, pollution, nuclear events, or war. *See Rappe, 12 DePaul Bus. L. J. at 351.*

If the hospital does not have business interruption or continued business interruption insurance, it should determine whether it is cost effective for the hospital to acquire such coverage. If the hospital chooses to acquire such coverage, the hospital should attempt to secure this coverage for the lifetime of its operations. The hospital should ensure that the insurance will provide coverage for the cancellation of elective hospital admissions, surgeries, and other such procedures.

In the alternative, a hospital instead may want to negotiate a mutual agreement with another local hospital or other hospitals that allow each to use the other's location in the event their facilities are damaged and cannot be immediately repaired so that the hospital can continue its operations. *See Id. at 356.* These agreements can include requirements for additional hospital shifts to cover all necessary patient care. *Id.* The hospital, if it decides to obtain business interruption insurance, can attempt to include the costs involved with such agreements into its coverage. *Id.*

Following the hospital's response to a mass casualty event, if the hospital has business interruption insurance, the hospital should determine what is covered under its policy and file the appropriate claims. The hospital should take care to retain sufficient documentation for each claim submitted.

IV. OTHER INSURANCE VEHICLES.

The hospital should investigate all other insurance vehicles that can help prevent dramatic losses following a mass casualty event, such as strong disability or life insurance policies to protect hospital employees. In addition, the hospital should ensure that it has appropriate

worker's compensation coverage. For more information on worker's compensation requirements, see Chapter One.

To prepare, the hospital should look into expanding its current insurance coverage. For example, the hospital should work with its insurer to find a vehicle through which it can insure for the indirect costs of a bioterrorism event, such as the costs of quarantining staff or the additional equipment and resource needs a hospital may have in a time of emergency. The hospital should also review any life insurance policies it provides for its employees, particularly with regard to any terrorism or war exclusions or limitations. Finally, if the hospital is having trouble securing insurance on the market, it may want to look into self-insurance. The hospital, possibly in conjunction with other area hospitals, may want to investigate the cost and feasibility of entering into a self-insurance pool or arrangement.

V. NON-INSURANCE PROTECTIONS.

The hospital also may be able to take advantage of non-insurance protections offered by the government to recover costs resulting from a mass casualty event. For instance, in an emergency situation, DHS may provide medical aid and temporary hospital accommodation to those with communicable diseases. Wis. Stat. § 252.02(2). This may reduce some of the burden on the hospital.

Hospitals also may want to combine their efforts and form a membership agreement for situations involving mass casualty events. Pursuant to such an agreement, member hospitals can agree to waive all claims against other members for loss, damage, personal injury, or death occurring as a consequence of performance of the agreement so long as the claim is not a result of gross negligence or willful misconduct.

Government protections may also be specific to the particular mass casualty event. For example, in response to the attacks on September 11, 2001, the federal government established a September 11 Victims Compensation Fund. This fund provided for the victims and their families that suffered losses from the terrorist attacks. This also limited potential litigation against the airlines and other private entities. Jessica Ramirez, *The Victims Compensation Fund*, 29 Transp. L. J. 283, 293 (2002). Such protections and corresponding liability limitations for hospitals may be established by the federal or Wisconsin government following a mass casualty event as well.

CHAPTER 9

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APPENDICES

A-K

APPENDIX A

State of Wisconsin
Department of Workforce Development
Equal Rights Division
Civil Rights Bureau

Physician or Practitioner Certification For Family or Medical Leave

Personal information you provide may be used for secondary purposes. See Section 15.04 (1) (m), Wisconsin Statutes for details.

Dear Physician or Practitioner:

To assist in establishing leave entitlements under Wisconsin's Family and Medical Leave Law (Section 103.10, Wisconsin Statutes) please answer the questions checked below and return this certification to Employer.

Employer Information

Employer Name			
Street Address	City	State	Zip Code

Employee/Patient Name

Employee Name	Patient Name (if not employee)
---------------	--------------------------------

Information Requested (Employer, please check the appropriate box (es) below identifying the information you need from the physician or practitioner.)

☐ Does _____ have a serious health condition? Yes No
 (patient name)

Note: Wisconsin's Family and Medical Leave Law (Section 103.10 Wisconsin Statutes) defines a **serious health condition** as a disabling physical or mental illness, injury, impairment or condition involving either inpatient care in a hospital, or outpatient care that requires continuing treatment or supervision by a health care provider.

☐ What date did the condition begin?

☐ What is the probable duration of the condition?

☐ Specify medical facts regarding the serious health condition (diagnosis not required).

☐ Please indicate the extent to which the employee is unable to perform his or her employment duties.

Physician/Practitioner Information

Physician/Practitioner Name (Please Print)	
Physician's Signature	Date Signed

Note to Employer: this information should be retained in a confidential medical file.

Certification of Health Care Provider for
Employee's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes.

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
☐ No ☐ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
☐ No ☐ Yes. If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature _____

Date _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (____) _____ Fax: (____) _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ No ___ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ___ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ☐ No ☐ Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary: _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____ No ____ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____ times per ____ week(s) ____ month(s)

Duration: ____ hours or ____ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

APPENDIX B

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

In general, to be eligible an employee must have worked for an employer for at least 12 months, have worked at least 1,250 hours in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: _____
Employee

FROM: _____
Employer Representative

DATE: _____

On _____, you informed us that you needed leave beginning on _____ for:

- _____ The birth of a child, or placement of a child with you for adoption or foster care;
- _____ Your own serious health condition;
- _____ Because you are needed to care for your _____ spouse; _____ child; _____ parent due to his/her serious health condition.
- _____ Because of a qualifying exigency arising out of the fact that your _____ spouse; _____ son or daughter; _____ parent is on active duty or call to active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- _____ Because you are the _____ spouse; _____ son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- _____ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- _____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
 - _____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ months towards this requirement.
 - _____ You have not met the FMLA's 1,250-hours-worked requirement.
 - _____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact _____ or view the FMLA poster located in _____.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by _____.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- _____ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request _____ is/_____ is not enclosed.
- _____ Sufficient documentation to establish the required relationship between you and your family member.
- _____ Other information needed: _____

_____ No additional information requested

If your leave does qualify as FMLA leave you will have the following responsibilities while on FMLA leave (only checked blanks apply):

_____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

_____ You will be required to use your available paid _____ sick, _____ vacation, and/or _____ other leave during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

_____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We _____ have/ _____ have not determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

_____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____.
(Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following rights while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
 - _____ the calendar year (January – December).
 - _____ a fixed leave year based on _____.
 - _____ the 12-month period measured forward from the date of your first FMLA leave usage.
 - _____ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have _____ sick, _____ vacation, and/or _____ other leave run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

_____ For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

_____ Applicable conditions for use of paid leave: _____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

_____ at _____.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

APPENDIX C

Designation Notice
(Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1215-0181

Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: _____

Date: _____

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.

We received your most recent information on _____ and decided:

_____ Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

_____ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: _____

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

_____ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position _____ is _____ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.
(Provide at least seven calendar days)

(Specify information needed to make the certification complete and sufficient)

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.

_____ The FMLA does not apply to your leave request.

_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 2009

APPENDIX D

Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181
Expires: 12/31/2011

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

Name of covered military member on active duty or call to active duty status in support of a contingency operation:

First Middle Last

Relationship of covered military member to you: _____

Period of covered military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached. ☐ Yes ☐ No ☐ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____

Probable duration of exigency: _____

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ☐ No ☐ Yes.

If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? ☐ No ☐ Yes.

Estimate schedule of leave, including the dates of any scheduled meetings or appointments: _____

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours _____ day(s) per event.

PART C:

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Certification for Serious Injury or
Illness of Covered Servicemember - -
for Military Family Leave (Family and
Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



OMB Control Number: 1215-0181

Expires: 12/31/2011

Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

**Certification for Serious Injury or Illness
of Covered Servicemember - - for
Military Family Leave (Family and
Medical Leave Act)**

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division



SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave: (This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

Name of Employee Requesting Leave to Care for Covered Servicemember:

First	Middle	Last
-------	--------	------

Name of Covered Servicemember (for whom employee is requesting leave to care):

First	Middle	Last
-------	--------	------

Relationship of Employee to Covered Servicemember Requesting Leave to Care:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

- (1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves? ☐ Yes ☐ No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No If yes, please provide the name of the medical treatment facility or unit:

- (2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ☐ Yes ☐ No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the Care to Be Provided to the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name and Business Address:

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider: _____

Telephone: () _____ Fax: () _____ Email: _____

PART B: MEDICAL STATUS

(1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No. If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

- (1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for this period of time: _____
- (2) Will the covered servicemember require periodic follow-up treatment appointments?
☐ Yes ☐ No If yes, estimate the treatment schedule: _____
- (3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No
- (4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? ☐ Yes ☐ No If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

APPENDIX E

APPENDIX 1

Sample Medical Staff Bylaw Provisions For Addressing Disaster Privileging

Section ___. Disaster Privileges.

A. Disaster privileges may be granted according to this Section ___ when the emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs.

B. The Hospital President, the Medical Staff President, or their designee(s) may grant disaster privileges on a case-by-case basis at their discretion to non-Medical Staff member practitioners upon presentation of a valid government-issued photo identification (for example, a driver's license or passport) and any of the following:

1. A current picture identification card from a health care organization that clearly identifies professional designation;
2. A current license, certification, or registration;
3. Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice);
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group;
5. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, and services in disaster circumstances; or
6. Confirmation by Hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.

C. The Incident Command Person, Emergency Department Physician On Duty, the Medical Staff President, or their designee(s) will have the overall responsibility for overseeing the performance of and assignment of duties to any practitioners granted disaster privileges.

D. Based on their oversight of each practitioner, the Incident Command Person, Emergency Department Physician On Duty, the Medical Staff President, or their designee(s) will need to make a determination, within 72 hours after the practitioner's arrival, as to whether assigned disaster responsibilities should continue.

E. Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners should occur as soon as the disaster is under control or within 72 hours from the time the practitioner presents him or herself to the Hospital, whichever comes first. If verification cannot be completed within 72 hours due to extraordinary circumstances, the Hospital will document the following:

1. The reason(s) it could not be performed within 72 hours of the practitioner's arrival;
2. Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment or services; and
3. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

F. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, verification should be performed as soon as possible.

G. All practitioners granted disaster privileges will be identified by a "Disaster Privileges Granted" ID badge or by another method that ensures that they are readily identified by Hospital staff.

H. Verification of the credentials and privileges of practitioners who have received disaster privileges shall be a high priority and shall begin as soon as the immediate situation is under control. The verification process for disaster privileges shall be identical to the process for temporary privileges to meet an important patient care need, set forth in Section ____ of these Bylaws.

I. The individuals who are permitted to grant disaster privileges, as set forth in paragraph B above, may terminate a practitioner's disaster privileges at any time. When the Hospital deems that the disaster or emergency situation no longer exists or is under control, disaster privileges shall expire. Termination or expiration of disaster privileges shall not give rise to fair hearing or appeal rights.

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

Chapter DHS 145

APPENDIX A

Communicable Diseases and Other Notifiable Conditions

CATEGORY I:

The following diseases are of urgent public health importance and shall be reported IMMEDIATELY by telephone or fax to the patient's local health officer upon identification of a case or suspected case. In addition to the immediate report, complete and mail an Acute and Communicable Diseases Case Report (DOH 4151) to the address on the form, or enter the data into the Wisconsin Electronic Disease Surveillance System, within 24 hours. Public health intervention is expected as indicated. See s. DHS 145.04 (3) (a).

