California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Reference Manual




California Department of PublicHealth

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Foundational Knowledge
Volume I: Hospitals
Volume II: Government-Authorized Alternate Care Sites
Volume III: Payers
Volume IV: Licensed Healthcare Clinics (available 2008)
Volume V: Long-Term Care Facilities (available 2008)
Volume VI: Licensed Healthcare Professionals (available 2008)
Hospital Operational Tools Manual
Government-Authorized Alternate Care Site Operational Tools Manual
Foundational Knowledge Training Guide
Hospital Training Guide
Government-Authorized Alternate Care Site Training Guide
Payer Training Guide
Reference Manual

Table of Contents

1. Introduction

The reference manual contains information to supplement the Standards and Guidelines for Healthcare Surge Volumes. It is intended to assist hospitals, local health departments, payers and other community participants in the development of healthcare surge plans by providing additional reference information related to the volumes.

The reference manual includes:

Acronym List: Definitions of acronyms used throughout the Standards and Guidelines for Healthcare Surge during Emergencies Manuals and Operational Tools.

Surge Regulations and Compliance Legal Matrix: Legal analysis of federal and State regulations and compliance issues completed by legal counsel during the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project. The information is legal opinion and should be used for reference only. This section also includes an overview of the current professional scope of practice guidelines for 16 of the California Healing Arts Boards as indicated in the California Business and Professions Code.

Applying the Incident Command System to the Hospital: Detailed information regarding the Incident Command System roles and responsibilities for hospitals.

All Facilities Letter 06-33: CDPH Licensing and Certification Temporary Permission for Increased Patient Accommodations: The application to request permission from CDPH Licensing and Certification District Office to temporarily exceed a facility's licensed bed capacity during a justified emergency.

Fatality Management Resources: Additional Guidance for Setting up Temporary Morgues: References that can be used as additional guidance for setting up temporary morgues.

Current Funding Sources: Overview of the existing funding and reimbursement programs in California and their rules and processes.

Funding Sources Eligibility, Benefits and Application Procedures: List of funding sources for which CDPH, local health departments, facilities or individuals may apply in order to meet the financial needs of planning and responding to a healthcare surge.

Full Text of Social Security Act, Section 1135 Waiver: Full text of the Section 1135 Waiver which under 42 U.S.C. Section 1320b-5 (section 1135 of the Social Security Act) grants the Secretary of Health and Human Services the authority to waive certain requirements of Centers for Medicare and Medicaid Services programs in an emergency area during an emergency period.

Funding Sources - Lessons Learned from Louisiana: Information on funding sources that were used during previous states of emergency to highlight the kinds of response that

may be possible in California.

Current Patient Rights Resource Guide: Listing of resources that provide information related to current patient rights.

California State Privacy Laws pertaining to Government-Authorized Alternate Care Sites: Information on California State laws regarding privacy of identity and health information with which Alternate Care Sites would be expected to comply.

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2. Acronym List

Acronym / Abbreviation	Phrase / Name
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
HICS	Hospital Incident Command System
HIPAA	Health Information Portability and Accountability Act
NIMS	National Incident Management System
SEMS	Standardized Emergency Management System

3. Surge Regulations and Compliance Legal Matrix

3.1. Introduction

The Surge Regulations and Compliance Legal Matrix lists specific state and federal statutes and regulations that relate to healthcare facilities and professionals operating during a healthcare surge. These statutes and regulations were researched during the course of the *Development of Standards and Guidelines for Healthcare Surge During Emergencies* project based on issues identified by project participants. This document was produced for research purposes and contains legal opinion. It should be used for reference purposes only.

The Surge Regulations and Compliance Legal Matrix content is organized by the following sections:

- Emergency Declarations
- Healthcare Facilities
- Alternate Care Sites
- Personnel
- Supplies / Pharmaceuticals / Equipment
- Administration
- Funding Sources
- Population Rights
- California Healing Arts: Professional Scope of Practice

Within each section, the following content is included as appropriate:

- **Issue to address:** The identified legal issue to be considered during the development of specified outputs. A legal review was performed to ensure inclusiveness of all relevant legal issues.
- **Current Applicable Legislation, Statute, Law:** A list of current statutes, regulations and standards to be considered while addressing the identified issues. A legal review was performed to ensure inclusiveness of all relevant legislation.
- **Current Compliance Requirements:** Text from the statutes, regulations and standards that describes the minimum requirements required to comply with the legislation in its current state.
- **Can law be flexed or altered? Are there applicable waivers?** A legal opinion to determine the extent to which the statute/regulation/standard can be flexed/altered/waived during a healthcare surge. This analysis includes the identification of current waivers/provisions that are built into the legislation for emergency situations.

3.2 Emergency Declarations

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
Are there pre-existing declarations and emergency orders that can be issued as needed during a healthcare surge?	**I. Declaration of Local Emergency - Government Code Section 8630**	**I. Declaration of Local Emergency - Government Code Section 8630** (a) A local emergency may be proclaimed only by the governing body of a city, county, or city and county, or by an official designated by ordinance adopted by that governing body. (b) Whenever a local emergency is proclaimed by an official designated by ordinance, the local emergency shall not remain in effect for a period in excess of seven days unless it has been ratified by the governing body. (c) (1) The governing body shall review, at its regularly scheduled meetings until the local emergency is terminated, the need for continuing the local emergency. However, in no event shall a review take place more than 21 days after the previous review. (2) Notwithstanding paragraph (1), if the governing body meets weekly, it shall review the need for continuing the local emergency at least every 14 days, until the local emergency is terminated. (d) The governing body shall proclaim the termination of the local emergency at the earliest possible date that conditions warrant.	**I. Declaration of Local Emergency - Government Code Section 8630**. The Office of Emergency Services has a sample proclamation in its "Emergency Proclamations Guide for Local Government."
	II. Local Emergency Defined - Government Code Section 8558(c)	**II. Local Emergency Defined - Government Code Section 8558(c)** "Local emergency" means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the territorial limits of a county, city and county, or city, caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, complications resulting from the Year 2000 Problem, or other conditions, other than conditions resulting from a labor	**II. Local Emergency Defined - Government Code Section 8558(c)**. The Office of Emergency Services has a sample proclamation in its "Emergency Proclamations Guide for Local Government." Any proclaimed emergency must meet the definition in

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		controversy, which are or are likely to be beyond the control of the services, personnel, equipment, and facilities of that political subdivision and require the combined forces of other political subdivisions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission.	this section.
	III. Mutual Aid - Government Code 8631	**III. Mutual Aid - Government Code 8631** In periods of local emergency, political subdivisions have full power to provide mutual aid to any affected area in accordance with local ordinances, resolutions, emergency plans, or agreements therefore.	**III. Mutual Aid - Government Code 8631**. Mutual aid is something that is requested. Office of Emergency Services has prepared "Emergency Managers Mutual Aid Guidance."
	IV. State Mutual Aid - Government Code Section 8632.	**IV. State Mutual Aid - Government Code Section 8632** State agencies may provide mutual aid, including personnel, equipment, and other available resources, to assist political subdivisions during a local emergency or in accordance with mutual aid agreements or at the direction of the Governor.	**IV. State Mutual Aid - Government Code Section 8632.** State mutual aid is authorized either by declarations and/or pre-existing agreements.
	V. Orders and Regulations - Government Code Section 8634.	**V. Orders and Regulations - Government Code Section 8634** During a local emergency the governing body of a political subdivision, or officials designated thereby, may promulgate orders and regulations necessary to provide for the protection of life and property, including orders or regulations imposing a	**V. Orders and Regulations - Government Code Section 8634**. These would be local orders. It is likely that

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		curfew within designated boundaries where necessary to preserve the public order and safety. Such orders and regulations and amendments and rescissions thereof shall be in writing and shall be given widespread publicity and notice. The authorization granted by this chapter to impose a curfew shall not be construed as restricting in any manner the existing authority of counties and cities and any city and county to impose pursuant to the police power a curfew for any other lawful purpose.	some local jurisdictions have them pre-drafted and ready to go.
	VI. State of Emergency Declaration, Proclamation – Government Code Section 8625	**VI. State of Emergency Declaration, Proclamation – Government Code Section 8625** The Governor is hereby empowered to proclaim a state of emergency in an area affected or likely to be affected thereby when: (a) He finds that circumstances described in Government Code Section 8558(b) exist; and either (b) He is requested to do so (1) in the case of a city by the mayor or chief executive, (2) in the case of a county by the chairman of the board of supervisors or the county administrative officer; or (c) He finds that local authority is inadequate to cope with the emergency.	**VI. State of Emergency Declaration, Proclamation – Government Code Section 8625**. There are pre-existing emergency proclamations that can be used to quickly fashion an appropriate order in the event of any qualifying emergency. Unless requested by a local jurisdiction, the Governor must independently find that the emergency exceeds local resources.
	VII. State of Emergency Defined - Government Code Section 8558.	**VII. State of Emergency Defined - Government Code Section 8558** (a) “State of war emergency” means the condition which exists immediately, with or without a proclamation thereof by the	**VII. State of Emergency Defined - Government Code Section 8558**. Governor must find that conditions meet State of

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Governor, whenever this state or nation is attacked by an enemy of the United States, or upon receipt by the state of a warning from the federal government indicating that such an enemy attack is probable or imminent. (b) "State of emergency" means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, complications resulting from the Year 2000 Problem, or other conditions, other than conditions resulting from a labor controversy or conditions causing a "state of war emergency," which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission.	Emergency definition, in addition to determining the inadequacy of local means.
	VIII. Powers During a State of Emergency, Authority and Power of Governor – Government Code Section 8627	**VIII. Powers During a State of Emergency, Authority and Power of Governor – Government Code Section 8627** During a state of emergency the Governor shall, to the extent he deems necessary, have complete authority over all agencies of the state government and the right to exercise within the area designated all police power vested in the state by the Constitution and laws of the State of California in order to effectuate the purposes of this chapter. In exercise thereof, he shall promulgate, issue, and enforce such orders and regulations as he deems necessary, in accordance with the provisions of Government Code Section 8567.	**VIII. Powers During a State of Emergency, Authority and Power of Governor – Government Code Section 8627**. These powers allow the Governor to issue orders to carry out his police power. Could be used to order a standard of care consistent with his responsibility under the Emergency Services Act to preserve greatest

