Legal and Regulatory Framework for Emergency Public Health Medical Response

1. Local Health Officer Authority

Local health boards and officers are responsible for maintaining health and sanitation within their own jurisdictions. This includes controlling and preventing the spread of communicable disease. See RCW 70.05.060 and .070. This authority is broad, and the local health boards and officers must work in consultation with the local health care community, emergency management, law enforcement, tribal governments, federal authorities, and with state agencies and institutions. See WAC 246-100-036. Local heath officers and boards have the authority to close schools and day care centers, chapter 246-110, and to require isolation and quarantine under rules adopted by State Board of Health per RCW 43.20.050(2)(d); WAC 246-100-006 through -070. Failing to comply with local health officer's orders for the prevention, suppression and control of dangerous, contagious and infectious diseases is a misdemeanor – RCW 70.05.120

2. State Board of Health

The State Board of Health has the authority to amend isolation and quarantine rules and procedures and communicable disease rules for use by local health officers; WAC 246-100-040 through -065. The Board of Health has the authority to adopt notifiable conditions rules, requiring notification from health care providers and facilities of certain diseases and conditions to the local health jurisdiction or the state Department of Health, to allow for surveillance and early detection of diseases of concern to the public health. The Board of Health has adopted these rules at chapter 246-101 WAC.

3. DOH Secretary Authority

The Secretary of the Department of Health has the authority to investigate outbreaks and epidemics and advise local health officers on measures to take to prevent and control the disease; RCW 43.70.130(5), as well as the authority to investigate, examine, sample or inspect any article or condition that is a threat to public health RCW 43.70.170. The statute also grants the Secretary free and unimpeded access to any place to carry out these responsibilities. The Secretary has the authority to issue orders prohibiting the disposition or sale of any food or other item involved in the investigation; RCW 43.70.180, .190. Finally, the Secretary can act in lieu of local boards if an emergency exists and the local board fails to act, RCW 43.70.130(4) and can act in lieu of a local health officer if the officer fails or is unable to act, agrees to the Secretary's involvement, or, in an emergency, the safety of the public health demands he or she act; RCW 43.70.130(7). The Secretary has no authority to declare a 'public health emergency' in Washington State, and has no authority to independently waive or suspend laws during an emergency.

4. Governor Emergency Authority

The Governor's authority in emergencies is derived from two sources. First, under the Governor's own statute, the Governor can proclaim an emergency when he or she finds that a public disorder, disaster, energy emergency, or riot exists which affects life, health, property, or the public peace. RCW 43.06.010(12). A proclamation is to be made only in the area affected, which could be a limited area or the entire state. *Id.*

After proclaiming a state of emergency, the Governor may issue orders imposing a curfew, limiting public gatherings, prohibiting the use of certain public ways, or prohibiting any activity he reasonably believes should be prohibited to help preserve and maintain life, health, property or the public peace. RCW 43.06.220(1).

RCW 43.06.220(2)(g) gives the Governor the authority to waive or suspend statutory and regulatory obligations or limitations and any statute, order, rule, or regulation if strict compliance therewith would in any way hinder necessary emergency action. After 30 days, any suspension

or waiver must be approved by the legislature by concurrent resolution or, if the legislature is not in session, by the majority and minority leaders of both houses of the legislature. RCW 43.06.220(4).

The Governor may order the state militia or the state patrol to assist local officials in restoring order in the area in which he or she proclaimed the emergency. RCW 43.06.270. The Governor has the further authority to declare limited or complete martial law. Violation of a Governor declared emergency proclamation is a gross misdemeanor. RCW 43.06.220(4).

Under the Emergency Management Act, chapter 38.52 RCW, the Governor may assume direct operational control over all or any part of the emergency management functions of the state. RCW 38.52.050. The Emergency Management Act also allows the Governor to make, amend, and rescind necessary orders, rules, and regulations to carry out the provisions of chapter 38.52 RCW. RCW 38.52.050(3)(a). Under RCW 38.52.110(2), after the issuance of an emergency proclamation, the governor can command the service and equipment of private citizens. An emergency proclamation also allows the Governor to use the services, equipment, supplies and facilities of state and local government agencies for an emergency response, and the personnel of those agencies are directed to cooperate with the governor; RCW 38.52.110(1). The Emergency Management Act also allows the Governor to enter into mutual aid arrangements with other states and territories or Canadian provinces and coordinate mutual aid agreements between political subdivisions of the state; RCW 38.52.050(3)(b).

