



Report of the FSMB Workgroup on Emergency Preparedness and Response

*Federation of State Medical Boards
May 2021*

INTRODUCTION

The Workgroup on Emergency Preparedness and Response (the “Workgroup”), which is chaired by Dr. Walker-McGill, began meeting in May 2020 to discuss the experiences and lessons learned from state and territorial medical boards (and other health professional regulatory boards, such as nursing and pharmacy) during the COVID-19 pandemic, identify key learnings and best practices, and consider potential recommendations for the ongoing crisis and to better prepare for future pandemics.

BACKGROUND

In February of 2020, the Chair of the Federation of State Medical Boards (FSMB) at the time, Scott Steingard, DO, created an *Ad Hoc Task Force on Pandemic Preparedness*, chaired by FSMB CEO Humayun Chaudhry, DO, MS, to begin addressing the potential needs of state medical and osteopathic boards (“medical boards”), related to medical licensure and regulation, and the U.S. healthcare workforce in the face of a possible pandemic due to the SARS-CoV-2 virus. The novel virus had been identified in Wuhan, China by the World Health Organization (WHO) in December 2019 as the cause of coronavirus disease 2019, also abbreviated COVID-19. On March 11, 2020, the WHO formally declared COVID-19 a global pandemic¹ and two days later, on March 13, 2020, President Donald Trump declared COVID-19 a national emergency in the United States.² Emergency declarations by governors in all U.S. states and territories followed shortly thereafter, resulting in widespread adoption of licensure waivers and modifications to enable and expand licensure portability, increase access to care (for in-person care and telemedicine) and expand healthcare workforce capacity.³ As the impact of COVID-19 continued into May 2020, FSMB’s new Chair, Cheryl Walker-McGill, MD, MBA, transformed the *ad hoc* task force into the *Workgroup on Emergency Preparedness and Response*.

¹ The Director of the World Health Organization [announces the designation of COVID-19 as pandemic](#).

² President Donald Trump issues a [Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease \(COVID-19\) Outbreak](#).

³ Information detailing state licensure modification and waivers during the pandemic is available on [FSMB’s COVID-19 Site](#).

The Workgroup held Zoom-based virtual meetings almost every three weeks since its formation to identify challenges and concerns facing medical boards. While the Workgroup will continue to meet in the coming year, it offers the following report and recommendations related to the COVID-19 pandemic and for similar public health and national emergencies that may develop in the future. The Workgroup may bring additional recommendations for consideration next year, including for other types of public health or national emergencies, as the COVID-19 pandemic continues into 2021.

WORKGROUP CHARGE

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

1. Coordinating and working with external stakeholders including but not limited to representatives from Administrators in Medicine (AIM), the National Association of Boards of Pharmacy (NABP), the National Council of State Boards of Nursing (NCSBN), the Emergency Management Assistance Compact (EMAC), and the federal government;⁴
2. Collecting and evaluating federal and state⁵ experiences and outcomes in response to the national emergency caused by the COVID-19 pandemic, including those measures related to expedited state and territorial medical licensure and other means of mobilizing and expanding the healthcare workforce and its resulting impact on the quality of, and access to, health care;
3. Evaluating existing policy resources including, but not limited to, the FSMB's policies related to telemedicine, physician wellness, and emergency licensure to identify and recommend policy modifications applicable in times of a public health and/or national emergency;
4. Identifying and recommending critical data elements and regulatory safeguards to ensure the integrity of the deployed health professional workforce during a public health and/or national emergency;
5. Evaluating the capacity and readiness of the FSMB's Physician Data Center (PDC) and other national databases to support the deployment of the healthcare workforce, both in person and through telehealth, in response to a public health and/or national emergency; and
6. Developing recommendations for universal tools and resources that could be used by state and federal agencies to efficiently and safely mobilize and expand the healthcare workforce in response to a public health and/or national emergency.

WORKGROUP PROGRESS AND RECOMMENDATIONS TO DATE

⁴ This primarily includes agencies within the U.S. Department of Health and Human Services.

⁵ "state" to include state and territorial medical and osteopathic boards, state emergency services offices, departments of public health, and other health professional regulatory boards, including nursing and pharmacy.