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
			number of lives.
	IX. Orders Suspending Non-Safety Related Restrictions on Relief - Government Code Section 8627.5.	**IX. Orders Suspending Non-Safety Related Restrictions on Relief - Government Code Section 8627.5** (a) The Governor may make, amend, or rescind orders and regulations during a state of emergency that temporarily suspend any state, county, city, or special district statute, ordinance, regulation, or rule imposing nonsafety related restrictions on the delivery of food products, pharmaceuticals, and other emergency necessities distributed through retail or institutional channels, including, but not limited to, hospitals, jails, restaurants, and schools. The Governor shall cause widespread publicity and notice to be given to all of these orders and regulations, or amendments and rescissions thereof. (b) The orders and regulations shall be in writing and take effect immediately on issuance. The temporary suspension of any statute, ordinance, regulation, or rule shall remain in effect until the order or regulation is rescinded by the Governor, the Governor proclaims the termination of the state of emergency, or for a period of 60 days, whichever occurs first.	**IX. Orders Suspending Non-Safety Related Restrictions on Relief - Government Code Section 8627.5**. These orders could be used to suspend permitting requirements for the establishment of facilities to distribute food or medical supplies.
	X. Powers of Governor for State-Level Emergency, Expenditures – Government Code Section 8566	**X. Powers of Governor for State-Level Emergency, Expenditures – Government Code Section 8566** The Governor is empowered to expend any appropriation for support of the California Emergency Services Act to carry out the provisions of this chapter.	**X. Powers of Governor for State-Level Emergency, Expenditures – Government Code Section 8566**. Combines with Government Code Section 8645 to allow Governor to fund activities under the Emergency Services Act.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	XI. Orders and Regulations - Government Code Section 8567.	**XI. Orders and Regulations - Government Code Section 8567** (a) The Governor may make, amend, and rescind orders and regulations necessary to carry out the provisions of this chapter. The orders and regulations shall have the force and effect of law. Due consideration shall be given to the plans of the federal government in preparing the orders and regulations. The Governor shall cause widespread publicity and notice to be given to all such orders and regulations, or amendments or rescissions thereof. (b) Orders and regulations, or amendments or rescissions thereof, issued during a state of war emergency or state of emergency shall be in writing and shall take effect immediately upon their issuance. Whenever the state of war emergency or state of emergency has been terminated, the orders and regulations shall be of no further force or effect. (c) All orders and regulations relating to the use of funds pursuant to Government Code Section 8645 Article 16 shall be prepared in advance of any commitment or expenditure of the funds. Other orders and regulations needed to carry out the provisions of this chapter shall, whenever practicable, be prepared in advance of a state of war emergency or state of emergency. (d) All orders and regulations made in advance of a state of war emergency or state of emergency shall be in writing, shall be exempt from Government Code Section 11340, Title 2, Division 3, Part 1, Chapter 3.5 but shall be subject to the approval of the Emergency Council. As soon thereafter as possible they shall be filed in the office of the Secretary of State and with the county clerk of each county.	**XI. Orders and Regulations - Government Code Section 8567**. These powers allow the Governor to issue orders to carry out his police power. Could be used to order a standard of care consistent with his responsibility under the Emergency Services Act to preserve greatest number of lives.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	XII. Suspension of Regulatory Statutes - Government Code Section 8571.	**XII. Suspension of Regulatory Statutes - Government Code Section 8571** During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Government Code Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.	**XII. Suspension of Regulatory Statutes - Government Code Section 8571**. This section could be used to suspend, or authorize Office of Emergency Services or CDPH to suspend, state regulatory statutes or regulations based on a determination that strict compliance would prevent or hinder the mitigation of the effects of the emergency. In either case, a list of statutes or regulations would be required. Could also be used to suspend Open Meeting Law requirements for professional boards.
	XIII. Orders and Regulations - Government Code Section 8567.	**XIII. Orders and Regulations - Government Code Section 8567** (a) The Governor may make, amend, and rescind orders and regulations necessary to carry out the provisions of this chapter. The orders and regulations shall have the force and effect of law. Due consideration shall be given to the plans of the federal government in preparing the orders and regulations. The Governor shall cause widespread publicity and notice to be given to all such orders and regulations, or amendments or rescissions thereof.	**XIII. Orders and Regulations - Government Code Section 8567**. These powers allow the Governor to issue orders to carry out his police power. Could be used to order a standard of care

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		(b) Orders and regulations, or amendments or rescissions thereof, issued during a state of war emergency or state of emergency shall be in writing and shall take effect immediately upon their issuance. Whenever the state of war emergency or state of emergency has been terminated, the orders and regulations shall be of no further force or effect. (c) All orders and regulations relating to the use of funds pursuant to Government Code Section 8645 Article 16 shall be prepared in advance of any commitment or expenditure of the funds. Other orders and regulations needed to carry out the provisions of this chapter shall, whenever practicable, be prepared in advance of a state of war emergency or state of emergency. (d) All orders and regulations made in advance of a state of war emergency or state of emergency shall be in writing, shall be exempt from Government Code Section 11340, Division 3, Part 1, Chapter 3.5 but shall be subject to the approval of the Emergency Council. As soon thereafter as possible they shall be filed in the office of the Secretary of State and with the county clerk of each county.	consistent with his responsibility under the Emergency Services Act to preserve greatest number of lives.
	XIV. Emergency or disaster declared by the President	**XIV. Emergency or disaster declared by the President** (a) All powers and authorities possessed by the President, any other officer or employee of the Federal Government, or any executive agency, as defined in 5 USC Section 105, as a result of the existence of any declaration of national emergency in effect on September 14, 1976, are terminated two years from September 14, 1976. Such termination shall not affect— (1) any action taken or proceeding pending not finally concluded or determined on such date; (2) any action or proceeding based on any act committed prior to such date; or (3) any rights or duties that matured or penalties that were incurred prior to such date. (b) For the purpose of this section, the words “any national	**XIV. Emergency or disaster declared by the President**. This Act places limits on the President’s ability to declare and sustain national emergencies.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		emergency in effect" means a general declaration of emergency made by the President.	
	XV. National Emergencies Act – 50 USC Section 1601	**XV. National Emergencies Act – 50 USC Section 1601** (a) The Congress hereby finds and declares that— (1) because disasters often cause loss of life, human suffering, loss of income, and property loss and damage; and (2) because disasters often disrupt the normal functioning of governments and communities, and adversely affect individuals and families with great severity; special measures, designed to assist the efforts of the affected States in expediting the rendering of aid, assistance, and emergency services, and the reconstruction and rehabilitation of devastated areas, are necessary. (b) It is the intent of the Congress, by this chapter, to provide an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage which result from such disasters by— (1) revising and broadening the scope of existing disaster relief programs; (2) encouraging the development of comprehensive disaster preparedness and assistance plans, programs, capabilities, and organizations by the States and by local governments; (3) achieving greater coordination and responsiveness of disaster preparedness and relief programs; (4) encouraging individuals, States, and local governments to protect themselves by obtaining insurance coverage to supplement or replace governmental assistance; (5) encouraging hazard mitigation measures to reduce	**XV. National Emergencies Act – 50 USC Section 1601**. This Act allows waiver of federal agency administrative conditions for assistance in declared major disasters.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		losses from disasters, including development of land use and construction regulations; and (6) providing Federal assistance programs for both public and private losses sustained in disasters	
	XVI. Robert T. Stafford Relief and Emergency Assistance Act – 42 USC Section 5121	**XVI. Robert T. Stafford Relief and Emergency Assistance Act – 42 USC Section 5121** (a) Emergencies If the Secretary determines, after consultation with such public health officials as may be necessary, 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, the Secretary may take such action as may be appropriate to respond to the public health emergency, including making grants, providing awards for expenses, and entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder as described in paragraphs (1) and (2). Any such determination of a public health emergency terminates upon the Secretary declaring that the emergency no longer exists, or upon the expiration of the 90-day period beginning on the date on which the determination is made by the Secretary, whichever occurs first. Determinations that terminate under the preceding sentence may be renewed by the Secretary (on the basis of the same or additional facts), and the preceding sentence applies to each such renewal. Not later than 48 hours after making a determination under this subsection of a public health emergency (including a renewal), the Secretary shall submit to the Congress written notification of the determination.	**XVI. Robert T. Stafford Relief and Emergency Assistance Act – 42 USC Section 5121**. This section allows a waiver by the Secretary of Health and Human Services of regulations pertaining, among other things, to the transfer of non-stabilized patients and the redirection of patients for screening for purposes of reimbursement. It does not appear to waive the Emergency Medical Treatment and Active Labor Act, or the ability of patients to bring civil actions for injuries sustained due to the Emergency Medical Treatment and Active Labor Act violations.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
What are the triggers for the implementation of surge standards and guidelines?	**I. 42 USC Section 1320b-5**	**I. 42 USC Section 1320b-5** (a) Purpose The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in 42 USC Section 1320b-5 (g)(1)) (1) that sufficient healthcare items and services are available to meet the needs of individuals in such area enrolled in the programs under subchapters XVIII, XIX, and XXI of this chapter; and (2) that healthcare providers (as defined in 42 USC Section 1320b-5 (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in 42 USC Section 1320b-5 (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. (b) Secretarial authority To the extent necessary to accomplish the purpose specified in 42 USC Section 1320b-5 (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to healthcare items and services furnished by a healthcare provider (or classes of healthcare providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX, or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to such subchapters), pertaining to— (1) (A) conditions of participation or other certification requirements for an individual healthcare provider or types of providers, (B) program participation and similar requirements for an individual healthcare provider or types of providers, and (C) pre-approval requirements; (2) requirements that physicians and other healthcare professionals be licensed in the State in which they provide such services, if they have equivalent licensing	**I. 42 USC Section 1320b-5** Absent a new standard, it must be assumed that, even after a disaster happens, the normal, current standards continue in effect for everyone who has not been disabled from strict compliance. In other words, unless a facility is simply incapable of complying with existing standards (in which case the facility must simply do what it can to protect its patients from harm), the existing standards ARE the surge standards until some legal action occurs which changes the standards. The legal triggers depend on whether the underlying requirement is federal or state. If federal, the “trigger” appears to be the Secretary’s authority to waive certain requirements for reimbursement under 42 USC 1320b-5, which authorizes, among other

