Policy Analysis of Health Professional Licensing During Disaster Response in the United States

Chris M. Buck
Wright State University - Main Campus

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Chris M. Buck

Wright State University
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Abstract

Since the 1950s the number of major disaster declarations has more than tripled. These disasters cause an increase in the number of sick and injured individuals. In order to handle this increased patient load, health professionals must be brought in from outside the area, often from surrounding states. Current health professional licensing is maintained by each state individually, with post-disaster assistance made available through the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the Pandemic and All-Hazards Preparedness Act (PAHPA), the Model State Emergency Health powers Act, the Nurse Licensure Compact, and the National Disaster Medical System. These programs along with proposed legislation and post-disaster evaluations of medical licensing have been analyzed in order to form four alternatives to the current system of medical licensing as well as desired outcomes. In order to compare the alternatives, Bardach’s Eight Fold Path has been used to create a policy analysis matrix. The results of the policy analysis gave the Status Quo lowest score and a proposed National Medical Licensing system the highest score. The highest score (National Medical Licensing System) corresponds with the greatest ability to meet the desired outcomes derived from the studied literature. It is therefore theorized that a National Medical Licensing system will substantially increase the efficiency and effectiveness. Further study is recommended to confirm the fiscal and political acceptability criteria of the policy analysis.

Keywords: disaster, emergency, health professional, medical licensing, response, volunteer
Policy Analysis of Health Professional Licensing During Disaster Response in the United States

Since the 1950s the number of major disaster declarations has more than tripled (Federal Emergency Management Agency [FEMA], 2013). A major disaster is defined as any natural catastrophe or a fire, flood, or explosion that occurs within the United States and for which the President determines that sufficient damage has occurred to warrant major disaster assistance (Robert T. Stafford Disaster Relief and Emergency Assistance Act [Stafford Act], 1988). These events overwhelm the ability of local governments, states, and local relief organizations. In order to respond to these emergencies, resources are drawn from around the United States. One of the largest challenges presented by these emergencies is the sudden influx of sick and injured people, known as medical surge. In order to meet the needs created by medical surge, personnel may need to be brought in from surrounding states. Effective utilization of out of state personnel is a significant issue for medical responders due to the current system of medical licensing. A policy analysis will be conducted in order to test whether more effective alternatives to the current medical licensing system exist.

Purpose Statement

For the purpose of this policy analysis, the problem is being defined as, “The current medical licensing system is too complex under disaster medical conditions.” In other words, the current medical licensing system severely limits the pool of available medical personnel that may be called on to respond during an emergency. Due to the number of acronyms used, a list of acronyms has been included in Appendix A.
Review of Literature

Medical licensing is a complex subject in the non-disaster context. Adding large-scale disasters and out of state professionals increases this complexity even further. In order to understand the complexity that medical licensing presents it is necessary to review the established procedures for requesting federal aid, alternative programs that have been suggested or implemented, and any issues that have arisen in the wake of a major disaster. Detailed state medical licensing and medical licensing in other countries falls outside the scope of this review.

Understanding the process by which federal disaster declarations are made is essential to fully understanding the issue at hand. A disaster has been defined by the American College of Emergency Physicians as “A sudden calamitous event bringing great damage, loss, or destruction,” and by the World Health Organization as “A sudden ecologic phenomenon of sufficient magnitude to require external assistance” (Zibulewsky, 2000, p. 144). In the United States, each state follows a very similar process when dealing with disasters. The earliest professional responders to arrive at the scene of a disaster are known as first responders and generally consist of police, fire fighters, and emergency medical service (EMS) personnel. They are trained to handle most small-scale incidents without further assistance. Should the incident grow in size, they are trained to use the Incident Command System (ICS) to manage the response effort. ICS is a response system designed to be flexible and scalable to meet the needs of any disaster. It achieves this by standardizing titles and responsibilities of those involved in the response. Additionally, the ICS strives to provide a common system that allows for the integration of outside resources. At this point, the highest-ranking member of the first responders (often the Fire Chief) assumes the role of the Incident Commander (IC). As the scale of a disaster increases and additional resources are needed, an Emergency Operations Center
(EOC) is established. The EOC provides a place where all local government leaders can coordinate the allocation of personnel and equipment to the disaster.

While local governments may be able to handle the majority of incidents inside their jurisdictions without outside assistance, some incidents will require more resources, both people and equipment, than are available. Should the local government be unable to supply the required resources, local Memorandums of Understanding (MOUs) may be activated. MOUs, in this case, are legal documents that outline the agreement for one local jurisdiction or private entity to supplement another local jurisdiction. Should the disaster require more resources than available through MOUs, an Intrastate Mutual Aid Compact (IMAC) may be activated if the state has one. These compacts are managed at the state level and allow for sharing of resources from all jurisdictions within a state.

In the event that a disaster grows to a level where an IMAC is insufficient to provide the required resources, the next stage is to make a request through the Emergency Management Assistance Compact (EMAC). The EMAC was ratified and signed into law (Public Law 104-321) in 1996. It offers assistance to states during governor-declared states of emergency by way of other states within the compact. All 50 states, the District of Colombia, Puerto Rico, Guam, and the US Virgin Islands have passed legislation to become an EMAC member. In order to receive assistance, the requesting EMAC member must follow the following process: 1) Develop internal procedures for implementing EMAC; 2) The governor of the state must declare a state of emergency; 3) Open the event in the online EMAC Operations System; 4) Request assistance, review offers to assist, and accept or decline the offers; 5) Receive mobilized resources from assisting state; 6) Review reimbursement package and reimburse the assisting state (Figure 1).
Figure 1. Overview of Emergency Management Assistance Compact Process. Figure obtained from: http://ema.ohio.gov/EMAC_Overview.aspx

Should the scale of a disaster be so large that it exceeds the available resources of the EMAC, the governor of an affected state may request federal assistance. This request comes in the form of a request that the President declare a major disaster. The governor of a state makes this request through the regional Federal Emergency Management Agency (FEMA) office. Accompanying this request (though occasionally completed after the request is made) is a document known as a preliminary disaster assessment (PDA). The PDA is created by state and federal officials and estimates the extent of damage caused to individuals and public facilities. In addition to the request, the governor must complete the following tasks:

- Execute the state’s emergency plan
- Provide information detailing the amount of local and state resources that have or will be allocated to the recovery effort
- Detail the amount and severity of damage caused
- Certify adherence to cost sharing requirements
- Estimate of the type and amount of assistance needed under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5206 (Stafford Act, 1988).
Based on the information provided, the President may choose to declare a major disaster or emergency. At this point, if a disaster or emergency is declared, federal assets may be activated to assist. On the medical response side, this step allows for the utilization of Disaster Medical Assistant Teams and other federalized health service personnel. Due to deficiencies in this system, several alternatives have been proposed to streamline medical response during disasters: these include the Pandemic and All-Hazards Preparedness Act (PAHPA), the Model State Emergency Health powers Act, the Nurse Licensure Compact, and the National Disaster Medical System.

**The Pandemic and All-Hazards Preparedness Act (PAHPA)**

The President signed the Pandemic and All-Hazards Preparedness Act (PAHPA) on December 19, 2006. The purpose of this act was to improve the federal government’s organization and effectiveness at dealing with emergencies. PAHPA gives the Assistant Secretary for Preparedness and Response (ASPR) responsibility over the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps (MRC).

The Medical Reserve Corps is a collection of volunteer local assets set up under the PAHPA in 2006. MRC volunteers are either health professionals or non-health professionals wishing to serve in an auxiliary or support capacity. For the context of this paper, a health professional is considered as any person who must maintain current certification or licensure to work in the field of physical or mental health. During times of a public health emergency, the Secretary of Health and Human Services has the authority to activate and deploy willing MRC members with the concurrence of the state, tribal, or local officials in the area of need. Also, during a public health emergency, the Secretary of Health and Human Services may appoint
individuals to serve as intermittent disaster-response personnel. Once appointed as intermittent disaster-response personnel, they are then granted the same protections as National Disaster Medical System (NDMS) personnel. NDMS personnel are temporary federal employees who may supplement the medical personnel of federal, state, tribal, or local governments. The NDMS will be discussed in more detail later.

Administrated by the Office of the Assistant Secretary for Preparedness and Response, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a national network of state-based systems. In this program, currently licensed and credentialed health professionals have their identities, licenses, credentials, accreditations, and hospital privileges verified in advance of a disaster. While a state based program, the Secretary of Health and Human Services may encourage (not require) states to extend legal authority for health professionals authorized in another state during times of a public health emergency (Public Health Security and Bioterrorism Preparedness and Response Act of 2002).

**The Model State Emergency Health Powers Act**

At the request of the Centers for Disease Control and Prevention (CDC), the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities drafted the Model State Emergency Health Powers Act. They identified that the power to act to protect public health was constitutionally given to the states; this act is aimed at state governments rather than federal. State officials questioned post event had many different responses as to the implementation of mutual aid and licensing concerns. One issue of primary concern was that, “Questions about liability for healthcare professionals were often answered by EMAC and state law, but a patchwork of regulations made answer to questions difficult in some cases.” Under article VI of the MSEHPA, the public health authority is given the power to waive licensing
requirements for healthcare personnel. By defining exactly who has this authority, MSEHPA answers one of the most prominent questions asked by state officials.

As of 2006, 38 states had passed bills or resolutions that included provisions from or related to MSEHPA. The MSEHPA was designed as a model law for all states to adopt. The measures it proposes were designed to give more power to state and local public health officials and allow for a rapid response to public health incidents. In a way, MSEHPA served as a common ground for public health law reform. Since model law is only intended to be used as a guide, states are permitted change the details as they see fit (Alden, 2005).

Even with a large (38 states) amount of support, the MSEHPA has received some significant criticism from policy analysts (Khan, 2010; Alden, 2005; Gostin, 2003). The criticism is based on two distinct factors: 1) States already have a broad amount of public health power and 2) MSEHPA grants state public health officials and governors “dictatorial powers.”

