Region V for Kids
Pediatric Disaster
Center of Excellence

Legal Considerations for Providing Pediatric Healthcare During a Disaster

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Using This Report:

This report serves as an introduction to the complex legal and ethical issues arising when providing health care during emergencies, disasters, or other circumstances where the customary standards of healthcare may not be achievable.
Your organization's legal counsel may have more specific recommendations pertinent to your state or locality. Ideally, the guidance in this report prepares users to ask their counsel well informed, concise questions.

The legal landscape surrounding healthcare during disasters and emergencies is often dynamic. The content of this report is valid and accurate at the time of publication but may change in the future. Additionally, hyperlinks embedded, and citations referenced within the report may become outdated. Users and counsel are recommended to revalidate source materials prior to acting upon the information contained in this report.

Executive Summary

As routine hospital operations transition into emergency operations during a disaster, emergency, or patient surge, the legal landscape may change to adapt to these altered circumstances. To perform their duties effectively and compliantly, emergency management and health care professionals need a basic understanding of the legal landscape that emerges during emergencies and disasters. While not a decision-making tool, this report provides primary information for emergency managers, healthcare administrators, and other decision-makers to operate legally and with minimal liability risk.

Section II of the report addresses the availability and scope of emergency powers at the federal, state, and local levels. Federal emergency powers authorize the President or the Secretary of the Department of Health and Human Services to implement changes to federal law to waive requirements that govern healthcare settings, expand liability protection for emergency response activities, expedite regulatory processes such as drug and vaccine approvals, and allocate resources to facilitate emergency response efforts.

State and local emergency powers may provide even greater latitude to government officials during declared emergencies and disasters, including authorization to coordinate responses across jurisdictions, to waive or amend laws that could impede emergency responses, to control movement of people and operations of businesses and activities, to expand professional scope of practice and modify licensure requirements for health care workers, to provide liability protections for health care workers and entities, to control uses and allocation of property, and to use state and local budgetary, personnel, and physical resources to pursue response efforts. All FEMA Region V states possess broad authority to alter their legal landscapes in response to an emergency or disaster.

Section III of the report provides an overview of how the legal framework governing health care capability and capacity applies during emergencies and disasters. Sustaining access to care under these situations may require expanding the number of health care providers available to care for patients. Legal provisions in FEMA Region V states permit changes to requirements for licensure, credentialing, and privileging of health care workers, alterations to the scope of practice permitted for specific professionals, and cross-jurisdictional cooperation and resource sharing. Additionally, state laws may facilitate expansion of structural capacity during emergencies through the approval of adaptive treatment areas and alternative care sites, and the waiver of facility licensure and certificate of need requirements that ordinarily limit such expansions. Finally, this section outlines the potential for expanding access to telehealth services under federal and state law during emergencies.

Section IV outlines the areas of federal and state law where immunity protections against liability may be found. Examples include immunity for health care providers during declared emergencies and disasters, Good Samaritan laws that provide protection from liability for providing care at the scene of an emergency, and specialized immunity protection that applies in specific circumstances, such as providing vaccinations. These immunity provisions vary considerably in their applicability, so health care providers and institutions can use this information, along with additional advice from legal counsel, to determine how these provisions will apply in a particular situation.

Section V examines how legal and ethical considerations affect decisions about allocation of scarce resources and the applicability of crisis standards of care. When surging demand and dwindling resources imperil the capacity of the healthcare system, providers may need to make difficult decisions about resource allocation. This section describes legal considerations in making these difficult decisions and explains the national and state-level frameworks that provide guidance on these issues. In addition, this section addresses the application of these allocation frameworks to pediatric health resources.

Section VI discusses family reunification process and requirements during disasters and emergencies, a topic that is integral to pediatric health care settings. Legal requirements applicable to family reunification are surprisingly underdeveloped in state law. Nevertheless, this section addresses the treatment of unaccompanied pediatric patients, custody issues, and health information privacy.

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I. Introduction

During a disaster or pandemic, hospital operations may have to transition from routine into emergency operations. If the emergency necessitates an emergency or disaster declaration, this can alter the legal landscape for healthcare organizations. The declaration may afford enhanced legal protection from liability for medical care delivered during the emergency or disaster, the invocation of crisis standards of care, and/or the need for scarce resource allocation. Hospital leadership and emergency management professionals need a baseline understanding of these critical legal concepts as well as their impact on their local jurisdictions. The following report presents the legal concepts and landscape that may exist during an emergency or disaster at the federal, state, and local levels for the FEMA Region V states: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. The report also specifically identifies legal and ethical issues that may pertain to providing pediatric health care during emergencies or disasters.

II. Emergency Authority

During emergencies, government officials can use a variety of legal tools to respond. At the federal, state, and local levels, laws empower officials to declare states of emergency, disaster, or public health emergency; to direct resources; and to issue new orders or waive existing laws. These emergency authorities enable rapid changes to the legal status quo and allow officials to act quickly to respond to urgent threats.

Changes to the legal landscape during emergencies or disasters have particular importance for health care providers and facilities providing patient care. Federal emergency declarations can relieve health care entities from federal requirements in order to bolster capacity and improve access. At the state and local levels, emergency declarations can unlock expedited rulemaking, empower public health officials in their response efforts, and provide legal flexibility. Providers must understand and follow legal actions at all three levels of government and remain apprised of the dynamic legal landscape during an emergency.

Brief overview of emergency declarations

Federal Stafford Act Emergency/Disaster – The President may declare an emergency or major disaster under the Stafford Act, 42 U.S.C. 5121-5208, authorizing FEMA to provide financial and other assistance to help affected communities and to coordinate federal responses.

Federal National Emergency Act – The President may declare a national emergency, under 50 U.S.C. 1601-1651, to access myriad powers, including redirecting federal funding or staff to address emergencies and waivers of specific federal laws.

Federal Public Health Emergency – The Secretary of DHHS may declare a federal public health emergency under section 319 of the Public Health Service Act in response to "significant outbreaks of infectious disease or bioterrorist attacks," enabling DHHS to accelerate procurements and funding distribution, investigate causes and solutions, promote coordination and social distancing measures, and temporarily waive some federal laws.

State/Tribal Emergency or Disaster – State and tribal governments may draw on their sovereign police powers and statutory or constitutional authorizations to declare emergencies or disasters, allowing state officials to implement a wide array of powers that may include waiver of state laws, coordination of response efforts, control of persons and property, and allocation of funding to response efforts. Many states also permit state health officials to issue orders to respond to public health emergencies.

Local Emergency – Local government officials may also have the authority to declare emergencies or disasters distinct from state action to address more localized emergencies through local orders that allocate resources, coordinate local emergency response, and implement local emergency policies.

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A. Federal Emergency Authority

Federal emergency authorities play an important role in emergency response. Federal requirements shape the health care delivery system, the public health response, and the resources available for different response actions. Emergency declarations give the federal government the authority to modify, relax, or add to these requirements.

Three distinct federal authorities allow for emergency declarations. The Robert T. Stafford Disaster Relief and Emergency Assistance Act ("Stafford Act") authorizes the President to declare an emergency or major disaster when requested by a state governor.[1] The National Emergencies Act also permits the President to declare a state of emergency for incidents that require a national response.[2] The Public Health Service Act allows the Secretary of the Department of Health and Human Services (DHHS) to make a determination that "(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."[3] Such a determination that a public health emergency (PHE) exists empowers the Secretary to take a range of actions to marshal public resources and waive a limited set of laws.[4] For example, the Secretary may relax limitations on using telemedicine to prescribe controlled substances, set aside certain provisions of the HIPAA Privacy Rule, mobilize the Strategic National Stockpile, and expedite emergency approval of a "drug, device, or biological product."[5]

A PHE determination becomes particularly important when coupled with an emergency or major disaster declaration by the President.[6] When there has been both a Presidential declaration and a PHE determination, the Secretary of DHHS gains greater authority to waive federal law that would otherwise govern healthcare settings. Specifically, under §1135 of the Social Security Act, the Secretary may waive requirements under Medicare, Medicaid, the State Children's Health Insurance Program, the Health Insurance Portability and Accountability Act (HIPAA), and the Emergency Medical Treatment and Active Labor Act (EMTALA), among others.[7] Accordingly, the Secretary may issue blanket waivers, which are applicable to all providers in the affected area. Absent a blanket waiver, providers may apply for individual waivers.[8]

During the COVID-19 response, the Secretary issued extensive blanket waivers under §1135.[9] These waivers permitted, for example, hospitals to screen patients for EMTALA purposes at offsite locations; relaxed medical staff requirements to permit providers with expired or as-yet-unissued privileges to practice; and expanded reimbursement for telemedicine. The Secretary may only waive federal requirements; state requirements remain in place. For instance, the Secretary may waive federal licensure requirements for purposes of reimbursement, but state licensure rules still apply unless separately changed.

Another important source of emergency authority arises from the Public Readiness and Emergency Preparedness (PREP) Act.[10] Under the PREP Act, the

Secretary of DHHS can provide "immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures." The process for providing immunity under the PREP Act requires the Secretary of DHHS to make a separate PREP Act declaration. Further, the President can utilize the Defense Production Act to require private companies to manufacture products essential to the national defense.

Finally, the Food and Drug Administration (FDA) may provide emergency use authorization (EUA) for certain countermeasures.[11] Among the predicates to issuing an EUA is a PHE declaration by the Secretary of DHHS. Subsequent to such a declaration, the FDA may issue an EUA, along with conditions on emergency use, upon finding that the countermeasure may be reasonably effective, safe, and necessary.

B. State and Local Emergency Authority

State emergency declarations are critical tools in emergency response. They empower state officials to address systemic needs in a rapidly changing environment. Health care providers look to these orders to clarify legal requirements and provide flexibility to ensure sufficient capacity to meet health care needs during the emergency. Public health officials rely on these orders to enhance their existing legal authority in times of exigency.

State laws furnish public officials with the power to declare emergencies.[12] There is substantial variation, however, in what that entails. Laws in all six states in FEMA Region V enable governors to declare emergencies or disasters. Additionally, all six states provide state and local public health officials with authority to respond to emergencies that threaten public health. These declarations allow state and local leaders to take necessary steps to respond, including:

- Coordinating response efforts across jurisdictions.
- Authorizing the use of state and local budgetary, personnel, and physical resources to pursue response efforts.
- Waiving or amending statutory or regulatory provisions that may impede effective responses.
- Controlling the movement of people, the distribution of resources, and the operations of schools, business, and other public and private sector entities.
- Entering into contractual relationships and controlling the use of property when necessary for protecting public health.
- Expanding the professional scope of practice for health care workers and other professionals and waiving or modifying licensure requirements for out-of-state health care workers; and
- Providing liability protections for health care workers and entities and authorizing changes to the standard of care.

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Key differences between the states emerge in the scope of power these laws provide. These differences shape who holds responsibility for emergency response. The following section provides an overview of the emergency powers delegated to the governor, state public health officials, and local public health officials in each state. Tribal governments in FEMA Region V jurisdictions may also have independent legal authority to respond to emergencies and disasters.