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area; (3) sanctions under 42 USC Section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section of such section if the transfer arises out of the circumstances of the emergency; (4) sanctions under 42 USC Section 1395nn (g) (relating to limitations on physician referral); (5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived; and (6) limitations on payments under 42 USC Section 1395w–21 (i) for healthcare items and services furnished to individuals enrolled in a Medicare+Choice plan by healthcare professionals or facilities not included under such plan. Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of subchapter XVIII of this chapter. (c) Authority for retroactive waiver A waiver or modification of requirements pursuant to this section may, at the Secretary's discretion, be made retroactive to the beginning of the emergency period or any subsequent date in	things, a waiver of certain the Emergency Medical Treatment and Active Labor Act requirements. However, this appears to fall far short of a complete waiver of the Emergency Medical Treatment and Active Labor Act. The Emergency Medical Treatment and Active Labor Act requirements are enforced through civil money penalties and private liability actions. Although, by waiving the Emergency Medical Treatment and Active Labor Act requirements, the Secretary may be foregoing his/her ability to seek civil money penalties, a person or receiving hospital harmed by an unlawful transfer would still have its ability to seek relief. If a state requirement, the Emergency Services Act proclamation of a state of emergency is the mechanism to trigger revised standards. The proclamation would need to revise the overall standard of care to

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		such period specified by the Secretary. (d) Certification to Congress The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include— (1) a description of (A) the specific provisions that will be waived or modified; (B) the healthcare providers to whom the waiver or modification will apply; (C) the geographic area in which the waiver or modification will apply; and (D) the period of time for which the waiver or modification will be in effect; and (2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a) of this section. (e) Duration of waiver (1) In general, a waiver or modification of requirements pursuant to this section terminates upon (A) the termination of the applicable declaration of emergency or disaster described in 42 USC Section 1320b-5 (g)(1)(A); (B) the termination of the applicable declaration of public health emergency described in 42 USC Section 1320b-5 (g)(1)(B); or (C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification under paragraph (2)). (2) Extension of 60-day periods: The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification under subparagraph (A) or (B) of paragraph (1).	preserving the most lives, or facilities to operate in accordance with the new standard, and separately suspend existing standards inconsistent with the new standard after determining that strict compliance with the existing standard will hinder the mitigation of the effects of the emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		(f) Report to Congress Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to Accomplish the purposes described in subsection (a) of this section, including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future. (g) Definitions For purposes of this section: (1) Emergency area; emergency period: An "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exists (A) an emergency or disaster declared by the President pursuant to the National Emergencies Act [50 USC Section 1601] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act [42 USC Section 5121]; and (B) a public health emergency declared by the Secretary pursuant to 42 USC Section 247d of this title. (2) Healthcare provider: The term "healthcare provider" means any entity that furnishes healthcare items or services, and includes a hospital or other provider of services, a physician or other healthcare practitioner or professional, a healthcare facility, or a supplier of healthcare items or services.	
	II. Suspension of Regulatory Statutes - Government Code Section 8567, 8571, 8627.	**II. Suspension of Regulatory Statutes - Government Code Section 8567, 8571, 8627** During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including Unemployment Insurance Code Section 1253 (d), where the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.	

3.3 Healthcare Facilities

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What are the limitations and criteria for providing out-of-scope services at a given facility? (e.g. altering use of unlicensed beds) *Each type of facility will have to refer to facility specific laws.*	**I. 22 CCR 70809**	**I. 22 CCR 70809** Patient accommodations limitations - "No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in cases of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity."	**I. 22 CCR 70809** (a) Per Health Safety Code Section 1276(b), this code can be flexed. Health Safety Code Section 1276(b) provides CDPH and Office of Statewide Health Planning and Development authority to flex existing standards and requirements under certain circumstances. Applicable to facilities under the jurisdiction of CDPH. Specific program flexibility may also be invoked per facility type. (b) The following regulations shall permit program flexibility by the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or the office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable. <u>Program Flexibility Regulations:</u> General Acute Care Hospital: Health and Safety Section 1276(b); 22 CCR 70809(a); General Acute Care Hospital: 22 CCR 70129

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			Acute Psychiatric Hospital: 22 CCR 71127 Skilled Nursing Facility: 22 CCR 72213 Intermediate Care Facility: 22 CCR 73227 Home Health Agency: 22 CCR 74689 Intermediate Care Facility/ Developmentally Disabled: 22 CCR 76227 Intermediate Care Facility/ Developmentally Disabled Habilitative**:** 22 CCR 76852 Psychiatric Health Facility: 22 CCR 77049 Adult Day Health Center: 22 CCR 78217 Correction Treatment Center**:** 22 CCR 79593 22 CCR 70809 - Yes. See flexibility and guidelines from All Facilities Letter 06-33; For other types of facilities, assess program flexibility regulations and use the AFL as guidelines for tailoring request.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations	**II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations** Accommodations for temporary hospital overcrowding - "CDPH Licensing & Certification district offices may grant hospitals, after review and when appropriate, temporary permission to exceed their licensed bed capacity."	**II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations** This letter provides flexibility to hospital facility requirements per a written request under limited circumstances. Program flexibility is an option in the case of a justified emergency. Temporary permission may be granted by the Director or her designee. *(All Facilities Letter 06-33, 04-28 includes template forms.)*
	III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) Environment of Care 4.10	**III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) Environment of Care 4.10** Environment of Care 4.10. An emergency in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in its community.	**III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) Environment of Care 4.10** There is no flexibility for these requirements. As part of a hospital's disaster plan, it must address care during a surge at alternate locations.
	IV. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, including 482.12	**IV. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, including 482.12** Conditions of Participation Section 482.12 Condition of participation: Governing Body.	**IV. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, including 482.12** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of

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		"The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body."	Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.
	V. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.51	**V. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.51** Conditions of Participation Section 482.51 Condition of participation: Surgical services. "If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. (a) Standard: Organization and staffing. The organization of the surgical services must be appropriate to the scope of the services offered. (1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy. (2) Licensed practical nurses and surgical technologists (operating room technicians) may serve as "scrub nurses'' under the supervision of a registered nurse. (3) Qualified registered nurses may perform	**V. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.51** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.

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		circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, Licensed practical nurses and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies."	
	VI. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.42	**VI. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.42** Conditions of Participation Section 482.42 Condition of participation: Infection control. The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.	**VI. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.42** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.
	VII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.41	**VII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.41** Section 482.41 Condition of participation: Physical environment. The hospital must be constructed, arranged, and maintained to	**VII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.41** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. (a) Standard: Buildings. The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. (1) There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available. (2) There must be facilities for emergency gas and water supply. (b) Standard: Life safety from fire. (1) Except as provided in paragraphs (b)(1)(i) through (b)(1)(iii) of this section, the hospital must meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association (which is incorporated by reference).	Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.
	VIII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.2	**VIII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.2** Conditions of Participation Section 482.2 Provision of emergency services by nonparticipating hospitals. (a) The services of an institution that does not have an agreement to participate in the Medicare program may, nevertheless, be reimbursed under the program if—(1) The services are emergency services; and	**VIII. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.2** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows

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		(2) The institution meets the requirements of section 1861(e) (1) through (5) and (7) of the Act. Rules applicable to emergency services furnished by nonparticipating hospitals are set forth in subpart G of part 424 of this chapter. (b) Section 440.170(e) of this chapter defines emergency hospital services for purposes of Medicaid reimbursement. Emergency Services by non participating hospitals Section 1861(e) of the Social Security Act defines the term "hospital" including hospital primary functions and operations.	program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.
	IX. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.12	**IX. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.12** Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.12 Standard: Care of patients. In accordance with hospital policy, the governing body must ensure that the following requirements are met: (1) Every Medicare patient is under the care of: (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified healthcare personnel to the extent recognized under State law or a State's regulatory mechanism.); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions	**IX. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.12** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.

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		which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist; and (vi) A clinical psychologist as defined in Section 410.71 of this chapter, but only with respect to clinical psychologist services as defined in Section 410.71 of this chapter and only to the extent permitted by State law. (2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy. (3) A doctor of medicine or osteopathy is on duty or on call at all times. (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that—(i) is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is—(A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors.	

