EMERGENCY PREPAREDNESS AND RESPONSE

Report of the FSMB Workgroup on Emergency Preparedness and Response
Adopted by the FSMB House of Delegates, April 2022

INTRODUCTION

The Federation of State Medical Boards ("FSMB") established the Ad Hoc Task Force on Pandemic Preparedness, now the Workgroup on Emergency Preparedness and Response (the "Workgroup"), in February 2020 to begin addressing the potential needs of state medical and osteopathic boards ("medical boards") as the spread and impact of COVID-19 within the United States was becoming apparent. The World Health Organization (WHO) formally declared the SARS-CoV2 virus a global pandemic on March 11, 2020, and the President of the United States declared COVID-19 a national emergency two days later. Emergency declarations in all U.S. states, territories, and the District of Columbia followed as cases of COVID-19 and viral infection surged across the nation.

COVID-19 created unforeseen challenges for the healthcare and regulatory communities, including medical boards and other agencies with responsibilities under state law to respond to such a novel emergency event. Major issues have included: the importance of verifying volunteer provider licensure and credentials; the exponential rise in the use of telemedicine and digital health to quickly shore up the health care workforce and expand access to care, particularly in areas hit hard by the virus; the challenges of misinformation, disinformation, and eroding trust in public institutions; combating racial and ethnic disparities in healthcare that were underscored by the pandemic; the need for updated emergency planning resources; the need for more uniformity in emergency licensure portability measures and processes; and the importance of a centralized system to identify and verify health care volunteers during a national or public health emergency.

The FSMB remains committed to assisting medical boards as they navigate the changing landscape. The FSMB created a COVID-19 website that tracked state-by-state license and regulatory information and provided COVID-19-specific resources. FSMB also used prior work on digital credentials and collaborative relationships with state and federal agencies to facilitate the deployment of volunteers across state lines without sacrifice to public safety, issued statements on matters of importance, advocated for improved data collection, and worked with health care regulatory boards and partner organizations to address multifaceted issues that arose during the pandemic.

FSMB WORKGROUP ON EMERGENCY PREPAREDNESS AND RESPONSE

In April 2021, the FSMB House of Delegates adopted *the Report and Recommendations of the Workgroup on Emergency Preparedness and Response* ("2021 Report") developed during the course of the first year of the COVID-19 pandemic. The 2021 Report's recommendations included several directives for the FSMB to address issues that became apparent during the COVID-19 pandemic. The widespread use of telemedicine technologies created a need to establish a workgroup to update the FSMB's *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)*. The disparities in healthcare underscored by the pandemic supported the development of strategies for state medical boards to help combat health inequities and bias in medical discipline in their jurisdictions. Accordingly, the FSMB formed the *Workgroup on Telemedicine* and the *Workgroup on Diversity, Equity and Inclusion in Medical Regulation*.

The 2021 Report also directed the FSMB to work with state medical boards, health professional regulatory boards, and relevant stakeholders to develop model language to clarify emergency licensure processes and to review and update the FSMB's *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards (2010)* ("2010 Document") to encompass lessons learned during COVID-19 and additional types of emergencies and disasters that may occur in the future. This Workgroup was charged with addressing those recommendations and continuing to monitor the COVID-19 pandemic as it stretched into its third year.

The following report, recommendations, and resources are designed to assist medical boards during the COVID-19 pandemic and in future public health and national emergencies.

WORKGROUP CHARGE

The *FSMB Workgroup on Emergency Preparedness and Response* was charged with:

1. Reviewing and updating the *FSMB's Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards (2010)* document to encompass lessons learned during COVID-19, including plans for additional types of emergencies and disasters that may occur in the future;
2. Evaluating outcomes related to emergency actions and other means of mobilizing and expanding the health care workforce to be used in developing model language to clarify emergency licensure processes for future public health emergencies. The Workgroup will develop:
    1) model language for state emergency orders that can provide uniformity in licensure portability measures used to mobilize the healthcare workforce during public health emergencies; and
    2) recommendations for state medical boards implementing emergency license portability measures used during public health emergencies.
3. Providing resources and tools for state medical boards to utilize during periodic reviews of their emergency preparedness plans.