State emergency powers are broad, and the breadth and flexibility of these powers was especially evident during the COVID-19 response. The extent of state emergency powers has sometimes been challenged with varying results. State legislators in Indiana, Michigan, Ohio, and Wisconsin have modified the scope of gubernatorial emergency powers since 2020. In Michigan, after the legislature sued the governor over her continuing renewal of emergency declarations, the Michigan Supreme Court ruled that the Emergency Powers of the Government Act of 1945 EPGA was an unlawful delegation of legislative power to the executive branch of state government.[13] Similarly, in Wisconsin, the legislature successfully challenged the authority of the state health department director to issue statewide stay-at-home orders.[14] The state legislatures in Indiana and Ohio introduced new limitations on the public health authority available to the governor, state health department, and local health departments.[15] By contrast, in Minnesota the state Supreme Court upheld the governor's authority to declare a peacetime emergency under the Emergency Management Act during the COVID-19 response.[16]

1. Gubernatorial Emergency Powers

In all six FEMA Region V states, the governor has broad discretionary powers to respond to emergencies or disasters. The scope and parameters of these powers varies across the states. State laws authorize governors to declare emergencies or disasters with specified maximum time limits. Michigan law only allows emergency declarations of up to 28 days, Illinois and Minnesota allow up to 30 days, Indiana and Wisconsin allow up to 60 days, and Ohio allows up to 90 days. However, while Illinois and Minnesota allow ongoing renewals of emergency or disaster declarations by their governors without specific legislative authorization, the law in Indiana, Michigan, Ohio, and Wisconsin requires legislative approval to extend these declarations beyond their initial term.

Once an emergency or disaster is declared, governors possess a range of powers to rapidly respond. Among the most consequential of these powers is the ability to waive or modify existing legal requirements to expedite state actions. In Michigan, for example, statutory authority allows the governor to declare a state of emergency and/or disaster, and grants the governor significant authority to respond rapidly to emerging threats.[17] Once an emergency or disaster has been declared, the governor may issue orders having the force of law.[18] Further, the governor may suspend then-existing laws and regulations when strict compliance would "prevent, hinder, or delay necessary action in coping with the disaster or emergency."[19] Illinois similarly allows the governor

to "suspend the provisions of any regulatory statute prescribing procedures for conduct of State business, or the orders, rules, or regulations of any State agency" that would "prevent, hinder or delay necessary action."[20] Wisconsin law provides the governor with authority to "[s]uspend" the provisions of any administrative rule if the strict compliance with the rule would prevent, hinder, or delay necessary actions to respond to the disaster."[21]

In Ohio, the governor may, concurrent with a declared emergency, request that the Department of Administrative Services suspend contracting and procurement requirements under law.[22] The governor may, upon request from an agency, determine an emergency exists to suspend certain rulemaking requirements and allow immediate effect.[23] In March 2020, Ohio Governor Mike DeWine invoked these powers in response to the COVID-19 pandemic.[24] The ability to waive rulemaking requirements was particularly important in managing the state's medical response to the pandemic. For example, Ohio's Department of Medicaid (ODM) issued emergency rules expanding telehealth services.[25] The governor's emergency determination permitted ODM to exercise its statutory powers quickly and responsively.[26] Michigan's governor may also permit emergency rulemaking under Michigan's Administrative Procedures Act.[27] This requires a finding by the issuing agency and the governor that "preservation of the public health, safety, or welfare requires promulgation of an emergency rule without following" the normal process.[28] This also enables agencies to enact rules effective on filing. As in Ohio, Michigan Medicaid used this power during COVID-19 to expand telehealth coverage.[29]

Governors may also issue executive orders that modify health care practice requirements. During the COVID-19 response, Michigan Governor Gretchen Whitmer issued orders waiving and modifying state scope of practice, licensure, and supervision requirements,[30] and orders relaxing certificate of need (CoN) and bed licensure requirements to support temporary or mobile health facilities.[31]

See Appendix A for comparison table of FEMA V Gubernatorial Emergency Powers

2. State Public Health Departments

State public health departments in all six FEMA Region V states have an integral role to play in disaster response. State laws bestow particular powers upon their respective public health departments in order to more effectively address infectious diseases and pandemics, but many public health powers can be applied to many types of emergencies and disasters.

State statutes and regulations typically grant state public health departments with broad authority to take steps to track the spread of communicable diseases and to intervene in various ways to protect the public's health when outbreaks and epidemics occur. The Ohio Department of Health (ODH) may issue "special or standing orders or rules for preventing the spread of contagious or infectious diseases."[32] Similarly, the

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Michigan Department of Health and Human Services (MDHHS) director, upon determining that "control of an epidemic is necessary to protect the public health," may issue orders prohibiting the gathering of people and establishing procedures "to insure continuation of essential public health services and enforcement of health laws."[33] The authority of MDHHS under the Public Health Code is distinct from the authority of the Governor. This authority may be especially broad and flexible as the statute states it is not limited to the provisions within the Public Health Code. [34] The Illinois Department of Public Health (IDPH) "shall investigate the causes of dangerously contagious or infectious diseases, especially when existing in epidemic form, and take means to restrict and suppress the same."[35] Wisconsin statutes grant its state health department broad authority to take steps to respond to threats from communicable disease. The Wisconsin Department of Health Services (WDHS) "may authorize and implement all emergency measures necessary to control communicable diseases."[36]

These broadly structured public health powers allow state health officials to initiate a range of actions to monitor threats to public health and to intervene, regardless of whether a state-level emergency or disaster has been declared. For example, the ODH is the "authority in matters of quarantine and isolation, which it may declare and enforce, when neither exists, and modify, relax, or abolish, when either has been established."[37] ODH also has authority over methods of implementing and encouraging immunizations against certain diseases.[38] Pursuant to this authority, ODH issued orders requiring masks, postponing elective surgeries, and requiring people to stay at home in response to COVID-19.[39] During COVID-19, the MDHHS director issued orders mandating masks, limiting public gatherings, and regulating hospital visitors.[40]

The IDPH may impose quarantine and isolation orders, and may order a place to be closed to the public to "prevent the probable spread of a dangerously contagious or infectious disease."[41] The IDPH may also require physical examinations and tests, the administration of vaccine, medications, or other treatments, and the observation and monitoring of persons, as well as the seizure or destruction of property.[42] The Indiana Department of Health (IDH) possesses authority to "order schools closed and forbid public gatherings when considered necessary to prevent and stop epidemics."[43] The IDH may also "establish quarantine" and "do what is reasonable and necessary for the prevention and suppression of disease."[44] Minnesota's state commissioner of health is authorized to collect and analyze health data, implement programs to safeguard public health, and issue quarantine and isolation orders when appropriate.[45] WDHS legal authority to control communicable diseases includes establishing "systems of disease surveillance and inspection," limiting "public gatherings in schools, churches, and other places to control outbreaks and epidemics," and promulgating and enforcing rules or issuing orders "for the control and suppression of communicable diseases, [and] for the quarantine and disinfection of persons, localities and things infected or suspected of being infected by a communicable disease."[46]

The scope of authority granted to state public health officials has been in flux in some states since the onset of the COVID-19 pandemic. MDHHS orders became even

more instrumental in responding to the COVID-19 pandemic after the October 2020 Michigan Supreme Court ruling that effectively limited the governor's power to issue emergency orders related to the pandemic. However, at least one Michigan state appellate court has found that the MDHHS' legal authority to issue orders in response to a pandemic to be an unconstitutional delegation of authority from the legislature.[47] As challenges to public health powers continue to be litigated, the scope of authority available to state and local officials may change.

Ohio's legislature enacted new restrictions on ODH in 2021. The state's general legislative assembly may rescind, by adopting a concurrent resolution, any special or standing orders or rules for preventing the spread of contagious or infectious disease enacted by ODH. In addition, the general assembly may rescind by concurrent resolution emergency rules adopted by ODH in response to a state of emergency or reinstate rules that were rescinded by ODH.[48] These changes to the law effectively give the legislature the ability to overturn any ODH actions designed to respond to infectious disease outbreaks by a majority vote.

Despite the WDHS having expansive statutory language authorizing state public health powers, the Wisconsin Supreme Court placed significant procedural limitations on the implementation of these powers in the 2020 case *Wisconsin Legislature v. Palm*.[49] The Court determined that COVID-19 orders issued by the WDHS under its statutory authority that limiting gatherings and closing schools and business were "rules" and therefore were invalid because they hadn't gone through a multistep rulemaking process. In addition, the Indiana Legislature updated their state laws in 2021, clarifying that IDH may only enforce health and safety requirements on religious organizations that meet a "compelling governmental interest and is the least restrictive means of furthering that compelling governmental interest."[50]

Other state agencies can also use emergency authority to promulgate expedited rules to respond to an emergency. Michigan's Occupational Safety and Health Administration (MIOSHA), for example, issued emergency rules governing workplaces.[51] In long-term emergencies without legislative extensions of emergency or disaster declarations, this type of emergency rule-making may be employed as an alternative legal authority to extend public health measures in specific circumstances.

See Appendix B for Quick Comparison of State Departments of Health Emergency Powers

3. Local Public Health Departments

Local health departments also have the authority to take action to address public health emergencies. In some cases, larger cities and counties may have the power to declare states of emergency depending on whether "home rule" applies. Home rule is a level of discretionary power given by the state to local governments to allow those local governments to better address local issues. Both Ohio and Michigan have provisions that

provide home rule powers to some local governments.[52] Minnesota provides local executive officials with the authority to declare emergencies, but these declarations can only be extended beyond three days with the consent of the local governing body.[53] Likewise, Indiana law permits the principal executive officer of a political subdivision to declare a local disaster emergency for a maximum of seven days absent further extension by the local governing body.[54] Wisconsin law, by contrast, grants local governments the option of declaring an emergency without similar time restrictions and authorizes local officials to do "what is reasonable and necessary for the prevention and suppression of disease."[55]

Michigan's local health departments have powers that largely overlap with the state health department. Pursuant to MCL 333.2235(2), local public health departments are the primary agencies tasked with the organization, coordination, and delivery of services and programs within their jurisdictions. They have parallel powers to address epidemics,[56] including ordering testing and detention.[57] They have the power to address imminent dangers and abate nuisances.[58] Further, they have the power to investigate public health matters and enforce their orders with misdemeanors or injunctions.[59] During the COVID-19 response, a number of municipal health departments issued orders on their own, such as orders requiring facial coverings, gathering and event restrictions, capacity limits for food service establishments, and workplace screening in Oakland, Washtenaw, and Ingham Counties.[60]

In Ohio, the local boards of health also retain authority to address public health emergencies. They may make orders for the prevention of communicable diseases through quarantines and abatement of nuisances that are considered dangerous to life or health.[61] During "epidemics of contagious or infectious diseases, or conditions or events endangering the public health," their orders may take immediate effect.[62] They have the power to isolate infected individuals, placard the premises,[63] destroy infected property,[64] provide free vaccinations,[65] and approve special hospitals constructed for contagious diseases.[66] Local health boards may also inspect a location where a person presumed to have a contagious disease is present, and have the authority to send the person to a hospital or other health care facility.[67] They may also prevent ingress and egress from the said location.[68] Quarantine guards with police powers may be employed to enforce the Ohio laws associated with the prevention of infectious disease.[69]

Minnesota permits delegation of authority to dispense medications or vaccinations from the state commissioner of health to local or tribal public health agencies during a declared emergency.[70]

The greater scrutiny applied to public health officials in recent years has also prompted revisions to the local public health authority. For instance, legal changes enacted in 2021 place additional restrictions on Ohio's local boards of health, limiting the issuance of quarantine or isolation orders "to individuals who have been medically diagnosed with [or] have come in direct contact with someone who has been medically

diagnosed with the disease that is the subject of the order"[71] and only allowing quarantine and isolation orders applicable to specific persons rather than a class of persons.[72]

C. Informal Authority: Enforcement Discretion

An additional source of legal flexibility during an emergency or disaster is enforcement discretion. Federal and state agencies may announce their intention to relax enforcement of certain laws during declared emergencies or disasters. While not formally altering laws on the books, such statements may signal to providers where regulators will not expect strict compliance with existing legal requirements.