Any illness caused by an agent that is foreign, exotic or unusual to Wisconsin, and that has public health implications⁴

Anthrax^{1,4,5}

Botulism^{1,4}

Botulism, infant^{1,2,4}

Cholera^{1,3,4}

Diphtheria^{1,3,4,5}

Haemophilus influenzae invasive disease, (including epiglottitis)^{1,2,3,5}

Hantavirus infection^{1,2,4,5}

Hepatitis A^{1,2,3,4,5}

Measles^{1,2,3,4,5}

Meningococcal disease^{1,2,3,4,5}

Outbreaks, foodborne or waterborne^{1,2,3,4}

Outbreaks, suspected, of other acute or occupationally-related diseases

Pertussis (whooping cough)^{1,2,3,4,5}

Plague^{1,4,5}

Poliovirus infection (paralytic or nonparalytic)^{1,4,5}

Rabies (human)^{1,4,5}

Ricin toxin^{4,5}

Rubella^{1,2,4,5}

Rubella (congenital syndrome)^{1,2,5}

Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV)^{1,2,3,4}

Smallpox^{4,5}

Tuberculosis^{1,2,3,4,5}

Vancomycin-intermediate Staphylococcus aureus (VISA) and Vancomycin-resistant Staphylococcus aureus (VRSA) infection^{1,4,5}

Yellow fever^{1,4}

CATEGORY II:

The following diseases shall be reported to the local health officer on an Acute and Communicable Disease Case Report (DOH 4151) or by other means or by entering the data into the Wisconsin Electronic Disease Surveillance System within 72 hours of the identification of a case or suspected case. See s. DHS 145.04 (3) (b).

Arboviral disease^{1,2,4}

Babesiosis^{4,5}

Blastomycosis⁵

Brucellosis^{1,4}

Campylobacteriosis (campylobacter infection)^{3,4}

Chancroid^{1,2}

Chlamydia trachomatis infection^{2,4,5}

Cryptosporidiosis^{1,2,3,4}

Cyclosporiasis^{1,4,5}

Ehrlichiosis (anaplasmosis)^{1,5}

E. coli 0157:H7, other Shiga toxin-producing E. coli (STEC), enteropathogenic E. coli, enteroinvasive E. coli, and enterotoxigenic E. coli.^{1,2,3,4}

Giardiasis^{3,4}

Gonorrhea^{1,2,4,5}

Hemolytic uremic syndrome^{1,2,4}

Hepatitis B^{1,2,3,4,5}

Hepatitis C^{1,2}

Hepatitis D^{2,3,4,5}

Hepatitis E^{3,4}

Histoplasmosis⁵

Influenza-associated pediatric death¹

Influenza A virus infection, novel subtypes

Kawasaki disease²

Legionellosis^{1,2,4}

Leprosy (Hansen Disease)^{1,2,3,4,5}

Leptospirosis⁴

Listeriosis^{2,4}

Lyme disease^{1,2}

Lymphocytic Choriomeningitis Virus (LCMV) infection⁴

Malaria^{1,2,4}

Meningitis, bacterial (other than Haemophilus influenzae, meningococcal or streptococcal, which are reportable as distinct diseases)²

Mumps^{1,2,4,5}

Mycobacterial disease (nontuberculous)

Psittacosis^{1,2,4}

Pelvic inflammatory disease²

Q Fever^{4,5}

Rheumatic fever (newly diagnosed and meeting the Jones criteria)⁵

Unofficial Text (See Printed Volume). Current through date and Register shown on Title Page.

Rocky Mountain spotted fever ^{1,2,4,5}	Lead intoxication (specify Pb levels)
Salmonellosis ^{1,3,4}	Other metal and pesticide poisonings
Syphilis ^{1,2,4,5}	Toxoplasmosis
Shigellosis ^{1,3,4}	Transmissible spongiform encephalopathy (TSE, human)
Streptococcal disease (all invasive disease caused by Groups A and B Streptococci)	Trichinosis ^{1,2,4}
Streptococcus pneumoniae invasive disease (invasive pneumococcal) ¹	Tularemia ⁴
Tetanus ^{1,2,5}	Typhoid fever ^{1,2,3,4}
Toxic shock syndrome ^{1,2}	Varicella (chickenpox) ^{1,3,5}
Toxic substance related diseases:	Vibriosis ^{1,3,4}
Infant methemoglobinemia	Yersiniosis ^{3,4}

CATEGORY III:

The following diseases shall be reported to the state epidemiologist on an AIDS Case Report (DOH 4264) or a Wisconsin Human Immunodeficiency Virus (HIV) Infection Confidential Case Report (DOH 4338) or by other means within 72 hours after identification of a case or suspected case. See s. 252.15 (7) (b), Stats., and s. DHS 145.04 (3) (b).

Acquired Immune Deficiency Syndrome (AIDS)^{1,2,4}
 Human immunodeficiency virus (HIV) infection^{2,4}
 CD4 + T-lymphocyte count < 200/mL, or CD4 + T-lymphocyte percentage of total lymphocytes of < 14²

Key:

¹ Infectious diseases designated as notifiable at the national level.

² Wisconsin or CDC follow-up form is required. Local health departments have templates of these forms in the Epinet manual.

³ High-risk assessment by local health department is needed to determine if patient or member of patient's household is employed in food handling, day care or health care.

⁴ Source investigation by local health department is needed.

⁵ Immediate treatment is recommended, i.e., antibiotic or biologic for the patient or contact or both.

Complying with Hospital Regulatory Obligations During Surge Capacity Operations



APPENDIX G

Kristin Miles
Washington State Attorney General's Office
University of Washington Division
November 17, 2009

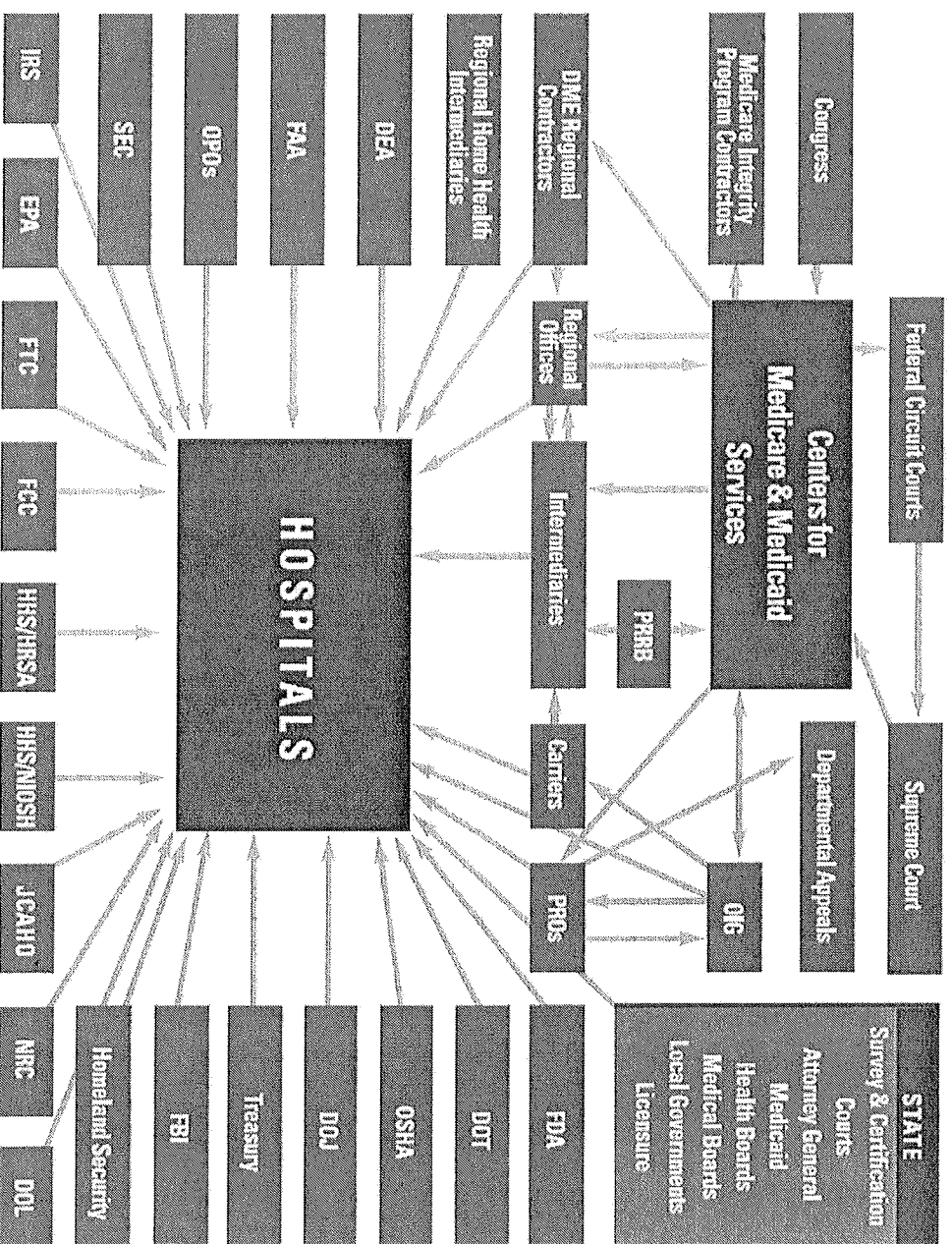
Introduction



- Hospital Regulation 101
- Conditions of Participation
- EMTALA
- CMS Waivers under § 1135
- What Do Hospitals Need from Health Officials

This presentation is the opinion of the presenter and should not be considered the official position of Washington Attorney General.

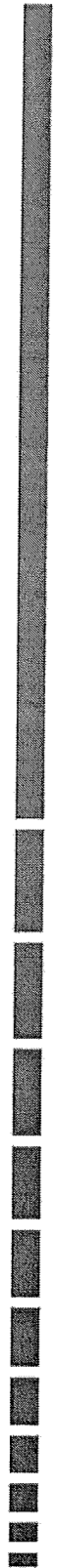
WHO REGULATES HOSPITALS?



Graphic:
American Hospital Association

*Now known as TJC

Hospital Regulation 101



Medicare Conditions of Participation State hospital licensing laws

Standards for all areas of hospital operations, including:
building/space standards and use; staffing
qualifications and procedures; medical records; food
service; quality assessment and utilization review;
discharge planning; and organ procurement.
(to name a few)

Special requirements for psychiatric or rehab facilities,
critical access hospitals, skilled nursing facilities

Plus optional accreditation and disease-specific certification
by The Joint Commission

EMTALA – The General Rule

- i. Anyone who presents for examination or treatment for any medical condition in an emergency department must receive a screening exam to determine if an emergency medical condition exists.
- ii. If such a condition is found, the hospital must provide stabilizing treatment.
- iii. In general, a hospital may not discharge or transfer a patient until the patient is stabilized.

EMTALA BASICS

- For any person “coming to the emergency department”
 - “Medical Screening Examination”
 - “Stabilization” of “emergency medical condition”
- Transfers restricted until patient is “stable”
- Fines or other sanctions for violation
 - Hospital
 - Physician
- Private enforcement

“Comes to the Emergency Dept.”