Among the provisions of the MSEHPA, the following were singled Khan (2010) noted the following as being especially problematic:

- A state Governor can unilaterally declare a public health emergency with no judicial oversight. The declaration allows the state to conscript health care providers and facilities indefinitely and against their will. It permits public health officers to coerce individuals to submit to examinations and forced treatment on penalty of being quarantined or criminally punished. It grants public health officials and those working under their authority broad immunity from liability, even for actions that cause permanent injury or death. Additionally, the MSEHPA authorizes the state public health authority to “waive any or all licensing requirements, permits, or fees as required by the State code and applicable orders, rules, or regulations for health care providers from other
jurisdictions to practice in this State” (p. 320-321).

While the MSEHPA pushed to grant greater power to public health officials in order to enhance their ability to combat emergencies, it did so without ensuring adequate oversight and accountability.

**Nurse Licensure Compact (NLC)**

The nurse licensure compact creates a system of automatic reciprocity for Registered Nurses (RNs) or Licensed Practical/Vocational Nurses (LPN/VN). The NLC was signed into law by its first participating states (Maryland, Texas, Utah, and Wisconsin) on 1 January 2000. There are currently 24 states participating in the compact (Figure 2). The model law that states must pass in order to join may be found in Appendix B.

![Figure 2. Map of states participating in the Nurse Licensure Compact. (National Council of State Boards of Nursing [NCSBN], 2012)](image)

As stated, the system is completely automatic; there are no additional applications or fees required for a nurse to join the compact (Miracle, 2007). A nurse, whose primary residence is in...
one of the participating states and has a valid nursing license in that state, is issued a compact (multi-state) license. This license allows the nurse to practice medicine, both physically and electronically, in any participating state without having to apply for a license in that individual state. When practicing medicine in a remote state (a state within the compact other than the nurses home state), the nurse is responsible for following the remote states practice laws (NCSBN, 2012).

The NLC system is highly advantageous to nurses, allowing them to work in multiple states without the hassle or cost of seeking licensure in each state they wish to practice medicine. The downside to the NLC system is that a nurse need only meet the minimum requirements to obtain an RN or LPN/VN license in their home state. Since some states have more stringent requirements than others, some states have resisted joining the compact for fear of harm to the public. The state of Ohio has listed the following reasons for delaying the introduction of legislation that would permit Ohio to join the NLC: 1) Lack of criminal background checks in all participating states; 2) Lack of absolute bars to licensure due to the commission of certain crimes; 3) Issues involving investigation of misconduct across state lines and communication of ongoing investigations between participating states. Due to these issues, the Ohio Board of Nursing is working with the National Council of State Boards of Nursing to ensure that the statutory and regulatory standards of the state of Ohio are met by the NLC before it seeks participation in the compact (Ohio Board of Nursing, 2012).

National Disaster Medical System

The National Disaster Medical System (NDMS) is a federally coordinated program designed to temporarily supplement the medical infrastructure of federal, state, tribal, or local governments. The NDMS was created in 1983 by executive order and now derives authority
from 42 USC § 300. The NDMS is made up of four distinct team types: Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, International Surgical, Medical Response Teams, and National Veterinary Medical Response Teams. Of these, Disaster Medical Assistance Teams (DMATs) are the only ones that deal with the treatment of sick/injured humans in the United States. Accordingly, the scope of NDMS teams being reviewed has been limited to DMATs.

DMATs are designed to be rapid-response elements, providing medical care in disaster areas until other federal or contracted medical services can be attained. They are intended to be self-sufficient for 72 hours without resupply and are deployed in two-week periods. DMATs are organized by a local sponsor and are a way to organize local medical resources. All members of a DMAT team are volunteers, commit to no specific length of time, and may resign at any time. In the event a DMAT is activated, its members become temporary federal employees. Due to their paid federal employment status, the professional licenses of these individuals are recognized by all states. Additionally, federal status provides liability protection under the Federal Tort Claims Act. The NDMS falls under the direction of the Assistant Secretary for Preparedness and Response.

**The Pandemic and All-Hazards Preparedness Act: Improving Public Health Emergency Response**

Since the terrorist attacks in 2001, emergency preparedness and response have been major goals in the United States. After hurricane Katrina, emergency preparedness and response plans were implemented and the limitations of these plans were seen. The presiding issues were that the plans did not have the authority of law (were not legally enforceable), lacked consistency, and broke down when implemented (Hodge, Gostin, & Vernick, 2007). In the area
of health care during emergency response, the ability to meet “surge capacity” was singled out as priority concern of all levels of government and within the private sector. Surge capacity refers to the ability to care for the mass influx of patients after a disaster. Part of meeting surge capacity is having enough qualified, licensed medical personnel. During the relief effort post-Hurricane Katrina, thousands of healthcare professionals faced the potential of legal liability issues due to varying laws, how they were deployed, and existing employment (Hodge, 2006). Confusion over liability issues deterred the deployment of and minimized the usefulness of highly skilled medical personnel (Hodge et al., 2007). These issues hampered the effectiveness of medical responders to the point that both medical and non-medical organizations called for national legislative reforms. Congress responded by attempting to pass the Hurricane Katrina Emergency Health Workforce Act and the Give Act. Both acts had the goal of reducing the liability exposure of volunteers, but neither act was passed. Subsequently, in 2007 the National Conference of Commissioners on Uniform State Laws prepared the Uniform Emergency Volunteer Health Practitioners Act (UEAHPA), which aimed to provide automatic license reciprocity and additional protections for volunteers at the state level. As of December 2012, only 13 states and the District of Columbia have enacted UEAHPA legislation, with the most recent adoption occurring by Nevada in 2011. Another option that has been posited is the idea of expanding the scope under which states “Good Samaritan” laws operate (North Carolina Institute of Public Health [NCIPH], 2009).

The Law and Emergencies: Surveillance for Public Health–Related Legal Issues During Hurricanes Katrina and Rita

Several legal issues arose in the aftermath of hurricanes Rita and Katrina. In order to study these issues, a study based upon a CDC public health surveillance study was devised. This
study found that legal issues faced by medical volunteers were significant. Issues stemmed from confusion surrounding legal liability and medical licensing once volunteers crossed state lines. This study specifically found that medical personnel were stopped by Mississippi government officials due to licensure concerns, had to deal with issues of prescription writing by out of state physicians, and trying to manage volunteers not dispatched by their home states and therefore not covered under the liability of the Emergency Management Assistance Compact (EMAC). Officials were found to have stated that the EMAC seemed to work well (or at least did not cause issues), but also identified several different methods used to address licensure concerns (Weiss, 2007).

In addition to the current process and proposed alternatives to medical licensing, two articles specifically discussing deficiencies in medical licensing were reviewed. These articles are particularly helpful in identifying the shortcomings of the current system and were used to identify criteria for grading alternatives.

**Physician Licensure During Disasters: A National Survey of State Medical Boards**

Following Hurricane Katrina, approximately 4500 physicians were displaced and only three of nine acute care hospitals remained open (Rudowitz, Rowland, & Shartzer, 2006). In response to this collapse of healthcare infrastructure, many out-of-state physician volunteers responded to help. Many of the volunteers did not maintain professional licensure in the states they were providing medical services in and were essentially practicing medicine without a license. By assisting, these volunteers had placed themselves at risk for civil/criminal penalties (Boyajian-O'Neil, Gronewold, Claros, & Elmore, 2008). It wasn’t until 12 days after Hurricane Katrina that Governor Kathleen Blanco issued an executive order that suspended normal licensing procedures, provided license reciprocity, and recognized volunteer physicians as agents
of the state of Louisiana for the purpose of tort liability.

In order to study the physician licensure policies of each state during disasters, a survey was given to the director of each state's (and the District of Colombia) medical board. The responses showed that 18 states had no exemption or expedited licensure process, 13 offered an expedited license process, and 19 states plus the District of Colombia offered exemption.

Licensure has been recognized as a serious issue for volunteer physicians. Physicians “federalized” with the US Public Health Service or through Disaster Medical Assistance Teams do not require state licensure and the Emergency Management Assistance Compact covers agents of the state, but neither addresses the concerns of private-sector physicians. Other strategies that may assist in licensing concerns are the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). The UEVHPA is a legislative guide on how to handle licensing of medical professionals during a disaster. The ESAR-VHP provides a way for states to verify licensures and credentials but has no provision that allows for license portability. This study shows that 35% of states have no policy in place for accelerated licensure in the event of a disaster, which may result in ineffective medical care in the wake of a disaster (Boyajian-O'Neil et al., 2008).

**Disaster Medical Response**

In the post disaster environment, physicians may provide the greatest benefit when acting as part of an organized response team (Campos-Outcalt, 2006). The two major concerns after a large-scale disaster are the immediate loss of life/associated injuries and threats to health that come from disruption of local infrastructure and relocation of large portions of the population. Continuing threats to health include epidemics that stem from overcrowding in shelters, water
supply issues, and poor sanitation. These health threats fall under the category of public health and require the re-establishment of public health surveillance systems to detect, track, and respond to outbreaks. With this in mind, volunteer physicians trained in disaster medicine and public health provide the most effective skillset. Additionally, mental health professionals provide a needed skill as survivors cope with post-traumatic stress and grief issues. Ultimately, for physicians to provide the most valuable skills, they should be trained in disaster medicine and public health, volunteer as part of an organized response, and understand the importance of re-establishing infrastructure in the affected area (Campos-Outcalt, 2006).