At the federal level, the Centers for Medicare and Medicaid Services exercised its enforcement discretion around billing requirements for vaccines at skilled nursing facilities in response to COVID-19.[73] The intent was to reimburse a greater variety of providers for vaccinations, notwithstanding existing statutory requirements.

In Ohio, the State Medical Board of Ohio (SMBO) announced it was suspending enforcement of certain requirements under Ohio's statutes and regulations in response to the pandemic.[74] Specifically, it relaxed practice requirements for anesthesiologist assistants, respiratory care limited permit holders, and physician assistants.

Michigan's licensure statute also provides an exemption for medical care during an emergency. MCL 333.16171(c) exempts "[a]n individual who by education, training, or experience substantially meets the requirements of this article for licensure while rendering medical care in a time of disaster or to an ill or injured individual at the scene of an emergency" from state licensure requirements. The Michigan Department of Licensing and Regulatory Affairs (LARA) issued further guidance on how it would enforce the provision. Rather than requiring individuals to apply to be granted an exemption, LARA's Bureau of Professional Licensing instead retrospectively examined and evaluated the relevant circumstance to determine whether an individual met the exemption criteria if a complaint was received.[75]

III. Health Care Capability and Capacity

Expanding health care capacity is a central challenge in emergency response. Acute demand stresses health care organization's normal operations, overwhelming their supply of providers or physical capacities. Federal and state laws require many health care facilities to create plans for emergency preparedness, and failure to do so risks future liability.[76] However, in developing these plans or reacting to ongoing emergencies, an array of federal and state legal considerations must be addressed. Adding to the complexity, emergency orders may relax, or add to, these requirements.

This section provides an overview of the legal framework for when health care organizations alter their capacity in the face of an emergency. It begins by discussing

issues around adding providers. Rules around licensing, scope of practice, privileging, and credentialing all impact how quickly entities may add personnel. It reviews tools like the Emergency Management Assistance Compact (EMAC) and memoranda of understanding (MOUs), which can help states and institutions address personnel needs or excess demand. Next, it discusses considerations for modifying or adding facilities. Similar to personnel, adding facilities or switching bed designations may implicate federal or state regulations. Finally, it provides an overview of the rules around telemedicine, an important tool to managing demand in an emergency.

A. Capability

Before providers can begin treating patients, they must meet an assortment of licensing, privileging, and credentialing requirements. Both federal and state laws impose relevant requirements. Federal rules from the Centers for Medicare & Medicaid Services (CMS) applying to reimbursement and conditions of participation may specify which providers can perform what services and where. Underlying these rules, however, are state laws that govern who may provide health care services. During emergencies that overwhelm existing capacity, public officials can employ some of the emergency authority tools described in Section II of this report to relax these rules and make it easier to expand the supply of health care providers. This section reviews these rules as they apply to FEMA Region V states, and how emergencies and disasters may affect them.

1. Licensing and Scope of Practice

Federal and state laws both govern who may provide health care services through licensing requirements. As is often the case, federal rules govern what federal insurance programs, e.g. Medicare, Medicaid, and CHIP, reimburse, either to providers themselves or to hospitals or EMS agencies. Even absent these federal requirements, state laws regulate the practice of health care professions within their state through licensure and scope of practice rules.

At the federal level, CMS reimbursement rules may specify licensure requirements for billing. During applicable emergencies, §1135 permits CMS to waive requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State."[77] During COVID-19, CMS implemented such waivers.[78] They also waived certification requirements for ambulance providers, deferring to state and local rules. Critically, CMS waivers only apply for federal reimbursement purposes and state laws addressing reimbursement, licensure, and scope of practice will continue to apply when these waivers are in place.

In all FEMA Region V states, state laws specify the licensure requirements for health care providers and define the scope of practice for each provider. State Boards of Medicine, Nursing, and Pharmacy implement these requirements.[79] A parallel

regulatory structure governs the certification of emergency medical service (EMS) providers.[80] There currently is no automatic licensure reciprocity for physicians or EMS providers in FEMA Region V states, although Indiana has enacted legislation that will allow EMS personnel reciprocity under the Emergency Medical Services Personnel Licensure Interstate Compact.[81] Indiana, Ohio, and Wisconsin have enacted the Nurse Licensure Compact, which allows for nurses who have obtained multistate licenses in any participating state to practice nursing in any other participating state.[82]

Controlled substances are another area of federal and state regulation. The federal Drug Enforcement Administration (DEA) requires providers to register in order to prescribe controlled substances.[83] DEA registration is contingent on state authorization to prescribe *in that state*.[84] Illinois, Indiana, and Michigan require licensed health care professionals to obtain an additional license to prescribe controlled substances.[85] Minnesota, Ohio, and Wisconsin do not require such a license,[86] although they do regulate how providers handle and prescribe such substances.[87]

During emergencies, however, state laws and officials may modify these requirements. Statutory provisions may relax licensure requirements or expand the scopes of practice for licensees during emergencies. This legal authority may be grounded within the broad emergency powers granted to some states—like Michigan—that allow the governor to waive existing legal requirements, including licensure laws. In response to COVID-19, Governor Whitmer waived licensing requirements to permit providers licensed in good standing in other states to practice within Michigan.[88] The Governor's executive order cited the EMA, stating that it was both "reasonable and necessary to provide limited and temporary relief from certain restrictions and requirements governing the provision of medical services."[89] Illinois possesses similarly broad waiver language under its Emergency Management Act.[90]

Additional legal authority to alter licensure requirements can be found explicitly in specific provisions within emergency powers acts and licensure statutes. Statutory laws in Illinois, Indiana, Michigan, and Minnesota authorize license reciprocity for professionals licensed in other states—including physicians, nurses, and physicians assistants—who are providing analogous professional services during a declared emergency or disaster.[91] For example, Michigan law includes a broad emergency provision that relaxes licensure requirements during a disaster or emergency, stating that "[a]n individual who by education, training, or experience substantially meets the requirements of this article for licensure while rendering medical care in a time of disaster or to an ill or injured individual at the scene of an emergency."[92]

In Ohio, licensure reciprocity authority varies according to profession. The State Board of Medicine found, during COVID-19, that they did not in fact have the authority to permit emergency licensure.[93] However, the State Medical Board implemented other changes to bolster health care capacity, including suspension of continuing education requirements and expanding the use of telemedicine.[94] In Ohio, the Nurse Practices Act exempts nurses licensed in another jurisdiction practicing during a declared disaster "if the individual's activities are limited to those activities that the same type of nurse may

engage in pursuant to a license issued under this chapter."[95] Similarly, for physician assistants, ORC 4730.04 specifies that out-of-state licensed physician assistants may provide "medical care, to the extent [they are] able" when needed during a disaster or emergency.

Numerous state law provisions also permit modification to professional scope of practice during emergencies. Ohio law authorizes the state Director of Health to implement protocols for the administration of drugs during a declared emergency authorizing certain persons to administer drugs "notwithstanding any statute or rule that otherwise prohibits or restricts the administration, delivery, or distribution of drugs by those individuals."[96] Likewise, Michigan authorizes an array of health care providers to practice, in addition to their typical scopes of practice, "the administration of anesthetics; minor surgery; intravenous, subcutaneous, or intramuscular procedure; or oral and topical medication; or a combination of these under the supervision of a member of the medical staff of a licensed hospital of this state, and may assist the staff member in other medical and surgical proceedings."[97]

Case study: EMS requirements in Michigan and Ohio

EMS certification and licensing requirements and scopes of practice are set out statutorily, but their day-to-day instructions are set out in protocols. In Michigan, Section 20919 of the Public Health Code requires each Medical Control Authority (MCA) to establish minimum protocols. Local MCAs may then develop local protocols, but these must be approved by the state and consistent with other protocols. In practice, this standardizes local EMS protocols around the state protocols. In Ohio, the medical director of the local EMS organization develops written protocols, but they must comply with state-developed or -approved trauma triage protocols. The state also issues treatment guidelines for local EMS organizations.

During disasters, these protocols may be adjusted to meet growing need. In Michigan, for example, MCAs may adopt emergency protocols to alter EMS providers' practices quickly. Additionally, the state may provide emergency protocols that the MCAs can then adopt. These protocols are valid for 60 days and may not conflict with other laws. During COVID-19, the state issued a number of protocols relaxing prior rules to address staffing shortages and minimize spread. Under the EMA, the governor may waive and modify statutory limitations on EMS providers' practices and licenses. When Michigan-based resources are exhausted, the state also has the ability to request Federal assistance through the State Emergency Operations Center (SEOC).

Advance planning may also help navigate licensure issues. Particularly for EMS providers, both Ohio and Michigan have laws permitting reciprocity agreements with out-of-state EMS providers. A 2013 Attorney General opinion delineates the legal underpinnings for these agreements in Ohio. Notably, while state law permits practice agreements for out-of-state providers, certain requirements around staffing and protocols still apply to these out-of-state providers.

2. Privileging and Credentialing

Credentialing and privileging are processes by which health care organizations verify and determine who may practice what professional services within their facilities. While the health care facility, not the government, drives the process, federal and state rules shape it. Furthermore, as in the other areas, federal and state emergency authorities may offer latitude during times of crisis.

Federal conditions of participation in Medicare, Medicaid, and CHIP require health care facilities to maintain standard processes for privileging and credentialing health care personnel.[98] State laws impose requirements on the privileging and credentialing process as well. The Joint Commission (TJC) issues its own standards on privileging and credentialing, which are voluntary but quite influential. Two important provisions cover credentialing and privileging during emergencies. For one, TJC provides a process by which hospitals may grant disaster privileges upon activation of its emergency management plan.[99] Importantly for this process, as explained above, FEMA Region V states have established volunteer registries under the federal Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). These registries may be used to quickly verify a volunteer's credentials. In another provision, TJC provides a process by which hospitals may provide temporary privileges to a new applicant awaiting final medical staff approval in order "to meet an important patient care need."[100] This includes when "the patient care volume exceeds the level that can be handled by currently privileged practitioners and additional practitioners are needed to handle the volume."[101] Hospital bylaws must describe the process for issuing emergency and temporary privileges.

3. Reciprocity and Multistate Cooperation

Other legal tools exist by which states and institutions may manage their personnel constraints. The Emergency Management Assistance Compact (EMAC) is a national compact, enacted by legislation in every state, that provides a mechanism by which a state experiencing an emergency or disaster may request help from other states.[102] Through EMAC, assisting states deploy response personnel (or other needed resources) to requesting states. Among its benefits is a streamlined way for providers to practice in states in which they are not licensed. Under Article V, licensees of the assisting state are considered licensed in the requesting state, subject to the requesting state's practice limitations and any further limitations the requesting state's governor may impose by executive order.[103] An important limitation for EMAC is that it generally only applies to public personnel. EMAC's generally provisions do not apply to private sector, non-governmental providers by themselves. However, private personnel may be deputized temporarily for purposes of the response.[104]

An additional tool to facilitate the expansion of available personnel is the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP).[105] This federal-state cooperative program standardizes the registration and

verification of volunteer health professionals to streamline their ability to join disaster response efforts. All FEMA Region V states participate in this program and manage their own registries.[106] Liability protections that come with these programs are discussed in Section IV of this report.