Since May 2020, the Workgroup has heard presentations from a number of speakers, including outside experts, and discussed the national and international status of the COVID-19 pandemic; ongoing state and federal response efforts; statistical information related to cases, transmission rates and fatalities; and available updates on vaccine development and administration. The Workgroup used its frequent meetings to identify and discuss the most pressing issues that have arisen, including the application of state and federal Executive and Emergency Orders, the rapidly changing landscape of utilization and regulation of telehealth, the impact of health inequities that the pandemic has underscored, the need to address the spread of misinformation that poses a challenge to public health-focused harm-reduction strategies, and the challenges faced by member medical boards in transitioning work to a remote environment.

The Workgroup has identified several pressing issues that are discussed below and offered several recommendations for further action.

Section 1. Verification of Provider Identity in a Public Health Emergency

At one point or another during the COVID-19 pandemic, all states and territories felt the need to issue temporary emergency waivers and modifications related to licensure requirements to meet surges in healthcare workforce demands.⁶ These modifications ranged from the creation of expedited licensure pathways to full waivers of state licensure requirements for certain practitioners with an active license in another state/jurisdiction.⁷ As these waivers were put into place, the FSMB's board of directors and senior staff recognized there was a dearth of specific guidance for rapidly mobilizing the healthcare workforce on a national scale and released its *Recommendations for Medical License Portability During the COVID-19 Pandemic*. These timely recommendations outlined critical licensure portability data elements that “contain safeguards that ensure that care being provided balances public health with public safety,” including steps that need to be taken to confirm practice eligibility, verify licensure, limit duration, and require documentation of all provider-patient interactions.⁸

The Workgroup discussed the implementation of waivers and modifications and agreed that while enhanced workforce mobility during a public health emergency may be needed to provide necessary patient care, it remains critical that the identity and licensure status of health care practitioners is verified prior to allowing them to provide health care services to patients. The Workgroup identified challenges states were experiencing in conducting and coordinating the necessary verifications in an expeditious manner. In addition to managing large numbers of volunteer applications, particularly in so-called COVID-19 “hot spots,” some states also faced challenges in coordinating verification efforts and activating or utilizing existing verification and

⁶ See [FSMB's COVID-19 Website](#).

⁷ State-specific information available in FSMB's chart titled [U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19](#).

⁸ FSMB [Recommendations for Medical License Portability During COVID-19 Pandemic](#).

mobility resources. As one example, the Emergency Management Assistance Compact (EMAC),⁹ which was previously adopted as law in all U.S. states, territories, and the District of Columbia, was not immediately activated and utilized in all jurisdictions during COVID-19. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP),¹⁰ a federal program designed to assist with verification of volunteers' credentials during disasters and was also created prior to COVID-19, was similarly not utilized across all jurisdictions at the onset of the pandemic.

Early in the crisis, the Workgroup decided to appoint a subcommittee to determine consensus on those critical data elements about health care providers that could support a uniform approach to verifying the identity and licensure status of volunteers offering their services across state or territorial boundaries in an emergency. In addition to identifying these data elements, the Workgroup served as a resource for the development and implementation of *ProviderBridge.org*, a new online data platform which was created by the FSMB with funding from the Coronavirus License Portability Grant Program of the Health Resources and Services Administration (HRSA).¹¹ The *ProviderBridge.org* platform streamlines the process for mobilizing licensed health care professionals during a public health or national emergency such as COVID-19 and is designed to also be useful for future public health or national emergencies, as well.”¹² Specific data elements (many of which the subcommittee and Workgroup also discussed) as critical to screen volunteering health care providers include verified information related to: name, current and past license(s) information, provider type, school, graduation year, specialty certification or area of practice, National Provider Identifier (NPI) number, any history of disciplinary action, and Drug Enforcement Agency (DEA) number. The *ProviderBridge.org* platform offers a customer service hub that contains resources for providers and others seeking to navigate current state licensure requirements, including those specific to telehealth, during these states of emergency.