- Individual presents at ED and requests exam or treatment for any medical condition (or has a request made on his behalf)
- Individual presents on hospital property other than ED and requests exam or treatment for what may be an emergency medical condition (or has a request made on his behalf)

Once a person arrives on site you cannot redirect them away without risking EMTALA sanctions.

“Medical Screening Exam”

- Process hospital must undertake in order to determine whether a medical emergency does or does not exist
 - Scope varies based on condition
 - Must be completed by qualified medical personnel
 - Includes lab and other diagnostic tests, and specialists, if needed
- Determines whether hospital must provide further treatment
 - Must stabilize any emergency medical condition discovered, or treat patient to extent of ability and transfer to hospital with capability and capacity for further treatment and stabilization

If there is no “emergency medical condition”
the hospital’s EMTALA obligations end.

Section 1135 Waiver

A provision of federal law that allows the federal government to alleviate some federal requirements that may hinder provision of patient care during an emergency

1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act +
2. The Secretary of HHS has declared a Public Health Emergency +
3. The Secretary invokes her/his waiver authority

Section 1135 Waivers

Purpose

Intended to reduce administrative burdens
on providers and
increase flexibilities in the delivery of health
care with the intent of
promoting greater access to care by
individuals affected by the emergency or
disaster.

Some Examples from Katrina

Waivers allowed

- Use of PPS-exempt psychiatric or rehab units, or facilities, for acute or intensive care.
- Payment, and waiver of sanctions, for services provided in good faith but not in compliance with normal Medicare requirements because of Katrina
- Payment to non-participating providers for crisis services provided to evacuees
- Waiver of pre-authorization or out-of-network authorization requirements for Medicare, Medicaid and SCHIP
- Payment of ambulance costs for patients transferred for evacuation

WHAT CAN BE WAIVED

- Conditions of Participation, provider certification requirements
- EMTALA sanctions for direction/relocation of patient to another location for MSE under state plan
- EMTALA sanctions for transfer of unstable individual if the transfer is necessitated by the declared 2009-H1N1 public health emergency
- Waiver lasts for duration of declared public health emergency

CANNOT BE WAIVED

- Eligibility for Medicare beneficiaries Medicare
- Statutory provisions that specify to whom Medicare payment is made.
 - Medicare payment cannot be made under the physician fee schedule directly to an RN or any other person who might be approved by state emergency to provide physician-scope of care. www.cms.hhs.gov/H1N1/Downloads/AlternativeCareSiteFactSheet.pdf page 3
- Statutory coverage provisions

EMTALA WAIVER CANNOT

- EMTALA waiver does not eliminate the obligation for hospital with capacity and capability to accept a transfer
- EMTALA waiver does not eliminate obligation to maintain a log of persons who ‘come to the emergency department’ seeking treatment
- EMTALA waiver does not eliminate obligation to provide necessary stabilizing treatment for emergency medical conditions and labor within the hospital’s capability and capacity

Waiver Requests - CoP

- Waive facility CoPs so that hospital's on-campus physical space can be used for inpatient and qualify for Medicare facility fee or professional fee payment
- Waive facility CoPs so that off-campus site can qualify as hospital-based and therefore qualify for Medicare facility fee or professional fee payment (outpatient or inpatient)
- Medicare ok usually = Medicaid ok

COPs – Waivers You Might Request

COP WAIVED

SO THAT

Limits on use of IPPS –
Exempt Units

Psychiatric or Rehab Units can be utilized for acute care, and that acute care is paid as acute care

Reporting Requirements
§ 482.13(g) (1)(i)-(ii),
A-0214

ICU patients whose death is caused by their disease process but who required soft wrist restraints to prevent pulling tubes/IVs may be reported later than close of business next business day, provided any death where restraint may have contributed is continued to be reported within standard time limits.

Medical Records Timing
§ 482.24; A-0469

Medical records can be fully completed later than 30 days following discharge

Verbal Orders
§ 482.24
A-0407, A-0454, A-0457

Verbal orders may be used more than ‘infrequently’ (read-back verification is done) and authentication may occur later than 48h

Medical Staff
§ 482.22(a); A-0341

So that physicians whose privileges will expire and new physicians can practice before full medical staff/governing body review and approval

Physical Environment
§ 482.41; A-0700 et seq

Non-hospital buildings/space can be used for patient care, provided sufficient safety and comfort is provided for patients and staff

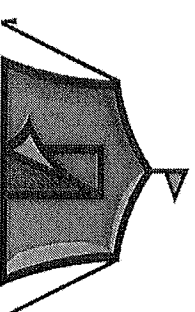
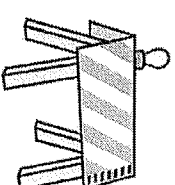
Increasing Bed Capacity

The number of inpatient beds at a hospital depends on:

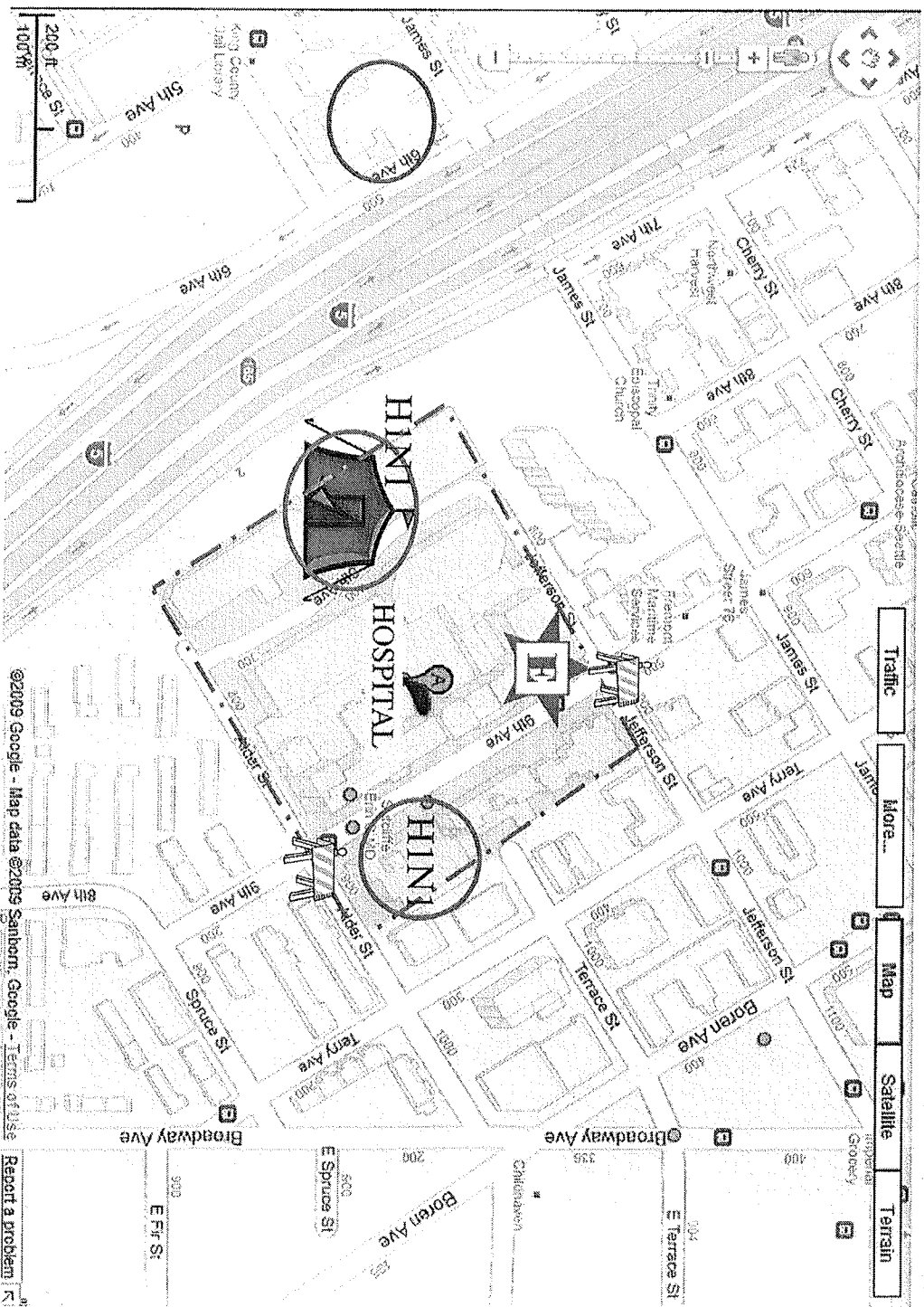
- State hospital license
- Medicare certification
- Hospitals often are not using all licensed/certified beds
 - Just need staff, supplies, etc to bring 'on-line'
- To exceed licensed/certified beds:
 - State process
 - Medicare process (+ Waiver if cannot meet CoPs)

A Hypothetical

- Patient 'self-sorting'
- Separate H1N1 assessment clinic on-site
- Directing patients from ED to other on-campus sites
- Redirection of pts in ED to other sites off-campus

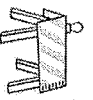


A Hypothetical



No EMTALA Waiver Needed

- Tailor Medical Screening Exams



- Meet patients outside ED and log them in
- Conduct basic triage for illness/severity/complaint
- Highest level emergencies enter ED for further screening and stabilizing treatment.



- Lesser severity emergencies are directed to other places on campus for further screening and stabilizing treatment.
- Patients without emergency medical conditions are directed to on-campus or off-campus locations as appropriate. (EMTALA does not apply if request is clearly not for emergency nature or when MSE indicates there is no emergency medical condition)

EMTALA Waiver Required

- Transfer patients to off-campus location before conducting medical screening exam
- Conduct triage and direct patients off-site for further medical screening and stabilizing treatment (have not determined emergency medical condition does not exist)
- Transfer unstable patients with emergency medical condition off-site for further stabilizing treatment
- Consider CoP waivers for facility standards so that alternate facilities can qualify for facility and professional fee payment

2009 H1N1 Waiver Requests

As of November 9, 2009, per CMS:

- 73 requests from 10 states
- 5 approved; 1 under consideration
- 64 withdrawn bc of direct communication with regional office and requestor - many were anticipatory/"just in case" requests for waiver
- Strongly committed to be fast as possible (and remember: waivers can be retroactive)
- All approved w/in average of 24h – longest 26h, shortest 21h

Making a Waiver Request

- No CMS prescribed form or elements
- Can be made by individual provider, health system or even LHO on behalf of area facilities.
- Some suggestions:
 - We request a waiver of: Specify the rule or language from Interpretive Guidelines you want waived
 - So that our hospital can: Describe the procedure/operation that prompts the request
 - This will promote access to care by: Describe how your request fits the waiver purpose and safely increases flexible access to care while decreasing administrative burden

Waiver Request Example - EMTALA

EMTALA waiver request

Hospital Information (address, contact person, #, etc)

Hospital requests waiver so that Hospital can transfer patients who may be unstable, prior to stabilization, in order to reserve certain Hospital capacity for specialized care that is only available at Hospital, including burn and complex multi-system trauma. Hospital is currently operating at x% of capacity with z% of ICU beds occupied.