More informal mechanisms may exist at the institutional level, by way of memoranda of understanding (MOUs) and other patient transfer agreements. Such agreements facilitate the leveling of the burden when disaster strikes to better match provider capacity. However, there are legal considerations to consider when transferring patients. Of particular note, EMTALA imposes requirements for the screening and stabilization of patients at covered facilities.[107] MOUs may not contract around these requirements, but emergencies may provide flexibility, permitting transfers to dedicated sites under certain circumstances. During COVID-19, CMS issued several FAQs addressing how hospitals could use the emergent legal flexibility to address surging emergency department demand.[108]

B. Capacity

Insufficient physical space may limit a health care organization's ability to provide adequate patient care during an emergency or disaster. Acute patient demand or damage to facilities may overwhelm existing capacity, resulting in the need for health care organizations to reconfigure their spaces to adapt (e.g., redesignating beds from adult to pediatric) or add alternative care sites (ACS). As discussed below, federal and state laws allow for several options to quickly expand capacity during times of emergency. At all times, health care organizations must remain cognizant of and compliant with state and federal requirements.

CMS requires providers participating in Medicare and Medicaid to have plans for sustaining or expanding capacity during emergencies.[109] During COVID-19, CMS provided guidance to facilitate ACS development and compliance with CMS requirements.[110] It offered three options—associating with an existing, participating hospital, enrolling with CMS as a new hospital, and partnering with a participating physician group—to achieve CMS compliance and funding. §1135 waivers play a key role in temporarily suspending specific requirements to enable the operation of ACS.

State health care facility licensure and certificate of need (CON) rules shape how health care organizations modify or add to their physical spaces. The scope of state CON requirements varies significantly. Illinois and Michigan have extensive CON laws that require state approval for expansions of health care operations across multiple types of facilities.[111] Indiana and Ohio have more limited CON laws that only apply to long-term care facilities.[112] Neither Minnesota nor Wisconsin have state CON requirements for healthcare facilities but do impose caps on the number of beds in hospitals (both states) and nursing homes (WI only).[113]

Legal Considerations

Several states explicit authorize emergency waivers of CON and related provisions to meet health care needs. For example, Michigan law explicitly grants the authority to waive CON requirements when necessary "for immediate or temporary relief due to natural disaster, fire, unforeseen safety consideration, or other emergency circumstances" provided that any increases in capacity are temporary.[114] During COVID-19, the state approved emergency beds within a matter of days, often on the same day. Minnesota law similarly allows for the waiver of its hospital construction moratorium during natural disasters so long as "the emergency waiver is limited in nature and scope only to those repairs necessitated by the natural disaster."[115] Legal authority to waive licensure and CON requirements, and to authorize the establishment of ACS, may also exists within broad emergency powers possessed by the governor.[116]

Sustaining adequate capacity to treat patients during emergencies and disasters may also require expanding or replacing qualified health care staff and procuring needed materials, such as medications, medical devices, and other important products. Legal and ethical considerations concerning these issues, and how to respond to shortages more generally, are discussed in Section V of this report.

C. Telemedicine/Telehealth

Telehealth provides an important tool for health care providers balancing surging demand with limited capacity. Telehealth permits the delivery of care without taking up needed physical space, avoids potential exposure in the case of contagious diseases, and limits the need to use medical resources like personal protective equipment (PPE). Further, telehealth allows for health care expertise to be shared without requiring a physical presence and can be used as an effective tool to increase access to specialized health care expertise when it is in short supply. The term "telehealth" and "telemedicine" are often used interchangeably, and legal definitions of telehealth and telemedicine overlap substantially, with telemedicine typically being recognized as a subset of the broader concept of telehealth. For instance, the Michigan Public Health Code defines "telehealth" as "the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine."[117]

Federal and state laws have expanded to permit telehealth in everyday health care operations. Some expansions of telehealth enacted to respond to the COVID-19 pandemic have been continued due to their positive impact on access to health care. Further, emergency legal authorities may facilitate even broader temporary expansions of telehealth when needed.

Federal law regulates telehealth largely through CMS reimbursement requirements under Medicare, Medicaid, and CHIP. These laws may impose face-to-face requirements for certain services and may limit the providers or services, which may utilize telemedicine. However, §1135 waivers may waive such requirements.[118]

Legal Considerations

Other relevant federal rules may come from the Health Insurance Portability and Accountability Act (HIPAA),[119] which regulates the privacy and security of patients' health data. During emergencies, federal laws in these areas may be relaxed. The DHHS Office of Civil Rights (OCR) announced it was exercising its enforcement discretion to facilitate telemedicine during the COVID-19 response, shielding providers from enforcement if they used telemedicine in good faith and offered examples of acceptable platforms.[120] Other COVID-19-related changes to telehealth regulation included the Coronavirus Preparedness and Response Supplemental Appropriations Act, which allowed HHS to temporarily waive certain Medicare restrictions on telehealth,[121] and the Drug Enforcement Administration's guidance that DEA-registered practitioners could prescribe schedule II-V controlled substances without the typical in-person required evaluations.[122] While some of these emergency provisions lapsed when the COVID-19 public health emergency ended in May 2023, coverage of behavioral/mental health telehealth services in the home for Medicare patients have been permanently allowed by law and other in-home telehealth services and in-person visit requirements for Medicare patients have been extended through September 30, 2025.

States primarily regulate telehealth/telemedicine along two axes: (1) as the regulator of health care and insurance within their state and (2) as the administrator of payor programs like Medicaid and CHIP.

In addition to telehealth-specific rules, providers must comply with general professional health care practice requirements. In all Region V states, providers caring for patients within that state must hold a license in that state.[123] State definitions, and exemptions, within licensure requirements are important. For instance, Ohio exempts from licensure requirements "[a] physician or surgeon residing on the border of a contiguous state and authorized under the laws thereof to practice medicine and surgery therein, whose practice extends within the limits of this state."[124] During COVID-19, SMBO specified this was a provision that permitted telemedicine for Ohio patients by out-of-state providers.

Indiana, Michigan, Ohio, and Wisconsin regulate telehealth by explicitly requiring patient consent, while Illinois and Minnesota law implicitly require consent.[125] Region V states also regulate the prescription of controlled substances through telehealth, with some states (Indiana, Michigan, Wisconsin) allowing medically-necessary prescriptions and other health care referrals, and other states (Minnesota, Ohio) restricting the prescription of controlled substances to providers who have conducted physical examinations.[126]

Region V states regulate insurance coverage of telemedicine. For example, both Minnesota and Ohio require health benefit plans to cover telemedicine in the same manner as coverage for the provision of in-person health care services.[127] All states reimburse some telehealth services through their Medicaid and CHIP programs.[128] However, state delivery and coverage of telehealth services varies and must comply

with state insurance, scope of practice, and privacy laws.[129] Wisconsin, for example, allows general health services, behavioral health services, dental consultations, case management services, and therapy services to be provide via telehealth through their state Medicaid program.[130]

During emergencies, Region V states have tools to expand quickly the use of telemedicine. All Region V states modified telehealth requirements during the COVID-19 response through newly enacted statutes, changes to regulations, and executive orders. In March 2020, the State Medical Board of Ohio waived in-person visit requirements, permitting the prescription of controlled substances via telemedicine.[131] Ohio's Medicaid program, with the governor's approval, implemented emergency rules during COVID-19 that expanded telemedicine's availability.[132] Furthermore, in March 2020, Governor DeWine expanded the use of telemedicine for mental health and behavioral health services through Executive Order 2020-05D.[133] Michigan's governor expanded telemedicine, for all payors including Michigan Medicaid, through EMA waivers.[134] Additionally, Michigan's EMS department issued emergency protocols to decline low-acuity patient transportation after telemedicine consultations[135] and Michigan's Medicaid program expanded its coverage of telemedicine.[136] Indiana's Family and Social Services Administration suspended telehealth restrictions for Medicaid services.[137] Minnesota and Illinois both enacted provisions that temporarily expanded insurance coverage for care provider via telehealth.[138] These examples demonstrate the significant flexibility available during emergencies to alter the legal restrictions on telehealth services and coverage to expand access to care.

IV. Liability & Immunity

Providers in emergencies face liability risks both familiar and unfamiliar. The biggest risks (e.g. malpractice, unlawful practice) are familiar, but surging demand, resource constraints, and the rapidly changing environment of an emergency present unique challenges. Other risks, like the liability for failure to plan, are particular to emergencies. A number of resources detail at some length the varied liability risks arising in disasters, particularly for pediatric providers.[139] This section focuses on federal and state laws that offer protections for health care providers in a disaster or emergency. In particular, it focuses on protection from liability for negligence and malpractice. Licensure requirements, statutory requirements like HIPAA, EMTALA, and Medicare conditions of participation are important sources of liability risk. However, federal and state governments have authority to waive or relax these provisions during emergencies.

A. Federal Immunity Protections

Several federal laws establish immunity protections from liability for health care providers and institutions depending on the circumstances. Provisions of the Federal Tort Claims Act may extend liability protections to cover certain federally funded health centers and free clinics, but its application is limited to the federal government and its

employees.[140] Federal law provides immunity to volunteers of nonprofit organizations and governments through the Volunteer Protection Act.[141] No emergency declaration is needed, and uncompensated volunteers are shielded from ordinary negligence liability so long as they are acting within the scope of their responsibilities.[142]

During declared emergencies, additional federal legal provision may apply. The Public Readiness and Emergency Preparedness (PREP) Act provides an important source of immunity from liability for health care entities and providers who face liability claims broadly arising from the provisions of designated countermeasures, as outlined in a declaration by the Secretary of DHHS.[143] During COVID-19, DHHS issued guidance signaling an expansive reading of the PREP Act immunity for COVID-19 response countermeasures.[144] Individuals appointed as disaster response personnel or volunteer medical reserves by the DHHS Secretary and state and local government personnel appointed by the federal government pursuant to the Stafford Act may also be covered.[145] The Coronavirus Aid, Relief & Economic Security (CARES) Act added immunity from health care malpractice claims for volunteer health professionals providing services in response to COVID-19 for the duration of the federal Public Health Emergency declaration.[146]

B. State Immunity Protections

State laws provide additional liability shields to health care workers and volunteers. A patchwork of statutes provides some limited protection, but care must be paid to whom and what they cover. The applicability of immunity will depend on key factors, among them where the care is provided, by which type of provider, whether the caregiver is compensated, and whether an emergency situation exists or has been declared. In most states, broad liability shields are possible under the governor's emergency authority. Good Samaritan protections are widely available for health care provided at the scene of an accident, but these statutes rarely apply to health care professionals in health care settings. This section briefly walks through state liability protections in FEMA Region V relevant to pediatric disaster response.

1. Immunity Shields During Declared Emergencies

State laws across FEMA Region V establish immunity protection for health care workers and other emergency responders who are participating in the response to a declared emergency or disaster.