The greatest downfall of the current system is that it consists of a patchwork of measures. Six distinctly different programs (EMAC, DMAT, NLC, UEAHPA, MSEHPA, and ESAR-VHP) that attempt to deal with the issue of medical licensing have been reviewed. In addition to these programs, countless numbers of Memorandums of Understanding exist within and between states that also attempt to resolve licensing issues. This study has also identified several authorities (US Public Health, State Public Health, State Medical Boards, Emergency Management Officials, Governors, State Legislature, and the Assistant Secretary for Preparedness and Response) that have some authority over medical licensing. Issues that arise during a disaster are often solved post-event; however, the trend is to produce solutions with little regard for standardization among the states. This results in vastly different procedures that must be followed depending on the state requiring aid. As seen after Hurricane Katrina, the confusion created due to this patchwork of laws and authority can prevent medical professionals from being effectively used as volunteers.
**Methods**

In order to evaluate the potential effects of changing the professional medical licensing system as it applies to emergency response, four alternatives will be compared. This comparison will be based on the eightfold path for policy analysis (Bardach, 2005). Bardach’s process was selected due to the systematic nature of the analysis. By breaking the process down into individual steps, measures can be taken to avoid the common mistakes made when performing a policy analysis. In particular this process focuses on 1) appropriately identifying the question, 2) researching, 3) constructing alternatives, 4) selecting comparison criteria, 5) projecting the outcomes, 6) confronting the trade-offs, 7) deciding, and 8) and telling the story. For these reasons, Bardach’s approach to policy analysis is best suited to graduate level policy analysis projects (Opollo, 2009).

A series of tables will be used to visually represent the comparison of alternatives. An explanation of each alternative will be provided in the data analysis section as a way to differentiate the options.

Table 1 describes the criteria selected to evaluate health professional licensing concerns. The criteria include applicability to government personnel, applicability to private medical personnel, automaticity during emergencies, automaticity of enrollment, financial acceptability, political acceptability, and the ability to offer a singular solution. These were selected in response to concerns raised in reviewed articles or recommendations directly made by reviewed articles.
Table 1

*Descriptions of Criteria used to Evaluate Health Professional Licensing Alternatives*

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Desired Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Government (state/tribal/local) Medical Personnel</td>
<td>The solution should apply to agents of the state/tribal/local government.</td>
</tr>
<tr>
<td>Applies to Private Medical Personnel</td>
<td>The solution should apply to non-governmental medical personnel.</td>
</tr>
<tr>
<td>Automaticity During Emergency</td>
<td>In the event of an emergency, the solution should go into effect without the need for any political process.</td>
</tr>
<tr>
<td>Automaticity of Enrollment</td>
<td>No action in addition to the normal licensing process should be required of an individual.</td>
</tr>
<tr>
<td>Financial Acceptability</td>
<td>The required funding to implement a solution should not be excessive.</td>
</tr>
<tr>
<td>Political Acceptability</td>
<td>The solution should be politically feasible.</td>
</tr>
<tr>
<td>Singular Solution</td>
<td>Due to the confusion experienced during past disasters, solutions should present a single, uniform solution to medical licensing.</td>
</tr>
</tbody>
</table>

Table 2 provides the scoring rubric used to assign grades based on each of the criteria. Scoring is based on whether a policy alternative does not meet the criteria, meets the criteria conditionally, or completely meets the criteria. A maximum of five points (three points in the case of applicability to government or applicability to private medical personnel) are given to policy alternatives that achieve the desired outcome.
### Table 2

**Scoring Rubric for Health Professional Licensing Alternatives**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Government (state/tribal/local) Medical Personnel</td>
<td>0: Does not apply to government personnel</td>
</tr>
<tr>
<td></td>
<td>1: Applies situationally to government personnel</td>
</tr>
<tr>
<td></td>
<td>3: Applies to all government personnel</td>
</tr>
<tr>
<td>Applies to Private Medical Personnel</td>
<td>0: Does not apply to private medical personnel</td>
</tr>
<tr>
<td></td>
<td>1: Applies situationally to private medical personnel</td>
</tr>
<tr>
<td></td>
<td>3: Applies to all private medical personnel</td>
</tr>
<tr>
<td>Automaticity During Emergency</td>
<td>0: Requires activation by some political process</td>
</tr>
<tr>
<td></td>
<td>5: Requires no political action in order to implement</td>
</tr>
<tr>
<td>Automaticity of Enrollment</td>
<td>0: Health care personnel must take deliberate action in order to enroll</td>
</tr>
<tr>
<td></td>
<td>3: Some health care personnel enrolled with no additional process</td>
</tr>
<tr>
<td></td>
<td>5: All health care personnel enrolled with no additional process</td>
</tr>
<tr>
<td>Financial Acceptability</td>
<td>1: Solution will require additional funding to be implemented.</td>
</tr>
<tr>
<td></td>
<td>3: Solution requires no additional funding and does not reduce funding</td>
</tr>
<tr>
<td></td>
<td>required.</td>
</tr>
<tr>
<td></td>
<td>5: Solution reduces funding need.</td>
</tr>
<tr>
<td>Political Acceptability</td>
<td>1: Requires extensive changes to current law on a state and federal level</td>
</tr>
<tr>
<td></td>
<td>including adoption of new law</td>
</tr>
<tr>
<td></td>
<td>3: Requires minor changes to current state/federal laws</td>
</tr>
<tr>
<td></td>
<td>5: Requires no change to current laws or procedures</td>
</tr>
<tr>
<td>Singular Solution</td>
<td>0: Process varies from state to state</td>
</tr>
<tr>
<td></td>
<td>5: Solution provides a single process that may be followed for all states</td>
</tr>
</tbody>
</table>

*Note:* Higher numbers indicate the desired outcome.

Finally, a policy analysis matrix (Table 3) will be used to assign numerical grades and compare each alternative with its ability to achieve the desired outcome. Total scores range from a low of 12 points to a high of 25 points. Higher scores indicate a greater theoretical ability for an alternative to meet the objectives of the criteria.
Results and Data Analysis

Using information gathered during the literature review process, four alternatives to the status quo were determined. These alternatives were either directly selected from the literature or extensions of programs that were already being implemented. The four alternatives include: The Uniform Emergency Volunteer Health Practitioners act, licensure compacts (an extension of the nurse licensure compact), a National Licensing system, and an expansion of “Good Samaritan” laws. The following descriptions of each alternative form the constraints on which each is graded.

Status Quo

One option to address the issue of medical licensing is to take no remedial action. By taking no action, the United States is left with a system run by each individual state. Each state is free to determine the minimum licensing requirements, associated fees, maintaining records of currently licensed individuals, and handling any investigations concerning medical licensure. Individuals seeking licensure in one state must only meet the requirements of that state.

Individuals seeking licensure in multiple states may do so by applying for licensure in each state. Applying for licensure in a remote state includes paying the appropriate fees and completing requirements ranging from a simple request for reciprocity to fulfilling all requirements of a new licensure in that state. Two exceptions to this rule are: 1) Nurses in the nurse Licensure Compact and 2) Individuals activated as intermittent disaster-response personnel under the authority of the Secretary of Health and Human Services.

Uniform Emergency Volunteer Health Practitioners Act

Created after the 2005 hurricane season by the Uniform Law Commission, the Uniform Emergency Health Practitioners Act (UEVHPA) was designed to address the issue of uniformity
in state laws as it relates to healthcare practitioners. Current legislation allows for the interstate recognitions of medical licenses by the federal government or actors of another state under specific federally sponsored programs, but do not address volunteer health professionals that fall outside of these circumstances. The UEVHPA aims to fix this missing piece of legislation and allows all licensed health practitioners the opportunity to assist in a disaster. As of 31 January 2012, the UEVHPA has been enacted in 13 states plus the District of Columbia and US Virgin Islands and legislation has been introduced in two additional states (Figure 3).

Figure 3. Map of states that have enacted Uniform Emergency Health Practitioners Act legislation. (Uniform Law Commission, 2012)

This legislation stemmed from issues encountered after Hurricane Katrina in 2005. Due to the unplanned and dissimilar nature of the executive orders and directives issued from state to state, both volunteers and emergency relief organizations had difficulty understanding the requirements they needed to meet. This ineffective organization made communication and
coordination among volunteer, agencies, and the state difficult leading to delayed delivery of care.

The goal of the UEVHPA is to provide a framework that will create a clearly understood set of rules that will allow for the rapid deployment of healthcare volunteers. One requirement of the UEVHPA is that volunteers must register in advance or during a disaster. Registration may be completed through the Emergency System for Advance Registration of Volunteer Health Professionals, the Medical Reserve Corps, registration systems setup by disaster relief organizations, or systems created in coordination with licensing boards or health professionals. The basis of the UEVHPA is that registration with one of the above systems will streamline the process of verifying that a volunteers’ license is valid and in good standing. The licensing boards in host states are ultimately given authority over out-of-state volunteers working within their jurisdiction. Licensing boards are also required to report any disciplinary actions taken to the volunteers’ home state. In regards to scope of practice, any volunteers will be required to adhere to scope of practice of the state in which the emergency exists and may not exceed the scope of practice in their licensing state unless expressly authorized by the host state. The UEVHPA was amended in 2007 to include options for civil liability coverage and workers compensation for volunteers who may be involved in legal issues or be injured respectively (Uniform Law Commission, 2012).

Licensure Compacts

The nurse licensure compact has set an example for compacts for all medical professionals. The basis behind the compact is that each state adopts the model legislation. Once adopted, the state becomes a participating member of the compact. Once in the compact, each medical license issued by a member state becomes a multi-state license valid in any
compact state. In cases of disciplinary action, a compact state may revoke the right of a person to practice in that state but cannot take action directly against the person’s license. Action against a license must be completed by the declared home state. Enrollment in the compact for states is voluntary and once in the compact enrollment of health care professionals becomes automatic.

**Proposed National Licensing System**

In order for a national licensing system to work, two significant prerequisites must first be met. First, a national standard must be created. This has the benefit of standardizing training requirements, establishing a minimum licensure requirement, and defining a scope of practice across the nation. The downside to a national standard is its creation. Currently every state sets its own standards. The development of a single national standard that met the approval of all states would be a challenging and costly task. Fortunately, not all national standards must be created outright. Many health care licensures already have national examinations; Emergency Medical Technicians (EMTs) have the National Registry, Nurses the National Counsel Licensure Examination (NCLEX), and Doctors have the United States Medical Licensing Exam (USMLE).