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	X. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.11	**X. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.11** Conditions of Participation Section 482.11: Compliance with Federal, State and local laws. (a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. (b) The hospital must be—(1) Licensed; or (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals. (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.	**X. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.11** Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor. Waivers may apply indirectly if meets federal threshold criteria and meets applicable state standards. Therefore, if state authority allows program flexibility, then so long as flexibility granted, the federal requirement of compliance with applicable standards could be met. Note that some areas do not allow for program flexibility.
	XI. California Disaster and Civil Defense Master Mutual Aid Agreement, Government Code Section 8631	**XI. California Disaster and Civil Defense Master Mutual Aid Agreement, Government Code Section 8631** Government Code Section 8631. Mutual Aid In periods of local emergency, political subdivisions have full power to provide mutual aid to any affected area in accordance with local ordinances, resolutions, emergency plans, or agreements therefore.	**XI. California Disaster and Civil Defense Master Mutual Aid Agreement, Government Code Section 8631** There is no flexibility for this statute. State authority to enter mutual aid agreements. *(Sample template mutual aid agreements may be viewed at the American Hospital Association Website)*

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XII. California Emergency Services Act, Section 8569 - 8570	**XII. California Emergency Services Act, Section 8569 - 8570** California Emergency Services Act Section 8569. The Governor shall coordinate the State Emergency Plan and those programs necessary for the mitigation of the effects of an emergency in this state; and he shall coordinate the preparation of plans and programs for the mitigation of the effects of an emergency by the political subdivisions of this state, such plans and programs to be integrated into and coordinated with the State Emergency Plan and the plans and programs of the federal government and of other states to the fullest possible extent. California Emergency Services Act Section 8570. The Governor may, in accordance with the State Emergency Plan and programs for the mitigation of the effects of an emergency in this state: (a) Ascertain the requirements of the state or its political subdivisions for food, clothing, and other necessities of life in the event of an emergency. (b) Plan for, procure, and pre-position supplies, medicines, materials, and equipment. (c) Use and employ any of the property, services, and resources of the state as necessary to carry out the purposes of this chapter. (d) Provide for the approval of local emergency plans. (e) Provide for mobile support units. (f) Provide for use of public airports. (g) Institute training programs and public information programs. (h) Make surveys of the industries, resources, and facilities, both public and private, within the	**XII. California Emergency Services Act, Section 8569 - 8570** To the extent program specific flexibility is not an option, the local health offices (by authority granted by the Board of Supervisors) have authority to issue orders requiring actions to take whatever measures necessary to preserve and protect public health.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		state, as are necessary to carry out the purposes of this chapter. (i) Plan for the use of any private facilities, services, and property and, when necessary, and when in fact used, provide for payment for that use under the terms and conditions as may be agreed upon. (j) Take all other preparatory steps, including the partial or full mobilization of emergency organizations in advance of an actual emergency; and order those test exercises needed to insure the furnishing of adequately trained and equipped personnel in time of need.	
	XIII. Out of Scope Supplemental Services – 22 CCR 70301	**XIII. Out of Scope Supplemental Services – 22 CCR 70301** Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means the provision of a supplemental service, shall obtain prior approval from the Department or a special permit if required by 22 CCR 70351. (b) The provisions of this Article shall apply only to any supplemental service for which a special permit is not required. (c) Any licensee who offers a supplemental service for which approval is now required under these regulations is authorized to continue furnishing such service without obtaining approval until the Department inspects and evaluates the quality of the service and determines whether such service meets the requirements for the service contained in these regulations. If the Department determines that the service	**XIII. Out of Scope Supplemental Services – 22 CCR 70301** A licensed general acute care hospital is required to have Department approval or a permit to provide supplemental services. The Department has existing authority to grant program flexibility if compliant with statutory authority. In the event a licensed facility requires a waiver that is beyond Departmental authority, the Governor may waive or suspend the applicable requirement pursuant to authority in the Emergency Services Act.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		meets such requirements, it shall notify the licensee in writing. If the Department determines that the service does not meet the requirements, it shall so notify the licensee of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the licensee shall cease and desist all holding out, advertising or otherwise representing that it furnishes such recognized service.	
	XIV. Out of Scope Special Services – 22 CCR 70351	**XIV. Out of Scope Special Services – 22 CCR 70351** Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means, the performance of a special service shall obtain a special permit from the Department. (b) The following supplemental services are also special services for which a special permit is required: (1) Basic emergency medical service. (2) Burn center. (3) Cardiovascular surgery service. (4) Chronic dialysis unit. (5) Comprehensive emergency medical service. (6) Intensive care newborn nursery service. (7) Psychiatric unit. (8) Radiation therapy service. (9) Renal transplant center.	**XIV. Out of Scope Special Services – 22 CCR 70351** This regulation requires a permit for a general acute care hospital to provide special services which include basic and comprehensive emergency medical service and burn centers. The Department has existing authority to grant program flexibility if compliant with statutory authority. In the event a licensed facility requires a waiver that is beyond Departmental authority, the Governor may waive or suspend the applicable requirement pursuant to authority in the Emergency Services Act.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
How and to what extent can staff to patient ratios be flexed?	**I. Health and Safety Code, Section 1276.4(l)**	**I. Health and Safety Code, Section 1276.4(l)** The department may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing licensed nurse-to-patient ratios. The department shall coordinate with the Board of Registered Nursing to ensure that staffing ratios are consistent with the Board of Registered Nursing approved nursing education requirements. This includes nursing clinical experience incidental to a work-study program rendered in a University of California clinical facility approved by the Board of Registered Nursing provided there will be sufficient direct care registered nurse preceptors available to ensure safe patient care	**I. Health and Safety Code, Section 1276.4(l)** Yes, there is flexibility for ratio requirement. The ratios that are applicable to license requirements for rural hospitals have flexibility. If conflict with scope of practice provisions exists, scope of practice provisions prevail to the extent there are any conflicts with ratio laws. Ratios can also be flexed for all facilities by a Governor order under state of emergency.
	II. 22 CCR Section 70217(q)	**II. 22 CCR Section 70217(q)** The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical intervention and care.	**II. 22 CCR Section 70217(q)** Program flexibility exists in the event of a “healthcare emergency: defined as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals.

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	III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23	**III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23** Condition of Participation Section 482.23: Nursing services. The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. (a) Standard: Organization. The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. (b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. (1) The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted	**III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23** Flexibility exists but waiver is subject to the discretion of Secretary of Health and Human Services and Assistance Secretary of Preparedness and Response waiver authority under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act to waive anything under its jurisdiction. No option based on state applicable standards.

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		under Section 405.1910(c) of this chapter. (2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.	
	IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10** *HR.1.10.* Standard: The hospital provides an adequate number and mix of staff consistent with the hospital's staffing plan. Rationale: An organization must provide appropriate types and numbers of qualified staff necessary to furnish the care, treatment, and services offered by the organization. This can be done either through traditional employer–employee arrangements or through contractual arrangements. *See* the "Nursing" chapter for additional information regarding the provision of nursing care services. Elements of Performance: The hospital has an adequate number and mix of staff to meet the care, treatment, and service needs of the patients. *LD.3.15*. Standard: The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital.	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10** Joint Commission requires hospitals to address care, flow of patient care and staffing under disaster surge circumstances. It does not provide any formal procedure for doing so, nor does it make any commitment to suspend accreditation requirements during a disaster.

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		Rationale: Managing the flow of patients through the hospital is essential to the prevention and mitigation of patient crowding, a problem that can lead to lapses in patient safety and quality of care. The emergency department is particularly vulnerable to experiencing negative effects of inefficiency in the management of this process. While emergency departments have little control over the volume and type of patient arrivals and most hospitals have lost the “surge capacity” that existed at one time to manage the elastic nature of emergency admissions, other opportunities for improvement do exist. Overcrowding has been shown to be primarily a hospital wide “system problem” and not just a problem for which a solution resides within the emergency department. Opportunities for improvement often exist outside the emergency department. This standard emphasizes the role of assessment and planning for effective and efficient patient flow throughout the hospital. To understand the system implications of the issues, leadership should identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment, and discharge. Supporting processes such as diagnostic, communication, and patient transportation are included if identified by leadership as impacting patient flow. Relevant indicators are selected and data is collected and analyzed to enable monitoring and improvement of processes. A key component of the standard addresses the needs of	

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		admitted patients who are in temporary bed locations awaiting an inpatient bed. Twelve key elements of care have been identified to ensure adequate and appropriate care for admitted patients in temporary locations. These elements have implications across the hospital and should be considered when planning care and services for these patients. Planning should also address the delivery of adequate care and services to those patients for whom no decision to admit has been made, but who are placed in overflow locations for observation or while awaiting completion of their evaluation. Additionally, the standard calls for indicator results to be made available to those individuals who are accountable for processes that support patient flow. These results should be regularly reported to leadership to support their planning. The hospital should improve inefficient or unsafe processes identified by leadership as essential in the efficient movement of patients through the hospital. Criteria should be defined to guide decisions about ambulance diversion. Elements of Performance: 1. Leaders assess patient flow issues within the hospital, the impact on patient safety, and plan to mitigate that impact. 2. Planning encompasses the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations, for example, postanesthesia care unit and	

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		emergency department areas. 3. Leaders and medical staff share accountability to develop processes that support efficient patient flow. 4. Planning includes the delivery of adequate care, treatment, and services to non-admitted patients who are placed in overflow locations. 5. Specific indicators are used to measure components of the patient flow process and address the following: Available supply of patient bed space. Efficiency of patient care, treatment, and service areas. Safety of patient care, treatment, and service areas. Support service processes that impact patient flow. 6. Indicator results are available to those individuals who are accountable for processes that support patient flow. 7. Indicator results are reported to leadership on a regular basis to support planning. 8. The hospital improves inefficient or unsafe processes identified by leadership as essential to the efficient movement of patients through the hospital. 9. Criteria are defined to guide decisions about initiating diversion. *NR.3.10.* Standard: The nurse executive establishes nursing policies and procedures, nursing standards, and a nurse staffing plan(s). Elements of Performance: 1. The nurse executive, registered nurses, and other designated nursing staff members write nursing policies and procedures; nursing standards of patient care, treatment, and services; standards of nursing practice; a nurse staffing plan(s); and standards to	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		measure, assess, and improve patient outcomes. 2. The nurse executive is responsible for ensuring that nursing policies, procedures, and standards describe and guide how the nursing staff provides the nursing care, treatment, and services required by all patients and patient populations served by the hospital and as defined in the hospital's plan(s) for providing nursing care, treatment, and services and as required by applicable law and regulation. 3. All nursing policies, procedures, and standards are defined, documented, and accessible to the nursing staff in written or electronic format. 4. The nurse executive or a designee(s) exercises final authority over those associated with providing nursing care, treatment, and services.	
How and to what extent can facility add unlicensed beds?	**I. 22 CCR Section 70809**	**I. 22 CCR Section 70809** Patient accommodations limitations (General Acute Care Hospital) - "No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in cases of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity."	**I. 22 CCR Section 70809** (a) Flexibility exists per Health and Safety Code Section 1276(b). Health and Safety Code Section 1276(b) provides the CDPH and Office of Statewide Health Planning and Development authority to flex existing standards and requirements under certain circumstances. Applicable to facilities under the jurisdiction of CDPH. Specific program flexibility may also be invoked per facility type. (b) The following regulations shall permit program flexibility by the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use