Hospital will provide available treatment (short of stabilization) to patients in order to decrease chance of decompensation during transfer. Hospital will transfer patients by method appropriate to their level of care needs and in compliance with EMTALA elements such as transfer of medical records.

Without waiver, 100% of Hospital intensive care capacity could be consumed by non-trauma/non-burn patients presenting at Hospital for H1N1-related emergencies (respiratory distress, etc) requiring stabilization.

County-area hospitals, through healthcare coalition, agree that preserving trauma and burn capacity at Hospital is critical and advance planning anticipates transfers of non-trauma/non-burn patients to other hospitals in order to preserve capacity at Hospital and promote access to appropriate care

Washington State Support for Hospitals During Emergencies

October 2009 Hospital Emergency Event Planning Process



Background

Washington hospitals are planning for the H1N1 influenza pandemic. Hospitals anticipate facing challenges during the event. These include, but are not limited to, bed availability, use of temporary locations, rooms, and provision of safe care.

1. Hospital rules require emergency preparedness plans. Plans need to address sufficient management structure, staff, equipment, drugs and supplies to provide safe care.
2. Emergency preparedness is defined in WAC 246-320-296:
 - (a) Establish and implement a disaster plan designed to address both internal and external disasters. The plan must be:
 - (i) Specific to the hospital;
 - (ii) Relevant to the geographic area
 - (iii) Readily put into action, 24 hours a day, seven days a week; and
 - (iv) Reviewed and revised periodically;
 - (b) Ensure the disaster plan identifies:
 - (i) Who is responsible for each aspect of the plan, and
 - (ii) Essential and key personnel responding to a disaster;
 - (c) Include in the plan:
 - (i) A staff education and training component;
 - (ii) A process for testing each aspect of the plan; and
 - (iii) A component for debriefing and evaluation after each disaster, incident or drill.
3. The Department of Health will not take enforcement action against a facility if the facility's actions are consistent with its emergency plan. The plan may include reference to bed overflow and availability, including temporary structures, modifications to existing room use, use of alternate locations, and use of beds in excess of the license limit.
4. Temporary hospital locations must be operated under the management of the hospital. The temporary hospital locations need to have a defined plan, including:
 - a. Staffing;
 - b. Basic equipment, supplies and medications to provide care based on patient needs;
 - c. Types of patients that would be admitted to these structures;
 - d. Infection control; and
 - e. Water, bathrooms, heat.
5. Payment and reimbursement issues are outside the scope of Health Systems Quality Assurance and the Department of Health. We will refer hospitals to the Centers for Medicare and Medicaid Services.

Public Health – Always Working for a Safer and Healthier Washington

What Hospitals Need from Health Officials

- Cross-jurisdiction coordination assistance
- Guidance
- Health Officer Orders
 - Priorities
 - Standards of Care
 - System Organization
 - EMTALA waivers are insufficient to protect critical resources such as trauma/burn capacity.
- Administrative relief

Hospitals Have Useful Expertise to Share with Health Officials

- Hospital expertise in Medicare/Medicaid billing rules
- Requirements for hospital or non-hospital care sites to qualify for Medicare/Medicaid facility or professional fee payment (inpatient or outpatient)
- Operations and healthcare delivery

A 'MUST READ' :

www.cms.hhs.gov/H1N1

Downloads

[Waiver or Modification of Requirements under Section 1135 of the Social Security Act \(10/27/09\) \[PDF, 321KB\]](#)

[Background and Q's & A's on President Obama's 10/24/09 Emergency Declaration for H1N1 Flu \(Posted: 10-28-09\) \[PDF, 124KB\]](#)

[H1N1 Fact Sheet - Requesting an 1135 Waiver \(11-04-09\) \[PDF, 66KB\]](#)

[H1N1 Fact Sheet - Hospital Alternative Care Sites during H1N1 Public Health Emergency \(10-27-09\) \[PDF, 200KB\]](#) Discusses hospital on-site and various entity off-site arrangements (CoP, billing, waivers)

[H1N1 - Medicare FFS - Emergency Qs & As \(11-13-09\) \[PDF 334KB\]](#)

[H1N1 - Medicare FFS - Emergency Qs & As that May be Implemented Only with a § 1135 Waiver \(11-13-09\) \[PDF 231KB\]](#) Discusses hospital on-site and various entity off-site arrangements (CoP, billing, waivers)

[H1N1 Fact Sheet-Medicare FFS Provider Billing \(9-25-09\) \[PDF, 70KB\]](#)

[CMS Pandemic Influenza Operations and Response Plan \[PDF, 3614KB\]](#)

[Guidance to States on New H1N1 Billing Codes \[PDF, 86KB\]](#)

[H1N1 Fact Sheet-Medicaid/CHIP Provider Billing \(10-26-09\) \[PDF, 108KB\]](#)

Section 1135 SSA (42 USC 1320b-5)

http://www.socialsecurity.gov/OP_Home/ssact/title11/1135.htm

Frequent
Updates

1023

WIS JI-CIVIL

1023

1023 MEDICAL NEGLIGENCE

In (treating) (diagnosing) (plaintiff)'s (injuries) (condition), (doctor) was required to use the degree of care, skill, and judgment which reasonable (doctors who are in general practice) (specialists who practice the specialty which (doctor) practices) would exercise in the same or similar circumstances, having due regard for the state of medical science at the time (plaintiff) was (treated) (diagnosed). A doctor who fails to conform to this standard is negligent. The burden is on (plaintiff) to prove that (doctor) was negligent.

A doctor is not negligent, however, for failing to use the highest degree of care, skill and judgment or solely because a bad result may have followed (his) (her) (care and treatment) (surgical procedure) (diagnosis). The standard you must apply in determining if (doctor) was negligent is whether (doctor) failed to use the degree of care, skill, and judgment which reasonable (general practitioners) (specialists) would exercise given the state of medical knowledge at the time of the (treatment) (diagnosis) in issue.

[Use this paragraph only if there is evidence of two or more alternative methods of treatment or diagnosis recognized as reasonable: If you find from the evidence that more than one method of (treatment for) (diagnosing) (plaintiff)'s (injuries) (condition) was recognized as reasonable given the state of medical knowledge at that time, then (doctor) was at liberty to select any of the recognized methods. (Doctor) was not negligent because (he) (she) chose to use one of these recognized (treatment) (diagnostic) methods rather than another recognized method if (he) (she) used reasonable care, skill, and judgment in administering the method.]

You have heard testimony during this trial from doctors who have testified as expert witnesses. The reason for this is because the degree of care, skill, and judgment which a reasonable doctor would exercise is not a matter within the common knowledge of laypersons. This standard is within the special knowledge of experts in the field of medicine and can only be established by the testimony of experts. You, therefore, may not speculate or guess what the standard of care, skill and judgment is in deciding this case but rather must attempt to determine it from the expert testimony that you heard during this trial.

(Insert the appropriate cause instruction. To avoid duplication, JI-1500 should not be given if the following two bracketed paragraphs are used.)

[The cause question asks whether there was a causal connection between negligence on the part of (doctor) and (plaintiff)'s (injury) (condition). A person's negligence is a cause of a plaintiff's (injury) (condition) if the negligence was a substantial factor in producing the present condition of the plaintiff's health. This question does not ask about "the cause" but rather "a cause." The reason for this is that there can be more than one cause of (an injury) (a condition). The negligence of one (or more) person(s) can cause (an injury) (a condition) or (an injury) (a condition) can be the result of the natural progression of (the injury) (the condition). In addition, the (injury) (condition) can be caused jointly by a person's negligence and also the natural progression of the (injury) (condition).]

[If you conclude from the evidence that the present condition of (plaintiff)'s health was caused jointly by (doctor)'s negligence and also the natural progression of (plaintiff)'s (injury) (condition), then you should find that the (doctor)'s negligence was a cause of the (plaintiff)'s present condition of health.]

[The evidence indicates without dispute that when (plaintiff) retained the services of (doctor) and placed (himself) (herself) under (doctor)'s care, (plaintiff) was suffering from some (disability resulting from injuries sustained in an accident) (illness or disease). (Plaintiff)'s then physical condition cannot be regarded by you in any way as having been caused or contributed to by any negligence on the part of (doctor). This question asks you to determine whether the condition of (plaintiff)'s health, as it was when (plaintiff) placed (himself) (herself) under the doctor's care, has been aggravated or further impaired as a natural result of the negligence of (doctor)'s (treatment) (diagnosis).]

(Insert appropriate damage instructions.)

[(Plaintiff) sustained injuries before the (treatment) (diagnosis) by (doctor). Such injuries have caused (and could in the future cause) (plaintiff) to endure pain and suffering and incur some disability. In answering these questions on damages, you will entirely exclude from your consideration all damages which resulted from the original injury; you will consider only the damages (plaintiff) sustained as a result of the (treatment) (diagnosis) of by (doctor).]

[It will, therefore, be necessary for you to distinguish and separate, first, the natural results in damages that flow from (plaintiff)'s original (illness) (injuries) and, second, those that flow from (doctor)'s (treatment) (diagnosis) and allow (plaintiff) only the damages that naturally resulted from the (treatment) (diagnosis) by (doctor).]

COMMENT

This instruction was approved by the Committee in 1963. It was revised in 1966, 1974, 1984, 1987, 1988, 1989, 1990, 1991, 1992, 1995, 1996, 1998, 2002, and 2009. The comment was updated in 1990, 1992, 1996, 2001, 2002, 2003, 2004, and 2005. The instruction was revised in 2009 to add "(diagnosis)" throughout the instruction to the alleged negligence.

The Committee recommends that the basic inquiry with respect to the defendant's conduct be framed in simple terms of negligence. Failure on the part of the doctor to conform to the applicable standard of care constitutes negligence. This form of submission is preferable to the form previously employed, *i.e.*, stating the duty in the question. The statement of the duty is the function of the instruction. The Committee recommends that the general negligence instruction, JI-Civil 1005, not be used in addition to this instruction.

There are a series of concepts involved in the instruction. The duty of the doctor in his or her care, treatment, and procedures; the effects of bad results on liability; the degree of care, skill, and judgment required to satisfy his or her duty; the duty allows a choice of accepted alternative methods of treatment; the doctor's liability cannot be predicated on other than expert testimony (except in a *res ipsa* case); and the issue is not on the judgment the doctor made but on the degree and skill he or she exercised in arriving at the judgment. The Committee concluded that foreseeability of injury or harm is inherent in the standard expressed in the first paragraph, and if an issue in the case, it must be addressed by expert testimony.

If the trial judge prefers, this instruction can be divided into its components (*i.e.*, negligence, cause, alternative care, damages, etc.) when instructing the jury and when providing the jury with written instructions during its deliberations.

Standard of Care. This instruction reflects the changes recommended by the Wisconsin Supreme Court in Nowatske v. Osterloh, 198 Wis.2d 419, 543 N.W.2d 25 (1996). The former version of this instruction was based on prevailing case law which measured ordinary care based on what an "average" physician would have done. The court in Nowatske said "the standard of care applicable to physicians in Wisconsin can not be conclusively established either by a reflection of what the majority of practitioners do or by a sum of the customs which those practitioners follow. Instead, the court said "it must be established by a determination of what it is reasonable to expect of a professional given the state of medical knowledge at the time of the treatment." Nowatske, *supra*, at 438-39.