Second, a national oversight organization would need to be created. This organization would be responsible for national testing, processing requests for licensure, keeping a database of licensures, and handling any investigations due to suspected misconduct concern a licensure. Being an oversight organization would allow implementation with little effect on the current state licensing systems. Each state would retain responsibility for the health care professionals within its borders, the change being the list of requirements the state must verify. Additionally, since no out of state applications will need to be processed, the workload on these organizations will be reduced, providing for possible cost savings.
The benefits of having a national licensing system include uniformity of training, requirements, and scope of practice. Additionally, medical professionals receive the benefit of a license that is valid across state lines and hospitals receive the benefit of knowing medical professionals from across the country are trained and certified to the same standards.

Expansion of Good Samaritan Laws

The Good Samaritan laws began with the passage of the first Good Samaritan statue in California. Good Samaritan laws vary widely from state to state, but all hold the idea of encouraging rapid assistance for emergency victims by alleviating the fear of legal liability for responders. One major concern with Good Samaritan laws is whether a responder has a duty to act. If a duty to act exists (such as for EMTs, police, and firemen) protections are generally provided by statutes other that then states Good Samaritan laws. Variations in the definition of an emergency, degree of physical assistance provided, duration of care, location of care, and even applicability to medical personnel change the relevance of Good Samaritan Laws to any given situation (Frieder, 2010).

In this context, expansion of Good Samaritan legislation would likely expand liability protection to those healthcare workers who volunteered to assist during or after a disaster in which they had no duty to act. It would also likely provide some legal grounds for Good Samaritans to be able to provide medical care without a license in the state in which the disaster occurred. These changes would keep the same general nature of the current laws with regards to different situations. In order to accomplish this, legislation would need to be changed in all states and territories. The trouble with simply expanding Good Samaritan legislation is that in many states this legislation does not cover those with a duty to act or for acts performed in a medical care facility. Due to these issues, Good Samaritan laws are not likely to apply to an
organized disaster response, but rather only to an individual providing immediate, temporary care post-disaster.

Each of these alternatives presents its own set of benefits and drawbacks. In order to compare the effectiveness of each, seven key criteria were identified. These criteria were selected either directly from the literature or as solutions to problems presented in the available literature. A policy analysis matrix was used to organize and compare the effectiveness of each alternative to the seven selected criteria (Table 3).

Table 3

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Status Quo</th>
<th>Uniform Emergency Volunteer Health Practitioners Act</th>
<th>National License Compact</th>
<th>National Medical Licensing</th>
<th>Expansion of Good Samaritan Laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to Government (State/tribal/local) Medical Personnel</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Applicable to Private Medical Personnel</td>
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<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Automaticity During Emergency</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Automaticity of Enrollment</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Financial Acceptability</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Political Acceptability</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Singular Solution</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>SCORING</td>
<td>12</td>
<td>13</td>
<td>22</td>
<td>25</td>
<td>17</td>
</tr>
</tbody>
</table>

Note: High scores indicate the desired outcome.

After careful consideration, grades were assigned to each alternative. These grades represent the extent to which the alternative achieves the desired outcome of each criterion (Table 2). In the category of applicability to government medical personnel, the status quo, a National License Compact, and National Medical Licensing received the maximum score (three) while the Uniform Emergency Volunteer Health Practitioners Act received the lowest score
The Uniform Emergency Volunteer Health Practitioners Act, National License Compact, and National Medical License all received the maximum score (three) for applicability to private medical personnel. National License Compacts, National Medical Licensing, and Expansion of Good Samaritan Laws received the maximum possible score (five) for Automaticity of Enrollment. The Uniform Emergency Volunteer Health Practitioners Act and Expansion of Good Samaritan Laws both received the maximum score (five) Financial Acceptability. The Status Quo, Uniform Emergency Volunteer Health Practitioners Act, and Expansion of Good Samaritan Laws received the maximum score (five) for Political Acceptability. Finally, National Medical Licensing was the only alternative to receive the maximum score (five) for being a Singular Solution.

The results of the policy analysis (Table 3) gave the status quo a score of 12. This benchmark indicates that any score greater than 12 signifies an anticipated improvement to the ability of health care professionals to respond post-disaster. The remaining alternatives scored from 13 to 25 points. The Uniform Emergency Health Practitioners Act and Expansion of Good Samaritan Laws received moderately increased scores, 13 and 17 respectively. The highest score, 25, was received by National Medical licensing with National License Compacts receiving slightly less with a score of 22. High scores represent an increased ability of each alternative to achieve the desired outcomes.

Discussion

After investigating the current medical licensing system, it is easy to see just how complicated it has become. The ideal solution to the current complexity would have several easily identifiable characterizes. In order to allow the largest number of medical personnel the opportunity to assist in relief efforts the solution would need to apply to both governmental and
private health care providers, as well as, requiring no additional action for a provider to enroll in the solution. One of the issues experienced in the past is confusion over whether or not medical personnel were legally eligible to provide medical care in a state where they were not licensed. This confusion stems from the conglomeration of state and federal laws that govern exceptions to medical licensing in the event of a disaster. In order to avoid confusion for volunteers, states, and disaster relief agencies, a single solution that can be implemented in all states and covers all health care personnel is ideal. Finally, we have to be concerned with the feasibility of implementing the solution. If a solution is too costly to implement, there will be resistance to approving it. Similarly if a solution is too politically controversial, there will be resistance to getting it approved.

Keeping all these aspects in mind, a policy analysis matrix was created. The criteria used in this matrix were developed from the literature review and were applied to grading five distinct policy options: The Status Quo, the Uniform Emergency Volunteer Health Practitioners Act, National License Compact, National Medical Licensing, and Expansion of Good Samaritan Laws.

The Status Quo received the maximum score for Political Acceptability and Applicability to Government Personnel; intermediate scores for Applicability to Private Medical Personnel and Financial Acceptability; and the minimum score for Automaticity of during an Emergency, Automaticity of Enrollment, and being a Singular Solution. The Uniform Emergency Volunteer Health Practitioners Act received the maximum score for Applicability to Private Medical Personnel, Political Acceptability and Financial Acceptability; no intermediate scores; and the minimum score for Applicability to government officials, Automaticity of during an Emergency, Automaticity of Enrollment, and being a Singular Solution. National License Compacts received
the maximum score for Applicability to government officials, Applicability to Private Medical Personnel, Automaticity of during an Emergency, and Automaticity of Enrollment; intermediate scores for Political Acceptability and Financial Acceptability; and the minimum score for, and being a Singular Solution. National Medical Licensing received the maximum score for Applicability to government officials, Applicability to Private Medical Personnel, Automaticity of during an Emergency, Automaticity of Enrollment, and being a Singular Solution; intermediate scores for Financial Acceptability; and the minimum score for Political Acceptability. Expansion of Good Samaritan Laws received the maximum score for Automaticity of during an Emergency, Political Acceptability, and Financial Acceptability; intermediate scores for Applicability to government officials and Applicability to Private Medical Personnel; and the minimum score for Automaticity of Enrollment and being a Singular Solution. The results from lowest to highest score were: The Status Quo with 12 points, Uniform Emergency Volunteer Health Practitioners Act with 13 points, Expansion of Good Samaritan Laws with 17 points, National License Compacts with 22 points, and National Medical Licensing System with 25 points.

The highest rated option given these criteria was a National Licensing System. National medical licensing received the highest possible score in all but two criteria: Financial and Political Acceptability. National Medical Licensing was the only option to meet the requirements of being a Singular Solution. In regards to Financial Acceptability, it is likely to pose little to no additional cost and presents an option to reduce costs. If such a program is selected, it is recommended that all health care licensing be consolidated into one organization. Rather than maintaining an individual organization for doctors, nurses, EMTs, etc. they could be consolidated to improve efficiency and reduce costs. Political Feasibility is the only area in
which National Medical Licensing received a lower grade that the current system. This is due to
the need to take the responsibility for establishing minimum requirements away from individual
states and place it under the purview of the federal government. Additionally, there is the task of
coordinating with all states in order to establish minimum requirements that meet the approval of
all involved. Should standardization be accomplished however, it would theoretically increase
the efficiency and effectiveness of disaster medical responders across the country. This would
result in more lives saved, more patients treated, reduced man-hours, reduced cost, and a more
rapid return to pre-disaster conditions.

While not a primary concern of this study, a national licensing system would also have an
effect during the daily job of many health care workers. It is particularly helpful to those
working in the telemedicine field, as it would affect their everyday job. Additionally, it would
provide benefits for those working in Air Medical Services and other patient transport services
that may be required to cross state lines while providing care and to wilderness rescue teams that
may find themselves performing rescues with members of several states or crossing state
boundaries in order to complete a rescue.

The results of this study are limited by several factors. First, a policy analysis is
inherently biased due to the assignment of value to various criteria. In order to minimize this
bias, a thorough literature review was conducted and details concerning how scoring was
performed were included. Second, while a comprehensive literature review was conducted, there
are a relatively few number of articles that deal directly with the effect of medical licensing on
disaster response. Finally, it is difficult to discern the extent to which medical licensing effects
disaster response. This is because many medical professionals choose not to assist due to
perceived issues with the system. Therefore, the magnitude of any changes to medical licensure
policy cannot be fully understood without further study.