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			has the prior written approval of the department or the office, as applicable. The approval of the department or the office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable. <u>Program Flexibility Regulations:</u> General Acute Care Hospital: Health and Safety Code Section 1276(b); 22 CCR 70809(a); General Acute Care Hospital: 22 CCR 70129 Acute Psychiatric Hospital: 22 CCR 71127 Skilled Nursing Facility: 22 CCR 72213 Intermediate Care Facility: 22 CCR 73227 Home Health Agency: 22 CCR 74689 Intermediate Care Facility/ Developmentally Disabled: 22 CCR 76227 Intermediate Care Facility/ Developmentally Disabled Habilitative: 22 CCR 76852 Psychiatric Health Facility: 22 CCR 77049 Adult Day Health Center: 22 CCR 78217 Correction Treatment Center: 22 CCR 79593 22 CCR 70809 - Yes. See flexibility and guidelines from All Facilities Letter 06-33; For other types of facilities, assess program flexibility regulations and

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			use the All Facilities Letter as guidelines for tailoring request. Subject to program flexibility upon approval by CDPH Licensing and Certification district offices.
	II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations (All Facilities Letter 06-33, 04-28)	**II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations (All Facilities Letter 06-33, 04-28)** Accommodations for temporary hospital overcrowding - "CDPH Licensing & Certification district offices may grant hospitals, after review and when appropriate, temporary permission to exceed their licensed bed capacity."	**II. CDPH All Facilities Letter on Temporary Permission for Increased Patient Accommodations (All Facilities Letter 06-33, 04-28)** Flexibility exists through All Facilities Letter 06-33per written request but under limited circumstances. Program flexibility is an option in the case of a justified emergency. Temporary permission may be granted by the director or her designee. *(All Facilities Letter 06-33, 04-28 includes template forms.)*
	III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) EC.4.10	**III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) EC.4.10** Compliance with Joint Commission standards is required for accreditation and deemed status. Environment of Care 4.10. An emergency in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in its	**III. Joint Commission Comprehensive Accreditation manual for Hospitals: The Official Handbook (2006) EC.4.10** There are no specific Joint Commission recommendations for use of beds during a surge. However, during an actual emergency, facilities should do what is required to care for patients and minimize injury and loss of life. Though Joint Commission does not provide specific guidance, or any commitment to suspend accreditation requirements, it is unlikely Joint Commission would inspect or issue deficiencies during an actual emergency. Hospitals should make best efforts to return to and resume

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		community. Elements of Performance: 1. The hospital conducts a hazard vulnerability analysis to identify potential emergencies that could affect the need for its services or its ability to provide those services. 2. The hospital establishes the following with the community: Priorities among the potential emergencies identified in the hazard vulnerability analysis. The hospital's role in relation to a communitywide emergency management program. An "all-hazards" command structure within the hospital that links with the community's command structure. 3. The hospital develops and maintains a written emergency management plan describing the process for disaster readiness and emergency management, and implements it when appropriate. 4. At a minimum, an emergency management plan is developed with the involvement of the hospital's leaders including those of the medical staff. 5. The plan identifies specific procedures that describe mitigation, preparedness, response, and recovery strategies, actions, and responsibilities for each priority emergency. 6. The plan provides processes for initiating the response and recovery phases of the plan, including a description of how, when, and by whom the phases are to be activated. 7. The plan provides processes for notifying staff when emergency response measures are initiated. 8. The plan provides processes for	operations under existing requirements a soon as able (i.e. the acute disaster phase is over).

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		notifying external authorities of emergencies, including possible community emergencies identified by the hospital (for example, evidence of a possible bioterrorist attack). 9. The plan provides processes for identifying and assigning staff to cover all essential staff functions under emergency conditions. 10. The plan provides processes for managing the following under emergency conditions: Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients). Staff support activities (for example, housing, transportation, incident stress debriefing). Staff family support activities. Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water). Security (for example, access, crowd control, traffic control). Communication with the news media. 11. Not applicable. 12. The plan provides processes for evacuating the entire building (both horizontally and, when applicable, vertically) when the environment cannot support adequate care, treatment, and services. 13. The plan provides processes for establishing an alternate care site(s) that has the capabilities to meet the needs of patients when the environment cannot support adequate care, treatment, and services including processes for the following: Transporting patients, staff, and equipment to the alternative care site(s). Transferring to and from the alternative care site(s), the necessities of patients (for example, medications, medical records).	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Tracking of patients. Interfacility communication between the hospital and the alternative care site(s). 14. The plan provides processes for identifying care providers and other personnel during emergencies. 15. The plan provides processes for cooperative planning with healthcare organizations that together provide services to a contiguous geographic area (for example, among hospitals serving a town or borough) to facilitate the timely sharing of information about the following: Essential elements of their command structures and control centers for emergency response. Names and roles of individuals in their command structures and command center telephone numbers. Resources and assets that could potentially be shared in an emergency response. Names of patients and deceased individuals brought to their hospitals to facilitate identifying and locating victims of the emergency. 16. Not applicable. 17. Not applicable. 18. The plan identifies backup internal and external communication systems in the event of failure during emergencies. 19. The plan identifies alternate roles and responsibilities of staff during emergencies, including to whom they report in the hospital's command structure and, when activated, in the community's command structure. 20. The plan identifies an alternative means of meeting essential building utility needs when the hospital is designated by its emergency management plan to provide continuous service during an emergency (for example, electricity, water, ventilation, fuel sources, medical gas/vacuum	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		systems). 21. The plan identifies means for radioactive, biological, and chemical isolation and decontamination.	
	IV. Conversion of Space for Other Uses – 22 CCR 70805	**IV. Conversion of Space for Other Uses – 22 CCR 70805** Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department.	**IV. Conversion of Space for Other Uses – 22 CCR 70805** This regulation requires written approval of the Department to convert licensed space for other uses. There are additional regulations applicable to physical plant space for the various types of licensed facilities or providers, including those that address patient accommodations and room requirements. Within certain parameters, the Department via its Director or designee may grant temporary permission for space and use conversion so long as within his or her discretionary authority. To the extent authority does not exist, for example patient room requirements, the Governor may suspend or waive pursuant to authority in the Emergency Services Act.
What are the criteria to determine if contaminated/ damaged facilities jeopardize staff or patient safety? (per California Occupational Safety and Health Administration)? Can they be flexed?	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30**	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30** Radioactive biological and chemical isolation and chemical decontamination An emergency in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30** There are no Joint Commission provisions for flexing standards. Safety, security and emergency management should be addressed in a disaster plan to ensure the safety of staff and patients.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		its community.	
	II. Penal Code Section 409.5	**II. Penal Code Section 409.5. Menaces to Public Health or Safety** (a) Whenever a menace to the public health or safety is created by a calamity including a flood, storm, fire, earthquake, explosion, accident, or other disaster, officers of the Department of the California Highway Patrol, police departments, marshal's office or sheriff's office, any officer or employee of the Department of Forestry and Fire Protection designated a peace officer by Penal Code Section 830.2 (g), any officer or employee of the Department of Parks and Recreation designated a peace officer by subdivision (f) of Penal Code Section 830.2, any officer or employee of the Department of Fish and Game designated a peace officer under Penal Code Section 830.2 (e), and any publicly employed full-time lifeguard or publicly employed full-time marine safety officer while acting in a supervisory position in the performance of his or her official duties, may close the area where the menace exists for the duration thereof by means of ropes, markers, or guards to any and all persons not authorized by the lifeguard or officer to enter or remain within the enclosed area. If the calamity creates an immediate menace to the public health, the local health officer may close the area where the menace exists pursuant to the conditions set forth in this section.	**II. Penal Code Section 409.5. Menaces to Public Health or Safety** If disaster creates an immediate menace to the public health the local health officer may close the area.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. 29 CFR 1910.120(a)(3), 1910.120(f)(2)(iv), 1910.120(q)(9)(i), 1910.120(q)(10), 1910.1000 - 1450	**III. 29 CFR 1910.120(a)(3)** Hazardous materials response team - an organized group of employees, designated by the employer, who are expected to perform work to handle and control actual or potential leaks or spills of hazardous substances requiring possible close approach to the substance. The team members perform responses to releases or potential releases of hazardous substances for the purpose of control or stabilization of the incident. A hazardous material response team is not a fire brigade nor is a typical fire brigade a hazardous material response team. A hazardous material response team, however, may be a separate component of a fire brigade or fire department. **29 CFR 1910.120(f)(2)(iv)** The medical surveillance program shall be instituted by the employer for the following employees: Members of hazardous material response teams. **29 CFR 1910.120(q)(9)(i)** Members of an organized and designated hazardous materials response team and hazardous materials specialist shall receive a baseline physical examination and be provided with medical surveillance as required in paragraph (f) of this section.	**III. 29 CFR 1910.120(a)(3)** Hazardous Materials and Waste: These regulations deal with safety requirements for dealing with hazardous materials including Hazardous Materials teams. Again, these are federal requirements and discuss critical elements of safety plans and requirements. As such, they are not subject to state waivers but would require intervention by the President.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		29 CFR 1910.120(q)(10) Chemical protective clothing. Chemical protective clothing and equipment to be used by organized and designated hazardous material response team members, or to be used by hazardous materials specialists, shall meet the requirements of 29 CFR 1910.120 (g)(3) through 29 CFR 1910.120 (g)(5).	
	IV. 29 USC Section 654	**IV. 29 USC Section 654** (a) Each employer— (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees; (2) shall comply with occupational safety and health standards promulgated under this Act. (b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct.	**IV. 29 USC Section 654** (1) With the exception of a Presidential order, there is no known authority to waive or suspend what is known ad the "general duty clause".
	V. 29 CFR 1910.38 Emergency Action Plans; Corresponding California Occupational Safety and Health	**V. 29 CFR 1910.38 Emergency Action Plans**	**V. 29 CFR 1910.38 Emergency Action Plans** Hazardous Materials and Waste: These regulations deal with safety requirements for dealing with