In addition to the deployment of licensed health care providers across states, the Workgroup discussed the role of medical students, residents and other health care trainees to address workforce capacity during the COVID-19 pandemic. In some cases, fourth-year medical students were given the option of early graduation to provide additional capacity for care (either on the front lines under supervision or to assist with data entry and telephonic and online communications with patients) in heavily impacted regions of the country. Resident physicians were also deployed to assist during the pandemic, oftentimes in areas outside of their area of specialty training in their accredited GME program. A physician in her 5th year of training as a fellow in cardiology, as one example under a type of scenario that was deemed acceptable by the Accreditation Council for Graduate Medical Education, was permitted to spend the bulk of her time engaged in supporting patients in a general

⁹ Additional information on the *Emergency Management Assistance Compact* is available at: <https://www.emacweb.org/>

¹⁰ Additional information on the Emergency System for Advance Registration of Volunteer Health Professionals is available at: <https://www.phe.gov/esarvhp/pages/about.aspx>

¹¹ Provider Bridge is made possible by grant funding through the Health Resources and Services Administration (HRSA), the U.S. Department of Health and Human Services (HHS), and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

¹² Additional information on *ProviderBridge* is available at: <https://www.providerbridge.org/>

medicine inpatient unit. The need for additional health care capacity led to at least 22 states approving pathways to practice for early medical school graduates via temporary permits or emergency licenses. In some states, such as New York, early graduates were given the title of “COVID-19 Junior Physician” to distinguish them from traditional residents and fellows in training. The availability of early graduates prompted national medical organizations, such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM), to begin discussing the types of guidance and resources that would be needed for early graduates and residents, including related to training and oversight.¹³ The Workgroup noted that while these efforts may be necessary in emergencies, it is critical that early graduates, resident physicians and other health care trainees be appropriately supervised and mentored for their safety and that of patients.

Section 2. Utilization of Telehealth During Public Health or National Emergencies

Enabling continuity of care across state lines can be a major concern during a public health or national emergency, particularly when travel restrictions are in place. Particularly in non-emergency times, continuity of care can be an issue for patients who need to travel to see their healthcare providers. This has already led to several states addressing this issue through adoption of legislation or an Executive Order¹⁴ and has also been a major focus of legislative efforts at the federal level during COVID-19. University students who were unable to access their university health care providers, particularly for mental health treatment, received the attention of policy makers due to the lack of clarity of state requirements regarding access to care across state lines. Healthcare systems utilized the relaxed licensure restrictions to take care of their patients with chronic conditions remotely, reducing the potential for exposure for their most vulnerable patients. However, policy inconsistencies among the states for remote access has been cited as problematic and contributing to confusion on the part of providers and patients alike, leading to a call by some policy makers to address license portability across state lines more uniformly and definitively during COVID-19 and future similar public health emergencies.¹⁵

Telehealth has been broadly used during the COVID-19 pandemic to address access to care, at one point surpassing all ambulatory in-person visits in the United States during a 6-8 week period early

¹³ Information on these issues has been made available by the American Medical Association, the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and the Accreditation Council for Graduate Medical Education (ACGME). The Coalition for Physician Accountability’s Statement on [Maintaining Quality and Safety Standards Amid COVID-19](#) and additional consensus statements issued during the COVID-19 pandemic are included in the Appendix.

¹⁴ For example, legislation enacted in New Jersey ensures that out-of-state healthcare practitioners may continue to provide telemedicine to New Jersey residents until 90 days following the public health emergency ([S. 2467](#)). In Virginia, [Executive Order 57](#) allowed health care practitioners with an active license issued by another state to provide continuity of care to their current patients who are Virginia residents through telehealth services.

¹⁵ In response to these concerns, legislators introduced the *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* ([S. 4421](#), [H.R. 8382](#)) with bipartisan support to allow health care professionals to provide in-person and telehealth services in any jurisdiction based on their authorization to practice in any one state or territory during a public health emergency.

in the crisis. Among its many benefits, telehealth-enabled providers were able to prevent potentially exposing patients and themselves to COVID-19. In late March of 2020, the Center for Medicare and Medicaid Services (CMS) acted under section 1135 of the Social Security Act (1135 Waivers) to expand the list of reimbursable telehealth services and remove the state-based licensure requirement for reimbursement when providing telehealth across state lines during a public health emergency.¹⁶ Many different technology platforms and modalities were deemed acceptable during the pandemic for delivering telehealth. For example, audio-only encounters have been widely utilized during COVID-19,¹⁷ and providers have highlighted the value of audio-only visits for those patients without access to smartphones, computers, or broadband internet access. Audio-only has been temporarily reimbursed at the national level to account for this utilization.¹⁸ Store-and-forward, new technology platforms (i.e. *FaceTime*, *Skype*, *Zoom*), and other online means may need to be made available for telemedicine purposes during emergencies in the future but patient privacy concerns will need to be addressed in all of them. When retrospective data from the COVID-19 pandemic are made available, successful and appropriate forms of telehealth will need to be identified and evaluated to increase access to care as needed during future emergencies.