This study suggests that in order to maximize the number of available health care professionals available during the event of a large-scale disaster a national licensing system for healthcare workers be implemented. In order to move forward with such an option additional studies should be conducted to determine more precisely the financial and political feasibility of such a program as well as a study determining exactly how a national licensing system would be designed and implemented.
References


Zibulewsky, J. (2000). Defining disaster: The emergency department perspective. *Proceedings (Baylor University Medical Center), 14*(2), 144-149.
Appendices

Appendix A – Acronyms

CDC  Centers for Disease Control and Prevention
DMAT  Disaster Medical Assistance Team
EMAC  Emergency Management Assistance Compact
EMS  Emergency Medical Services
EOC  Emergency Operations Center
ESAR-VHP  Emergency System for Advance Registration of Volunteer Health Professionals
FEMA  Federal Emergency Management Agency
IC  Incident Commander
ICS  Incident Command System
IMAC  Intrastate Mutual Aid Compact
LPN  Licensed Practical Nurse
MOU  Memorandum of Understanding
MRC  Medical Reserve Corps
MSEHPA  Model State Emergency Health Powers Act
NDMS  National Disaster Medical System
NLC  Nurse Licensure Compact
PAPHA  Pandemic and All-Hazards Preparedness Act
RN  Registered Nurse
UEAHPA  Uniform Emergency Volunteer Health Practitioners Act
VN  Vocational Nurse
Appendix B – Nurse Licensure Compact Model Law (NCSBN, 2013)

Adopted as model law on November 6, 1998

ARTICLE I
Findings and Declaration of Purpose
a. The party states find that:
   1. the health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
   2. violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
   3. the expanded mobility of nurses and the use of advanced communication technologies as part of our nation's healthcare delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
   4. new practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;
   5. the current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant to both nurses and states.
b. The general purposes of this Compact are to:
   1. facilitate the states' responsibility to protect the public's health and safety;
   2. ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
   3. facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;
   4. promote compliance with the laws governing the practice of nursing in each jurisdiction;
   5. invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

ARTICLE II
Definitions
As used in this Compact:
a. "Adverse Action" means a home or remote state action.
b. "Alternative program" means a voluntary, non-disciplinary monitoring program approved by a nurse licensing board.
c. "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws, which is administered by a non-profit organization composed of and controlled by state nurse licensing boards.
d. "Current significant investigative information" means: investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.
e. "Home state" means the party state which is the nurse's primary state of residence.
f. "Home state action" means any administrative, civil, equitable or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.
g. "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.
h. "Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical/vocational nurse in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.
i. "Nurse" means a registered nurse or licensed practical/vocational nurse, as those terms are defined by each party's state practice laws.
j. "Party state" means any state that has adopted this Compact.
k. "Remote state" means a party state, other than the home state, where the patient is located at the time nursing care is provided, or, in the case of the practice of nursing not involving a patient, in such party state where the recipient of nursing practice is located.
l. "Remote state action" means any administrative, civil, equitable or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state, and cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.
m. "State" means a state, territory, or possession of the United States, the District of Columbia.
n. "State practice laws" means those individual party's state laws and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline.
o. "State practice laws" does not include the initial qualifications for licensure or requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE III
General Provisions and Jurisdiction

a. A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical/vocational nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.
b. Party states may, in accordance with state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.
c. Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.
d. This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advanced practice registered nurse authorization.
e. Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

ARTICLE IV
Applications for Licensure in a Party State

a. Upon application for a license, the licensing board in a party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any restrictions on the multistate licensure privilege, and whether any other adverse action by any state has been taken against the license.
b. A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.
c. A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of such change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.
d. When a nurse changes primary state of residence by:
1. moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;
2. moving from a non-party state to a party state, and obtains a license from the new home state, the individual state license issued by the non-party state is not affected and will remain in full force if so provided by the laws of the non-party state;
3. moving from a party state to a non-party state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

**ARTICLE V**

**Adverse Actions**

In addition to the General Provisions described in Article III, the following provisions apply:

a. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report any significant current investigatory information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.

b. The licensing board of a party state shall have the authority to complete any pending investigations for a nurse who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate action(s), and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

c. A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.

d. For purposes of imposing adverse action, the licensing board of the home state shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, it shall apply its own state laws to determine appropriate action.

e. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.

f. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state's laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.

**ARTICLE VI**

**Additional Authorities Invested in Party State Nurse Licensing Boards**

Notwithstanding any other powers, party state nurse licensing boards shall have the authority to:

a. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse;

b. Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

c. Issue cease and desist orders to limit or revoke a nurse's authority to practice in their state;

d. Promulgate uniform rules and regulations as provided for in Article VIII(c).

**ARTICLE VII**

**Coordinated Licensure Information System**

a. All party states shall participate in a cooperative effort to create a coordinated data base of all licensed registered nurses and licensed practical/vocational nurses. This system will include information on the
licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.

b. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.

c. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.

d. Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

e. Any personally identifiable information obtained by a party states’ licensing board from the coordinated licensure information system may not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

f. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information, shall also be expunged from the coordinated licensure information system.

g. The Compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

ARTICLE VIII
Compact Administration and Interchange of Information

a. The head of the nurse licensing board, or his/her designee, of each party state shall be the administrator of this Compact for his/her state.

b. The Compact administrator of each party state shall furnish to the Compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this Compact.

c. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states, under the authority invested under Article VI (d).

ARTICLE IX
Immunity

No party state or the officers or employees or agents of a party state's nurse licensing board who acts in accordance with the provisions of this Compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this Compact. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

ARTICLE X
Entry into Force, Withdrawal and Amendment

a. This Compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.

b. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the Compact of any report of adverse action occurring prior to the withdrawal.

c. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

d. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.
ARTICLE XI
Construction and Severability

a. This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

b. In the event party states find a need for settling disputes arising under this Compact:
   1. The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the Compact administrator in the home state; an individual appointed by the Compact administrator in the remote state(s) involved; and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
   2. The decision of a majority of the arbitrators shall be final and binding.

Optional Enabling Language

Optional enabling act provisions may be appropriate for states to utilize when looking to enact the NLC into law depending on the needs of the state.

1. The Nurse Licensure Compact is hereby enacted and entered into with all other jurisdictions that legally join in the compact, which is, in form, substantially as follows:
2. "The head of the nurse licensing board" as used to define the compact administrator in Article VIII(a) shall mean xxxxxxx.
3. To facilitate cross-state enforcement efforts, the legislature finds that it is necessary for [this state] to have the power to recover from the affected nurse the costs of investigations and disposition of cases resulting from adverse actions taken by this state against that nurse. Coordinating language shall be inserted in the appropriate location in the Nurse Practice Act.
4. This Compact is designed to facilitate the regulation of nurses, and does not relieve employers from complying with statutorily imposed obligations.
5. This Compact does not supersede existing state labor laws.
6. To facilitate workforce planning, the legislature finds it necessary for [this state] to grant the board of nursing the authority to collect employment data on nurses practicing on the multi-privilege in the NLC, on a provided form, provided that the submission of this data is not a requirement for practice under the multi-state privilege.

Nurse Licensure Compact (NLC) Model Rules and Regulations for RNs and LPN/VNs

Article 6D and 8C of the Nurse Licensure Compact grant authority to the Compact Administrators to develop uniform rules to facilitate and coordinate implementation of the Compact.

As Amended August 4, 2008

1. Definition of terms in the Compact.

For the Purpose of the Compact:
   a. "Board" means party state's regulatory body responsible for issuing nurse licenses.
   b. "Information system" means the coordinated licensure information system.
   c. "Primary state of residence" means the state of a person's declared fixed permanent and principal home for legal purposes; domicile.
   d. "Public" means any individual or entity other than designated staff or representatives of party state Boards or the National Council of State Boards of Nursing, Inc.

Other terms used in these rules are to be defined as in the Interstate Compact.

2. Issuance of a license by a Compact party state.

For the purpose of this Compact:
a. As of July 1, 2005, no applicant for initial licensure will be issued a compact license granting a multi-state privilege to practice unless the applicant first obtains a passing score on the applicable NCLEX examination or its predecessor examination used for licensure.

b. A nurse applying for a license in a home party state shall produce evidence of the nurse's primary state of residence. Such evidence shall include a declaration signed by the licensee. Further evidence that may be requested may include but is not limited to:
   i. Driver's license with a home address;
   ii. Voter registration card displaying a home address;
   iii. Federal income tax return declaring the primary state of residence.
   iv. Military Form no. 2058 - state of legal residence certificate; or
   v. W2 from US Government or any bureau, division or agency thereof indicating the declared state of residence.
   (Statutory basis: Articles 2E, 4C, and 4D)

c. A nurse on a visa from another country applying for licensure in a party state may declare either the country of origin or the party state as the primary state of residence. If the foreign country is declared the primary state of residence, a single state license will be issued by the party state. (Statutory basis: Article 3E)

d. A licensee issued by a party state is valid for practice in all other party states unless clearly designated as valid only in the state which issued the license. (Statutory basis: Article 3A and 3B)

e. When a party state issued a license authorizing practice only in that state and not authorizing practice in other party states (i.e. a single state license), the license shall be clearly marked with words indicating that it is valid only in the state of issuance. (Statutory basis: Article 3A, 3B, and 3E)

f. A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multi-state licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed thirty (30) days. (Statutory basis: Articles 4B, 4C, and 4D[1])

g. The licensure application in the new home state of a nurse under pending investigation by the former home state shall be held in abeyance and the thirty-(30) day period in section 2f shall be stayed until resolution of the pending investigation.
   (Statutory basis: Article 5[B])

h. The former home state license shall no longer be valid upon the issuance of a new home state license.
   (Statutory basis: Article 4D[1])

i. If a decision is made by the new home state denying licensure, the new home state shall notify the former home state within ten (10) business days and the former home state may take action in accordance with that state's laws and rules.

3. Limitations on multi-state licensure privilege - Discipline.

a. Home state Boards shall include in all licensure disciplinary orders and/or agreements that limit practice and/or require monitoring the requirement that the licensee subject to said order and/or agreement will agree to limit the licensee's practice to the home state during the pendency of the disciplinary order and/or agreement. This requirement may, in the alternative, allow the nurse to practice in other party states with prior written authorization from both the home state and such other party state Boards. (Statutory basis: State statute)

b. An individual who had a license which was surrendered, revoked, suspended, or an application denied for cause in a prior state of primary residence, may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state(s) of adverse action. Once eligible for licensure in the prior state(s), a multistate license may be issued.