The Report and Recommendations of the Workgroup are summarized below.

REPORT AND RECOMMEDATIONS

Section 1. Updating the FSMB's *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards (2010)*

The COVID-19 pandemic created calls to action for updating emergency preparedness plans and resources at the international, national, local, and organizational levels. As organizations including the *Global Preparedness Monitoring Board (GPMB)* and *The Independent Panel for Pandemic Preparedness and Response* revisited and revised emergency preparedness efforts, focusing on a range of matters from broad strategic planning to achieve better coordination and financial investments in preparedness, to strengthening international actions and the capabilities of the World Health Organization.[1] Understanding the need for domestic regulatory preparedness to align with, and build upon, this global effort, the FSMB focused its efforts on reviewing resources most important for medical boards to have available for future public health emergencies.

The 2021 Report highlighted that the FSMB's 2010 document "was created after Hurricane Katrina devastated parts of the United States and focused mainly on the needs of state medical boards during a natural disaster, without including many resources specific to long-term/chronic events." It also noted that a revised version should include a "broader range of emergency planning resources." Accordingly, the document has been revised to reflect the need for state medical boards to integrate new technological capabilities into their workflow and use such technology to enhance the agility of regulators to respond to unforeseen disruptions in operations or stresses upon the healthcare system. It also includes external resources and new sections highlighting specific areas of concern identified during the COVID-19 pandemic. The revised document has been retitled *Emergency Preparedness and Response: Resources for State Medical Boards*, (hereinafter "resource guide") and is intended to be a living document that will change and expand to encompass resources, including those identified or developed by state medical boards. The resource guide will be available on FSMB's website for medical boards to consult when planning for, or responding to, public health or other emergencies.

The *resource guide* is available as an attachment and specific information on new issues addressed is outlined below.

Section 2. Resources and Tools for State Medical Board Emergency Preparedness

In addition to technical changes, resources have been included that provide information on several issues that medical boards are confronting in the wake of the COVID-19 pandemic. These issues include: the need for medical boards to have all-hazards planning in place for emergencies; challenges with the application of crisis standards of care; establishing strategic communication plans and combating misinformation and disinformation; managing workforce and staffing challenges for boards to continue critical functions during a public health emergency; and the impact of COVID-19 on the wellness of health care providers and medical board staff.

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[1] *E.g.,* Global Preparedness Monitoring Board's 2021 Report: *From Worlds Apart to a World Prepared*, available at: https://www.gpmb.org/annual-reports; The Independent Panel for Pandemic Preparedness and Response's report, *COVID-19: Make it the Last Pandemic* (2021) available at: https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf

All-Hazards Planning

The 2021 Report highlighted the need for the inclusion of an "all-hazards" approach to emergency planning in the resource guide. The importance of all-hazards planning has been underscored by the many different threats and hazards medical boards may face in the future. In addition to threats posed by another pandemic, emergencies related to cybersecurity, grid-loss or extended power outages, and violent attacks could occur. There is generally not a one-sized approach for medical boards in preparing for future emergencies, so the development of a plan that can be utilized in multiple scenarios is extremely important.

All-hazards plans typically identify possible hazards or threats and an organization's vulnerabilities to them, and then seek to create general strategies for addressing them.[2] For medical boards, these vulnerabilities may include: insufficient hardware or software for remote-work operations; limitations on legal authority to hold meetings or hearings virtually; staffing shortages; lack of alternative communication systems if internet connectivity or the electric grid are compromised; or potential loss of access to critical data in a cyberattack. Several resources developed to assist in the creation of all-hazards plans are included in *the resource guide.*

Crisis Standards of Care

The National Academy of Medicine[3] defined "crisis standards of care" in 2009 as "a substantial change in usual healthcare operations and the level of care (that) 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."[4] Individual states, localities, and healthcare systems have also defined crisis standards of care and developed guidance documents for use during emergencies.[5]