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	Administration reference - 8 CCR 3220	(a) Application. An employer must have an emergency action plan whenever an Occupational Safety and Health Administration standard in this part requires one. The requirements in this section apply to each such emergency action plan. (b) Written and oral emergency action plans. An emergency action plan must be in writing, kept in the workplace, and available to employees for review. However, an employer with 10 or fewer employees may communicate the plan orally to employees. (c) Minimum elements of an emergency action plan. An emergency action plan must include at a minimum: (1) Procedures for reporting a fire or other emergency; (2) Procedures for emergency evacuation, including type of evacuation and exit route assignments; (3) Procedures to be followed by employees who remain to operate critical plant operations before they evacuate; (4) Procedures to account for all employees after evacuation; (5) Procedures to be followed by employees performing rescue or	hazardous materials including Hazardous Materials teams. Again, these are federal requirements and discuss critical elements of safety plans and requirements. As such, they are not subject to state waivers but would require intervention by the President.

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		medical duties; (6) The name or job title of every employee who may be contacted by employees who need more information about the plan or an explanation of their duties under the plan. (d) Employee alarm system. An employer must have and maintain an employee alarm system. The employee alarm system must use a distinctive signal for each purpose and comply with the requirements in 29 CFR 1910.165. (e) Training. An employer must designate and train employees to assist in a safe and orderly evacuation of other employees. (f) Review of emergency action plan. An employer must review the emergency action plan with each employee covered by the plan; (1) When the plan is developed or the employee is assigned initially to a job; (2) When the employee's responsibilities under the plan change; and (3) When the plan is changed.	

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	VI. 29 CFR 1910.120 Hazardous waste operations and emergency response;Corresponding California Occupational Safety and Health Administration reference - 8 CCR 5192	**VI. 29 CFR 1910.120 Hazardous waste operations and emergency response** 29 CFR 1910.120(a)(1)(v) This section covers the following operations, unless the employer can demonstrate that the operation does not involve employee exposure or the reasonable possibility for employee exposure to safety or health hazards: Emergency response operations for releases of, or substantial threats of releases of, hazardous substances without regard to the location of the hazard. 29 CFR 1910.120(b)(1) Employers shall develop and implement a written safety and health program for their employees involved in hazardous waste operations. The program shall be designed to identify, evaluate, and control safety and health hazards, and provide for emergency response for hazardous waste operations. 29 CFR 1910.120(b)(4)(i) The site safety and health plan, which must be kept on site, shall address the safety and health hazards of each phase of site operation and include the requirements and procedures for employee protection. 29 CFR 1910.120(b)(4)(ii) The site safety and health plan, as a minimum, shall address the following:	

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		A safety and health risk or hazard analysis for each site task and operation found in the workplan. Employee training assignments to assure compliance with paragraph (e) of this section. Personal protective equipment to be used by employees for each of the site tasks and operations being conducted as required by the personal protective equipment program in paragraph 29 CFR 1910.120 (g)(5). Medical surveillance requirements in accordance with the program in 29 CFR 1910.120 (f). Frequency and types of air monitoring, personnel monitoring, and environmental sampling techniques and instrumentation to be used, including methods of maintenance and calibration of monitoring and sampling equipment to be used. Site control measures in accordance with the site control program required in paragraph (d) of this section. Decontamination procedures in accordance with 29 CFR 1910.120 (k). An emergency response plan meeting the requirements of 29 CFR 1910.120 (l) for safe and effective responses to emergencies, including the necessary personal protective equipment and other equipment.	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Confined space entry procedures. A spill containment program meeting the requirements of 29 CFR 1910.120 (j). 29 CFR 1910.120(c)(4) The following information to the extent available shall be obtained by the employer prior to allowing employees to enter a site: Location and approximate size of the site. Description of the response activity and/or the job task to be performed. Duration of the planned employee activity. Site topography and accessibility by air and roads. Safety and health hazards expected at the site. Pathways for hazardous substance dispersion. Present status and capabilities of emergency response teams that would provide assistance to on-site employees at the time of an emergency. Hazardous substances and health hazards involved or expected at the site and their chemical and physical properties. 29 CFR 1910.120(c)(6)	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Monitoring. The following monitoring shall be conducted during initial site entry when the site evaluation produces information which shows the potential for ionizing radiation or immediately dangerous to life and health conditions, or when the site information is not sufficient reasonably to eliminate these possible conditions: Monitoring with direct reading instruments for hazardous levels of ionizing radiation. Monitoring the air with appropriate direct reading test equipment for (i.e., combustible gas meters, detector tubes) for immediately dangerous to life and health and other conditions that may cause death or serious harm (combustible or explosive atmospheres, oxygen deficiency, toxic substances.) Visually observing for signs of actual or potential immediately dangerous to life and health or other dangerous conditions. An ongoing air monitoring program in accordance with paragraph (h) of this section shall be implemented after site characterization has determined the site is safe for the start-up of operations. 29 CFR 1910.120(c)(7) Risk identification. Once the presence and concentrations of specific hazardous substances and health hazards have been established, the risks associated with these substances shall be identified. Employees	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		who will be working on the site shall be informed of any risks that have been identified. In situations covered by the Hazard Communication Standard, 29 CFR 1910.1200, training required by that standard need not be duplicated. Risks to consider include, but are not limited to: Exposures exceeding the permissible exposure limits and published exposure levels immediately dangerous to life and health concentrations Potential Skin Absorption and Irritation Sources Potential Eye Irritation Sources Explosion Sensitivity and Flammability Ranges Oxygen deficiency 29 CFR 1910.120(g)(5) Personal protective equipment program. A personal protective equipment program, which is part of the employer's safety and health program required in 29 CFR 1910.120 (b) or required in 29 CFR 1910.120 (p)(1) and which is also a part of the site-specific safety and health plan shall be established. The personal protective equipment program shall also address the elements listed below. When elements, such as donning and doffing procedures, are provided by the manufacturer	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		of a piece of equipment and are attached to the plan, they need not be rewritten into the plan as long as they adequately address the procedure or element. Personal protective equipment selection based upon site hazards, Personal protective equipment use and limitations of the equipment, Work mission duration, Personal protective equipment maintenance and storage, Personal protective equipment decontamination and disposal, Personal protective equipment training and proper fitting, Personal protective equipment donning and doffing procedures, Personal protective equipment inspection procedures prior to, during, and after use, Evaluation of the effectiveness of the Personal protective equipment program, and Limitations during temperature extremes, heat stress, and other appropriate medical considerations. 29 CFR 1910.120(k)(2)(i) A decontamination procedure shall be	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		developed, communicated to employees and implemented before any employees or equipment may enter areas on site where potential for exposure to hazardous substance exists. 29 CFR 1910.120(l)(1)(i) An emergency response plan shall be developed and implemented by all employers within the scope of 29 CFR 1910.120 (a)(1)(i) through 29 CFR 1910.120 (a)(1)(ii) to handle anticipated emergencies prior to the commencement of hazardous waste operations. The plan shall be in writing and available for inspection and copying by employees, their representatives, Occupational Safety and Health Administration personnel and other governmental agencies with relevant responsibilities.	
What Centers for Medicare and Medicaid Services, Joint Commission, State of California requirements for physical plant be waived?	**I. Health and Safety Code Sections 127015, 127125, 129680**	**I. Health and Safety Code Section 127015** The office succeeds to and is vested with all the duties, powers, purposes, responsibilities, and jurisdiction of the State Department of Health relating to health planning and research development. The office shall assume the functions and responsibilities of the Facilities Construction Unit of the former State Department of Health, including, but not limited to, those functions and responsibilities performed pursuant to the following provisions of law:	**I. Health and Safety Code Sections 127015, 127125, 129680** Health and Safety Code can be flexed by statute. Program flexibility is an option if in compliance with other laws and approved by CDPH OR the Office of Statewide Health Planning and Development. See additional requirements such as notice if temporarily flexing certain requirements, temporarily relocating services * Note: flexibility for Americans with Disabilities Act requires Federal Waiver per Health and Safety Code Section 1276.05d.