4. Information System.

a. Levels of access
   i. The Public shall have access to nurse licensure information limited to:
      a. the nurse's name,
      b. jurisdiction(s) of licensure,
      c. license expiration date(s),
      d. licensure classification(s) and status(es),
e. public emergency and final disciplinary actions, as defined by contributing state authority, and
f. the status of multi-state licensure privileges.

ii. Non-party state Boards shall have access to all Information System data except current significant investigative information and other information as limited by contributing party state authority.

iii. Party state Boards shall have access to all Information System data contributed by the party states and other information as limited by contributing non-party state authority. 
(Statutory basis: 7G)

b. The licensee may request in writing to the home state Board to review the data relating to the licensee in the Information System. In the event a licensee asserts that any data relating to him or her is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The Board shall verify and within ten (10) business days correct inaccurate data to the Information System.
(Statutory basis: 7G)

c. The Board shall report to the Information System within ten (10) business days
i. disciplinary action, agreement or order requiring participation in alternative programs or which limit practice or require monitoring (except agreements and orders relating to participation in alternative programs required to remain nonpublic by contributing state authority),
ii. dismissal of complaint, and
iii. changes in status of disciplinary action, or licensure encumbrance.
(Statutory basis: 7B)

d. Current significant investigative information shall be deleted from the Information System within ten (10) business days upon report of disciplinary action, agreement or order requiring participation in alternative programs or agreements which limit practice or require monitoring or dismissal of a complaint. (Statutory basis: 7B, 7F)

e. Changes to licensure information in the Information System shall be completed within ten (10) business days upon notification by a Board. (Statutory basis: 7B, 7F)
Appendix C – Uniform Emergency Volunteer Health Practitioners Act

UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT
(Last Revised or Amended in 2007)

drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS ONE-HUNDRED-AND-SIXTEENTH YEAR
PASADENA, CALIFORNIA

July 27 – August 3, 2007

WITHOUT PREFATORY NOTE OR COMMENTS

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By
NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
Uniform Emergency Volunteer Health Practitioners Act

Drafted by:
Uniform Law Commission (ULC), 211 E. Ontario Street, Suite 1300, Chicago, IL 60611
312-915-0195, www.nccusl.org

Brief description of act:
The Uniform Emergency Volunteer Health Practitioners Act (UEVHPA) provides a state with a procedure for recognizing another state's licenses for healthcare practitioners who volunteer to provide assistance for the duration of an emergency requiring substantial health care assistance. UEVHPA was prompted by the difficulties during the 2005 hurricane season on the gulf coast. Many health care practitioners (doctors, nurses, veterinarians, for example) from other states volunteered services, but were denied the opportunity or were delayed because they were not initially licensed in the disaster states. Federal provisions for interstate cooperation do not reach to most private practitioners. UEVHPA calls for the creation of a registration system which out-of-state practitioners may use either before or during a disaster. The system may coincide with existing federal/state systems. Upon registration, practitioners are expressly allowed to contribute their professional skills to existing organized disaster efforts. UEVHPA was amended in 2007 to address the issues of workers' compensation coverage and protection from some aspects of civil liability.

Questions about UEVHPA?
For further information contact the following persons:
Michael Kerr, ULC Legislative Director: 312-915-0195, michael.kerr@nccusl.org
Raymond P. Pepe, Chair of the UEVHPA drafting committee: rpepe@klng.com

Notes about ULC Acts:
For information on the specific drafting rules used by the ULC, the ULC Procedural and Drafting Manual is available online at www.nccusl.org.

Because these are uniform acts, it is important to keep the numbering sequence intact while drafting.

In general, the use of bracketed language in ULC acts indicates that a choice must be made between alternate bracketed language, or that specific language must be inserted into the empty brackets. For example: “An athlete agent who violates Section 14 is guilty of a [misdemeanor] [felony] and, upon conviction, is punishable by [ ].”

A word, number, or phrase, or even an entire section, may be placed in brackets to indicate that the bracketed language is suggested but may be changed to conform to state usage or requirements, or to indicate that the entire section is optional. For example: “An applicant for registration shall submit an application for registration to the [Secretary of State] in a form prescribed by the [Secretary of State]. [An application filed under this section is a public record.] The application must be in the name of an individual, and, except as otherwise provided in subsection (b), signed or otherwise authenticated by the applicant under penalty of perjury.”

The sponsor may need to be consulted when dealing with bracketed language.
UNIFORM EMERGENCY VOLUNTEER HEALTH PRACTITIONERS ACT

SECTION 1. SHORT TITLE. This [act] may be cited as the Uniform Emergency Volunteer Health Practitioners Act.

SECTION 2. DEFINITIONS. In this [act]:

(1) "Disaster relief organization" means an entity that provides emergency or disaster relief services that include health or veterinary services provided by volunteer health practitioners and that:

(A) is designated or recognized as a provider of those services pursuant to a disaster response and recovery plan adopted by an agency of the federal government or [name of appropriate governmental agency or agencies]; or

(B) regularly plans and conducts its activities in coordination with an agency of the federal government or [name of appropriate governmental agency or agencies].

(2) "Emergency" means an event or condition that is an [emergency, disaster, or public health emergency] under [designate the appropriate laws of this state, a political subdivision of this state, or a municipality or other local government within this state].

(3) "Emergency declaration" means a declaration of emergency issued by a person authorized to do so under the laws of this state [a political subdivision of this state, or a municipality or other local government within this state].

(4) "Emergency Management Assistance Compact" means the interstate compact approved by Congress by Public Law No. 104-321, 110 Stat. 3877 [cite state statute, if any].

(5) "Entity" means a person other than an individual.

(6) "Health facility" means an entity licensed under the laws of this or another state to provide health or veterinary services.

(7) "Health practitioner" means an individual licensed under the laws of this or another state to provide health or veterinary services.

(8) "Health services" means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of individuals or human populations, to the extent necessary to respond to an emergency, including:

(A) the following, concerning the physical or mental condition or functional status of an individual or affecting the structure or function of the body:

(i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care; and

(ii) counseling, assessment, procedures, or other services;

(B) sale or dispensing of a drug, a device, equipment, or another item to an individual in accordance with a prescription; and

(C) funeral, cremation, cemetery, or other mortuary services.

(9) "Host entity" means an entity operating in this state which uses volunteer health practitioners to respond to an emergency.

(10) "License" means authorization by a state to engage in health or veterinary services that are unlawful without the authorization. The term includes authorization under the laws of this state to an individual to provide health or veterinary services based upon a national certification issued by a public or private entity.
(11) “Person” means an individual, corporation, business trust, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(12) “Scope of practice” means the extent of the authorization to provide health or veterinary services granted to a health practitioner by a license issued to the practitioner in the state in which the principal part of the practitioner’s services are rendered, including any conditions imposed by the licensing authority.

(13) “State” means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(14) “Veterinary services” means the provision of treatment, care, advice or guidance, or other services, or supplies, related to the health or death of an animal or to animal populations, to the extent necessary to respond to an emergency, including:

(A) diagnosis, treatment, or prevention of an animal disease, injury, or other physical or mental condition by the prescription, administration, or dispensing of vaccine, medicine, surgery, or therapy;

(B) use of a procedure for reproductive management; and

(C) monitoring and treatment of animal populations for diseases that have spread or demonstrate the potential to spread to humans.

(15) “Volunteer health practitioner” means a health practitioner who provides health or veterinary services, whether or not the practitioner receives compensation for those services. The term does not include a practitioner who receives compensation pursuant to a preexisting employment relationship with a host entity or affiliate which requires the practitioner to provide health services in this state, unless the practitioner is not a resident of this state and is employed by a disaster relief organization providing services in this state while an emergency declaration is in effect.

Legislative Note: Definition of “emergency”: The terms “emergency,” “disaster,” and “public health emergency” are the most commonly used terms to describe the circumstances that may lead to the issuance of an emergency declaration referred to in this [act]. States that use other terminology should insert the appropriate terminology into the first set of brackets. The second set of brackets should contain references to the specific statutes pursuant to which emergencies are declared by the state or political subdivisions, municipalities, or local governments within the state.

Definition of “emergency declaration”: The references to declarations issued by political subdivisions, municipalities or local governments should be used in states in which these entities are authorized to issue emergency declarations.

Definition of “state”: A state may expand the reach of this [act] by defining this term to include a foreign country, political subdivision of a foreign country, or Indian tribe or nation.

SECTION 3. APPLICABILITY TO VOLUNTEER HEALTH PRACTITIONERS. This [act] applies to volunteer health practitioners registered with a registration system that complies with Section 5 and who provide health or veterinary services in this state for a host entity while an emergency declaration is in effect.

SECTION 4. REGULATION OF SERVICES DURING EMERGENCY.

(a) While an emergency declaration is in effect, [name of appropriate governmental agency or agencies] may limit, restrict, or otherwise regulate:

(1) the duration of practice by volunteer health practitioners;
(2) the geographical areas in which volunteer health practitioners may practice;

(3) the types of volunteer health practitioners who may practice; and

(4) any other matters necessary to coordinate effectively the provision of health or veterinary services during the emergency.

(b) An order issued pursuant to subsection (a) may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].

(c) A host entity that uses volunteer health practitioners to provide health or veterinary services in this state shall:

(1) consult and coordinate its activities with [name of the appropriate governmental agency or agencies] to the extent practicable to provide for the efficient and effective use of volunteer health practitioners; and

(2) comply with any laws other than this [act] relating to the management of emergency health or veterinary services, including [cite appropriate laws of this state].

SECTION 5. VOLUNTEER HEALTH PRACTITIONER REGISTRATION SYSTEMS.

(a) To qualify as a volunteer health practitioner registration system, a system must:

(1) accept applications for the registration of volunteer health practitioners before or during an emergency;

(2) include information about the licensure and good standing of health practitioners which is accessible by authorized persons;

(3) be capable of confirming the accuracy of information concerning whether a health practitioner is licensed and in good standing before health services or veterinary services are provided under this [act]; and

(4) meet one of the following conditions:

(A) be an emergency system for advance registration of volunteer health-care practitioners established by a state and funded through the Department of Health and Human Services under Section 319I of the Public Health Services Act, 42 USC Section 247d-7b [as amended];

(B) be a local unit consisting of trained and equipped emergency response, public health, and medical personnel formed pursuant to Section 2801 of the Public Health Services Act, 42 U.S.C. Section 300hh [as amended];

(C) be operated by a:

(i) disaster relief organization;

(ii) licensing board;

(iii) national or regional association of licensing boards or health practitioners;

(iv) health facility that provides comprehensive inpatient and outpatient health-care services, including a tertiary care and teaching hospital; or

(v) governmental entity; or

(D) be designated by [name of appropriate agency or agencies] as a registration system for purposes of this [act].

