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Despite progress in hospital and public health preparedness, the U.S. health system remains poorly positioned to respond to large scale public health emergencies and disasters. The forces of health care economics continue to shrink overall bed capacity, increase reliance on just-in-time supply chains, and reduce attention to non-revenue-generating activities such as preparedness. Disaster healthcare experts cite a health system capacity gap to manage large numbers of casualties and a capability gap to manage cases requiring specialized care, such as radiation injury or pediatric trauma.

In contrast to conventional efforts that build structures for health system response, the Nebraska Regional Disaster Health Response Ecosystem (NRDHRE) is striving to create a regional ecosystem. Ecosystems are self-sufficient assemblies of linked and complementary components. They are less amenable to direct control, but they are self-actuating, adaptable, and self-scaling. Ultimately, we aim to achieve a sustainable ecosystem of healthcare preparedness that re-engineers health system actions and coordination during response, taps into the vast human capital and logistical resources of non-traditional responders, and provides economic incentives to weave preparedness into the fabric of community. Complementing current disaster preparedness and response efforts, such an ecosystem can make significant strides in addressing the existing gaps of capacity, specialty care, and continuity in health system disaster preparedness.

As NRDHRE continues to strengthen health system response capabilities in Nebraska, key personnel must recognize the regulatory and statutory boundaries in which they must operate. If leaders understand the current legal landscape, they can begin to identify gaps that may impede or enablers that may accelerate progress toward a more responsive ecosystem.
GUIDE INTRODUCTION

This Legal Reference Guide will assist all healthcare teams in coalitions to be better equipped to understand the legal references in Nebraska related to disaster situations and response. It is intended to serve as a quick reference to the laws and regulations involved in healthcare disaster response in the state of Nebraska. The information in this guide is specific to Nebraska state laws and regulations, and therefore, may not apply to other states. This guide should not be considered legal advice, but rather as an informational reference tool.
Emergency Declarations

In the state of Nebraska, an emergency declaration can occur at three levels: federal, state, and local. Each of these types of declarations involve different levels of authority and grant different types of powers. When an emergency is declared, it is critical to understand what type of declaration is in place.

FEDERAL DECLARATIONS

Under the Stafford act, the President has discretion to declare an emergency or disaster, in order to provide federal assistance to a state affected by an incident. There are two types of declarations: emergency declarations and major disaster declarations. An emergency can be declared when the President determines that an incident has occurred that exceeds a state’s ability to adequately respond. A major disaster declaration can occur for any natural catastrophe (tornado, hurricane, snowstorm, drought, flood, etc.) that the President determines has caused damage of such severity as to justify federal assistance to supplement state or local resources. Both of these types of declaration allow federal agencies to assist state and local efforts in emergency response.

In order for an emergency or major disaster to be declared at the federal level, the governor or the affected state must submit a request to the President within 30 days of the incident occurring. In this request, the governor must demonstrate that the incident has gone beyond the state’s capability to respond, and that federal assistance is necessary to protect property, public health and safety, or to lessen or avert the threat of a disaster. If the President approves the governor’s request and an emergency or disaster is declared, then certain federal resources are made available to the affected state. These resources typically deal primarily with emergency management functions.
Federal Public Health Emergency Declarations

Similar to Stafford Act declarations, the Secretary of the U.S. Department of Health and Human Services can declare public health emergencies. These declarations occur when the Secretary determines that either a disease or disorder presents a public health emergency, or that a public health emergency otherwise exists. Public Health Emergency declarations allow the Secretary to either waive or modify existing federal legal requirements that relate to healthcare or public health. These declarations can also provide for the use of 1135 waivers, which are discussed in more detail later in the guide.
STATE PROCLAMATIONS

Under the Nebraska Emergency Management Act, the governor may issue a state of emergency proclamation if he or she determines that a disaster or emergency has occurred, or that there is an imminent threat of a disaster or emergency1. State of emergency proclamations activate state, city, or local emergency management organizations and emergency operations plans that may be applicable to the area affected by the incident. The proclamation serves as the authority for deploying supplies or materials that may be need in the emergency response.