Nearly all U.S. jurisdictions created mechanisms during the COVID-19 pandemic to allow for the practice of telehealth across state lines in order to provide timely, safe and robust health care during pandemic surges.¹⁹ The variability by jurisdiction for licensing waivers and processes, however, created confusion among some physicians and regulators.²⁰ The Workgroup concurred that there is value in the development and promulgation of model state legislative language on the use of telehealth during a public health emergency. Such model language should address the following:

- Intent of the Executive/Emergency Order.
- Scope and Duration of the Executive/Emergency Order.
- Language providing the jurisdiction in which the patient is located with the ability to verify a provider's identity, investigate complaints, and take disciplinary action against a provider's license in the jurisdiction, when warranted.
- Language clarifying that laws of the state where the patient is located will apply for health care providers practicing across state lines.
- Clarification regarding remote care where there is an existing physician-patient relationship.

¹⁶ A summary of the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers is available at: <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

¹⁷ Several states explicitly allowed the use of audio-only telemedicine encounters during the emergency. See [CT Executive Order 7G](#), [Delaware House Bill 348](#), [Iowa Emergency Proclamation](#), and [Montana Governor's Directive on telemedicine and telehealth services](#).

¹⁸ The CMS list of covered telehealth services for the COVID-19 pandemic is available at: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

¹⁹ See FSMB's chart titled [U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19](#).

²⁰ State medical boards have already recognized the need for some uniformity during emergencies. See [FSMB Report of the FSMB Board of Directors: Emergency Licensure Following a Natural Disaster](#).

FSMB policy affirms that the standard of care in the practice of medicine should be the same regardless of platform or modality, whether in-person or virtual. The Workgroup agreed that this policy should apply to emergency situations, as well.²¹

Section 3. Commitment to the Utilization of Scientific Evidence

The Workgroup has repeatedly discussed the importance of scientific information in combatting a pandemic. Throughout the COVID-19 pandemic, there have been national and international concerns about the spread of false or misleading information undermining containment efforts and endangering public health. The widespread promotion and sharing of misinformation (and even disinformation) have occurred on social media and other platforms, at times by licensed professionals, prompting national and global organizations to affirm the importance of scientific evidence when combatting a global pandemic.²²

There have been reports of health care providers ignoring scientific evidence regarding the treatment and/or mitigation of COVID-19. An FSMB survey of state medical boards during the pandemic found that 64% of respondents confirmed that they had received complaints of physicians failing to wear face coverings during patient encounters. Accordingly, the FSMB's Ethics and Professionalism Committee, chaired by FSMB Board Member Jeffrey Carter, MD, considered the matter and suggested the FSMB's Board of Directors issue a public statement on the matter, which it did, affirming that "(w)earing a face covering is a harm-reduction strategy to help limit the spread of COVID-19, especially since physical distancing is not possible in health care settings. When seeing patients during in-person clinical encounters, physicians and physician assistants have a professional responsibility to wear a facial covering for their own protection, as well as that of their patients and society as a whole."²³

Section 4. Combatting Racial and Ethnic Disparities in Healthcare and Public Health Emergencies

Racial and ethnic disparities in healthcare have historically been exacerbated during public health emergencies, and this has been the case with the COVID-19 pandemic.²⁴ The principle of justice dictates that all patients deserve equal consideration and equitable provision of care according to their individual needs. The failure to provide care according to patient needs puts patients at risk. As such, state medical boards have a role in addressing health inequity during emergency and non-emergency times.

²¹ The FSMB's [Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine](#) identifies the need for a consistent standard of care "notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications," at page 2.