5. WA Liability Protections (During Emergency), Providers, Volunteers, Facilities

Under RCW 38.52.180(2), the state accepts all legal liability for damage to property or injury or death to persons caused by actions taken under the authority of chapter 38.52 RCW. RCW 38.52.180(6) suspends the requirement for a license to practice any “professional, mechanical or other skill” for any authorized emergency worker, who, in the course of providing emergency care, practices the professional, mechanical or other skill. The Emergency Management Act defines an “emergency worker” as “any person who is registered with a local emergency management organization or the department and holds an identification card issued by the local emergency management director or the department for the purpose of engaging in authorized emergency management activities or is an employee of the state of Washington or any political subdivision thereof who is called upon to perform emergency management activities.” RCW 38.52.010(8). When liability arises from the actions of private citizens who register as emergency workers, the Emergency Management Act makes registered emergency workers immune from liability. Further, the Act makes all other related entities and agencies immune from liability, including the state and local governments directing the emergency response. RCW 38.52.180(3). This immunity for emergency workers applies only if the workers were acting within the scope of assigned duties under the direction of emergency managers, and the liability-triggering acts or omissions did not constitute gross negligence or willful or wanton misconduct. RCW 38.52.180(4). Further, in order to receive liability protections, workers must be working under a mission number assigned by the state Emergency Management Division. WAC 118-04-240. State and local government employees, who register as emergency workers are indemnified by the State for liabilities arising from their acts or omissions, if the liability-triggering acts or omissions were within the scope of assigned duties under the direction of emergency managers and did not constitute gross negligence or willful or wanton misconduct. RCW 38.52.180(2).

6. Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)

Chapter 70.15 RCW authorizes an entity to use volunteer health practitioners who are licensed in this state or in others to respond to a Governor-proclaimed emergency and get the benefit of workers compensation and liability protections. Those licensed and in good standing in other states need not obtain a Washington license. Volunteers must be registered in a volunteer health practitioner registration system. The UEVHPA provides liability protection for acts or omissions while providing services. A practitioner that is injured or dies during deployment is deemed an employee of the state for the purpose of receiving benefits under the workers compensation law of this state. The volunteer practitioner’s scope of practice is limited to the

scope authorized to be practiced in the state of Washington, unless modified by the Department of Health. The Department may control the duration and location of practice, the types of practitioners who may practice, and any other matters necessary to coordinate the provisions of health services during the emergency.

7. Federal Emergency Management Authorities

The President of the United States, under the Stafford Act (42 U.S.C. §§ 5121-5207), has the authority to declare two types of emergencies – an 'Emergency Declaration' and a 'Major Disaster Declaration.' In the event of an emergency or major disaster, the Governor or Tribal leader of the affected area must request a Presidential declaration. 42 U.S.C. §§ 5170, 5191. If the President declares an emergency, the affected area can receive certain assistance from the federal government.

The President also has the authority to declare a "national emergency" under the National Emergencies Act (NEA), 50 U.S.C. 1601 *et seq*. An NEA declaration does not create any emergency authority on its own, but triggers other emergency authorities in federal statutes. The President must specifically name the statutes that the NEA declaration triggers – they are not automatic. The NEA has been used in the past for public health emergencies. For example. President Barack Obama issued an NEA declaration for the H1N1 influenza pandemic in 2009, in order to allow The U.S. Department of Health and Human Services (HHS) Secretary to issue waivers under section 1135 of the Social Security Act ("1135 Waivers"). 42 U.S.C.1320b-5. These 1135 Waivers are discussed below.

The Secretary of the United States Department of Health and Human Services (HHS) has the authority, independent of the Presidential Stafford Act Authority, to declare a 'public health emergency.' 42 U.S.C. § 247d. However, the scope of the HHS Secretary's public health emergency declaration authority is narrow, and can only be exercised where "(1) a disease or disorder presents a public health emergency; or (2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists." 42 U.S.C. § 247d(a)(1) and (2). The emergency terminates within 90 days, or sooner if decided by the Secretary. The HHS Secretary must notify congress of the declaration within 48 hours. The HHS Secretary has further authority under a declared public health emergency to do the following, among other things:

- Make grants to State and local agencies, provide awards for expenses, enter into contracts, and conduct and support investigations into the cause, treatment, or prevention of the specific disease or disorder. 42 U.S.C. § 247d (a)
- Access funds appropriated to the Public Health Emergency Fund. 42 U.S.C. § 247d(b).
- Grant extensions or waive sanctions related to deadlines for submitting data or reports required under laws administered by the Secretary. 42 U.S. Code § 247d(d).