Additionally, a state emergency proclamation allows the governor to suspend or waive state-level laws or regulations that may interfere with response efforts. This can include state medical licensing rules. When a proclamation is issued, the language of the proclamation will specifically state which, if any, state laws or regulations have been waived or suspended. It is critical to note that a state of emergency proclamation cannot waive or suspend federal laws, such as HIPAA or EMTALA. Federal laws and regulations can only be affected by Federal declarations.

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1 Per the Nebraska Emergency Management Act, disaster is defined as any event or the imminent threat thereof causing widespread or severe damage, injury, or loss of life or property resulting from any natural or manmade cause. Emergency is defined as any event or the imminent threat thereof causing serious damage, injury, or loss of life or property resulting from any natural or manmade cause which, in the determination of the Governor or the principal executive officer of a local government, requires immediate action to accomplish the purposes of the Emergency Management Act and to effectively respond to the event.
LOCAL DECLARATIONS

In Nebraska, a local emergency may be declared by the mayor or other principal executive officer of a local government, who determines that a disaster or an emergency has occurred in their jurisdiction. A local emergency declaration will activate any applicable city, village, or county emergency operations plans. Local emergency declarations carry the least amount of authority out of the three possible levels of declarations.
VOLUNTEERS

When dealing with volunteers in an emergency or disaster response, liability protections and workers’ compensation are often two of the biggest questions that arise. The Nebraska Emergency Management Act grants certain legal protections from liability to “emergency management workers.” The Nebraska Emergency Management Act includes volunteers in the definition of emergency management workers. In order to benefit from the Act’s protections against liability, volunteers must be:

- Formally organized and
- Acting in coordination with or under the direction of a local or state emergency operations plan.

This inclusion provides formally organized volunteers the same liability protections that full-time emergency management workers have as long as they meet the organization and coordination requirements. Additionally, any formally organized, state authorized emergency response volunteer is included in the definition of an employee under the Nebraska Workers’ Compensation Act. This ensures that volunteers, who meet that criteria, can receive workers’ compensation for any injuries received in the course of their volunteering.

The law states that emergency management workers—including volunteers—who meet the criteria above cannot be held liable for the death or injury of people or damage to property that occurs as a result of their emergency response work. Additionally, the Nebraska Attorney General has stated that this liability protection extends to volunteers even when they are engaged in training or exercises. However, an emergency management worker or volunteer who acts with willful misconduct, gross negligence, or
bad faith in the performance of their duties will not be protected against liability.

One of the best ways to ensure that volunteers are protected from liability is to use volunteers that are a part of a formally organized group or program, such as the Medical Reserve Corps (MRC) or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).

The Medical Reserve Corps is a national network of volunteers, both medical and non-medical, who often deploy in emergencies to assist in response efforts. The MRC has regional units across the state of Nebraska, with individual MRC coordinators for each region. Similarly, the ESAR-VHP program allows medical professionals to register as volunteers who may be deployed in a declared emergency. One of the added benefits of using ESAR-VHP for volunteers is that volunteers are already licensed and have gone through a background check process. This can save healthcare facilities from needing to go through that process prior to utilizing their volunteers.
HEALTHCARE WORKERS

In addition to any liability protections granted to healthcare workers acting as volunteers, Nebraska also has certain laws that protect licensed medical professionals working in their professional capability. The Nebraska Hospital-Medical Liability Act sets parameters on what type of medical malpractice suits may be filed, what monetary awards may be given in a suit, and how long a claimant has to file a malpractice suit after an incident. While there is not language in the act that specifically relates to providing healthcare in a disaster, the law could potentially play a role in determining how facilities and providers are protected in the event of a lawsuit.

The Nebraska Emergency Medical Services Practice Act provides protection from liability to any Nebraska-licensed out-of-hospital emergency care provider (such as EMT or EMS providers), physician assistant, registered nurse, or licensed practical nurse who provides public emergency care in good faith. That liability protection is waived however if the provider acts in bad faith or is willfully negligent.