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		Chapter 1 (commencing with Health and Safety Code Section 127125) of Part 2, Article 1 (commencing with Health and Safety Code Section 127750) of Chapter 1, Article 3 (commencing with Health and Safety Code Section 127975) of Chapter 2, and Article 1 (commencing with Health and Safety Code Section 128125) of Chapter 3 of Part 3, Part 6 (commencing with Health and Safety Code Section 129000) and Part 7 (commencing with Health and Safety Code Section 129675), Health and Safety Code Section 127050; Chapter 10 (commencing with Health and Safety Code Section 1770) of Division 2; and Health and Safety Code Section 13113. **Health and Safety Code Section 127125.** As used in this chapter, "office" means the Office of Statewide Health Planning and Development and "office director" means the director of the office. Any reference in this chapter to the State Department of Health, the department, the state department, or the Director of Health shall be deemed a reference to the office in the Health and Welfare Agency. **Health and Safety Code Section 129680.** It is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical,	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		the forces generated by earthquakes, gravity, and winds. In order to accomplish this purpose, the office shall propose proper building standards for earthquake resistance based upon current knowledge, and provide an independent review of the design and construction of hospital buildings. (b) Local jurisdictions are preempted from the enforcement of all building standards published in the California Building Standards Code relating to the regulation of hospital buildings and the enforcement of other regulations adopted pursuant to this chapter, and all other applicable state laws, including plan checking and inspection of the design and details of the architectural, structural, mechanical, plumbing, electrical, and fire and panic safety systems, and the observation of construction. The office shall assume these responsibilities. (c) Where local jurisdictions have more restrictive requirements for the enforcement of building standards, other building regulations, and construction supervision, these requirements shall be enforced by the office. (d) Each local jurisdiction shall keep the office advised as to the existence of any more restrictive local requirements. Where a reasonable doubt exists as to whether the requirements of the local jurisdiction are more restrictive, the effect of these requirements shall be determined by the Hospital Building Safety Board.	

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		It is further the intent of the Legislature that the office, with the advice of the Hospital Building Safety Board, may conduct or enter into contracts for research regarding the reduction or elimination of seismic or other safety hazards in hospital buildings or research regarding hospital building standards.	
	II. Joint Commission Environment of Care 1.10 - 1.20, 2.10, 3..10, 4.10, 6.10, 7.10, 7.20, 8.30 Environment of Care Standards	**II. Joint Commission Environment of Care Standards** Environment of Care 42.41 Environment must be maintained to ensure the safety and well being of patients to include emergency power, lighting, gas and water.	**II. Joint Commission Environment of Care 1.10 - 1.20, 2.10, 3..10, 4.10, 6.10, 7.10, 7.20, 8.30 Environment of Care Standards** There are no Joint Commission provisions for flexing standards. Safety, security and emergency management should be addressed in a disaster plan to provide care at alternate care sites to meet the needs of patients.
	III. 42 CFR 482.11 and 482.41: compliance with federal state and local laws and other applicable standards; physical environment standards		**III. 42 CFR 482.11 and 482.41** Codes can be flexed but only if waived by the Secretary of Health and Human Services or Assistant Secretary of Preparedness Response under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act. The Centers for Medicare and Medicaid Services may waive life safety code requirements if an unreasonable hard ship on a facility so long as the waiver does not adversely affect the health and safety of the patients.
How to comply with Clinical Laboratory Improvement Amendments - clinical lab	**I. 42 USC Section 263a: 42 CFR 493.1**	**I. 42 USC Section 263a: 42 CFR 493.1** (a) Regulations set forth the conditions that all labs must meet to perform testing on human	**I. 42 USC Section 263a: 42 CFR 493.1** These regulations can be flexed by the Secretary of Health and Human Services or Assistant

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
standards during a catastrophic emergency?		specimens. Laboratory broadly defined at 42 CFR 493.2. Deemed status may be granted subject to appropriate state and Centers for Medicare and Medicaid Services review and approval. See also 21 USC Section 301 *et seq***.** for relevant food and drug requirements	Secretary of Preparedness and Response under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act (pursuant to HR 3448 Section 143). Standards vary on the complexity of testing. Sanctioned provisions begin at 42 CFR 493.1800 *et seq*. Request for flexibility should include waiver of enforcement.
	II. 42 USC Section 247d - Public Health Emergencies	**II. 42 USC Section 247d - Public Health Emergencies**	**II. 42 USC Section 247d - Public Health Emergencies** The Secretary of Health and Human Services can take any appropriate action to respond to a public health emergency including treatment or prevention of disease. Option may be to send written request from the Governor seeking secretary's approval to allow Lab Operations during a disaster response outside the confines of the regulatory requirements. There may also be less stringent requirements on public labs. May also access powers of the Local Health Department or Governor under the Emergency Services Act.
	III. 22 CCR 70241, 70243, 70247, 70249	**III. 22 CCR 70241.** Clinical laboratory service means the performance of clinical laboratory tests with appropriate staff, space, equipment and supplies. **22 CCR 70243**. (a) Clinical laboratories shall be operated in conformance with the California Business and Professions Code	

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		Sections 1200 to 1322, inclusive, Division 2, Chapter 3 and 17 CCR 1030 to 1057. (b) All hospitals shall maintain clinical laboratory services and equipment for routine laboratory work, such as urinalysis, complete blood counts, blood typing, cross matching and such other tests as are required by these regulations. (c) All hospitals shall maintain or make provision for clinical laboratory services for performance of tests in chemistry, microbiology, serology, hematology, pathology and such other tests as are required by these regulations. (d) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. (e) The responsibility and the accountability of the clinical laboratory service to the medical staff and administration shall be defined. (f) The director of the clinical laboratory shall assure that: (1) Examinations are performed accurately and in a timely fashion	