Indiana law provides liability protection for any emergency management worker reasonably attempting to comply with a state disaster emergency order.[147]Additional provisions apply immunity protections to providers participating in the state's Intrastate Mutual Aid Compact.[148]

Illinois law provides immunity to state officials and employees and their representatives engaged in emergency management and response activities, as well as

any private person, firm, or corporation that "renders assistance" to the state during an actual or impending disaster.[149]

The Michigan EMA provides immunity from tort liability for personnel engaged in disaster relief activities. MCL §30.411(3) extends the government's tort liability immunity to "private or volunteer personnel" who are "training for or responding to an actual, impending, mock, or practice disaster or emergency." MCL §30.411(4) extends immunity to an enumerated list of licensed health care providers, including those not licensed in state, rendering services "during a state of disaster declared by the governor and at the express or implied request of a state official or agency or county or local coordinator or executive body." Subsection (5) also expands these providers' scopes of practice to include "the administration of anesthetics; minor surgery; intravenous, subcutaneous, or intramuscular procedure; or oral and topical medication; or a combination of these under the supervision of a member of the medical staff of a licensed hospital of this state," as well as assisting "the staff member in other medical and surgical proceedings." These protections are subject to the limitations of the EMA, covered in Section 1.

Minnesota law provides for immunity from civil liability and administrative sanctions for any person or organization providing health care or health-related services whether paid or volunteer during a declared emergency.[150]

Ohio also provides immunity from liability to health care workers, EMS workers, and registered volunteers during declared emergencies. Under ORC §5502.281, a registered volunteer is not liable for services "within the scope of the volunteer's responsibilities during an emergency declared by the state or political subdivision."[151] Relatedly, §ORC 5502.30 provides broad immunity for, among others, emergency management volunteers from liability during "any hazard, actual or imminent, and subsequent to the same[.]"[152] During declared disasters, ORC §2305.2311 provides immunity for health care providers and certain EMS providers administering emergency care in a disaster except where the misconduct constitutes "reckless disregard for the consequences so as to affect the life or health of the patient."[153] Importantly, the providers must still adhere to their scopes of authority and other applicable laws. This provision also exempts actions for wrongful death from this immunity.

Wisconsin provides immunity to state and local government entities and their employees and volunteers during declared emergencies.[154]

2. Targeted COVID-19 Immunity

Michigan enacted two laws providing targeted immunity from liability related to the COVID-19 pandemic. The Pandemic Health Care Immunity Act provided immunity from liability to healthcare providers and healthcare facilities supporting Michigan's COVID-19 response.[155] The Response and Reopening Liability Assurance Act also provided immunity from liability claims related to alleged COVID-19 exposure to

individuals who acted in compliance with federal, state, and local laws related to COVID-19.[156] Further, the governor extended specific liability protections for "any licensed health care professional or designated health care facility" providing medical services in support of the state's COVID-19 response through executive order.[157]

In 2020, the Ohio legislature, in HB 606, enacted a specific extension of this immunity in response to COVID-19.[158] Similarly to Michigan, the immunity provisions in place in Ohio applied only to ordinary negligence and do not provide immunity for gross negligence, willful and wanton misconduct, criminal misconduct, or intentional harm.

Illinois used its emergency authority to extend immunity to health care facilities, professionals, and volunteers who were rendering assistance to the state during the term of the COVID-19 gubernatorial disaster proclamation.[159]

Wisconsin also enacted COVID-19-specific liability exemptions, which shielded organizations and their employees from civil liability related to exposure to COVID-19, and health care professionals and providers for the provision of health care services, unless the relevant act constituted willful, wanton or intentional misconduct.[160]

3. Good Samaritan Provisions

Good Samaritan laws establish immunity from civil liability for anyone providing health care services at the scene of an emergency. These laws vary in application across states, with some limiting the application of these immunity protections to uncompensated non-professionals while others grant health professionals immunity if they are providing services outside their usual professional settings.

Illinois law provides broad immunity protections for health care professionals and disaster relief volunteers who provide health care services without compensation.[161]

Michigan's Good Samaritan Statute provides immunity for physicians, physician assistants, registered nurses, licensed practical nurses, and licensed EMS providers providing good-faith, uncompensated care at the scene of an emergency.[162] The Statute also provides immunity for people using CPR or AED in good faith response to an emergency when they are under no duty to act.[163] A more limited statute, MCL §691.1502, provides immunity to health care providers responding, in good faith, to emergency situations within hospitals or other licensed health care facilities. This immunity applies when the provider's response is not pursuant to their actual hospital duty, or whether any prior patient relationship existed.

Minnesota provides general immunity from liability for any person rendering emergency care, advice, or assistance at the scene of an emergency, but excludes from this immunity protection people acting during the course of regular employment or

receiving or expecting to receive compensation for the assistance, or those who engage in willful or wanton misconduct.[164]

Ohio law provides immunity from liability to people responding to emergency situations outside of health care settings, including but not limited to health care providers, administering emergency care without compensation (with some limited exceptions) at the scene of an emergency.[165] Acts of willful or wanton misconduct are excluded from these protections. Further, many health care providers qualify for immunity from liability claims when providing care without compensation or other remuneration to indigent and uninsured persons.[166] EMS providers, other health care workers providing assistance, medical directors, and EMS organizations receive immunity under Ohio law from liability "resulting from the individual's administration of emergency medical services."[167]Another potential source of immunity is ORC §§9.85–86.[168] These statutes, in conjunction with ORC §109.36, extend the governmental immunity enjoyed by public employees to individuals "that, at the time a cause of action against the person, partnership, or corporation arises, is rendering medical, nursing, dental, podiatric, optometric, physical therapeutic, psychiatric, or psychological services pursuant to a personal services contract or purchased service contract with a department, agency, or institution of the state."[169]

Wisconsin grants immunity from civil liability for any person who renders emergency care at the scene of an emergency, but this provision does not apply to health care providers providing care within their usual scope of employment.[170]

4. Other State Immunity Provisions

Indiana provides immunity for licensed health care workers who provide voluntary health care services without compensation if the patient receives care outside a health care facility and is notified of and agrees to receive care despite this immunity protection.[171]

Public health representatives in Michigan receive immunity. MCL §§333.2228 and 2465 provide immunity to state and local health officials from liability incurred in the performance of official functions.[172] It does not include wanton and willful misconduct.

C. Immunization Immunity

Liability shields apply to mass immunization programs authorized by MDHHS or local health departments. Covered providers include individuals authorized to participate without compensation in an MDHHS approved mass immunization program, but not the drug manufacturers.[173] Likewise, the Michigan code protects EMS providers from liability if they are "providing services to a patient outside a hospital, in a hospital before transferring patient care to hospital personnel, or in a clinical setting that are consistent with the individual's licensure or additional training required by the medical

control authority . . . or consistent with an approved procedure for that particular education program."[174] All of these immunity provisions apply only to ordinary negligence and do not extend liability protection to acts of gross negligence, willful and wanton misconduct, criminal misconduct, or intentional harm.

V. Scarce Resource Allocation and Crisis Standards of Care

When emergencies or disasters strike, surging demand and dwindling resources may force health care and public health systems to modify their care models. These difficult resource allocation decisions give rise to challenging legal, ethical, and practical questions. What obligations do providers have to each patient when they do not have the capacity to treat them all as they would under conventional circumstances? What legal constraints shape these decisions? How can decision-makers balance the immediate needs of individual patients against the longer-term needs of the population? The related issues of crisis standards of care (CSC) and scarce resource allocation (SRA) become central to this discussion.

According to the National Academies of Sciences, Engineering, and Medicine (NASEM) Rapid Expert Consultation on COVID-19, CSC "are applied when a pervasive or catastrophic disaster make it impossible to meet usual healthcare standards."[175] In the wake of a catastrophic event, the healthcare system sometimes must alter its operations in order to ensure a safe and ethical delivery of necessary care. In these instances, conventional standards of care cannot be sustained given a lack of resources, including health care personnel, physical space, and medical supplies. CSC exist along a continuum of medical standards of care. As needs surge and health resources decline, the standard of care shifts from "conventional care" to "contingency care." Contingency care approximates conventional care but recognizes the need to make adjustments in order to achieve substantially similar outcomes. CSC apply only when "when resources are so depleted that functionally equivalent care is no longer possible." Distinct from contingency care, CSC reflect a substantial change from conventional care.[176]

CSC are relevant to, but not determinative of, the legal standard of care. Normally, the legal standard of care in health care settings requires health care providers to do what "a reasonable health care practitioner would do under similar circumstances based, in part, on available resources."[177] This standard is sensitive to the circumstances in which care is provided. In other words, as circumstances change, so do the expectations of what a reasonable health care practitioner would do. A reasoned decision to follow well-established CSC likely satisfies legal requirements of reasonable care, but the legal standard remains fact-intensive and subject to post-hoc fact finding.[178] Because of this, there may be some divergence between CSC plans and the legal standard imposed by a court after the fact. Some of the liability protections for health care professionals reviewed in Section IV of this report were enacted to address this liability risk. However, these variable and piecemeal immunity protections do not cover every scenario of care that may arise during an emergency.

Allocating and prioritizing scarce resources can be an extremely difficult task that imposes a burden on health care personnel to make agonizing decisions when a stage of contingency or crisis has been reached. CSC plans can reduce this burden somewhat by providing thoughtful guidance and training developed in *advance* of a crisis, thus reducing the likelihood that health care providers will have to make ad hoc triage decisions during a stressful emergency. As a result, creating well-reasoned CSC and SRA plans are critical to providing best practices for allocating scarce resources in ways that will comport with legal and ethical obligations.[179] Formulating and implementing such plans mitigates the legal risk that courts will find the actions taken during an emergency were not reasonable. Planning is also an obligation in its own right. Hospitals face an assortment of obligations and incentives to plan for disasters,[180] including federal conditions of participation and grant conditions, state licensure obligations, and negligence liability for failure to plan.

This section provides an overview of the considerations underlying CSC and SRA planning. It begins by reviewing the national landscape. It then reviews the state environments in FEMA Region V states. Finally, it discusses how CSC and SRA apply to the treatment of children.

A. National Guidance

Though no national law or policy for CSC or SRA exists, organizations like the Institute of Medicine (IOM) and the National Academies of Sciences, Engineering, and Medicine (NASEM) have issued influential guidance on these topics at a national level. The IOM developed much of the original guidance on CSC in a series of reports that informed both federal and state CSC and SRA policies.[181] As COVID-19 emerged as a crisis in March 2020, the National Academies of Sciences, Engineering, and Medicine (NASEM) supplemented this prior work with a rapid expert consultation on CSC.[182]

NASEM's framework centers on five key elements undergirding responsible CSC planning:

- Strong ethical grounding in the core ethical principles of fairness, duty to care, duty to steward resources, transparency in decision making, consistency, proportionality, and accountability
- Engagement, education, and communication with the provider community and public at large
- Consideration of the legal authorities and environment around CSC implementation
- Clear indicators, triggers, and lines of responsibility
- Evidence-based clinical operations

Addressing the vagueness inherent in an overarching framework, a variety of institutions and scholars have worked to flesh them out further. NASEM has offered

guidance on how they translate to a systems-level, including information for hospitals, EMS providers, out-of-hospital providers, state and local governments, and public health officials.[183] The AMA Code of Medical Ethics provides criteria for providers making these decisions.[184] Other organizations, like ASPR-TRACIE and the Hastings Center, have served as repositories of work done on CSC planning across a variety of fields.[185]

B. State Frameworks

States have important roles to play in shaping CSC planning.[186] States play prominent roles in the legal environment shaping health care and emergency preparedness. CSC plans must be sensitive to the unique legal environment of each state. States also direct public health, EMS, and emergency management services during emergencies and disasters. Consequently, many states have issued state-level guidance on CSC planning.[187]

State guidance documents may periodically change and therefore it is vital to be aware of the latest applicable guidance in your jurisdiction. Additionally, the HHS Office of Civil Rights has legal authority to review state CSC plans that are alleged to violate federal anti-discrimination laws. In 2020, OCR entered into consent agreements with several state and local jurisdictions whose scarce resource allocation plans deprioritized access to scarce resources for people with disabilities.