Standard of Care: Unlicensed First-Year Resident. The Wisconsin Supreme Court in Phelps v. Physicians Ins. Co., 2005 WI 85, 282 Wis.2d 69, 698 N.W.2d 643, has held that unlicensed first-year residents should be held to:

the standard of care applicable to an unlicensed first-year resident . . . Although we anticipate this new standard of care to be lower than that of an average licensed physician in some cases, we do not expect that it will become a grant of immunity. After all, unlicensed first-year residents are graduates of a medical school who provide sophisticated health care services appropriate to their "in training" status. Therefore, unlicensed residents could still be found negligent if, for example, they undertook to treat outside the scope of their authority and expertise, or they failed to consult with someone more skilled and experienced when the standard of care required it.

The court characterized the status of an unlicensed first-year resident as "unique." It said the resident's authority was limited:

Although [resident] could refer to himself as an "M.D.," his freedom of action was more restricted than that of a licensed physician. Indeed, the circuit court found that Dr. Lindemann "had no authority or privileges to provide primary obstetrical care," and "was not supposed to act as the primary attending physician." Rather, "[h]is primary duty was

to assess and report findings and differential diagnoses to an upper level senior resident or to the attending obstetrician."

Effect of Bad Results. The second paragraph states the rule as to the effects of bad results on the doctor's liability. Bad results raise no presumption of negligence. DeBruine v. Voskuil, 168 Wis. 104, 169 N.W. 288 (1918); Ewing v. Goode, 78 F. 442 (S.D. Ohio 1897); Wurdemann v. Barnes, 92 Wis. 206, 66 N.W. 111 (1896); Francois v. Mokrohisky, *supra*; Finke v. Hess, 170 Wis. 149, 174 N.W. 466 (1920); Hoven v. Kelble, 79 Wis.2d 444, 256 N.W.2d 379 (1976). See also Nowatske v. Osterloh, *supra*.

The judgment of a doctor in his or her care, treatment, and procedures, whether good, bad, honest or mistaken, is not at issue on his or her liability. The issue raised is whether in making the judgment, he or she exercised that degree of care and skill imposed on him or her. If he or she failed to meet that standard, he or she was negligent and liable. Christianson v. Downs, *supra*; Hoven v. Kelble, *supra*; Carson v. Beloit, 32 Wis.2d 282, 145 N.W.2d 112 (1966); Wurdemann v. Barnes, *supra*; Jaeger v. Stratton, 170 Wis. 579, 176 N.W. 61 (1920).

"Not omniscience, but due care, diligence, judgment, and skill are required of physicians. When they meet such test, they are not liable for results or errors in judgment." Jaeger v. Stratton, *supra*.

"The question . . . is not whether a physician has made a mistake; rather, the question is whether he was negligent." Francois v. Mokrohisky, *supra*.

"The law . . . recognizes the medical profession for what it is: a class of fallible men, some of whom are unusually well qualified and expert, and some of whom are not. The standard to which they must conform is determined by the practices of neither the very best nor the worst of the class." Francois v. Mokrohisky, *supra*.

In 1988, the court in Schuster v. Altenberg, *supra*, reaffirmed the concept that liability will not be imposed under this negligence standard for mere errors in judgment. It quoted from its earlier holdings:

The law governing this case is well settled. A doctor is not an insurer or guarantor of the correctness of his diagnosis; the requirement is that he use proper care and skill. Knief v. Sargent, 40 Wis.2d 4, 8, 161 N.W.2d 232 (1968). The question is not whether the physician made a mistake in diagnosis, but rather whether he failed to conform to the accepted standard of care. Francois v. Mokrohisky, 67 Wis.2d 196, 201, 226 N.W.2d 470 (1975). Christianson v. Downs, 90 Wis.2d 332, 338, 279 N.W.2d 918 (1979).

The second paragraph also deals with the extent and quality of the doctor's treatment required to satisfy his or her duty. A doctor is not required to exercise the highest degree of care, skill, and judgment. Hrubes v. Faber, 163 Wis. 89, 157 N.W. 519 (1916); DeBruine v. Voskuil, *supra*; Jaeger v. Stratton, *supra*; Trogun v. Fruchtmann, *supra*; Christianson v. Downs, *supra*; Carson v. Beloit, *supra*; Francois v. Mokrohisky, *supra*; Hoven v. Kelble, *supra*.

Alternative Methods. The bracketed language at the bottom of page one can be used in cases when there is evidence that more than one method of treatment or diagnosis is recognized as reasonable. See Nowatske v. Osterloh, *supra*, at 448. The reasonable pursuit of an accepted alternative method does not

establish a doctor's liability, even if experts disagree on the method used. A physician is required by statute to inform a patient about the availability of all alternate, viable medical treatments and the benefits and risks of these treatments, Wis. Stat. § 448.30. For claims based on a failure by a physician to adequately inform a patient, see Wis JI-Civil 1023.2 Malpractice: Informed Consent.

Unnecessary and improper treatment constitutes medical malpractice. Northwest Gen. Hosp. v. Yee, 115 Wis.2d 59, 61-62, 339 N.W.2d 583 (1983).

Expert Testimony. Expert testimony is needed to support a finding of negligence on the part of the doctor. Kuehnemann v. Boyd, 193 Wis. 588, 214 N.W. 326 (1927); Holton v. Burton, *supra*; Lindloff v. Ross, 208 Wis. 482, 243 N.W. 403 (1932); Ahola v. Sincok, 6 Wis.2d 332, 94 N.W.2d 566 (1959); Froh v. Milwaukee Medical Clinic, S.C., 85 Wis.2d 308, 270 N.W.2d 83 (Ct. App. 1978); McManus v. Donlin, 23 Wis.2d 289, 127 N.W.2d 22 (1964); Treptau v. Behrens Spa, Inc., *supra*.

That degree of care and skill (of a physician) can only be proved by the testimony of experts. Without such testimony, the jury has no standard which enables it to determine whether the defendant failed to exercise the degree of care and skill required of him or her. Kuehnemann v. Boyd, *supra*; Holton v. Burton, *supra*; Lindloff v. Ross, *supra*.

Causation. The court in Young v. Professionals Ins. Co., 154 Wis.2d 742, 454 N.W.2d 24 (Ct. App. 1990), was critical of an earlier version of JI-1023 relating to cause. The present instruction concerning situations when there is evidence of both negligence and a condition of health resulting from the natural progression of a disease (injury) correctly states that a doctor's negligence may be causal, notwithstanding, that the plaintiff's present condition of health may in part be the result of the natural progression of plaintiff's disease (injury). This is because Wisconsin has long adopted the "substantial factor test" in deciding causation questions and no longer requires that the negligence be the sole or proximate cause. Matuschka v. Murphy, 173 Wis. 484, 180 N.W. 821 (1921), has been overruled because it is "likely to misstate the law of causation." See Young, *supra* at 749.

This instruction comports with the supreme court's decision in Fischer v. Ganju, 168 Wis.2d 834, 485 N.W.2d 10 (1992). In Fischer, the supreme court stated that a paragraph from a prior version JI-1023 (1989) was "less than completely accurate." The version given by the trial judge in Fischer in January 1990 was based on the 1989 version of this instruction which was published in April of 1989. This version was revised by the committee following the decision in Young v. Professionals Ins. Co., *supra*. The revised JI-1023 was published in May of 1991 as part of the 1991 supplement. This revision (1991) changed the language of the prior version dealing with causation. It has not been revised since the 1991 supplement. The Committee has closely compared this present version of JI-1023 to the court's criticism of the 1989 version of the instruction. The Committee concludes that the causation language of the present instruction is consistent with the discussion of causation in the Fischer decision and accurately states the law of causation in medical malpractice pre-existing condition cases.

Specialists. See Johnson v. Agoncillo, 183 Wis.2d 143, 515 N.W.2d 508 (Ct. App. 1994), where the First District Court of Appeals held that under current Wisconsin law, a doctor who practices one medical specialty is not held to the standard of care of another medical specialty, even when treating a patient in that latter specialty. Dr. Agoncillo was a family practitioner treating a high-risk obstetrical patient. Plaintiff Johnson requested an instruction that would hold Agoncillo to the standard of the "average physician who

treats high risk obstetrical patients. . . ." The trial judge refused to give such an instruction and the court of appeals affirmed, stating:

Thus, that Dr. Agoncillo chose to care for and treat Ms. Johnson during her high-risk pregnancy did not transform his class of physician to that of those who treat high-risk obstetrical patients; he was and he remained a general family practitioner who treated obstetrical patients and, as instructed by the trial court, he was thus 'required to use the degree of care, skill, and judgment which is usually exercised in the same or similar circumstances' by the average physician in that class.

The court went on to say, however, that the physician who attempts to treat a patient outside her or his expertise is not, thereby, immunized from liability. Referring to a cardiologist who treats a cancer patient, the court said in Johnson at 152:

If competent evidence establishes that the average cardiologist would either refer the cancer patient to an oncologist or would consult with an oncologist, the cardiologist could be found negligent for not referring or consulting.

Captain of Ship Doctrine. In a recent decision, the plaintiff in a medical malpractice action argued that the surgeon should be held vicariously liable for the negligence of two hospital nurses from a county-owned hospital who were responsible for counting sponges. Lewis v. Physicians Ins. Co., 2001 WI 60, 243 Wis.2d 648, 627 N.W.2d 484. The hospital was county-owned and, therefore, its liability at the time was limited to \$50,000.

The trial court, on summary judgment, agreed with the plaintiff's argument that, as a matter of law, the surgeon is the "captain of the ship" and is responsible for the actions of the parties that were in the operating room. Interestingly, the plaintiff did not argue that the surgeon was vicariously liable for the nurses' actions under the doctrine of respondeat superior. Both the court of appeals and supreme court rejected the adoption of the captain of the ship doctrine to impose liability on the doctor. The supreme court said the "captain of the ship doctrine" has lost its vitality across the country as plaintiffs have been able to sustain actions against full-care modern hospitals for the negligence of their employees.

Psychiatric Malpractice Claims. The Wisconsin Supreme Court recognized in Schuster v. Altenberg, supra, that a psychiatrist may be negligent by:

1. negligent diagnosing and treating, including failing to warn of side effects of medication,
2. failing to warn a patient's family of the patient's condition and its dangerous implications,
3. failing to seek the commitment of the patient.

Warning a patient of risks associated with a condition and the patient as to appropriate conduct constitutes treatment as to which a physician must use ordinary care. Schuster v. Altenberg, supra.

A psychiatrist may be held liable to third parties for failing to warn of the side effects of medication if the side effects were such that a patient should have been cautioned against driving, because it was foreseeable that an accident could result causing harm to the patient or third parties.

A psychotherapist has the duty to warn third parties or to institute proceeding for the detention or commitment of a dangerous individual for the protection of the patient or the public.

Dental Malpractice. If the defendant is a dentist, appropriate changes should be made in the instruction. For dental malpractice, see Albert v. Waelti, 133 Wis.2d 142, 394 N.W.2d 752 (Ct. App. 1986).