After the issuance of both a presidential declaration of an emergency and the DHHS Secretary's issuance of a public health emergency declaration, the U.S. Department of Health and Human Services (HHS) Secretary may further grant waivers under section 1135 of the Social Security Act ("1135 Waivers"). 42 U.S.C. 1320b-5. Under this authority, the HHS Secretary may waive Titles XVIII, XIX, or XXI of the Social Security Act or any regulation thereunder, so long as they pertain to the following:

- "Conditions of participation or other certification requirements for an individual health care provider or types of providers, program participation and similar requirements for an individual health care provider or types of providers, and pre-approval requirements." 42 U.S.C. 1320b-5(b)(1)
- "Requirements that physicians and other health care professionals be licensed in the State in which they provide such services, if they have equivalent licensing in another

State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;" 42 U.S.C. 1320b-5(b)(2)

- Actions under the Emergency Medical Treatment & Labor Act (EMTALA) relating to transfer of non-stabilized patients, and alternative location screening pursuant to a state emergency preparedness plan. 42 U.S.C. 1320b-5(b)(3)
- Sanctions relating to limitation on physician referrals. 42 U.S.C. 1320b-5(b)(4)
- Modification of deadlines and timetables for performance of required activities. 42 U.S.C. 1320b-5(b)(5)
- "Limitations on payments under section 1851(i) for health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care professionals or facilities not included under such plan." 42 U.S.C. 1320b-5(b)(6)
- Sanctions resulting from violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S. C. 1320d-2, as it relates to:
    - Patient Consent to speak with the patient's family members regarding the patient's medical treatment
    - HIPAA's requirement to honor the patient's request to opt out of the facility's directory
    - Distribution of notice of privacy practices
    - The patient's right to request privacy restrictions and confidential communications. 42 U.S.C. 1320b-5(b)(7)

8. Emergency Credentialing and Licensure Verification

Liability immunity (RCW 4.24.810) Credentialing or granting practice privileges to health care providers responding to emergencies.

(1) Except as provided in subsection (2) of this section, any health care provider credentialing or granting practice privileges to other health care providers to deliver health care in response to an emergency is immune from civil liability arising out of such credentialing or granting of practice privileges if: (a) the health care provider so credentialed or granted practice privileges was responding to an emergency: and (b) the procedures utilized for credentialing and granting practice privileges were substantially consistent with the standards for granting emergency practice privileges adopted by the joint commission on the accreditation of health care organizations.

(2) This section does not apply to acts or omissions constituting gross negligence or willful or wanton misconduct.

Licensure Verification

Licensure status of individuals providers and Health Care Facilities can be verified thru the Department Of Health Credential Search System (data.wa.gov.portal) that is available 24/7 to the public and Health Care Community.

Emergency Volunteer Health Practitioners (Chapter 70.15 RCW)

Under the authority of the Uniform Emergency Volunteer Health Practitioner Act (chapter 70.15 RCW), while an emergency proclamation of the Governor is in effect, a volunteer health practitioner who is licensed in another state may practice in Washington without obtaining a Washington license if he or she is in good standing in all states of licensure and is registered in the volunteer health practitioner system. The first step for a volunteer to register is to complete the Emergency Volunteer Health Practitioners Application. The application and more information is available on our website at:
https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020/HealthcareProviders/Em

ergencyVolunteerHealthPractitioners.

9. Regulatory Flexibility (Q&A)

Hospitals and medical providers in Washington State periodically encounter a high number of patients seeking medical care due to widespread medical events such as the annual flu outbreak. During surge events, hospitals often seek guidance from the Department of Health related to surge capacity, variances, EMS requirements, etc. The following FAQs were developed by the Department of Health to assist Washington State hospitals in making business decisions in order to meet patient needs. These FAQs are for informational purposes only and not intended to serve as specific legal advice. Please refer to your hospital emergency preparedness plan and legal counsel for guidance.

Medical Surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive an event and maintain or rapidly recover operations that were compromised.

Q: Can hospitals extend emergency department care beyond 24 hours for unanticipated surge capacity?

A: *Yes. We recognize that length of stay will vary during surge times. However, to the extent they are able, facilities are encouraged to find space other than the emergency department for care beyond 24 hours.*

Q: During an epidemic, can a hospital exceed their approved number of inpatient and/or emergency department beds? Will using extra beds, maybe in hallways, possibly be overlooked during an inspection? Or, is there a process to request a temporary increase in beds (and if so, what is the process)?