This section reviews the available guidance in FEMA Region V states. Notably, Michigan and Minnesota have developed detailed CSC guidance plans. Both states were early pioneers in state-level CSC guidance, and Minnesota's materials have been particularly influential to other states that have developed CSC guidance. Illinois and Wisconsin have also developed some state-level guidance on CSC, while Indiana and Ohio have not formally adopted specific state-level guidance in this area.

Minnesota's CSC Framework is widely recognized as some of the most comprehensive guidance documents available addressing responses to health resource scarcity during emergencies.[188] The state has integrated the CSC Framework into its emergency response operations plan and developed targeted documents that explore ethical and legal considerations, as well as specific materials for health care and EMS settings.[189] Minnesota's frameworks and their robust, multidisciplinary statewide advisory groups allowed for rapid implementation of crisis surge strategies during the COVID-19 response.[190]

Michigan has issued state-level CSC guidance, most recently updated in 2022.[191] Michigan's CSC Guidelines outline the goals, ethical principles, and allocation criteria to be used in CSC planning. The Guidelines do not present rigid or formalized steps of instructions for allocating and prioritizing scarce resources, but rather provide a set of guidelines and criteria that can be utilized by decision-makers using their best professional discretion.[192] The state has aligned the Guidelines with the Michigan Department of Health and Human Services Emergency Operations Plan. The Michigan

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Guidelines also provide a robust set of additional resources, with specific guidance materials for EMS, hospitals and health systems, lawyers, state and local government departments and officials, long-term care facilities, and palliative care settings. It includes tools and resources specific to pediatric patients.

Case study: Michigan's Crisis Standards of Care Guidelines

The Michigan Guidelines furnish criteria by which CSC planners may, or may not, base allocation choices. It organizes them into three categories: acceptable allocation criteria, problematic allocation criteria, and unacceptable allocation criteria. Under acceptable criteria, the plan recognizes the ethical propriety of prioritizing scarce resources based on medical prognosis, including consideration of the patient's medical condition, the likelihood of a positive medical response, the relative risk of harm posed by not treating the patient, and other indicators of short-term survivability and favorable medical outcomes. Focusing on short-term, rather than long-term, prognosis ensures that allocation decisions do not become an inadvertent proxy for a patient's age, health status, or disability status. Support for critical infrastructure provides another legitimate justification to prioritize allocation of scarce resources to workers who perform essential functions.

Next, the Guidelines discuss three potentially problematic criteria that may be used in a context-sensitive manner: age, lottery, and first come/first served. Acknowledging their controversial nature but not disclaiming their utility, the Guidelines state that these criteria may be useful in distinguishing otherwise indistinguishable cases. Decision-makers are cautioned to use these criteria with appropriate procedural protections to ensure that they are implemented equitably, fairly, and transparently, including advanced notice to the public that they will be utilized.

Finally, the Guidelines detail criteria that are unacceptable as bases for allocation decisions. Social characteristics may not be utilized to make allocation decisions. These include, but are not limited to, "age (with very limited exceptions), color, criminal history, disability, ethnicity, familial status, gender identity, height, homelessness, immigration status, incarceration status, marital status, mental illness, national origin, poverty, race, religion, sex, sexual orientation, socio-economic status, substance use disorder, use of government resources, veteran status, or weight." Categorization of people according to these types of characteristics is often used as pretext for favoritism, discrimination, and reduced access for minority groups. Criteria related to social worth, including "job status, training or education, social standing, personal or familial relationships, belief systems, political affiliations, the ability to pay for health care or services, or any other measurement of a person's social standing" are also inappropriate to use in allocation decision-making.

Many other states have enacted ethical and practical guidance for addressing Crisis Standards of Care using similar criteria.

Illinois has developed CSC guidance, publishing a White Paper containing ethical guidance for CSC and incorporating site-specific resource allocation tactics for EMS and health care settings into an annex of the state Catastrophic Incident Response plan.[193] During the COVID-19 response, Illinois provided additional specific guidance to hospitals facing potential shortages that could lead to CSC.[194] Additionally, the Illinois legislature passed a law in 2024 that requires the Illinois Department of Public Health to develop and disseminate a state crisis standards of care plan that "addresses situations in which a conventional response moves to a crisis response and key resources may be affected."[195]

The Wisconsin Department of Health Services established a State Disaster Medical Advisory Committee in April 2020 to develop policy recommendations for "the equitable and fair delivery of medical services to those who need them under resource-constrained condition" such as CSC.[196] This Committee produced ethical frameworks for allocating COVID-19 therapeutics and vaccines that were used by state officials to direct distributions of scarce COVID-19 vaccines when they became available.[197]

Indiana and Ohio do not currently have recognized state-level policies addressing CSC or SRA. The Indiana Department of Health published a COVID-19 response plan in March 2020 that addresses the need to plan for general and pediatric medical surge capacity. However, this plan doesn't explicitly provide guidance for CSC decision making. The Ohio Hospital Association published guidelines in 2020, which were updated in 2025, to aid hospitals and other institutional decision makers in their CSC planning efforts.[198] Additionally, the Ohio Department of Development Disabilities issued guidance during the COVID-19 pandemic reminding health care organizations of their duties toward vulnerable populations.[199] This guidance stated "[a] person's disability status, presence of underlying health conditions, race, or ethnicity cannot be determining factors to exclude them from lifesaving medical treatment or prioritization for scarce medical resources" and reinforced the need for decision-making based on individualized clinical assessment. Further, the guidance cautioned against certain indicators, like the Sequential Organ Failure Assessment (SOFA) and Glasgow Coma Score, as unreliable and highlighted patient rights around transparency and having family or caregivers present when decisions are made.

C. Application of Crisis Standards of Care to Children and Allocation of Pediatric Health Resources

Few of the guidance protocols discussed above explicitly address how scarce resource allocation and crisis standards of care explicitly affect children and the availability of pediatric health resources. However, pediatric-specific considerations may become relevant to allocation decisions implicated by crisis standards of care.

One pertinent question is whether age should be considered when allocating scarce medical resources. While some bioethicists have argued that children should

receive higher consideration than adults for scarce resources, for both legal and ethical reasons, state CSC plans have cautioned against using age as a criterion to prioritize patient access to scarce medical resources. Michigan's CSC guidance document, for example, states that "age may only be used as a factor for scarce resource allocation in the very rare circumstances where no other approach will suffice to differentiate between similarly situated individual and such an approach has received public approval and does not offend notions of fairness and equity."[200] Minnesota's CSC Ethical Guidance similarly rejects the use of age for prioritization decision-making unless tied to clinical prognosis.[201]

Another important issue arises when allocation of resources for pediatric care implicates the availability of overall medical resources. During the COVID-19 response, some hospitals repurposed pediatric areas to serve adult patients when the number of adult patients exceeded hospital capacity, effectively reducing the capacity for pediatric care. Likewise, resource and infrastructure disparities between urban and rural areas may result in pediatric patients in underserved areas being effectively excluded from medical care needed during shortage situations. While several FEMA Region V states have developed plans for pediatric care during emergency resource shortages,[202] and hospital systems have established triage protocols for pediatric and neonatal patients,[203] more specific guidance is needed to assist decision-makers involved in pediatric triage decision-making.[204]

V. Family Reunification

Disasters and emergencies may result in separation between family members, including between children and their parents/legal guardians. Hospitals, first responders, and government agencies may encounter and need to temporarily provide care for children separated from their families, as well as assisting in the process of reunification of these separated children with their families. Family reunification can raise complex legal and policy issues. These issues, like many of the other areas addressed in this report, are regulated by an inconsistent patchwork of laws and systems.[205] While the FEMA Region V states have not developed a comprehensive set of legal requirements related to family reunification during emergencies and disasters, state laws involving informed consent for treatment, health information privacy, child custody, and immigration may apply to family reunification efforts. Moreover, it is an ethical imperative that crisis planners develop appropriate family reunification policies.[206]

See Appendix C for an Ethical Framework for Family Reunification

Congress has authorized the National Center for Missing & Exploited Children (NCMEC) to administer the National Emergency Child Locator Center and the Unaccompanied Minor Disaster Registry to assist in reuniting missing children with their parents or legal guardians during disasters and emergencies.[207]

FEMA Region V states have also developed guidance for family reunification. For example, the Illinois Emergency Operations Plan contains a Reunification Support appendix that outlines state-supported reunification efforts for missing individuals, including children, built on cooperation between the American Red Cross and multiple state agencies.[208] Minnesota, Michigan, Indiana, and Ohio have also developed detailed guidelines for addressing family reunification during a surge of pediatric patients.[209] In addition, Michigan, Minnesota, and Wisconsin have statutory provisions that require schools to have an emergency plan that includes procedures for parent-student reunification.[210] Minnesota extends this requirement to child care centers as well.[211]

Finally, several national or regional organizations, including the American Academy of Pediatrics and the American Red Cross, have developed guidance for supporting unaccompanied children in hospital and health care settings and facilitating family reunification after disasters and emergencies.[212]

A. Treatment of Unaccompanied Pediatric Patients

Decisions made related to the treatment of pediatric patients are subject to the applicable legal standards of care (see section IV) and must comply with informed consent standards. However, hospitals and other health care providers may legally treat pediatric patients who need urgent, life-saving or stabilizing health care even if their parent or legal guardian is not present to give consent for this care. Health care providers and institutions may face liability for medical malpractice, health information privacy breaches, and other violations of law.

B. Custody

Hospitals and government agencies should develop procedures to accurately establish the identity of children and their appropriate legal custodial parent or guardian consistent with state policies. These procedures will facilitate reunification, as well as prevent children from being released to the wrong family or to an unauthorized noncustodial parent. Accurate identification of children may also allow for better medical care when children are matched with existing medical records. Failure to follow careful procedures during the reunification process could expose health care providers to liability.

Determining the identity of an unaccompanied child and reuniting that child with the appropriate parent or legal guardian may necessitate coordination between a health care provider and relevant government agencies, including potentially state or local law enforcement, child welfare agencies, state and local courts, and the NCMEC.[213] If a child's parent/guardian cannot be located or is incapacitated, the health care provider may need to work with these same partners to secure a safe location for the child to stay.

C. Health Information Privacy

The reunification process will often require the sharing of personal information. While HIPAA limits sharing of personal health information without consent under many circumstances, information shared pursuant to the reunification process will almost certainly fall within the “routine use” or “disaster situations” exceptions under Federal regulations.[214] If school records are involved, similar exceptions under FERPA will likely apply.