Crisis standards of care ("CSCs") were implemented in jurisdictions across the nation during the COVID-19 pandemic.[6] The application of CSCs differed related to timing of case surges and limited access to personal protective equipment (PPE) such as protective masks, or ventilators –

[2] E.g., FEMA Planning Guides, available at: https://www.fema.gov/emergency-managers/national-preparedness/plan; Ready.gov planning information, available at: https://www.ready.gov/planning; CDC All Hazards Preparedness Guide, available at: https://www.cdc.gov/cpr/documents/ahpg_final_march_2013.pdf.
[3] The National Academy of Medicine was previously the Institute of Medicine.
[4] Institute of Medicine's Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations, *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report (2009),* summary available at: https://www.ncbi.nlm.nih.gov/books/NBK32748/
[5] Examples of crisis standards of care documents can be found in Appendix I of the Resource Guide (Attachment 1).
[6] *E.g.,* Alaska activates the State's Crisis Standards of Care for multiple health care facilities; Idaho activates crisis standards of care in three health districts in southern Idaho; Johns Hopkins Bayview Medical Center Activates Crisis Standards of Care;

and were often implemented at the local or facility level.[7] Challenges with CSCs have captured the attention of several organizations, including the National Academies of Science, Engineering and Medicine (NASEM), which established the "*Evolving Crisis Standards of Care and Lessons Learned: A Workshop Series*" in 2021.[8] Throughout the series, NASEM heard presentations from a range of stakeholders impacted by CSCs and will release a final proceedings to the public.

While medical boards generally do not develop CSCs, it is important that they continue to be aware of changing standards of care within their jurisdictions during emergencies in order to appropriately address and evaluate complaints brought before them.

Misinformation, Disinformation, and Strategic Communication Plans

The onslaught and rapid spread of misinformation and disinformation regarding the COVID-19 pandemic, treatments for the virus, and efficacy and safety of COVID-19 vaccines has been a major concern on the international, national, and local scale. Misinformation and disinformation, specifically when shared by licensed health care professionals, has continued to raise alarm with medical boards, policy makers, and the public. The FSMB's 2021 Board Survey found that as of October 2021: 67% of boards experienced an increase in complaints related to licensee dissemination of false or misleading information, 21% had taken disciplinary actions against licensees disseminating false or misleading information, and 39% had received complaints related to COVID-19 vaccine administration.

Medical boards cannot predict what the next public health or national emergency will be, or the misinformation and disinformation that may arise in its wake, but the COVID-19 pandemic and previous emergencies have shown that medical boards will have to grapple with risks to patient safety and potential exploitation that may arise during future emergencies.

Clear and consistent messaging to the public enhances public trust that regulatory mechanisms are functioning to ensure that public safety remains a concern during the uncertainty of crisis. Additionally, such an effort is an effective tool to counter the spread of disinformation among the public.

Strategic communications to licensees are also a critical component of a board's emergency preparedness plan. Medical boards need to be prepared to communicate important information to licensees during an emergency, including notices related to delays in licensing applications, closure of offices, and other changes to board operations.

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[7] *See* Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. *Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do?* NAM Perspectives. Discussion, National Academy of Medicine, Washington, DC, available at: https://doi.org/10.31478/202108e

[8] The National Academies' *Evolving Crisis Standards of Care and Lessons Learned: A Workshop Series* will "re-explore the recommendations from the IOM's 2009 "Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report" and 2012 report "Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response" alongside ongoing lessons from the COVID-19 pandemic, with a particular focus on disaster planning, legal and equity considerations, and staffing considerations." Information on the Workshop Series is available at: https://www.nationalacademies.org/our-work/evolving-crisis-standards-of-care-and-lessons-learned-a-workshop-series --

Health Care Provider Wellness

The COVID-19 pandemic resulted in extreme stress and burnout in the health care workforce – an impact that could be expected to be repeated in future emergencies. Medical boards should be aware of the toll on the health and wellness of licensees and board staff that is often exacerbated by emergencies and encourage the availability of systems-based support dedicated to providing resources and supporting wellness.