Additionally, most hospitals and other healthcare facilities have general liability insurance that can protect them from wrongful death or injury claims by patients. These insurance policies may vary from facility to facility.
ALTERNATE CARE SITES

In an emergency or surge situation — a situation in which there may be a sudden and/or large increase in patients needing medical assistance — hospitals or other healthcare facilities may find it necessary to create alternate care sites to allow them to better serve patients. In planning for the use of alternate care sites, each healthcare facility should consider the needs that are unique to its circumstances and patients. As emergency plans are developed, healthcare facilities should ensure that any necessary memoranda of understanding or mutual aid agreements are in place with sites that may be used as alternate care sites. One of the best ways for healthcare facilities to coordinate agreements is through their local healthcare coalition. By engaging multiple facilities, healthcare coalitions can help organize potential alternate care sites across a broader geographic region.

Healthcare facilities may choose to utilize telehealth services to reduce the amount of care that must be provided on-site at the facility. Typically, telehealth agreements between healthcare facilities will include language to ensure that any physicians or other providers providing telehealth services are appropriately licensed and credentialed to practice across facilities. This protects healthcare facilities from liability that could stem from using unlicensed providers.
CRISIS STANDARDS OF CARE

During disasters, healthcare providers will often need to adapt the services they can provide in order to address the emergency. These adaptations are referred to as crisis standards of care. Crisis standards of care can be broken down into two separate concepts: medical standards of care and legal standards of care. Medical standards of care involve the care requirements placed on healthcare providers through laws or professional standards. Legal standards of care however are broader and relate to the care that a provider must use in a given circumstance based on what a reasonable healthcare provider would do in similar circumstances. Legal standards of care can vary between states, with many states setting specific circumstances for when crisis standards of care should be implemented. In litigation, courts will use the legal standard of care to help determine whether a provider violated their duties as a healthcare practitioner.

As noted above, legal crisis standards of care are generally set at the state level, however the state of Nebraska has declined to adopt any formal crisis standards of care. Without a governing state law, it is difficult for healthcare providers to know what standard they will be held to in court. 1135 waivers, which are discussed later in this guide, and the liability provisions mentioned previously in this guide can help protect providers from negative outcomes that may arise from adapting their care or services in the event of an emergency.

Individual healthcare facilities may enact policies and procedures stating how they intend to provide care in a crisis. As facilities determine their own internal crisis standards of care, it is important that they recognize that the care that can be reasonably provided in an emergency is likely not the same standard of care as may apply in normal day to day operations. Therefore, the unique circumstances of each disaster or emergency will likely provide a standard of care unique to each situation. Healthcare facilities should work closely with their legal counsel as they develop facility-specific crisis standards of care.
ISOLATION AND QUARANTINE

In Nebraska, in the event of a pandemic or public health emergency, issues of quarantine and isolation are addressed by the Nebraska Department of Health and Human Services (DHHS) and local public health departments (LPHDs) across the state. Nebraska uses the term “directed health measures” (DHMs) to refer to its isolation and/or quarantine efforts. Either Nebraska DHHS or the LPHDs have the authority to issue and enforce DHMs. DHMs may include orders for:

- Quarantine of individuals, populations, buildings, or animals, who have been exposed to a communicable disease or illness but who are not yet ill,
- Isolation of individuals who are infected with a communicable illness or disease,
- Decontamination, or removal of contaminating material from a person or object, or
- Other measures identified as effectives by public health authorities.

In order to issue a DHM for any of the above orders, the director of DHHS must follow a detailed decision process to determine whether a DHM is necessary and appropriate. Once it is determined that a DHM should be issued, the issuing body must follow detailed notice requirements to ensure that all affected parties receive sufficient notice and due process. If an individual receives a DHM and disagrees with the order, they may request a hearing and present evidence to show that the DHM should be modified or terminated.

If a DHM is in place and an individual violates the order, law enforcement is required to assist in enforcement of the order. Individuals who violate a DHM can potentially be found guilty of a misdemeanor.
If a healthcare facility believes they have a patient presenting with a communicable illness or disease, or a patient who has been exposed to a biological, chemical, radiological, or nuclear agent, they should notify Nebraska DHHS to begin the process for determining whether a DHM should be issued.
Other Legal Issues

1135 WAIVERS

In the event that both the President declares an emergency and the Secretary of Health and Human Services declares a public health emergency, the HHS Secretary may choose to waive or suspend certain legal and/or regulatory requirements through the use of 1135 waivers. An 1135 waiver may waive the following legal or regulatory requirements:

- Medicare or Medicaid conditions of participation
- EMTALA sanctions
- Licensure requirements (as they relate to Medicare or Medicaid reimbursement)
- HIPAA sanctions and penalties.