A: *A hospital can exceed their approved number of inpatient and/or emergency department beds in surge/emergency situations. We realize that there are times when hospitals become very busy and may resort to placing beds in hallways to manage short-term needs, particularly during emergencies or surge situations. While this is allowable, hospitals must continue to have the capacity to maintain patient safety and well-being, fire and life safety regulations, infection control standards, and building structural integrity.*

If exceeding licensed bed capacity is necessary, the hospital should make a written request for an exemption as required in WAC 246-320-026. The request may be made by e-mail. The exemption request should include:

- *A brief description of the unique circumstances requiring the exemption;*
- *The number of additional beds required to meet patient needs and the expected duration the additional beds will be required to address the emergent need; and*
- *An acknowledgement that:*
    - *Patient safety, health or well-being is not being threatened;*

- *Fire and life safety regulations, infection control standards, or other codes or regulations will not be reduced;*
- *Structural integrity of the building would not be impaired.*

The exemption request should be sent to the Department of Health, Office of Community Health Systems ***(HospitalMedicalSurge@doh.wa.gov)*** *prior to setting up inpatient beds exceeding licensed bed capacity. The Department of Health will provide a response to requests within 24 hours. Approval of the exemption does not authorize the hospital to increase the number of state licensed beds. The exemption approval will be time limited and allow the hospital, under the described unique circumstances, to set up and operate beds beyond the licensed limitation.*

A Certificate of Need (CoN) review and approval is not required for the temporary set up of beds needed to meet surge requirements. If the hospital seeks a permanent increase in its licensed bed capacity, a Certificate of Need review and approval is required.

Q: Are there special considerations for Critical Access Hospitals who may exceed their licensed bed capacity?

A: *For critical access hospitals, the requirements are different since federal rules do not allow these hospitals to go over their 25-bed limit. However, there are creative ways for critical access hospitals to manage surge events, such as using observation beds and holding patients in the ED to manage inpatient volume.*

Q: Who has the authority to make the decision to divert patients to another hospital when resources are temporarily unavailable?

A: *A hospital should refer to their diversion policy for the emergency department to divert patients to another hospital. Note that being on divert does not change the requirements for screening and stabilization under EMTALA. Patients presenting to the hospital must still be screened and stabilized, as required by law.*

Q: Do hospitals need to follow a formal process for converting areas necessary to handle surge capacity?

A: *No, there is no formal CRS process for accommodating surge capacity. Construction Review Services (CRS) is available to provide technical assistance to facilities upon request.*

Q: Can the Washington state Secretary of Health waive the CoN review requirements to increase my hospital's bed capacity beyond its current licensed beds to deal with a medical surge?

A: *Certificate of Need review is not required for increasing capacity during surge events. Please refer to the process above for requesting an exemption in these circumstances. Once the emergency has passed, the hospital's inpatient bed capacity must go back to the previous CoN-approved pre-emergency level. A permanent increase in licensed bed capacity does require a Certificate of Need review and approval; the requirement cannot be waived by the Secretary.*

Q: Can a hospital apply for an 1135 waiver during surge events?

A: *An 1135 waiver can only be granted if there is a presidential and HHS Secretary emergency declaration.*

Q: If a hospital has Prospective Payment System-Exempt Psychiatric or Rehabilitation Units, can those beds be converted to Medical Surgical beds?

A: *Although under state law there is no need for a CoN review to use the beds temporarily to deal the medical surge, federal rules do not allow converting beds that are part of an Inpatient Psych or Rehab PPS-Exempt Unit for use by medical surgical patients.*

Q: Can EMS transport individuals to an urgent care clinic rather than to a hospital emergency room when they know resources – beds and people – have been exhausted?

A: *Washington rules do not allow EMS to transport patients to urgent care clinics. Hospitals can support the Department of Health to encourage patients to call their primary health care provider, discuss their symptoms and seek medical advice on whether they need to go to the emergency department. However, once EMS is activated a patient can be transported by EMS only to an emergency department.*

Q: What pharmacy implications might I consider during a medical surge situation?

A: *Hospital pharmacies should work with wholesalers to ensure there is an adequate supply of Tamiflu or other needed medication available.*

In rural areas, medical staff might consider a collaborative drug therapy (CDT) agreement with pharmacists within their community so individuals have greater access to needed medication such as Tamiflu. This agreement could be time limited.

For questions related to pharmacy, please call the Pharmacy Commission at 360-236-4946.