Section 3. Model Language for Uniformity in Licensure Portability During Public Health Emergencies

As outlined in the 2021 Report, the variability of licensing waivers and processes during the COVID-19 pandemic created some confusion for licensees and regulators. In reviewing options for enhancing uniformity in license portability for future emergencies, the Workgroup discussed several mechanisms utilized during the COVID-19 pandemic including executive orders, state medical board actions, and interstate compacts. During the COVID-19 pandemic, at least: 26 governors issued Executive Orders mentioning licensure; 27 state medical boards and state agencies issued guidance, clarification, regulations, or orders related to licensure processes; four jurisdictions mentioned interstate compacts and model laws impacting licensure; and 10 jurisdictions passed new legislation related to licensure.[9]

The Workgroup also received presentations from experts on both the Emergency Management Assistance Compact ("EMAC") and the Uniform Emergency Volunteer Health Practitioners Act ("UEVHPA") to understand emergency licensure portability models already enacted in many jurisdictions. The Workgroup then considered whether EMAC and UEVHPA could address confusion without drafting additional model language. Areas in need of clarification included: intent, scope and duration of an executive or emergency order; clarification on jurisdictional and disciplinary authorities; and clarification that the laws of the state where the patient is located apply when practicing across state lines.

EMAC has been adopted as law in all U.S. jurisdictions.[10] It can be activated during an emergency by Executive Order of the Governor of the "requesting state," and create license reciprocity for covered health practitioners to provide care in the requesting state.[11] The UEVHPA was drafted by the Uniform Law Commission following Hurricanes Rita and Katrina in 2005, with the purpose of establishing "a robust and redundant system to quickly and efficiently facilitate the deployment and use of licensed practitioners to provide health and veterinary services in response to declared emergencies."[12] UEVHPA recognizes EMAC, which covers the "deployment of licensed health practitioners employed by state and local governments to other jurisdictions to provide emergency

[9] Examples of actions are available in APPENDIX H: State Emergency Licensure Responses Utilized During COVID-19 in the resource guide (Attachment 1).
[10] Additional information on EMAC is available at: https://www.emacweb.org/
[11] Emergency Management Assistance Compact, Article V: License and Permits. Additional information on the EMAC process is available at: https://www.emacweb.org/index.php/learn-about-emac/how-emac-works
[12] Uniform Law Commission, *Uniform Emergency Volunteer Health Practitioners Act* available at: https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=632ad7d2-8b4c-eecf-c61e-912840ac3a0e (This version includes a prefatory note and comments from the ULC Drafting Committee.)

services without having to be licensed in the affected jurisdictions,"[13] but creates additional processes for licensed volunteers not employed by government. Unlike EMAC, however, UEVHPA is not a compact - it is a model law that leaves some flexibility to the states to determine how the language is adopted into their own statutes.

Since 2006, UEVHPA has been adopted in 18 states and the District of Columbia, and it was introduced in additional jurisdictions during the COVID-19 Pandemic.[14]

The following five goals are addressed in UEVHPA's text[15]:

1. Establishes a system for the use of volunteer health practitioners capable of functioning autonomously even when routine methods of communication are disrupted;
2. Provides reasonable safeguards to assure that volunteer health practitioners are appropriately licensed and regulated to protect the public's health;
3. Allows states to regulate, direct, and restrict the scope and extent of services provided by volunteer health practitioners to promote disaster recovery operations;
4. Provides limitations on the exposure of volunteer health practitioners to civil liability to create a legal environment conducive to volunteerism;
5. Allows volunteer health practitioners who suffer injury or death while providing services pursuant to this act the option to elect workers' compensation benefits from the host state if such coverage is not otherwise available.