(b) While an emergency declaration is in effect, [name of appropriate agency or agencies], a person authorized to act on behalf of [name of governmental agency or agencies], or a host entity, may confirm whether volunteer health practitioners
utilized in this state are registered with a registration system that complies with subsection (a). Confirmation is limited to obtaining identities of the practitioners from the system and determining whether the system indicates that the practitioners are licensed and in good standing.

(c) Upon request of a person in this state authorized under subsection (b), or a similarly authorized person in another state, a registration system located in this state shall notify the person of the identities of volunteer health practitioners and whether the practitioners are licensed and in good standing.

(d) A host entity is not required to use the services of a volunteer health practitioner even if the practitioner is registered with a registration system that indicates that the practitioner is licensed and in good standing.

Legislative Note: If this state uses a term other than “hospital” to describe a facility with similar functions, such as an “acute care facility”, the final phrase of subsection (a)(4)(C)(iv) should include a reference to this type of facility – for example, “including a tertiary care, teaching hospital, or acute care facility.”

SECTION 6. RECOGNITION OF VOLUNTEER HEALTH PRACTITIONERS LICENSED IN OTHER STATES.

(a) While an emergency declaration is in effect, a volunteer health practitioner, registered with a registration system that complies with Section 5 and licensed and in good standing in the state upon which the practitioner’s registration is based, may practice in this state to the extent authorized by this [act] as if the practitioner were licensed in this state.

(b) A volunteer health practitioner qualified under subsection (a) is not entitled to the protections of this [act] if the practitioner is licensed in more than one state and any license of the practitioner is suspended, revoked, or subject to an agency order limiting or restricting practice privileges, or has been voluntarily terminated under threat of sanction.

SECTION 7. NO EFFECT ON CREDENTIALING AND PRIVILEGING.

(a) In this section:

(1) “Credentialing” means obtaining, verifying, and assessing the qualifications of a health practitioner to provide treatment, care, or services in or for a health facility.

(2) “Privileging” means the authorizing by an appropriate authority, such as a governing body, of a health practitioner to provide specific treatment, care, or services at a health facility subject to limits based on factors that include license, education, training, experience, competence, health status, and specialized skill.

(b) This [act] does not affect credentialing or privileging standards of a health facility and does not preclude a health facility from waiving or modifying those standards while an emergency declaration is in effect.

SECTION 8. PROVISION OF VOLUNTEER HEALTH OR VETERINARY SERVICES; ADMINISTRATIVE SANCTIONS.

(a) Subject to subsections (b) and (c), a volunteer health practitioner shall adhere to the scope of practice for a similarly licensed practitioner established by the licensing provisions, practice acts, or other laws of this state.

(b) Except as otherwise provided in subsection (c), this [act] does not authorize a volunteer health practitioner to provide services that are outside the practitioner’s scope of practice, even if a similarly licensed practitioner in this state would be permitted to provide the services.

(c) [Name of appropriate governmental agency or agencies] may modify or restrict the health or veterinary services that
volunteer health practitioners may provide pursuant to this [act]. An order under this subsection may take effect immediately, without prior notice or comment, and is not a rule within the meaning of [state administrative procedures act].

(d) A host entity may restrict the health or veterinary services that a volunteer health practitioner may provide pursuant to this [act].

(e) A volunteer health practitioner does not engage in unauthorized practice unless the practitioner has reason to know of any limitation, modification, or restriction under this section or that a similarly licensed practitioner in this state would not be permitted to provide the services. A volunteer health practitioner has reason to know of a limitation, modification, or restriction or that a similarly licensed practitioner in this state would not be permitted to provide a service if:

1. The practitioner knows the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service; or
2. From all the facts and circumstances known to the practitioner at the relevant time, a reasonable person would conclude that the limitation, modification, or restriction exists or that a similarly licensed practitioner in this state would not be permitted to provide the service.

(f) In addition to the authority granted by law of this state other than this [act] to regulate the conduct of health practitioners, a licensing board or other disciplinary authority in this state:

1. May impose administrative sanctions upon a health practitioner licensed in this state for conduct outside of this state in response to an out-of-state emergency;
2. May impose administrative sanctions upon a practitioner not licensed in this state for conduct in this state in response to an in-state emergency; and
3. Shall report any administrative sanctions imposed upon a practitioner licensed in another state to the appropriate licensing board or other disciplinary authority in any other state in which the practitioner is known to be licensed.

(g) In determining whether to impose administrative sanctions under subsection (f), a licensing board or other disciplinary authority shall consider the circumstances in which the conduct took place, including any exigent circumstances, and the practitioner’s scope of practice, education, training, experience, and specialized skill.

Legislative Note: The governmental agency or agencies referenced in subsection (c) may, as appropriate, be a state licensing board or boards rather than an agency or agencies that deal[s] with emergency response efforts.

SECTION 9. RELATION TO OTHER LAWS.

(a) This [act] does not limit rights, privileges, or immunities provided to volunteer health practitioners by laws other than this [act]. Except as otherwise provided in subsection (b), this [act] does not affect requirements for the use of health practitioners pursuant to the Emergency Management Assistance Compact.

(b) [Name of appropriate governmental agency or agencies], pursuant to the Emergency Management Assistance Compact, may incorporate into the emergency forces of this state volunteer health practitioners who are not officers or employees of this state, a political subdivision of this state, or a municipality or other local government within this state.

Legislative Note: If a state adopting this act is a party to emergency assistance compacts in addition to the Emergency Management Assistance Compact, references to these other compacts should be added to this section.
SECTION 10. REGULATORY AUTHORITY. [Name of appropriate governmental agency or agencies] may promulgate rules to implement this [act]. In doing so, [name of appropriate governmental agency or agencies] shall consult with and consider the recommendations of the entity established to coordinate the implementation of the Emergency Management Assistance Compact and shall also consult with and consider rules promulgated by similarly empowered agencies in other states to promote uniformity of application of this [act] and make the emergency response systems in the various states reasonably compatible.

Legislative Note: If a state adopting this act is a party to emergency assistance compacts in addition to the Emergency Management Assistance Compact, references to these other compacts should be added to this section.

SECTION 11. LIMITATIONS ON CIVIL LIABILITY FOR VOLUNTEER HEALTH PRACTITIONERS[; VICARIOUS LIABILITY].

Alternative A

(a) Subject to subsection (c), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is not liable for damages for an act or omission of the practitioner in providing those services.

(b) No person is vicariously liable for damages for an act or omission of a volunteer health practitioner if the practitioner is not liable for the damages under subsection (a).

(c) This section does not limit the liability of a volunteer health practitioner for:

(1) willful misconduct or wanton, grossly negligent, reckless, or criminal conduct;

(2) an intentional tort;

(3) breach of contract;

(4) a claim asserted by a host entity or by an entity located in this or another state which employs or uses the services of the practitioner; or

(5) an act or omission relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

(d) A person that, pursuant to this [act], operates, uses, or relies upon information provided by a volunteer health practitioner registration system is not liable for damages for an act or omission relating to that operation, use, or reliance unless the act or omission is an intentional tort or is willful misconduct or wanton, grossly negligent, reckless, or criminal conduct.

(e) In addition to the protections provided in subsection (a), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is entitled to all the rights, privileges, or immunities provided by [cite state law.]

Alternative B

(a) Subject to subsection (b), a volunteer health practitioner who receives compensation of $500 or less per year for providing health or veterinary services pursuant to this [act] is not liable for damages for an act or omission of the practitioner in providing those services. Reimbursement of, or allowance for, reasonable expenses, or continuation of salary or other remuneration while on leave, is not compensation under this subsection.

(b) This section does not limit the liability of a volunteer health practitioner for:

(1) willful misconduct or wanton, grossly negligent, reckless, or criminal conduct;

(2) an intentional tort;
(3) breach of contract;
(4) a claim asserted by a host entity or by an entity located in this or another state which employs or uses the services of the practitioner; or
(5) an act or omission relating to the operation of a motor vehicle, vessel, aircraft, or other vehicle.

(c) A person that, pursuant to this [act], operates, uses, or relies upon information provided by a volunteer health practitioner registration system is not liable for damages for an act or omission relating to that operation, use, or reliance unless the act or omission is an intentional tort or is willful misconduct or wanton, grossly negligent, reckless, or criminal conduct.

[(d) In addition to the protections provided in subsection (a), a volunteer health practitioner who provides health or veterinary services pursuant to this [act] is entitled to all the rights, privileges, or immunities provided by [cite state law].]

SECTION 12. WORKERS’ COMPENSATION COVERAGE.

(a) In this section, “injury” means a physical or mental injury or disease for which an employee of this state who is injured or contracts the disease in the course of the employee’s employment would be entitled to benefits under the workers’ compensation [or occupational disease] law of this state.

(b) A volunteer health practitioner who dies or is injured as the result of providing health or veterinary services pursuant to this [act] is deemed to be an employee of this state for the purpose of receiving benefits for the death or injury under the workers’ compensation [or occupational disease] law of this state if:

(1) the practitioner is not otherwise eligible for such benefits for the injury or death under the law of this or another state; and

(2) the practitioner, or in the case of death the practitioner’s personal representative, elects coverage under the workers’ compensation [or occupational disease] law of this state by making a claim under that law.

(c) The [name of appropriate governmental agency] shall adopt rules, enter into agreements with other states, or take other measures to facilitate the receipt of benefits for injury or death under the workers’ compensation [or occupational disease] law of this state by volunteer health practitioners who reside in other states, and may waive or modify requirements for filing, processing, and paying claims that unreasonably burden the practitioners. To promote uniformity of application of this [act] with other states that enact similar legislation, the [name of appropriate governmental agency] shall consult with and consider the practices for filing, processing, and paying claims by agencies with similar authority in other states.