Determination of Future Economic Damages. In a claim based on injury from any treatment or operation performed by, or from any omission by, a person who is a health care provider, the determination of future economic damages must reflect present value, life expectancy, and the effects of inflation. Specifically, Wis. Stat. § 893.55(4)(e) states:

(e) Economic damages recovered under ch 655 for bodily injury or death, including any action or proceeding based on contribution or indemnification, shall be determined for the period during which the damages are expected to accrue, taking into account the estimated life expectancy of the person, then reduced to present value, taking into account the effects of inflation.

The Committee interprets this subsection as requiring the jury to make a reduction based on the time value of money and to consider inflation in determining future economic damages. The Committee believes that the statutory language quoted above does not mean that the trial judge should make allowance for present value of money or inflation immediately after the jury has determined economic damages or on motions after verdict.

Medical Negligence Damage Caps. There is a single cap on noneconomic damages recoverable from health care providers for medical malpractice. Maurin v. Hall, 2004 WI 100, 274 Wis.2d 28, 682 N.W.2d 866. The amount of the cap is determined by whether the patient survives the malpractice or whether the patient dies. When the patient survives, the cap is contained in Wis. Stat. § 893.55(4)(d). When the patient dies, the cap is contained in Wis. Stat. § 895.04(4). In cases where medical malpractice leads to death, the wrongful death cap applies in lieu of - - not in addition to - - the medical malpractice cap.

Bystander Recovery Claims for Negligent Infliction of Emotional Distress Based on Misdiagnosis. See the committee commentary to Wis. JI-Civil 1510 and 1511.

1023.7 PROFESSIONAL NEGLIGENCE: REGISTERED NURSES AND LICENSED TECHNICIANS PERFORMING SKILLED SERVICES

At the time in question, (defendant) was a (registered nurse) (licensed technician) serving in this capacity at _____ Hospital. As a (registered nurse) (licensed technician), it was (defendant)'s duty in (describe the service rendered (plaintiff) to use the degree of care, skill, and judgment which reasonable (registered nurses) (licensed technicians) would exercise in the same or similar circumstances, having due regard for the state of learning, education, experience, and knowledge possessed by (registered nurses) (licensed technicians) at the time in question. A (registered nurse) (licensed technician) who fails to conform to this standard is negligent. The burden is on (plaintiff) to prove that (defendant) was negligent.

A (registered nurse) (licensed technician) is not negligent solely because a bad result may have followed (describe the professional service rendered by the defendant). The standard you must apply in determining if (defendant) was negligent is whether (defendant) failed to use the degree of care, skill, and judgment which a reasonable (registered nurse) (licensed technician) would exercise at the time the service was rendered.

You have heard considerable testimony during this trial from experts in the field of nursing and medicine who have been called as expert witnesses by both sides. The reason for this is because the degree of care, skill, and judgment which a reasonable (registered nurse) (licensed technician) would exercise is not a matter within the common knowledge of laypersons. These standards are within the special knowledge of experts in the field of nursing and medicine and can only be established by their testimony. You, therefore, may not speculate or guess what those standards of care,

skill, and judgment are in deciding this case but rather must attempt to determine this from the expert testimony that you have heard during this trial.

(Insert appropriate burden of proof instruction.)

(Insert appropriate cause instruction.)

COMMENT

The instruction and comment were originally approved in 1974 and revised in 1988 and 1998.

The instruction was revised in 1998 to conform to the explanation of professional negligence in Nowatske v. Osterloh, 198 Wis.2d 419, 543 N.W.2d 265 (1996). See Comment to Wis JI-Civil 1023. The previous version of this instruction based the standard of care on what was "usually exercised" by registered nurses or licensed technicians or what "the average" registered nurse or technician would do.

Tills v. Elmbrook Memorial Hosp., Inc., 48 Wis.2d 665, 180 N.W.2d 699 (1970); Shier v. Freedman, 58 Wis.2d 269, 206 N.W.2d 166 (1973); Trogun v. Fruchtman, 58 Wis.2d 596, 207 N.W.2d 297 (1973).

For the requirement of expert testimony on the standard of professional nursing care, see Kujawski v. Arbor View Health Care Center, 139 Wis.2d 455, 407 N.W.2d 249 (1987).

APPENDIX I



A Valued Voice

WISCONSIN HOSPITAL
ASSOCIATION, INC.

8510 Research Park Dr, P.O. Box 259038
Madison, WI 53725-9038



Wisconsin Medical Society
Your Doctor. Your Health.

330 East Lakeside Street, P.O. Box 1109
Madison, WI 53701-1109

August 27, 2009

Karen Timberlake
Secretary
Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53707

Subject: Liability protections for health care workers during an emergency

Dear Secretary Timberlake:

First, we would like to thank you and your staff for your strong efforts preparing Wisconsin for a potential flu outbreak this fall. Your staff is leading crucial discussions and planning sessions throughout the state addressing key issues.

One part of the State's effort has been establishing the State Expert Panel on the Ethics of Disaster Preparedness. The documents prepared by this Panel offer important guidance to health care providers who may need to confront ethically complex issues during a public health emergency. One of the documents encourages providers to prepare for that possibility by developing guidelines concerning the allocation of scarce resources. While it is a difficult topic, your staff, health care providers, ethicists, and others around the state have been discussing appropriate guidelines for the possible triaging and rationing of scarce resources.

As we have seen during recent national disasters, there have been times when health care providers have had to make very difficult care decisions. These decisions can mean that patients do not receive the care they would expect during normal times, essentially the health care provider ends up functioning under altered standard of care. While these difficult decisions make sense during the disaster, in the calm that follows, health care providers are concerned that their decisions will be second-guessed, exposing them to potential civil and criminal liability. It is well known among health care providers that physicians and others who were faced with making difficult allocation decisions have faced both criminal and civil liability for their actions. This fear might make some providers reluctant to implement guidelines concerning the use of scarce resources and other guidelines that providers are developing. The goal of the guidelines is to save as many lives as possible; we are concerned that we will not meet the goal if providers do not implement the guidelines.

To help hospitals, physicians, clinics, and other health care providers prepare for a public health emergency we ask the following:

1. During a public health emergency like the H1N1 flu, we anticipate that most of the health care will be provided by practitioners who are employed and on the job. As their services will not be volunteer services, protections available to certain volunteers might not be available to them. Does the Department of Health Services or other state agency have the authority to protect health care workers from potential civil and criminal liability through issued orders (s. 166.03(1)(b)), direction from the State (s. 166.03(10)), waived administrative rules (s. 166.03(1)(b)) or other means when health care workers implement the guidelines encouraged by the Department?
2. Is the Department prepared to issue the orders or directives necessary to protect health care workers from potential civil and criminal liability should the health care workers need to implement the guidelines?
3. Is the Department prepared to issue an order directing hospitals and their medical staffs to implement the allocation procedures they have developed in response to the H1N1 pandemic?

Thank you for your attention to this important issue. We appreciate the work of the State Expert Panel on the Ethics of Disaster Preparedness and the Wisconsin Division of Public Health. We are hopeful that the Department will be able to assure health care workers that they will be protected from potential civil and criminal liability if they are called upon to implement the ethical guidelines developed from the State's good efforts.

Sincerely,



Stephen F. Brenton
President
Wisconsin Hospital Association



Susan Turney, MD, MS, FACP, FACMPE
Chief Executive Officer/EVP
Wisconsin Medical Society



Jim Doyle
Governor

Karen E. Timberlake
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF PUBLIC HEALTH

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September 21, 2009

Stephen F. Brenton
President
Wisconsin Hospital Association
5510 Research Park Drive
P.O. Box 259038
Madison, WI 53725-9038

Dear Mr. Brenton:

Thank you for your letter to Secretary Karen E. Timberlake regarding the preparations and plans of the Wisconsin Division of Public Health for the expected return of H1N1 influenza this fall, especially as these plans pertain to statutes that offer liability protections to hospitals. Secretary Timberlake has asked me to respond to your letter on her behalf and I welcome the opportunity to do so.

As a sovereign, only the legislature may assume civil liability on behalf of the state; neither this department nor any other state agency is so authorized. As you know, there are specific instances throughout the statutes in which the legislature has chosen to offer indemnification and legal representation, e.g., for health care volunteers under certain circumstances. In addition, the department may assume responsibility for the acts of its agents under the parameters of Wis. Stat. § 895.46. Whether a person or entity is an agent within that context is very much a matter of the particular circumstances, and a department order to follow certain protocols would not necessarily confer that status. Therefore, I cannot give you the assurances you seek.

Along with seeking the advice of your legal counsel as to how duties of care, and therefore liability, will be affected by emergency responses, you may wish to ask for their assessment of how the federal Public Readiness and Emergency Preparedness (PREP) Act at 42 USC 247d-6d will apply to your intended activities. Under the PREP Act and the federal declarations made pursuant to it, there will be immunity from tort liability (other than arising from willful misconduct) for persons within the chain of the dispensing and administering of antivirals for H1N1 and H1N1 vaccinations.

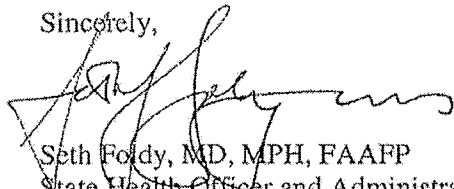
Stephen Brenton
September 21, 2009
page-2-

In answer to your specific questions:

1. At this stage of the H1N1 outbreak and response it is too early to tell what, if any, orders this department may issue to practitioners and what, if any, waiver of administrative rules might be necessary to implement guidelines. We started the process in spring of assessing if any rules might need to be waived under the Governor's declaration and that will be a continuing process throughout the upcoming season.
2. As I said above, it is too early to know what orders we may or may not issue to the health care community. Those orders, in any event, will not necessarily insulate health care workers from liability.
3. Again, it is too early to tell what orders may or may not be issued to hospitals and their medical staff.

Thank you for your continued active role in preparing Wisconsin for a potential H1N1 influenza outbreak.

Sincerely,



Seth Foidy, MD, MPH, FAAFP
State Health Officer and Administrator
Division of Public Health

cc: Susan Turney, MD, MS, FACP, FACMPE

the Ethics of Healthcare Disaster Preparedness

Guidelines for the Triage of Patients¹

Given the very serious ramifications of limited resources in a disaster and its accompanying decisions and outcomes, there is an ethical responsibility on the part of health care providers to prepare themselves for how they will allocate scarce resources in a disaster.

The State Expert Panel on the Ethics of Disaster Preparedness in collaboration with the Wisconsin Division of Public Health, Hospital Emergency Preparedness Program and the Wisconsin Hospital Association has developed a series of brochures, entitled "The Ethics of Health Care Disaster Preparedness." These documents provide guidance to health care organizations and staff so that all have a better understanding of why certain decisions are made, how these decisions are informed by the ethical principles in this document and how these decisions will be implemented when there are limited resources.