1135 waivers are only in effect for a limited period of time, with most waivers lasting either until the end of the declared emergency period or 60 days from the date the waiver was published. In the case of waivers relating to HIPAA or EMTALA sanctions, the waiver only lasts for a 72-hour period, starting from the activation of a facility’s disaster protocol.

In order to obtain an 1135 waiver, healthcare facilities that are affected by an emergency should contact their CMS regional office or state survey agency and request a waiver. The facility’s request should include an explanation of the need for the waiver request and an anticipated duration of time needed for the waiver to be in place.

1135 waivers may be issued retroactively, but until a facility has received a waiver, they should continue to operate under their normal operating requirements. In some circumstances, a “blanket” waiver may be issued for an entire area impacted by an emergency. However, even if a blanket waiver is in place,
individual facilities should still notify their CMS regional office or state survey agency that they are operating under the waiver’s authority.
HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) governs the use of patients’ protected health information (PHI) in a healthcare setting. The HIPAA Privacy and Security Rules ensure that patients’ PHI is safely and privately maintained, and that unauthorized disclosures do not occur. In an emergency, healthcare facilities, or covered entities under HIPAA, must ensure that all HIPAA requirements are still followed. While sanctions for violating HIPAA may be waived under an 1135 waiver, it is best for healthcare facilities to maintain HIPAA compliance at all times and ensure that HIPAA’s mandates will be followed when planning for an emergency or disaster.

Under the HIPAA privacy rule, covered entities may disclose an individual’s PHI without their prior authorization only in specific circumstances. Those circumstances include:

- If disclosure is necessary to treat the patient,
- To a legally authorized public health authority, who requires the information for public health purposes,
- To individuals at risk of contracting or spreading a disease or condition (if authorized by other law),
- To family, friends, or other individuals who may be involved in or responsible for a patient’s care,
- To legally authorized disaster relief organizations, (which can include any public or private entity, such as the Nebraska Emergency Management Agency or the American Red Cross, that is authorized by law or charter to provide disaster relief), in the event that they are coordinating family notification efforts, or
- If there is an imminent threat to public health or safety.

In any other circumstance, a covered entity should ensure that they have the patient’s authorization before disclosing any of their PHI.

Anytime a disclosure is made under HIPAA, the covered entity should ensure that only the minimum necessary information is
disclosed, unless the disclosure is to a fellow healthcare provider for treatment purposes. Covered entities should also document all disclosures of PHI. HIPAA requires covered entities to keep records of disclosure of patient PHI, and additionally to provide a log of PHI disclosure or use to patients upon request so that they may see how their information has been disclosed.

As mentioned above, an 1135 waiver *may* waive the sanctions for violating some of the HIPAA privacy requirements. Those requirements that may be included in an 1135 waiver are:

- The requirements to obtain a patient's agreement to speak with family members or friends involved in the patient’s care,
- The requirement to honor a request to opt out of the facility directory,
- The requirement to distribute a notice of privacy practices,
- The patient's right to request privacy restrictions, and
- The patient's right to request confidential communications.

However, unless a covered entity is sure that they have obtained an 1135 waiver, they should maintain compliance with all of the above requirements.
EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that affects any hospital with an emergency department that participates in Medicare. Under EMTALA, those hospitals must perform a medical screening exam for any individual who comes to the emergency department, regardless of the individual’s ability to pay. If the exam shows that an emergency medical condition exists, then the hospital must either treat and stabilize the individual or transfer the individual to a hospital that has the capacity to stabilize and treat the individual’s condition.

In a surge or mass casualty situation, meeting the requirements of EMTALA can be difficult for hospitals. If an 1135 waiver has been granted, using the process explained above, then sanctions for violating the requirements of EMTALA may be waived. Without an 1135 waiver however, hospitals are expected to follow the requirements of EMTALA even in an emergency or disaster. While 1135 waivers can be applied retroactively, hospitals should not rely on the possibility of an 1135 waiver being eventually issued. In order to reduce their possible risk of liability or sanctions, hospitals should try to maintain EMTALA compliance throughout an emergency.