Legislative Notes: The bracketed term “occupational disease” should not be used in states that do not have specific occupational disease laws.

States should review their workers’ compensation and occupational disease laws to determine whether they have appropriate provisions for providing wage loss benefits to volunteer health practitioners. If necessary, an additional subsection cross referencing special provisions included in workers’ compensation laws for calculating wage-loss benefits for volunteers, or designating how wage loss benefits for volunteers will be determined, should be added to this section.

States should also review their workers’ compensation and occupational disease laws to determine whether current laws may provide more expansive benefits to volunteers than are otherwise provided by this act, such as benefits for injuries or deaths occurring during disaster training or drills. If current state laws provide more expansive benefits and states wish to extend such benefits to volunteer health practitioners under this act, a provision should be added to this section conforming the scope of benefits available under this act to those available under the other laws.

This section defers to other provisions of state law to determine whether and to what extent the option to elect workers’
compensation or occupational disease benefits constitutes the exclusive remedy against the state for injuries or death that occurs when acting as a volunteer health practitioner in the state. If existing state laws do not adequately address this topic, states should consider whether appropriate language clarifying whether and to what extent these benefits constitute an exclusive remedy should be added to this section.

SECTION 13. UNIFORMITY OF APPLICATION AND CONSTRUCTION. In applying and construing this uniform act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

SECTION 14. REPEALS. The following acts and parts of acts are repealed:

(1) ...........

(2) ...........

SECTION 15. EFFECTIVE DATE. This [act] takes effect . . . .
### Appendix D – Tier 1 Core Public Health Competencies Met

<table>
<thead>
<tr>
<th>Domain #1: Analytic/Assessment</th>
<th>Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the health status of populations and their related determinants of health and illness (e.g., factors contributing to health promotion and disease prevention, the quality, availability and use of health services)</td>
<td>X</td>
</tr>
<tr>
<td>Describe the characteristics of a population-based health problem (e.g., equity, social determinants, environment)</td>
<td>X</td>
</tr>
<tr>
<td>Use variables that measure public health conditions</td>
<td></td>
</tr>
<tr>
<td>Use methods and instruments for collecting valid and reliable quantitative and qualitative data</td>
<td>X</td>
</tr>
<tr>
<td>Identify sources of public health data and information</td>
<td>X</td>
</tr>
<tr>
<td>Recognize the integrity and comparability of data</td>
<td>X</td>
</tr>
<tr>
<td>Identify gaps in data sources</td>
<td>X</td>
</tr>
<tr>
<td>Adhere to ethical principles in the collection, maintenance, use, and dissemination of data and information</td>
<td>X</td>
</tr>
<tr>
<td>Collect quantitative and qualitative community data (e.g., risks and benefits to the community, health and resource needs)</td>
<td></td>
</tr>
<tr>
<td>Use information technology to collect, store, and retrieve data</td>
<td>X</td>
</tr>
<tr>
<td>Describe how data are used to address scientific, political, ethical, and social public health issues</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #2: Policy Development and Program Planning</th>
<th>Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gather information relevant to specific public health policy issues</td>
<td>X</td>
</tr>
<tr>
<td>Describe how policy options can influence public health programs</td>
<td>X</td>
</tr>
<tr>
<td>Explain the expected outcomes of policy options (e.g., health, fiscal, administrative, legal, ethical, social, political)</td>
<td>X</td>
</tr>
<tr>
<td>Gather information that will inform policy decisions (e.g., health, fiscal, administrative, legal, ethical, social, political)</td>
<td>X</td>
</tr>
<tr>
<td>Describe the public health laws and regulations governing public health programs</td>
<td>X</td>
</tr>
<tr>
<td>Participate in program planning processes</td>
<td></td>
</tr>
<tr>
<td>Incorporate policies and procedures into program plans and structures</td>
<td></td>
</tr>
<tr>
<td>Identify mechanisms to monitor and evaluate programs for their effectiveness and quality</td>
<td>X</td>
</tr>
<tr>
<td>Demonstrate the use of public health informatics practices and procedures (e.g., use of information systems infrastructure to improve health outcomes)</td>
<td></td>
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<tr>
<td>Apply strategies for continuous quality improvement</td>
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<thead>
<tr>
<th>Domain #3: Communication</th>
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<tbody>
<tr>
<td>Identify the health literacy of populations served</td>
<td></td>
</tr>
<tr>
<td>Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency</td>
<td>X</td>
</tr>
<tr>
<td>Solicit community-based input from individuals and organizations</td>
<td></td>
</tr>
<tr>
<td>Convey public health information using a variety of approaches (e.g., social networks, media, blogs)</td>
<td></td>
</tr>
<tr>
<td>Participate in the development of demographic, statistical, programmatic and scientific presentations</td>
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<tr>
<td>Apply communication and group dynamic strategies (e.g., principled negotiation, conflict resolution, active listening, risk communication) in interactions with individuals and groups</td>
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<thead>
<tr>
<th>Domain #4: Cultural Competency</th>
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<tbody>
<tr>
<td>Incorporate strategies for interacting with persons from diverse backgrounds (e.g., cultural, socioeconomic, educational, racial, gender, age, ethnic, sexual orientation, professional, religious affiliation, mental and physical capabilities)</td>
<td></td>
</tr>
<tr>
<td>Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability and delivery of public health services</td>
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<tr>
<td>Respond to diverse needs that are the result of cultural differences</td>
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<tr>
<td>Describe the dynamic forces that contribute to cultural diversity</td>
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<tr>
<td>Domain #5: Community Dimensions of Practice</td>
<td>Used</td>
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<tr>
<td>Describe the need for a diverse public health workforce</td>
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<tr>
<td>Participate in the assessment of the cultural competence of the public health organization</td>
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<tr>
<td>Recognize community linkages and relationships among multiple factors (or determinants) affecting health (e.g., The Socio-Ecological Model)</td>
<td></td>
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<tr>
<td>Demonstrate the capacity to work in community-based participatory research efforts</td>
<td></td>
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<tr>
<td>Identify stakeholders</td>
<td>X</td>
</tr>
<tr>
<td>Collaborate with community partners to promote the health of the population</td>
<td></td>
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<tr>
<td>Maintain partnerships with key stakeholders</td>
<td></td>
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<tr>
<td>Use group processes to advance community involvement</td>
<td></td>
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<tr>
<td>Describe the role of governmental and non-governmental organizations in the delivery of community health services</td>
<td>X</td>
</tr>
<tr>
<td>Identify community assets and resources</td>
<td></td>
</tr>
<tr>
<td>Gather input from the community to inform the development of public health policy and programs</td>
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<tr>
<td>Inform the public about policies, programs, and resources</td>
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<tr>
<th>Domain #6: Public Health Sciences</th>
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<tbody>
<tr>
<td>Describe the scientific foundation of the field of public health</td>
</tr>
<tr>
<td>Identify prominent events in the history of the public health profession</td>
</tr>
<tr>
<td>Relate public health science skills to the Core Public Health Functions and Ten Essential Services of Public Health</td>
</tr>
<tr>
<td>Identify the basic public health sciences (including, but not limited to biostatistics, epidemiology, environmental health sciences, health services administration, and social and behavioral health sciences)</td>
</tr>
<tr>
<td>Describe the scientific evidence related to a public health issue, concern, or, intervention</td>
</tr>
<tr>
<td>Retrieve scientific evidence from a variety of text and electronic sources</td>
</tr>
<tr>
<td>Discuss the limitations of research findings (e.g., limitations of data sources, importance of observations and interrelationships)</td>
</tr>
<tr>
<td>Describe the laws, regulations, policies and procedures for the ethical conduct of research (e.g., patient confidentiality, human subject processes)</td>
</tr>
<tr>
<td>Partner with other public health professionals in building the scientific base of public health</td>
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<tr>
<th>Domain #7: Financial Planning and Management</th>
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<tbody>
<tr>
<td>Describe the local, state, and federal public health and health care systems</td>
</tr>
<tr>
<td>Describe the organizational structures, functions, and authorities of local, state, and federal public health agencies</td>
</tr>
<tr>
<td>Adhere to the organization’s policies and procedures</td>
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<tr>
<td>Participate in the development of a programmatic budget</td>
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<tr>
<td>Operate programs within current and forecasted budget constraints</td>
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<tr>
<td>Identify strategies for determining budget priorities based on federal, state, and local financial contributions</td>
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<tr>
<td>Report program performance</td>
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<tr>
<td>Translate evaluation report information into program performance improvement action steps</td>
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<tr>
<td>Contribute to the preparation of proposals for funding from external sources</td>
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<tr>
<td>Apply basic human relations skills to internal collaborations, motivation of colleagues, and resolution of conflicts</td>
</tr>
<tr>
<td>Demonstrate public health informatics skills to improve program and business operations (e.g., performance management and improvement)</td>
</tr>
<tr>
<td>Participate in the development of contracts and other agreements for the provision of services</td>
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<tr>
<td>Describe how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision making</td>
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<tr>
<th>Domain #8: Leadership and Systems Thinking</th>
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<tbody>
<tr>
<td>Incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals</td>
</tr>
<tr>
<td>Describe how public health operates within a larger system</td>
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<tr>
<td>Activity</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>Participate with stakeholders in identifying key public health values and a shared public health vision as guiding principles for community action</td>
</tr>
<tr>
<td>Identify internal and external problems that may affect the delivery of Essential Public Health Services</td>
</tr>
<tr>
<td>Use individual, team and organizational learning opportunities for personal and professional development</td>
</tr>
<tr>
<td>Participate in mentoring and peer review or coaching opportunities</td>
</tr>
<tr>
<td>Participate in the measuring, reporting and continuous improvement of organizational performance</td>
</tr>
<tr>
<td>Describe the impact of changes in the public health system, and larger social, political, economic environment on organizational practices</td>
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