The State Expert Panel has produced this document primarily as a basis for discussion so health care physicians and other clinicians can participate in a dialogue that will further refine these guidelines. The desired outcomes of these discussions include:

- *a greater awareness of the ethical issues that will arise during a disaster*
- *an understanding of the ethically justifiable expectations regarding what to expect from the health care system during a disaster*

*Before reading this brochure, you are encouraged to read the brochure
"Ethics of Health Care Disaster Preparedness."*

The State Expert Panel assumes that health care providers have been committed to these preparedness efforts and can attest to the significant accomplishments that	have been made since the events of 9/11. The State Expert Panel believes its responsibility is to identify the	ethical issues that will occur in a disaster, to provide initial guidance regarding ethical decision-making, to provide a forum for discussion of these ethical issues and then to
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¹ This section is heavily indebted to the work done by the New York State Workgroup on Ventilator Allocation in an Influenza Pandemic, New York State Department Of Health/New York State Task Force on Life & the Law, "Allocation of Ventilators in an Influenza Pandemic: Planning Document", March 2007

This brochure was completed by the State Expert Panel on the Ethics of Disaster Preparedness in collaboration with the Wisconsin Hospital Association and the Hospital Preparedness Program, Wisconsin Division of Public Health and provides information only and is not to be construed as legal advice.

take the results from these discussions and share them with health care organizations throughout Wisconsin. Health care providers need to understand that even with health care organizations "being prepared" and following all of these ethical guidelines, there may be loss of life for those who do not receive the necessary treatment due to limited resources.

In a disaster, it is very likely that there will be a significant imbalance between available resources and the needs of many patients. There not only will be longer waits for treatment, but, more likely, there will be patients who do not receive the treatment necessary and even patients for whom there will be no treatment available due to lack of human and/or material resources.

With limited resources, there will not be enough to go around for every one in need. Thus, these resources must be allocated to achieve the greater good for the community.

Health care providers nationally and in the State of Wisconsin are working to develop guidelines for the triage of patients so that treatment decisions are made that best serve the greater good of the community and that meet the values that are proposed in this brochure series.

It is evident that such triage guidelines will only be applied when absolutely necessary. Thus, health

care providers have an ethical responsibility not only to have these guidelines in place, but also to ensure that these guidelines will be applied only after every other remedy has been implemented.

The State Expert Panel is recommending that these guidelines for the allocation (triage) of scarce resources meet the following criteria:

1. Be consistent with the Ethics Principles and Procedural Values, addressed in this brochure series
2. Be applied consistently across the state
3. Be based on evidence-based practices to the extent that these practices are available
4. Reflect the current best practices for the triage of critical care patients
5. They are tiered so that, as the number of patients increases and resources are further depleted, these criteria can become more stringent
6. Allocate resources to save as many lives as possible
7. Have the consensus of health care providers, especially those involved in the response to the disaster, through open review and discussion and an opportunity for comment
8. Have the consensus of the general public through open review and discussion and an opportunity for comment

The State Expert Panel also recom-

mends that the following nine prerequisites be in place at all hospitals:

Clinical Review Committee

A critical tool in accomplishing the above criteria for the allocation of scarce resources is the Clinical Review Committee.

Desired Outcomes:

- The hospital should establish now a multi-disciplinary committee to review admissions, procedures and allocation of resources so that the Committee can learn how to make such decisions without the stress and urgency that will occur in a disaster. This committee should meet regularly to discuss triage protocols so that it is prepared to implement these guidelines when necessary.
- This will necessarily involve the education of physicians and health care professionals in the application of these protocols through educational programs and especially table-top exercises and other such simulations.

Surge Capacity

Hospitals are to ensure that there is a system in place to manage a surge of patients.

Desired Outcomes:

- There is a process for canceling elective admissions and procedures.
- There is a process for triaging

admissions and procedures that are of an emergent nature versus those that are of an urgent nature.

- There is a process for limiting outpatient procedures that may have the potential for hospital admission.
- There is also to be a plan in place to deploy surge beds², especially surge beds that increase the number of critical care beds. This also involves a plan to bring on additional staff, supplies and equipment.
- The hospital is to have a sufficient inventory of personal protective equipment that will be needed in an infectious disease outbreak.

Patient Triage Principles

Triage policies that are developed by the Clinical Review Committee are to apply to all patients.

Desired Outcomes:

- A resource allocation system is to be applied to all hospitalized patients in need of medical treatment, whether inpatient or outpatient, and not just those affected by the disaster.
- There are to be no non-clinical exclusion criteria such as age, employment, economic status, etc. In addition, health care workers should not be treated as a special class of patients for the purpose of triage³.

Collaboration Among Health Care Providers

Hospitals will be operating under the Incident Command System (ICS) during such an incident. The Incident Command System provides a process for the allocation of resources through the Emergency Operations Center. However, it is incumbent upon health care providers to make sure there is collaboration among all providers.

Desired Outcomes:

- There is to be a policy for the sharing of supplies and equipment among health care organizations⁴. A disaster, such as a pandemic, may move gradually across the state. Not all facilities will be affected at the same time. The Clinical Review Committee should think through the implications of sharing resources and supplies with those health care organizations in immediate need, knowing that the donor hospital may eventually be in need of these same supplies, equipment and personnel. The ethical dilemma is "Does a donor hospital hold onto supplies when the requesting hospital is in dire need, knowing that these same supplies may be needed within a few days or weeks by the donor hospital?"
- Hospitals within health care systems will have access to their

system's resources. This raises ethical issues for these health care systems. "Do these systems prioritize the allocation of resources only for system hospitals or will they allocate resources to any hospital in need?"

Implementation of Triage Protocols

The hospital should adopt a system to ensure that all members of the Medical Staff and all employees are educated in the protocols for the allocation of scarce resources.

Desired Outcomes:

- The hospital is to have a process in place to educate physicians and other health care professionals on these protocols prior to any disaster.
- It is recommended that there be a triage officer such as a Critical Care Specialist, who will make these triage decisions versus the attending physician. Centralizing this decision-making will allow this person to have a big picture perspective, make decisions based on preceding decisions and thus become more scientific and objective in the decisions made.

Conservation and Rationing of Resources

Protocols for the conservation and rationing of resources need to be established now and have the op-

² Surge beds are defined as beds that can be set and staffed in addition to the current staffed beds

³ Allocation of other resources such as personal protective equipment, anti-viral medications and vaccines are based on different ethical principles and may well favor health care workers.

⁴ In the State of Wisconsin, all hospitals have already signed Memoranda of Understanding sharing supplies, equipment and staff.

portunity to be reviewed and agreed upon prior to implementation.

Desired Outcomes:

- Each department and service within the hospital should establish protocols for the conservation of resources that should be implemented at the beginning of the incident to maximize resources. This may include, for example, defining "essential patient treatment," e.g., given a shortage of staff and a surge of patients, what are those basic and essential tasks that nurses need to fulfill.
- Each department and service within the hospital should establish protocols for the rationing of scarce resources should this become necessary.
- Each department and service within the hospital needs to have a program for educating its staff and all those involved in treatment in these conservation and rationing protocols along with testing these protocols through periodic exercises.

Note: Various workgroups, organizations and professional associations are in the process of developing protocols for the conservation and rationing of scarce resources. As these protocols become available, they are placed on the following web sites: www.wha.org under Emergency Preparedness and www.pandemic.wisconsin.gov under Health Care.

Palliative Care

Existing policies and procedures for determining which patients can benefit from palliative care should be followed to the extent that these are applicable in a disaster. Palliative care is to be offered to all patients for whom life-saving treatments are not available or for those who altruistically choose to forgo treatment.

Desired Outcomes:

- There needs to be a process for family members to receive the necessary education and information to better understand the decision-making process to place a loved one in palliative care.
- The hospital should have a plan for a surge of patients in need of palliative care, including education and support for the caregivers.

Quality Review

The Clinical Review Committee should have a process to make sure that all of its decisions and protocols are reviewed on an on-going basis.

Desired Outcomes:

- When decisions are being made to allocate scarce resources, the hospital is to have a process for the daily and/or periodic review of triage decisions to ensure that 1) all decisions are follow-

ing established criteria and 2) there is access to evolving clinical evidence that may necessitate change in these triage and treatment protocols.

Education

The Clinical Review Committee is responsible for ensuring that there is a process to widely communicate its work.

Desired Outcomes:

- The hospital should have a process in place, prior to any incident, to educate clinicians and staff in the protocols for the allocation of scarce resources.
- The hospital should also have a process to educate the community and its patients about how the allocation of scarce resources may affect treatment decisions.
- The hospital is also to have a process to educate the community and its patients about how scarce resources may affect treatment decisions, especially upon admission of the patient to the hospital during a disaster.

If you have questions or comments on the content of this brochure or to order additional copies of this brochure and other brochures in the series or to report on the Desired Outcomes developed by your organization, please email dhsethics@dhs.wisconsin.gov.

the Ethics of Healthcare Disaster Preparedness

Ethical Responsibilities of Health Care Leadership

Given the very serious ramifications of limited resources in a disaster and its accompanying decisions and outcomes, there is an ethical responsibility on the part of health care leadership to prepare themselves for decision-making and the allocation of scarce resources in a disaster. Since the events of 9/11, health care organizations have devoted significant time along with human and financial resources to evaluate their capacity and capability in preparedness for a response to a disaster. These efforts have been supplemented with federal preparedness funds to assist health care organizations in this costly endeavor.

The State Expert Panel on the Ethics of Disaster Preparedness in collaboration with the Wisconsin Division of Public Health, Hospital Emergency Preparedness Program and the Wisconsin Hospital Association has developed a series of brochures, entitled "The Ethics of Health Care Disaster Preparedness." This brochure should be read as an introduction to the brochure series. These documents provide guidance to health care organizations and staff so that all have a better understanding of why certain decisions are made, how these decisions are informed by the ethical principles in this document and how these decisions will be implemented when there are limited resources.

The State Expert Panel has produced this brochure primarily as a basis for discussion so health care leadership can participate in a dialogue that will further refine these guidelines. The desired outcomes of these discussions include:

- *a greater awareness of the ethical issues that will arise during a disaster*
- *an understanding of the ethically justifiable expectations regarding what to expect from the health care system during a disaster*

*Before reading this brochure, you are encouraged to read the brochure
"Ethics of Health Care Disaster Preparedness."*

The State Expert Panel believes its responsibility is to identify the ethical issues that will occur in a disaster, to provide initial guidance regarding ethical decision-making, to provide a forum for discussion of these ethical issues and then to take the results from these discussions and share them with health care organi-

zations throughout Wisconsin. Health care leadership needs to understand that even with health care organizations "being prepared" and following all of these ethical guidelines, there may be loss of life for those who do not get the necessary treatment due to limited resources.

The following Ethical Responsibilities are based on the Ethics Principles and Procedural Values as explained in the brochure "Ethics of Health Care Disaster Preparedness". These responsibilities are formatted as a checklist with a rationale for each checklist item and a recommended desired outcome for each responsibility.

This brochure was completed by the State Expert Panel on the Ethics of Disaster Preparedness in collaboration with the Wisconsin Hospital Association and the Hospital Preparedness Program, Wisconsin Division of Public Health and provides information only and is not to be construed as legal advice.

It is the hope of the State Expert Panel that senior management and the Board of Directors at health care organizations will meet to discuss amongst themselves these responsibilities and achieve the recommended desired outcome. Because of the many responsibilities for health care leadership, administrators may need to delegate certain tasks to other personnel or departments.

1. To provide consistent and rational leadership in organizing a response to the crisis at hand.

Rationale: Leaders need to set a tone of calmness and confidence; to participate in planning and exercising disaster plans; to collaborate with other emergency responders outside of the health care organization; to understand how to manage the incident using the Incident Command System; to seek out and to disseminate accurate information.