While following the requirements of EMTALA can be difficult in an emergency, there are certain adjustments hospitals can make to relieve some of that burden. For example, if an emergency incident or surge is occurring, the affected hospital would likely want to transfer the individual to a less affected hospital once the medical screening exam had occurred. If an emergency situation occurs on site of the hospital and providers feel that they cannot safely conduct a screening exam, then they may delay care until the safety considerations are resolved. Hospitals may also choose to set up alternative screening areas on their campus so that they may triage presenting patients more easily. If emergency management and the local healthcare coalitions choose to establish an alternate care site which is not affiliated with any hospital, then EMTALA would not apply.
VULNERABLE POPULATIONS

In any given emergency or disaster situation, the needs of vulnerable or at-risk populations must be considered. There are a number of laws and regulations that address the needs of vulnerable populations. However, the definition of “vulnerable populations” will be defined differently depending on which law or regulation is in use. The Public Health Service Act and the Affordable Care Act both include the following groups or characteristics in their description of at-risk or vulnerable populations:

- People with disabilities,
- Older adults,
- Individuals with limited English proficiency (LEP),
- Race/color/national origin,
- Sex, and
- Socioeconomic status.

More generally, vulnerable or at-risk populations are described as individuals having functional or access needs.

In creating their emergency plans, healthcare facilities must consider the unique needs of the vulnerable populations they are likely to treat in a disaster or emergency. Any facility evacuation or shelter-in-place plans should include provisions ensuring that their unique needs are met.

Nevertheless, it is important to note that community shelters should not be divided into general and special needs shelters. Creating shelters that are not accessible to all populations runs the risk of violating the Americans with Disabilities Act. All efforts should be made to make sure that shelters are accessible, regardless of disability.
Nebraska is a party to a number of interstate agreements that allow for coordination of resources and skilled clinical workers across state lines. The two most important of these compacts are the Emergency Management Assistance Compact (EMAC) and the Nurse Licensure Compact (NLC).

EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC)

The Emergency Management Assistance Compact (EMAC) is a mutual aid agreement that has been adopted by all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands. EMAC allows states to coordinate their requests and the deployment of resources in an emergency. In a state-declared emergency, the governor and the Nebraska Emergency Management Agency (NEMA) can assess whether to activate their EMAC agreement. If they choose to activate EMAC, requests can be made to other states for assistance and shared resources.

EMAC provides liability and workers’ compensation protections to out-of-state individuals who are deployed in response to an EMAC request. Under the language of the Compact, any individual who provides aid under an official EMAC request cannot be held legally liable under certain claims while assisting in an emergency unless he or she acted with extreme carelessness or an intent to harm. Additionally, any workers’ compensation benefits that the individual would be entitled to in his or her home state will be carried with him or her while working in the requesting state. The state that requests aid or resources is responsible for any financial costs or reimbursement incurred as a result of the request.
Much like the immunity protections previously mentioned for volunteers, the protections included in EMAC are limited by formal organization and direction. These protections do not support spontaneous volunteers or a spontaneously assembled response.
NURSE LICENSURE COMPACT

Nebraska is a party to the Nurse Licensure Compact (NLC). The NLC utilizes a multistate license, so that registered nurses (RNs) and licensed practical/vocational nurses (LPNs and LVNs) who are registered in an NLC state may also practice in any other NLC state. The NLC standardizes licensing requirements across participating states, so that all nurses who obtain a multistate license face the same licensure requirements. These requirements also include a federal and state background check. By participating in the NLC, nurses from other participating states may easily deploy to Nebraska in an emergency, while ensuring that their licensing requirements have been met.
REFERENCES

American with Disabilities Act, 42 U.S.C. 12101 et seq.

Emergency Medical Treatment and Active Labor Act, 42 U.S.C. 1395dd.


Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 et seq.

OTHER RESOURCES

Emergency Management Assistance Compact  
https://www.emacweb.org/

Nebraska Medical Reserve Corps and Emergency System for Advance Registration of Volunteer Health Professionals  
https://volunteers.ne.gov/ESAR-VHP/faces/jsp/login.jsp

Nurse Licensure Compact  
https://www.ncsbn.org/nurse-licensure-compact.htm
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