PUBLIC HEALTH EMERGENCIES & THE LAW

June 5, 2020

PART II

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TOPICS

- Federal, State, Local and Tribal Relations: Then and Now
- Emergency Workers and Health Care Practitioner Volunteers
- Alternate Care Sites
- Crisis Standards of Care

PARTNERS IN EMERGENCY PREPAREDNESS

LOCAL

- Home rule
- County Health Depts./Districts & Local Emergency Management Depts.
- Local law enforcement

STATE

- Governor, EMD (Military Dept.), DOH
- CEMP & ESFs
- WSP, National Guard
- ch. 38.52, 43.06, & 43. 70 RCW

TRIBAL/FEDERAL

- Sovereignty/ Treaties
- Stafford Act
- Public Health Emergencies Act
- National Emergencies Act

COVID-19 RESPONSE

LOCAL

- Quickly moved to State-Local Partnership
- "Boots on the ground"
- Data collection & reporting
- Individual isolation & quarantine actions/orders
- Partnership with local private health industries

STATE/TRIBAL

- 2/29/20 Governor's 1st COVID-19 Emergency Proclamation (after 1st diagnosed case & 1st confirmed COVID-19 death in U.S.)
- Many tribes issued emergency proclamations
- Multiple ESFs activated

FEDERAL

- CDC diagnostic testing issues
- "not a supply clerk"
- Abdication of coordination role
- MIA (except Congressional funding)

Potential Interventions for Pandemics

- Goal: save lives
- Combine interventions at three levels
  - Individual and household
  - Community-wide:
    - pharmaceutical
    - non-pharmaceutical
  - International

Potential Interventions

Individual / Household

Hand hygiene
Respiratory etiquette
Infection control
Living space control
Isolation of ill
Designated care provider
Facemasks

Community-Wide

Pharmaceutical:
Treatment of ill
Prophylaxis of exposed
Vaccination if available

Nonpharmaceutical:
Isolation of ill
Quarantine of exposed
Alternate care sites
Social distancing
- School closures
- Sequestration of kids
- Workplace
- Adult distancing

International

Containment-at-source
Support efforts to reduce transmission
Travel advisories
Layered screening of travelers
Health advisories
Limited points of entry

The Yin and the Yang of Disaster Volunteers

- Large scale disaster events overwhelm government resources
- Volunteers can aid in the response; untrained volunteers can impede the response
- Management of volunteers requires structure and, ideally, training
- Best established in advance of emergency events
- Washington's emergency volunteers laws; chapters 38.52 RCW and 70.15 RCW

EMERGENCY VOLUNTEERS

Ch. 38.52 RCW

- Lead agency: Military Dept. (EMD)
- "emergency workers" & "covered emergency workers"
  - Distinguishing feature = from private vs. public sector employment (unless on leave without pay)
- Licensing requirements waived RCW 38.52.180(6)
- Requires a mission number and registration (or a state or local employee called upon to perform EM activities)

Ch. 70.15 RCW

- Lead agency: Dept. of Health
- "Volunteer health practitioner" (VHP) licensed in this or another state and in good standing
- Must provide services through a "host entity" during the emergency
- Cannot receive compensation pursuant to a preexisting relationship with the host entity or affiliate
- Registration with DOH

VOLUNTEERS LIABILITY & WORKERS COMP

Ch. 38.52 RCW

- "Covered emergency workers" immune
  - Immunity extended to supervisors, facility, private sector employer, state & local gov't, and more
- "Emergency workers" indemnified
- Neither available for gross negligence or willful or wanton misconduct
- Separate workers compensation program in Military Dept., not LNI

Ch. 70.15 RCW

- VHPs immune
  - Similar extension to others associated with VHP as "covered emergency workers"
- No immunity for gross negligence or willful or wanton misconduct
- Workers compensation through LNI (DOH pays premiums)

Volunteer HCPs: RCW 70.15

Scopes of Practice

- DOH may limit, restrict, or otherwise regulate
  - Duration of practice by VHPs
  - Geographical areas where practice
  - Practitioner types
  - Any other matter necessary to effectively coordinate medical/veterinary care during emergency
- Unless modified by DOH, VHPs' scope are those for similarly licensed practitioners in WA (unless scope is narrower in home state, in which case that is the scope for those practitioners)
- Host entities sponsoring VHP's may also restrict scope

EMAC/PNEMA – USE OF VHP VOLUNTEERS

Emergency Management Assistance Compact (EMAC)

- Codified in ch. 38.52 RCW
- Authorizes mutual aid via state resources and personnel across state lines
- Adopted by all 50 states, D.C., U.S. Virgin Islands, Puerto Rico, Guam & Mariana Islands

Pacific Northwest Emergency Management Arrangement (PNEMA)

- Congressionally approved mutual aid agreement
- Partners: Washington, Oregon, Alaska, Idaho, British Columbia, Yukon Territory