Desired Outcomes:

- Health care Leadership knows its organizational Emergency Operations Plan.
- Health care Leadership plays an active role in the development of its organization Emergency Operations Plan.
- Health care Leadership actively participates in the Emergency Operations Plan exercise.

2. To have a process in place at the health care organization for personnel to think through and discuss their "duty to care."

Rationale: All health care professionals and, indeed, all health care workers, because of their commitment to the Mission and Values of their organization, have committed themselves in a special way to care for their patients. However, there is no policy that can be written to tell the health care worker what to do when faced with a conflict between caring for patients, caring for family and other personal concerns. The State Expert Panel believes that health care leadership has a responsibility to provide their personnel with an opportunity to think through and dis-

cuss this "duty to care" and develop their own personal plan along with their family members on how they will respond to their work responsibilities in a disaster.

Desired Outcomes:

- Health care Leadership has discussed at the Board and Executive Management level the "duty to care" and its implications on organizational policy and practice.
- Health care Leadership provides forums for its employees to discuss "duty to care" and to act upon recommendations coming from these discussions.

3. To have a plan in place to keep personnel safe in a disaster.

Rationale: Health care leadership is ethically and legally bound to provide a safe working environment. It is incumbent upon health care leadership to anticipate the needs of its workers in a surge or a sustained disaster incident. To a great extent, on-going disaster preparedness initiatives and completing the required Hazards Vulnerability Analyses address these issues. For example, many health care organizations have increased stockpiles of personal protective equipment to protect their staff in an outbreak of infectious disease.

Desired Outcomes:

- Health care Leadership has completed an analysis of the needs of its workers in a disaster and has a plan in place to address these needs.
- Health care Leadership has discussed with personnel the issues that may arise when there are limited resources.
- Health care Leadership, to the extent possible, has developed plans to manage the resources that will affect staff safety and health.

4. To have a plan in place to allow personnel to care for their family, pets, property and other personal concerns when called to serve in a disaster.

Rationale: Health care workers are moms and dads, grandparents, relatives and friends and thus are also committed to

their loved ones. Health care workers need to know that their loved ones are cared for during a disaster, that they have the capability to communicate with them, and that their loved ones are protected from the effects of the disaster. Planning should consider working with personnel to determine what they believe their needs will be when serving in a disaster. Health care leadership should make their best effort to meet the needs of their personnel.

Desired Outcomes:

- Health care Leadership has identified the personal needs that staff will need to attend to in a disaster.
- Health care Leadership, to the extent possible, has developed plans to assist staff to attend to their personal needs in a disaster.

5. To have a plan in place for the allocation of limited and scarce resources.

Rationale: Issues about the allocation of scarce resources must be thought through beforehand even though it is difficult to anticipate all the variables that may occur in particular disasters. However, it must be anticipated that the disaster will create dire circumstances and there may be either limited or no resources available. This scarcity of resources may be community and even state wide. Conservation and allocation of scarce resources will be necessary.

Desired Outcomes:

- Health care Leadership has asked all nursing departments, ancillary services departments and the Medical Staff to identify conservation and rationing protocols that will be implemented in a disaster.
- Health care Leadership has established a multi-disciplinary Clinical Review Committee to design, review and approve medical triage and treatment guidelines that can be implemented when there are scarce resources.

6. Leaders must be collaborative with other emergency responders¹.

Rationale: Leaders must recognize that

¹ An emergency responder is broadly defined as any private or local, tribal or state governmental entity that has authority, roles, responsibilities and resources that can be applied in an emergency situation.

they are part of a national, state, regional and local team, and part of the National Response Framework and the National Incident Management System. Health care leadership has a responsibility to know how to function under the Incident Command System to integrate its efforts with those of other emergency response partners. This collaboration is to include planning and exercising with local and regional private and governmental partners and other health care organizations.

Desired Outcomes:

- Health care Leadership has instituted the Incident Command System as a response to all emergency incidents.
- Health care Leadership has ensured that its Emergency Operations Plan is integrated with the plan of other hospitals and other emergency responders.
- Health care Leadership has exercised with its emergency response partners in a Unified Command scenario.

7. Leaders must be non-competitive.

Rationale: To achieve "the greater good for the community" leaders must set aside competitive goals and do what is best for the community. Leaders must ensure that there are agreements in place for sharing supplies, equipment and personnel and also for triaging and accepting patients, based on what is best for the patients and the community.

Desired Outcomes:

- Health care Leadership has signed a Memorandum of Understanding with other hospitals for sharing supplies, equipment and personnel and also for triaging and accepting patients, based on what is best for the patients and the community.
- Health care Leadership is encouraged to meet with neighboring hospitals throughout the area and even the region to determine the high level issues that could come into play as hospitals are in need of one another.

8. Leaders must keep the health care infrastructure operational.

Rationale: Leaders must ensure that the health care organization can operate on its own, at a minimum, for 96 hours and potentially for longer periods of time. This means rethinking strategies such as "just-in-time" inventories. This must include plans for the conservation of supplies and also plans to ensure that there are adequate personnel and policies for "essential patient care" that extends the productivity of personnel.

Desired Outcomes:

- Health care Leadership has asked nursing and ancillary departments to identify how long they can provide care with existing inventories.
- Health care Leadership is to determine whether inventories need to be increased so that there is at least a 96 hour supply available.
- Health care Leadership should determine how the organization will operate if there are no state or federal assets that can assist the organization.

9. Leaders must be present and communicate consistently with their personnel and patients.

Rationale: Leaders must ensure there is a process for personnel to be kept apprised of information that they need to know to do their job and function properly in a disaster situation. This process also includes ensuring that there are methodologies in place for leadership to listen to the needs of their personnel and patients.

Desired Outcomes:

- Health care Leadership is to have a plan to remain present and visible to staff and patients during a disaster.
- Health care Leadership must exercise the Incident Command System especially in regard to communications so that all messages are consistent with those given by other authorities.

10. Leaders must recognize that they may not be the decision makers in all instances

Rationale: Leaders must have a process in

place for decisions to be made at the proper time by the proper persons. Functioning under the Incident Command System will provide the structure for such decision-making. Leadership is to ensure that the health care organization is well versed and well practiced in the implementation of the Incident Command System.

Under the Incident Command System, the "Agency Executive" maintains the responsibility for the overall operations of the health care organization. Leadership must assign the appropriate persons with back-ups who can assume the top eight positions² of the Incident Command System, understanding that the type of incident will determine which person can best fulfill these roles.

Desired Outcomes:

- Health care Leadership has predefined its roles, to the extent possible, and those persons who will assume the Command positions under the Incident Command System.

11. Leaders are to include recovery in their disaster planning.

Rationale: Leaders are responsible for the safety and well-being of personnel. Based on past disaster experiences, personnel debriefing and support resources are to be identified so that they are readily available as soon as needed. It is likely that recovery resources will need to be in place for long periods of time after the disaster, since many will be affected by post-disaster distress.

Desired Outcomes:

- Health care Leadership has plans to mobilize debriefing and support resources to support staff, patients and the community after the disaster.
- Health care Leadership has plans to maintain debriefing and support resources for the long-term.

12. Leaders have a responsibility to plan for continuity of operations.

Rationale: Given the high potential for the depletion of material and human resources

² These top eight positions are: Incident Commander, Public Information Officer, Liaison Officer, Safety Officer, Operations Chief, Planning Chief, Logistics Chief and Finance/Administration Chief.

in a disaster, the health care organization must not weaken itself to the degree that it cannot survive and continue to serve as an asset to the community. There needs to be planning for continuity of care and recovery so that the health care organization can continue its mission after the disaster.

Desired Outcomes:

- Health care Leadership has completed projections on financial losses that may likely be sustained in a disaster along with a financial recovery plan.
- Health care Leadership has completed a review of all insurance policies to determine if there are any exclusions or limitations that could negatively affect the organization in a disaster.

13. Leadership has written plans, guidelines, and policies in place about requesting staff, over a prolonged period of time (weeks and months), to work long hours, multiple shifts and to assume high risk duties that may occur in times of a disaster.

Rationale: The organization has a responsibility to develop plans, guidelines and policies for expected eventualities. Each organization should have policies to manage human resource issues in a disaster. Leadership should involve the workers themselves in the development of these policies. These policies should be made known to workers prior to any incident.

Desired Outcomes:

- Health care Leadership has convened focus groups of staff to identify staffing and personnel issues that will arise in a disaster and to play a role in the development of policies that will be implemented in a disaster.

14. Leadership has plans, guidelines and policies in place about how to respond to staff that do not show up for work and to recognize what are acceptable reasons for work absences.

Rationale: Employees will obviously be faced with conflicting obligations and

some will not show up for work because of these conflicts. This could result from directives of Public Health authorities, calling for the closing of schools and day-care. Others may not show up simply out of fear. There may also be good reasons for health care workers not to report to work such as when they are sick. Given health care worker shortages today, these issues must be thought out beforehand so that operations can return to normal as soon as possible. There is the likelihood that there may be the "disaster after the disaster" as employees confront other employees, who may not be perceived to have done their fair share during the disaster.

Desired Outcomes:

- Health care Leadership has convened focus groups of staff to identify staffing and personnel issues that will arise in a disaster, especially regarding those staff that do not show up for work and do not follow existing policy for absenteeism. Health care leadership is to play a role in the development of human resource policies that will be implemented in a disaster.

15. Leadership has a process in place for the managers and supervisors to monitor the stress levels and demands on staff during the disaster.

Rationale: Employees will be working under harsh conditions and will be professionally and personally affected by the disaster and the decisions that are being made. The organization has the responsibility to have a system in place to monitor the safety and well-being of its employees, given the fact that managers, supervisors and administrators will also be affected.

Desired Outcomes:

- Health care Leadership has a system in place, given the limitations of Employee Health Services or its equivalent in a disaster, to monitor the physical and mental well-being of employees.

16. Leadership has a plan in place (developed prior to the disaster) to care for

the family members of health care workers and also community members and their needs in a disaster, as applicable.

Rationale: During Hurricane Katrina some health care workers came to work only if they knew they could bring family members. Health care organizations found that they quickly ran out of food and supplies and could not take care of even the basic needs of these families. In addition, many community members sought refuge in hospitals.

Desired Outcome:

- Health care Leadership is to anticipate that it may also need to provide services to family members of staff and also community members, who see the organization as a place of refuge. The organization needs to consider, in collaboration with community Emergency Management, how basic needs will be cared for in the community.

17. Leadership facilitates, to the extent possible, that the Human Resource decisions that are made at one health care organization are consistent with the decisions made at other health care organizations across the state.

Rationale: Consistency of approach in caring for personnel is necessary in a disaster. Health care organizations have an obligation to collaborate in the development of these plans so that they are able to not only learn from one another but also so that personnel can be assured that there will be consistency in how all health care workers will be treated in a disaster.

Desired Outcomes:

- Health care Leadership meets through their professional associations or with their peers to discuss policies that may need to be implemented in a disaster and how these policies can be applied equally and consistently across all organizations.

If you have questions or comments on the content of this brochure or to order additional copies of this brochure and other brochures in the series or to report on the Desired Outcomes developed by your organization, please email dhsethics@dhs.wisconsin.gov.