Conclusion

While not legal advice, this report provides an overview of legal issues that may apply during an emergency or disaster. The information focuses primarily on the federal, state, and local law applicable to the FEMA Region V states (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin). However, the legal information discussed in this report may be useful to any emergency planners, health care professionals, and others who may need to understand the legal landscape in health care settings during disasters and emergencies, particularly those providing pediatric health care during emergencies or disasters.

Appendix A:
A Comparison of Governor's Emergency Powers in Region V for Kids States

State	Emergency Declaration Authority	Duration Limit	Legislative Oversight	Powers Granted	Extensions Allowed?
Illinois	Governor can declare emergency/disaster via statute (20 ILCS 3305/7)	30 days	Legislature must approve extension beyond 30 days	Suspend statutes, control movement, commandeer resources	Renewals by governor without legislative authorization
Indiana	Governor declares under IC 10-14-3-12	60 days	No statutory requirement for legislative approval	Control travel, seize property, mobilize National Guard	Yes, with legislative approval
Michigan	Governor declares under Emergency Management Act (PA 390 of 1976)	28 days	Must get legislative approval for extension	Issue orders with the force of law; permit emergency rulemaking	Yes, with legislative approval
Minnesota	Declared under Chapter 12 of Minnesota Statutes	30 days	Must be extended by Executive Council (first) and Legislature (after 30 days)	Close facilities, restrict movement, use property	Renewals by governor without legislative authorization
Ohio	Governor declares under §107.42	90 days	Legislature can terminate by joint resolution	Suspend laws and rule-making requirements, direct emergency resources	Yes, with legislative approval
Wisconsin	Governor declares under § 323.10	60 days	Must get legislative approval to extend beyond 60 days	Issue orders, direct resources, restrict movement	Yes, with legislative approval

- **Common Powers** across all states: control of movement, suspension of certain regulations, allocation of state resources, and activation of the National Guard.
- **Legislative Checkpoints**: Indiana, Michigan, Ohio and Wisconsin require the legislature to approve extensions beyond initial duration.

Appendix B:
A Comparison of State Departments of Health Powers in Region V for Kids States

State	Department Name	Legal Authority	Key Powers	Emergency Role
Illinois	Illinois Department of Public Health (IDPH)	20 Ill. Comp. Stat. 2305/2(a)	Quarantine/isolation, mandatory reporting, inspection of facilities, regulate labs and sanitation	Lead on infectious disease response; can issue health mandates
Indiana	Indiana Department of Health (IDH)	Indiana Code Title 16	Enforce quarantine/isolation, investigate disease outbreaks, regulate public health systems	Supports governor, works with local health officers and EMA
Michigan	Michigan Department of Health and Human Services (MDHHS)	Public Health Code (MCL 333.1101)	Issue emergency orders, enforce testing/vaccination/isolation, regulate facilities and reporting	Can issue statewide emergency health orders independently
Minnesota	Minnesota Department of Health (MDH)	Minnesota Statutes Chapters 144, 145	Quarantine authority, data collection, enforce health codes, manage statewide health alerts	Directs state health response; coordinates hospital/public health surge capacity
Ohio	Ohio Department of Health (ODH)	Ohio Revised Code Chapter 3701	Issue public health orders, quarantine/isolation, regulate health facilities, require reporting	Has broad emergency authority but subject to legislative recission
Wisconsin	Wisconsin Department of Health Services (DHS)	Wisconsin Statutes Chapters 250-255	Issue communicable disease orders, enforce testing/quarantine, regulate public health infrastructure	Can issue orders during declared public health emergencies but the state Supreme Court case introduced procedural limitations

Appendix C:
Ethical Framework for Family Reunification

Debra DeBruin, PhD (lead author) and the Legal and Ethics Working Group of Region V for Kids Pediatric Disaster Center of Excellence*

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Mass casualty incidents (MCI) may involve the separation of children from their caregivers, either because the incidents occur when children are away from their parents (for example, at school or in childcare), or simply due to the chaotic nature of the MCI. In such incidents, it is imperative that measures are implemented to reunify families.

Unfortunately, crisis response plans often fail to incorporate consideration of family reunification. As such, they fail to adequately protect vulnerable members of our society from significant harm. National groups have offered planning tools for family reunification.[1,2,3] These tools provide valuable resources; they focus on how to incorporate family reunification into emergency operations plans. Few, if any, resources provide ethical guidance for preparedness regarding family reunification.

This document fills that gap by providing an ethical framework for family reunification during disasters. It is intended to guide organizational preparedness and care delivery at hospitals across FEMA Region V. It also aims to provide a basis for consistent response to the need for family reunification among institutions and systems across the region, to promote transparency, fairness and equity. This guidance incorporates the input of the Region V for Kids Legal and Reunification Workgroups. It analyzes the ethical values common in the crisis response plans of the six states in Region V in order to apply those common values to family reunification preparedness. This guide also incorporates reunification guidance from national groups.[4,5,6] The result is a framework that outlines the region's fundamental ethical commitments as they relate to family

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[1] American Academy of Pediatrics (AAP), in collaboration with Massachusetts General Hospital Center for Disaster Medicine. Family Reunification Following Disasters: A Planning Tool for Health Care Facilities. July 2018. Available at https://downloads.aap.org/AAP/PDF/AAP-Reunification-Toolkit.pdf.

[2] US Department of Homeland Security (USDHS), Federal Emergency Management Administration (FEMA), American Red Cross (ARC), and National Center for Missing & Exploited Children (NCM&EC). Post-Disaster Reunification of Children: A Nationwide Approach. November 2013. Available at https://www.ready.gov/sites/default/files/2019-06/post_disaster_reunification_of_children.pdf.

[3] American Red Cross (ARC). Reunification Standards and Procedures. January 2017. Available at https://nationalmasscarestrategy.org/wp-content/uploads/2017/02/ReunificationStandardsandProcedures.pdf.

[4] AAP. July 2018. Available at https://downloads.aap.org/AAP/PDF/AAP-Reunification-Toolkit.pdf.

[5] USDHS, FEMA, ARC, and NCM&EC. November 2013. Available at https://www.ready.gov/sites/default/files/2019-06/post_disaster_reunification_of_children.pdf.

[6] ARC. January 2017. Available at https://nationalmasscarestrategy.org/wp-content/uploads/2017/02/ReunificationStandardsandProcedures.pdf.

reunification. The commitments are then refined into actionable ethical objectives that must be met regarding family reunification, so that the fundamental ethical commitments can be honored in a time of crisis.

Moral commitments: Given the trauma associated with family separation due to MCIs – including both significant emotional distress and serious safety risks – it is critical that the process for family reunification be ***trustworthy***. This requires that the following ethical norms be reflected in response to these incidents.

- **Accountability** – Hospital leadership, in collaboration with governmental agencies and community partners, should be accountable to the community, to the children and families who are separated by crisis, and to the health professionals who must respond to the crisis.
- **Transparency** – A clear, shared understanding of reunification plans not only promotes their implementation but also provides a basis for public confidence.
- **Beneficence** – Reunification plans should be designed to protect the public from harm by mitigating harms associated with family separation during crises, and avoiding harms created by inadequate planning for family reunification.
- **Respect individuals and groups** – Individual rights should be respected, and plans should strive to reflect the values of the communities that they will affect.
- **Fairness and equity** – Duties of fairness require both fair processes and substantively fair treatment of individuals and groups. Hospitals should also work to ensure that the benefits and burdens of reunification plans are equitably distributed across populations.

Ethical objectives: To honor the fundamental moral commitments outlined above, hospitals should meet the following ethical objectives with respect to family reunification. Creating and implementing reunification plans with an eye toward achieving these objectives will also promote **trustworthiness** of crisis response.

- To promote **accountability**:
    - Hospitals should recognize and act upon their duty to plan. Impromptu decision-making during disaster undermines the trustworthiness of the response given the difficulty of creating and implementing reasonable plans during a crisis, and the tendency of ad hoc decision-making to fail to meet the ethical standards outlined in this framework. Thus, the failure to plan increases risks to children and families affected by separation; it also creates moral and psychological distress for professionals who must respond to crisis without adequate support.
    - Hospitals should ensure plans fulfill their ethical obligations to safeguard vulnerable children and effectively reunite them with their caregivers.
    - Hospitals should devise plans that are evidence based, where possible, and reflect best practices.
    - Hospital reunification plans should include processes for review and revision to promote improvement.
- To promote **transparency**:
    - Hospitals should clearly communicate reunification plans with personnel who may be involved in implementing them. Failure to do so increases the risk that response will be ad hoc and ineffective, with the attendant harms noted above.
    - Hospitals should also disseminate information regarding family reunification plans as widely as possible, in different languages, using a variety of approaches,

materials, and venues for distribution of information, to effectively reach diverse members of the public who may be affected by family separation.
    - Care should be taken to adequately inform the public without creating fear and to avoid, or counter, dissemination of misinformation.

- To promote **beneficence** (protect the public from harm):
    - Hospital personnel should receive training to recognize and respond to harms associated with family separation.
        - "Children who are separated from families are extremely vulnerable and are at risk for significant physical and mental trauma, neglect, abuse, and even exploitation."[7]
        - Children's caregivers and other loved ones also suffer due to separation.
    - Reunification plans should incorporate best practices to:
        - Promote safety of unaccompanied children, for example, by developing/implementing plans for definitively identifying, registering and tracking them, and ensuring that they are released only to appropriate custodial caregivers.
        - Provide trauma-informed care, for example, by establishing a Pediatric Safe Area that provides supervision, as well as comfort needs, while they await reunification, and providing behavioral health supports to help address their distress.
        - Effectively reunite children with their caregivers, for example, by "facilitating efficient information sharing among hospitals and other response partners to support family reunification."[8]

- To respect individuals and groups:
    - Hospitals should establish plans for protecting basic needs for safety and privacy of unaccompanied children and other family members seeking reunification. These plans should include creation of a Hospital Family Reunification Center that will serve as "a private and secure place for families to gather, receive, and provide information regarding children and other loved ones who may have been involved in the incident."[9]
    - The commitment to respect individuals also grounds a duty to provide the best care possible in the crisis circumstances, including care for sick or injured children who may be unaccompanied or unidentified, and a focus on trauma-informed care for all unaccompanied children.
    - Plans should also reflect the values of the communities that they will affect. Ideally, plans will be shaped by community input. This will help ensure that the response is culturally appropriate and recognizes access barrier and functional needs.

- To promote fairness and equity:
    - Plans should incorporate decision-making processes that consistently apply only ethically relevant (nondiscriminatory, non-arbitrary) considerations. For example, personnel involved in crisis response should ensure that family members

[7] AAP. July 2018. See p. 1. Available at https://downloads.aap.org/AAP/PDF/AAP-Reunification-Toolkit.pdf.
[8] AAP. July 2018. See p 16. Available at https://downloads.aap.org/AAP/PDF/AAP-Reunification-Toolkit.pdf.
[9] AAP. July 2018. See p. 16. Available at https://downloads.aap.org/AAP/PDF/AAP-Reunification-Toolkit.pdf.

seeking information are treated consistently, with no special privilege being offered to any particular individuals or groups, for example, based on ability to pay, health system affiliation, immigration status, religion, etc.