RCW 70.15.080 (2): permits the inclusion of 70.15 registered VHPs in EMAC or PNEMA response at the discretion of DOH

FIRST USE OF RCW 70.15: COVID-2019

- Enacted in 2018 legislative session
- Medical surge resources – King and Snohomish Hospitals
- Federal Medicare/Medicaid standards waived for telehealth care delivery
- Retired Washington HCPS returned to active status and registered as VHPs
  - Included legislators, state employees, private sector employees returning to practice to lend assistance
- Oregon and Idaho practitioners registered to provide continuity of care for Washington resident patients
  - Required to be working with a Washington host entity
  - Mental health providers, continuity of care for their Washington patients

ALTERNATE CARE FACILITIES

- Complex, lengthy regulatory processes to establish a new health care facility or to expand a health care facility (HCF)
- Emergency events triggering a surge of patients can overwhelm HCFs
- HCFs need the ability to quickly expand or set up new temporary facilities, aka “alternate care facilities”
- Governor can waive or suspend regulatory requirements for HCFs [RCW 43.06.220(2)(g)] – waivers needed to establish ACFs
- During COVID-19, ACF examples:
  - Harborview screening tent
  - CenturyLink field hospital

HEALTH CARE STANDARD OF CARE

RCW 7.70.030 –

No health care malpractice award for injuries unless the plaintiff proves by a preponderance of the evidence that one or more of the following occurred:

(1) the injury resulted from ***the failure of the health care provider (HCP) to follow the accepted standard of care***;

(2) a HCP promised the patient or the patient's representative that the injury would not occur;

(3) the injury resulted from health care to which the patient or his representative did not consent.

STATUTORY DEFINTION: STANDARD OF CARE

RCW 7.70.040 –

The following shall be necessary elements of proof that injury resulted from the failure of the health care provider (HCP) to follow the accepted standard of care:

(1) The HCP failed to exercise that degree of care, skill, and learning expected of a ***reasonably prudent HCP*** at that time in the profession or class to which he belongs, in the state of Washington, ***acting in the same or similar circumstances***;

(2) Such failure was a proximate cause of the injury.

CRISIS STANDARDS OF CARE

- "Standard of care" flexes, so crisis standards are not a legal necessity [RCW 7.70.040: "reasonably prudent HCP . . . acting in the same or similar circumstances"]
- Reasons for developing crisis standards of care:
  - Some HCPs are trained in disaster medicine – many are not
  - In advance of a disaster, training on crisis standards of care better assures a range of consistency in treatment decisions
  - Lack of consistency triggers public mistrust, which can be dangerous during a disaster
  - Communication of those crisis standards can help adjust public expectations when it is not "business as usual"

HURRICANE KATRINA – MEMORIAL HOSPITAL

Is this a failure to establish the standard of care in advance of a catastrophe?

Doctor, 2 nurses held in Katrina deaths
Arrest order: patients given morphine; 2nd-degree murder charges filed

HURRICANE KATRINA – NURSING HOME

Genesis of Crisis Standards of Care (2005)

Nursing home owners face charges
Couple charged with 34 counts of negligent homicide

HURRICANE KATRINA – LEGAL OUTCOME

- Dr. Anna Pou – grand jury declined to indict
  - Five Days at Memorial authored by Sheri Fink
- Owners of St. Rita's Nursing Home – acquitted
- Memorial Hospital (Tenet Healthcare Corp.) – class action lawsuit settled $25 million (187 patients & 800 visitors – bodies of 45 patients found)

CRISIS STANDARDS OF CARE: GUIDANCE

- 2005 Office of the Assistant Secretary for Preparedness and Response (ASPR) issued *Altered Standards of Care in a Mass Casualty Event*
- 2009 Institute of Medicine: *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations* – IOM Definition:

"Crisis standards of care" is defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.

WASHINGTON'S CRISIS STANDARDS OF CARE

Scarce Resource Management & Crisis Standards of Care:

https://nwhrn.org/wp-content/uploads/2020/03/Scarce_Resource_Management_and_Crisis_Standards_of_Care_Overview_and_Materials-2020-3-16.pdf

- Conventional Capacity
- Contingency Capacity
- Crisis Capacity

- Ethical Principles: Fairness, Duty to Care, Duty to Steward Resources, Transparency, Consistency, Proportionality, Accountability
- Intended to be an iterative document

COMPLAINT FILED WITH DHHS, OCR

- March 23, 2020, filed by Disability Rights Washington, Arc of the United States and Self Advocates in Leadership, alleging violation of ADA
- Since filing, exploring collaborative solution

WHEN IT COMES TO GLOBAL HEALTH, THERE IS NO ‘THEM’ . . . ONLY ‘US.’

--- GLOBAL HEALTH COUNCIL