²² See Coalition for Physician Accountability's [Statement to Safeguard the Public, Protect our Health Care Workforce during the COVID-19 Pandemic](#).

²³ [FSMB Statement on Wearing Face Coverings During Patient Care](#).

²⁴ See [American Medical Association's COVID-19 Health Equity Resources](#).

The Workgroup heard presentations from esteemed scholars with expertise in health equity addressing the root causes of health disparities, health inequity in Community Health Centers, the historical context of inequality in healthcare, and potential resources and strategies that may be used to identify discrimination and systems that exacerbate inequities. These presentations and the thoughtful Workgroup discussions that followed highlighted the fact that health inequity goes far beyond the scope of the COVID-19 pandemic, and that data related to race, ethnicity, and other factors must inform any strategy for addressing it. The Workgroup recognized the lack of data collection in these areas and limited availability of existing data during the pandemic.

The Workgroup acknowledges the systemic causes of many health disparities and recognizes the important role that state medical boards may be able to play in addressing them. However, progress in this area will be limited without the requisite data to foster a greater understanding of the causes of disparities to inform the development of potential strategies that allow the medical community to combat health inequity beyond the COVID-19 pandemic.

Section 5. State Medical Board Planning for Future Emergencies

The COVID-19 pandemic revealed a dearth of resources for interstate and intrastate coordination in response to national emergencies as states were challenged in facilitating the national mobilization of the healthcare workforce. The pandemic also highlighted challenges related to the emergency training and redeployment of healthcare professionals within their own states, prompting national groups like the *Coalition for Physician Accountability*, of which the FSMB is a charter member, to develop resources for use during COVID-19.²⁵ In light of these experiences, the Workgroup agreed that it would be beneficial for state public health and emergency management offices and state medical boards to establish working relationships and procedures to prepare for future emergencies. Periodic meetings between state public health and emergency management offices and state medical boards in non-emergency times may also aid strategic planning efforts when emergencies occur.

The Workgroup recommends emergency planning documents include “all-hazards” approaches to address both short-term incidents and long-term/chronic emergencies like COVID-19. CMS defines an all-hazards approach as “an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters....”²⁶ Such planning documents take an integrated approach and focus on organizational capacity, which would allow state medical boards to be prepared for a range of emergency scenarios. The FSMB’s 2010 document, *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards*, 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. The document requires updating to include a broader range of emergency planning resources.

²⁵ Coalition for Physician Accountability’s Statement on [Maintaining Quality and Safety Standards Amid COVID-19](#).

²⁶ CMS Emergency Preparedness Regulation, [Clarifications on Definitions](#).

The COVID-19 pandemic required every state and territorial medical board to transition daily operations to remote work (“Work from Home”) and to conduct board meetings and hearings virtually. This was a challenge as many boards did not have the authority under their state or territory’s Open Meeting laws to meet virtually. Accordingly, Open Meeting laws had to be modified by gubernatorial Executive Orders, state and territorial legislative actions, and emergency declarations in at least 40 states to address this issue.²⁷

Section 6. Recommendations

The FSMB House of Delegates adopted as policy the following six recommendations:

The FSMB recommends that:

Recommendation 1: The FSMB should work with state medical boards, health professional regulatory boards, and relevant stakeholders to develop model language to clarify emergency licensure processes.

Recommendation 2: The FSMB should establish a Workgroup to update the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (2014)*, taking into account the lessons learned during the COVID-19 pandemic.

Recommendation 3: The FSMB should develop strategies for state medical boards to help combat health inequities and bias in medical discipline in their jurisdictions.

Recommendation 4: State medical boards should engage in periodic reviews of their emergency preparedness plans to ensure that such plans include current contact information for staff, state emergency management offices, partner organizations and procedures for communications.

Recommendation 5: The FSMB should review and update its *Emergency and Disaster Preparedness Plan: A Guide for State Medical Boards* document to encompass lessons learned during COVID-19, including plans for additional types of emergencies and disasters that may occur in the future.

Recommendation 6: State medical boards should identify their capabilities for remote operations during emergencies and remain informed of any emergency changes to their state’s open-meeting laws during such times.

²⁷ See Law360, [Public Meeting Requirements in the Age of COVID-19](#).

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