UEVHPA requires all volunteers to be registered with a system capable of verifying license and credentials prior to deployment.[16]

EMAC and UEVHPA create an existing legal framework that was utilized during COVID-19. The Workgroup reviewed their ability to address the uniformity concerns for license portability in future emergencies and determined that the FSMB should support states' adoption of UEVHPA.[17]

Additionally, the FSMB's 2021 Board Survey found that 60% of state medical boards activated existing emergency procedures and 88% developed new emergency procedures during the COVID-19 pandemic.[18] The FSMB will work with medical boards to gather information on new and existing policies they utilized during COVID-19 and include them in the resource guide.

Sample emergency orders for activating EMAC are available in the resource guide.

Section 4. Implementing License Portability Measures During Public Health Emergencies

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[13] *Id.*

[14] A list of jurisdictions that have adopted UEVHPA is available at: https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d

[15] Uniform Law Commission, *Uniform Emergency Volunteer Health Practitioners Act* (with Prefatory Note and Comments)https://www.uniformlaws.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=632ad7d2-8b4c-eecf-c61e-912840ac3a0e at Page 1.

[16] *Id* at Page 18.

[17] The FSMB, along with many other organizations, served as an official observer of the ULC's drafting committee for UEVHP and provided comments.

[18] The FSMB 2021 Board Survey had an 83% response rate.

During COVID-19, medical boards implemented protocols for continuing their critical function of protecting the public, even under emergency circumstances.[19] It is vitally important to have mechanisms in place to implement licensure modifications and waivers during a public health emergency.

State medical boards needed to navigate a range of state licensure waivers and modifications during COVID-19, particularly with regard to telehealth, in order to mobilize the nation's workforce to combat surges.[20] To assist with the movement of volunteer health care providers, the FSMB, through funding from the Health Resources and Services Administration ("HRSA") of the U.S. Department of Health and Human Services ("HHS"), developed Provider Bridge (ProviderBridge.org). Provider Bridge was launched during the COVID-19 pandemic and is an online tool that makes it easier to connect health care providers with health care entities during public health emergencies. It fills a critical role to help facilitate the movement of volunteer health care providers to quickly increase access to care in areas of need. The platform includes a directory of state and federal resources and a dedicated customer service hub to help ease the burden on health care professionals and support licensure portability.

Provider Bridge allows healthcare professionals to register and voluntarily submit their credentials and professional background information to treat patients in-person or via telehealth in impacted areas. It allows clinicians to obtain official, digital documents of licensure and other critical information that can be accepted by licensing and healthcare entities during states of emergency. It also allows health care entities to access a database of information for verified, volunteer clinicians willing to provide telehealth services or in-person care during emergencies. Provider Bridge is currently available to physicians, physician assistants, and nurses.

As an established, centralized volunteer registration tool that can quickly identify and verify credentials of volunteer health care providers, Provider Bridge will be critically important in the event of another public health emergency. It can be used by emergency response agencies responsible for volunteer coordination in states where oversight of licensure waivers falls outside medical board control. Medical boards are encouraged to make licensees aware of Provider Bridge so they may choose to register as a potential volunteer in advance of future public health emergencies.

Section 5. Recommendations

The FSMB recommends that:

> **Recommendation 1:** The FSMB will maintain and update *Emergency Preparedness and Response: Resources for State Medical Boards* on its website and continue to work directly with state medical boards to collect resources they have identified or developed to address emergencies.

[19] As mentioned, the FSMB's 2021 Board Survey found that 60% of state medical boards activated existing emergency procedures and 88% developed new emergency procedures during the COVID-19 pandemic.
[20] FSMB COVID-19 Website, available at: https://www.fsmb.org/advocacy/covid-19/

Recommendation 2: Medical boards should make licensees aware of Provider Bridge so they may choose to register as potential volunteers in advance of future public health emergencies.

Recommendation 3: The FSMB will support state and territorial member boards interested in pursuing the adoption of the Uniform Emergency Volunteer Health Practitioners Act.

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