- Plans should incorporate provisions to honor duties of reciprocity. That is, professionals who shoulder the responsibilities of family reunification should be appropriately supported, including being provided with resources to address emotional and moral distress.
- The benefits and burdens of reunification services should be equitably distributed across the population. For example, more privileged groups should not receive more privileged services, such as hospitals prioritizing robust reunification services for families that are affiliated with the facility's health system. Nor should any groups bear disproportionate burdens, such as those associated with culturally inappropriate programs, or those associated with involving questions about immigration status in reunification services.
- Reasonable efforts should be made to mitigate barriers to accessing support (for example, ability to pay for services) and address functional needs (for example, appropriate translation services).

Indiana - Indiana-Crisis-Standards-of-Care-Signed-41814.pdf (documentcloud.org)
Illinois - CSC Ethics White Paper Final Draft (illinois.gov)
Michigan - 2022 MDHHS Ethical Guidelines (michigan.gov)
Minnesota - Minnesota Crisis Standards of Care Framework (state.mn.us)
Ohio - ohio-guidelines-for-allocation-of-scarce-medical-resources-clean-final.pdf (caahq.com)
Wisconsin - https://www.bing.com/ck/a?!&&p=8bf0f6e2e9d928ecJmltdHM9MTY4NTQwNDgwMCZpZ3VpZD0wNjI4ZTYxYi1mYzczLTY2ZDEtMWFhNy1mN2ZkZmRmNzY3MmMmaW5zaWQ9NTI0MQ&ptn=3&hsh=3&fclid=0628e61b-fc73-66d1-1aa7-f7fdfdf7672c&psq=WISCONSIN+DEPARTMENT+OF+HEALTH+SERVICES+Crisis+Standards+of+Care+Framework+and+Allocation+of+Scarce+Resources&u=a1aHR0cHM6Ly9wdWJsaWNtZWV0aW5ncy53aS5nb3YvZG93bmxvYWQtYXR0YWNobWVudC9lZDkzODZlYi02MGUwLTQ3MjUtYWRkZS0zN2UyMGI1MmI1OTQ&ntb=1

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[1] Under the Stafford Act, the President may declare a "major disaster" and/or an "emergency." 42 U.S.C. §§5170, 5191. A "major disaster" is "any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this chapter to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby." An "emergency" is "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States." 42 U.S.C. §5122.
[2] The National Emergencies Act lays out the process by which the President may declare an emergency "[w]ith respect to Acts of Congress authorizing the exercise, during the period of a national emergency, of any special or extraordinary power." 50 U.S.C. §1621.
[3] 42 U.S.C. §247d(a).
[4] OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, *Public Health Emergency Declaration* (last visited Jun. 20, 2025), https://aspr.hhs.gov/legal/PHE/Pages/Public-Health-Emergency-Declaration.aspx.
[5] 21 U.S.C. §360bbb–3(a)(1).
[6] OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, *Legal Authority of the Secretary* (last visited Jun 20, 2025), https://aspr.hhs.gov/legal/Pages/Legal-Authority-of-the-Secretary.aspx.
[7] 42 U.S.C. §1320b–5(b). Importantly, waivers of EMTALA requirements under non-pandemic emergencies and HIPAA requirements only last for 72-hours after implementation of a hospital's disaster protocols. All other waivers last for the duration of the PHE or 60 days, whichever is shorter. However, the Secretary may renew the waiver at the end of the 60-day period for additional 60-day periods as long as the PHE lasts.
[8] CTRS. FOR MEDICARE AND MEDICAID SERVS., *Requesting an 1135 Waiver* (Nov. 4, 2009), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Requesting-an-1135-Waiver-101.pdf.
[9] CTRS. FOR MEDICARE AND MEDICAID SERVS., *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers* (May 24, 2021), https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.
[10] OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, *Public Readiness and Emergency Preparedness Act* (last visited Jun. 20, 2025), https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx.
[11] OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, *Public Health Emergency Determinations to Support an Emergency Use Authorization* (last visited Jun. 20, 2025), https://aspr.hhs.gov/legal/Section564/Pages/default.aspx
[12] NETWORK FOR PUB. HEALTH L., *Emergency Declaration Authority across All States and D.C.: Table* (Jun. 16, 2015), https://www.networkforphl.org/wp-content/uploads/2020/01/Emergency-Declaration-Authorities.pdf.
[13] See *In re Certified Questions from the United States District Court*, 958 N.W.2d 274 (Mich. 2020). See also, Complaint, *Midwest Inst. of Health v. Whitmer*, No. 1:20-CV-414, 2020 WL 3248785 (W.D. Mich. June 16, 2020). The state legislature later repealed the Emergency Powers of the Government Act.
[14] See *Wis. Legis. v. Palm*, 391 Wis.2d 497 (2020).
[15] S.B. 22, 134th Gen. Assemb., Reg. Sess. (Ohio 2021) (enacted).
[16] *Snell v. Walz*, 6 N.W.3d 458 (Minn. May 10, 2024).
[17] Mich. Comp. Laws §30.403(3–4). The Emergency Management Act (EMA) defines "emergency" as "any occasion or instance in which the governor determines state assistance is needed to supplement local efforts and capabilities to save lives, protect property and the public health and safety, or to lessen or avert the threat of a catastrophe in any part of the state." The EMA defines "disaster" as "an

occurrence or threat of widespread or severe damage, injury, or loss of life or property resulting from a natural or human-made cause, including, but not limited to, fire, flood, snowstorm, ice storm, tornado, windstorm, wave action, oil spill, water contamination, utility failure, hazardous peacetime radiological incident, major transportation accident, hazardous materials incident, epidemic, air contamination, blight, drought, infestation, explosion, or hostile military action or paramilitary action, or similar occurrences resulting from terrorist activities, riots, or civil disorders."

[18] *Id.*

[19] Mich. Comp. Laws §30.405(1)(a).

[20] 20 Ill. Comp. Stat. §3305/7.

[21] Wis. Stat. §323.12(4)(d).

[22] Ohio Rev. Code § 125.06.

[23] Ohio Rev. Code § 119.03(G)(1).

[24] Ohio Exec. Order No. 2020-01D (Mar. 9, 2020), https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/executive-order-2020-01-d.

[25] OHIO DEPT. MEDICAID, *COVID-19 Emergency Telehealth Rules: Summary of Updated Guidance* (Jul. 17, 2020), https://medicaid.ohio.gov/static/Providers/COVID19/Telehealth/COVID-19-Emergency-Telehealth-Rules-Updated-Guidance-07-17-2020.pdf.

[26] Ohio Exec. Order No. 2020-05D (Mar. 19, 2020), https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/executive-order-2020-05d.

[27] Mich. Comp. Laws §24.248.

[28] *Id.*

[29] MICH. DEPT. OF HEALTH & HUMAN SERVS., *Bulletin Number MSA 20-13: COVID-19 Response*, (Mar. 20, 2020), https://www.michigan.gov/documents/mdhhs/MSA_20-13_684352_7.pdf; MICH. DEPT. OF HEALTH & HUMAN SERVS., *Bulletin Number MSA 20-09: General Telemedicine Policy Changes* (Mar. 12, 2020), https://www.michigan.gov/documents/mdhhs/MSA_20-09_683712_7.pdf.

[30] Mich. Exec. Order No. 2020-30 (Mar. 30, 2020), *rescinded* https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523481--,00.html.

[31] Mich. Exec. Order No. 2020-13 (Mar. 17, 2020), *rescinded* https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-522016--,00.html.

[32] Ohio Rev. Code §3701.13.

[33] Mich. Comp. Laws §333.2253.

[34] Pursuant to Mich. Comp. Laws 333.1111(2), the Public Health Code must be "liberally construed for the protection of the health, safety, and welfare of the people of th[e] State." See also, Nicholas Bagley, *Emergency Public Health Powers in Michigan*, THE INCIDENTAL ECONOMIST (Mar. 20, 2020), https://theincidentaleconomist.com/wordpress/emergency-public-health-powers-in-michigan/.

[35] 20 Ill. Comp. Stat. 2305/2(a).

[36] Wis. Stat. §252.02.

[37] *Id.*

[38] *Id.*

[39] OHIO DEPT. OF HEALTH, *Director's Order for Facial Coverings Throughout the State of Ohio* (Nov. 13, 2020), https://content.govdelivery.com/attachments/OHOOD/2020/07/23/file_attachments/1502455/Director%27s%20Order%20Statewide%20facial%20coverings%2007.23.20.pdf; OHIO DEPT. OF HEALTH, *RE: Director's Order for the Management of Non-essential Surgeries and Procedures throughout Ohio* (Mar. 17, 2020), https://content.govdelivery.com/attachments/OHOOD/2020/03/17/file_attachments/1403950/Director%27s%20Order%20non-essential%20surgery%203-17-2020.pdf; OHIO DEPT. OF HEALTH, *RE: Amended Director's Order that All Persons Stay at Home Unless Engaged in Essential Work or Activity* (Apr. 2, 2020), https://content.govdelivery.com/attachments/OHOOD/2020/04/02/file_attachments/1418062/Signed%20Amended%20Director%27s%20Stay%20At%20Home%20Order.pdf.

[40] MICH. DEPT. OF HEALTH AND HUMAN SERVS., *Gatherings and Facemask Order* (Oct. 29, 2020), https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-543708--,00.html; MICH. DEPT. OF HEALTH AND HUMAN SERVS., *Emergency Order Under MCL 333.2253 – Exceptions to Temporary Restrictions on Entry into Certain Facilities* (Jun. 3, 2020),

https://content.govdelivery.com/attachments/MIEOG/2020/06/03/file_attachments/1465801/MDHHS%20epidemic%20order%20-%20exceptions%20to%20facility%20entry%20restrictions.pdf.
[41] 20 Ill. Comp. Stat. §2305/2.
[42] 20 Ill. Comp. Stat. §2305/2.
[43] Ind. Code §16-19-3-10.
[44] Ind. Code §16-19-3-9.
[45] Minn. Stat §144.419-144.4196.
[46] Wis. Admin. Code §252.02.
[47] See *T & V Assocs. v. Dir. of HHS,* 15 N.W.3d 313 (Mich. Ct. App. 2023)
[48] S.B. 22, 134th Gen. Assemb., Reg. Sess. (Ohio 2021) (enacted).
[49] *Wis. Legislature v. Palm*, 942 N.W.2d 900 (Wis. 2020).
[50] Ind. Code §16-19-3-10; Ind. Code §10-14-3-12.5.
[51] MICH. DEPT. OF OCCUPATIONAL SAFETY AND HEALTH ADMIN., *COVID-19 Workplace Requirements*, https://www.michigan.gov/documents/leo/COVID-19_Workplace_Guidelines_for_Outpatient_Healthcare_Facilities_691894_7.pdf.
[52] Mich. Comp. Laws §117.1 *et seq*. Ohio Const. Art. XVIII, § 3; Mich. Comp. Laws 117.1; *See also* Mun. Home Rule, Vol. 135, Issue 5 (Mar. 8, 2024), https://www.lsc.ohio.gov/assets/organizations/legislative-service-commission/files/municipal-home-rule.pdf.
[53] Minn. Stat §12.29.
[54] Ind. Code §10-14-3-29.
[55] Wis. Admin. Code §252.03.
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