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		(2) Procedures are established governing the provision of laboratory services for outpatients. (3) Laboratory systems identify the patient, test requested, date and time the specimen was obtained, the time the request reached the laboratory, the time the laboratory completed the test and any special handling which was required. (4) Procedures are established to ensure the satisfactory collection of specimens. (5) A communications system to provide efficient information exchange between the laboratory and related areas of the hospital is established. (6) A quality control system within the laboratory designed to ensure medical reliability of laboratory data is established. The results of control tests shall be readily available in the hospital. (7) Reports of all laboratory examinations are made a part of the patient's medical record as soon as is practical. (8) No laboratory procedures are performed except on the order of a	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		person lawfully authorized to give such an order. (g) Tissue specimens shall be examined by a physician who is certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology or possesses qualifications which are equivalent to those required for certification. Oral specimens may be examined by a dentist who is certified or eligible for certification as an oral pathologist by the American Board of Oral Pathology. A record of his findings shall become a part of the patient's medical record. (1) A tissue file shall be maintained at the hospital or the principal office of the consulting pathologist. (h) The use, storage and disposal of radioactive materials shall comply with the California Radiation Control Regulations, 17 CCR. (i) Where the hospital depends on outside blood banks, there shall be a written agreement governing the procurement, transfer and availability of blood. (j) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		22 CCR 70247. (a) There shall be sufficient equipment and supplies maintained to perform the laboratory services being offered. (b) The hospital shall maintain blood storage facilities in conformance with the provisions of 17 CCR 1002(g). Such facilities shall be inspected at appropriately short intervals each day of the week to assure these requirements are being fulfilled. **22 CCR 70249.** (a) Adequate laboratory space a determined by the Department shall be maintained. (b) If tests on outpatients are to be performed, outpatient access to the laboratory shall not traverse a nursing unit.	
What requirements under California Occupational Safety and Health Administration, Office of Statewide Planning and Development, CDC-National Institute for Occupational Safety and Health can be waived? Occupational Safety and Health Administration Best Practices for Hospital-Based First Receivers of Individuals from Mass Casualty Incidents	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30**	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30** Radioactive biological and chemical isolation and chemical decontamination Environment of Care 4.10. An emergency in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in its community.	**I. Joint Commission Environment of Care 4.10 see also Environment of Care 1.10, 1.20, 3.10 & 8.30** There are no Joint Commission provisions for flexing standards. Safety, security and emergency management should be addressed in a disaster plan to ensure the safety of staff and patients.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	II. Penal Code Section 409.5	**II. Penal Code Section 409.5. Menaces to Public Health or Safety** (a) Whenever a menace to the public health or safety is created by a calamity including a flood, storm, fire, earthquake, explosion, accident, or other disaster, officers of the Department of the California Highway Patrol, police departments, marshal's office or sheriff's office, any officer or employee of the Department of Forestry and Fire Protection designated a peace officer by Penal Code Section 830.2 (g), any officer or employee of the Department of Parks and Recreation designated a peace officer by Penal Code Section 830.2 (f), any officer or employee of the Department of Fish and Game designated a peace officer under Penal Code Section 830.2 (e), and any publicly employed full-time lifeguard or publicly employed full-time marine safety officer while acting in a supervisory position in the performance of his or her official duties, may close the area where the menace exists for the duration thereof by means of ropes, markers, or guards to any and all persons not authorized by the lifeguard or officer to enter or remain within the enclosed area. If the calamity creates an immediate menace to the public health, the local health officer may close the area where the menace exists pursuant to the conditions set forth in this section.	**II. Penal Code Section 409.5. Menaces to Public Health or Safety** If disaster creates an immediate menace to the public health the local health officer may close the area.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. 29 CFR 1910.120(a)(3), 1910.120(f)(2)(iv), 1910.120(q)(9)(i), 1910.120(q)(10), 1910.1000-1450	**III. 29 CFR 1910.120(a)(3)** Hazardous materials response team - an organized group of employees, designated by the employer, who are expected to perform work to handle and control actual or potential leaks or spills of hazardous substances requiring possible close approach to the substance. The team members perform responses to releases or potential releases of hazardous substances for the purpose of control or stabilization of the incident. A hazardous materials response team is not a fire brigade nor is a typical fire brigade a hazardous materials response team. A hazardous materials response team, however, may be a separate component of a fire brigade or fire department. **29 CFR 1910.120(f)(2)(iv)** The medical surveillance program shall be instituted by the employer for the following employees: Members of hazardous materials response teams. **29 CFR 1910.120(q)(9)(i)** Members of an organized and designated hazardous materials response team and hazardous materials specialist shall receive a baseline physical examination and be provided with medical surveillance as required in 29 CFR 1910.120 (f).	**III. 29 CFR 1910** Hazardous Materials and Waste regulations deal with safety requirements for dealing with hazardous materials including Hazardous Materials teams. These are federal requirements and discuss critical elements of safety plans and requirements. As such, they are not subject to state waivers but would require intervention by the President.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		29 CFR 1910.120(q)(10) Chemical protective clothing. Chemical protective clothing and equipment to be used by organized and designated hazardous materials response team members, or to be used by hazardous materials specialists, shall meet the requirements of 29 CFR 1910.120 (g)(3) through (5).	
	IV. 29 USC Section 654	**IV. 29 USC Section 654** (a) Each employer— (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees; (2) shall comply with occupational safety and health standards promulgated under this Act. (b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct.	**IV. 29 USC Section 654** Under the general duty clause (29 USC Section 654(a)(1)), employers are required to furnish their employees with a working environment free from recognized hazards. The specific duty clause at 29 USC Section 654(a)(2) requires employers to comply with the specific workplace safety and health regulations promulgated by the Secretary of Labor. Violation of either clause may lead to civil or criminal sanctions against the employer. Employers who are likely to assist in an emergency by means other than evacuation (rescue efforts) are required by federal regulation to have a written emergency response plan (29 CFR 1910.120(q). There are no emergency provisions to waive the general duty clause. This is a federal law so any relief would have to come from the President. In the event of a disaster, having a written disaster plan may likely mitigate risk both of harm to employees and risk of prosecution for violating the Occupational Health and Safety Administration.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. 29 CFR 1910.38 Emergency Action Plans; Corresponding California Occupational Safety and Health Administration reference - 8 CCR 3220	**V. 29 CFR 1910.38 Emergency Action Plans** (a) Application. An employer must have an emergency action plan whenever an Occupational Safety and Health Administration standard in this part requires one. The requirements in this section apply to each such emergency action plan. (b) Written and oral emergency action plans. An emergency action plan must be in writing, kept in the workplace, and available to employees for review. However, an employer with 10 or fewer employees may communicate the plan orally to employees. (c) Minimum elements of an emergency action plan. An emergency action plan must include at a minimum: (1) Procedures for reporting a fire or other emergency; (2) Procedures for emergency evacuation, including type of evacuation and exit route assignments; (3) Procedures to be followed by employees who remain to operate critical plant operations before they	**V. 29 CFR 1910.38 Emergency Action Plans** Employers must have emergency action plans for evacuations and other emergencies that address procedures for evacuating; medical first-aid care; training; contact lists, and the like. This is a federal standard. These plans must be in place, and therefore do not appear to require waiver.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		evacuate; (4) Procedures to account for all employees after evacuation; (5) Procedures to be followed by employees performing rescue or medical duties; (6) The name or job title of every employee who may be contacted by employees who need more information about the plan or an explanation of their duties under the plan. (d) Employee alarm system. An employer must have and maintain an employee alarm system. The employee alarm system must use a distinctive signal for each purpose and comply with the requirements in 29 CFR 1910.165. (e) Training. An employer must designate and train employees to assist in a safe and orderly evacuation of other employees. (f) Review of emergency action plan. An employer must review the emergency action plan with each employee covered by the plan; (1) When the plan is developed or the employee is assigned initially to a job; (2) When the employee's	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		responsibilities under the plan change; and (3) When the plan is changed.	
	VI. 29 CFR 1910.120 Hazardous waste operations and emergency response; Corresponding California Occupational Safety and Health Administration reference - 8 CCR 5192	**VI. 29 CFR 1910.120 Hazardous waste operations and emergency response** This section covers the following operations, unless the employer can demonstrate that the operation does not involve employee exposure or the reasonable possibility for employee exposure to safety or health hazards: Emergency response operations for releases of, or substantial threats of releases of, hazardous substances without regard to the location of the hazard. 29 CFR 1910.120(b)(1) Employers shall develop and implement a written safety and health program for their employees involved in hazardous waste operations. The program shall be designed to identify, evaluate, and control safety and health hazards, and provide for emergency response for hazardous waste operations. 29 CFR 1910.120(b)(4)(i) The site safety and health plan, which must be kept on site, shall address the safety and health hazards of each phase of site operation and include the requirements and procedures for employee protection. 29 CFR 1910.120(b)(4)(ii)	**VI. 29 CFR 1910.120 Hazardous waste operations and emergency response** Hazardous Materials and Waste regulations deal with safety requirements for dealing with hazardous materials including Hazardous Materials teams. Again, these are federal requirements and discuss critical elements of safety plans and requirements. As such, they are not subject to state waivers but would require intervention by the President.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		The site safety and health plan, as a minimum, shall address the following: A safety and health risk or hazard analysis for each site task and operation found in the workplan. Employee training assignments to assure compliance with paragraph (e) of this section. Personal protective equipment to be used by employees for each of the site tasks and operations being conducted as required by the personal protective equipment program in 29 CFR 1910.120 (g)(5). Medical surveillance requirements in accordance with the program in 29 CFR 1910.120 (f). Frequency and types of air monitoring, personnel monitoring, and environmental sampling techniques and instrumentation to be used, including methods of maintenance and calibration of monitoring and sampling equipment to be used. Site control measures in accordance with the site control program required in 29 CFR 1910.120 (d). Decontamination procedures in accordance with paragraph (k) of this section. An emergency response plan meeting the requirements of 29 CFR 1910.120 (l) for safe and effective responses to emergencies,	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		including the necessary personal protective equipment and other equipment. Confined space entry procedures. A spill containment program meeting the requirements of 29 CFR 1910.120 (j). 29 CFR 1910.120(c)(4) The following information to the extent available shall be obtained by the employer prior to allowing employees to enter a site: Location and approximate size of the site. Description of the response activity and/or the job task to be performed. Duration of the planned employee activity. Site topography and accessibility by air and roads. Safety and health hazards expected at the site. Pathways for hazardous substance dispersion. Present status and capabilities of emergency response teams that would provide assistance to on-site employees at the time of an emergency. Hazardous substances and health hazards involved or expected at the site and their	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		chemical and physical properties. 29 CFR 1910.120(c)(6) Monitoring. The following monitoring shall be conducted during initial site entry when the site evaluation produces information which shows the potential for ionizing radiation or immediately dangerous to life and health conditions, or when the site information is not sufficient reasonably to eliminate these possible conditions: Monitoring with direct reading instruments for hazardous levels of ionizing radiation. Monitoring the air with appropriate direct reading test equipment for (i.e., combustible gas meters, detector tubes) for immediately dangerous to life or health and other conditions that may cause death or serious harm (combustible or explosive atmospheres, oxygen deficiency, toxic substances.) Visually observing for signs of actual or potential immediately dangerous to life or health or other dangerous conditions. An ongoing air monitoring program in accordance with 29 CFR 1910.120 (h) shall be implemented after site characterization has determined the site is safe for the start-up of operations. 29 CFR 1910.120(c)(7) Risk identification. Once the presence and concentrations of specific hazardous	

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		substances and health hazards have been established, the risks associated with these substances shall be identified. Employees who will be working on the site shall be informed of any risks that have been identified. In situations covered by the Hazard Communication Standard, 29 CFR 1910.1200, training required by that standard need not be duplicated. Risks to consider include, but are not limited to: Exposures exceeding the permissible exposure limits and published exposure levels Immediately Dangerous to Life and Health Concentrations Potential Skin Absorption and Irritation Sources Potential Eye Irritation Sources Explosion Sensitivity and Flammability Ranges Oxygen deficiency 29 CFR 1910.120(g)(5) Personal protective equipment program. A personal protective equipment program, which is part of the employer's safety and health program required in 29 CFR 1910.120 (b) or required in 29 CFR 1910.120 (p)(1) and which is also a part of the site-specific safety and health plan shall be established. The personal protective equipment program shall also address the elements listed below. When	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		elements, such as donning and doffing procedures, are provided by the manufacturer of a piece of equipment and are attached to the plan, they need not be rewritten into the plan as long as they adequately address the procedure or element. Personal protective equipment selection based upon site hazards, Personal protective equipment use and limitations of the equipment, Work mission duration, Personal protective equipment maintenance and storage, Personal protective equipment decontamination and disposal, Personal protective equipment training and proper fitting, Personal protective equipment donning and doffing procedures, Personal protective equipment inspection procedures prior to, during, and after use, Evaluation of the effectiveness of the Personal protective equipment program, and Limitations during temperature extremes, heat stress, and other appropriate medical considerations.	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		29 CFR 1910.120(k)(2)(i) A decontamination procedure shall be developed, communicated to employees and implemented before any employees or equipment may enter areas on site where potential for exposure to hazardous substance exists. 29 CFR 1910.120(l)(1)(i) An emergency response plan shall be developed and implemented by all employers within the scope of 29 CFR 1910.120 (a)(1)(i) through (ii) to handle anticipated emergencies prior to the commencement of hazardous waste operations. The plan shall be in writing and available for inspection and copying by employees, their representatives, Occupational Safety and Health Administration personnel and other governmental agencies with relevant responsibilities.	
	VII. National Institute for Occupational Safety and Health, OSH Act of 1970, 29 CFR 671	**VII. National Institute for Occupational Safety and Health, OSH Act of 1970, 29 CFR 671** OSH Act of 1970, Section 22. It is the purpose of this section to establish a National Institute for Occupational Safety and Health in the Department of Health and Human Services in order to carry out the policy set forth in section 2 of this Act and to perform the functions of the Secretary of Health and Human Services under Osh Act of 1970 Sections 20 and 21, 29 USC 669 and 29 USC	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		670. OSH Act of 1970 Section 20(a)(1). (a) (1) The Secretary of Health and Human Services, after consultation with the Secretary and with other appropriate Federal departments or agencies, shall conduct (directly or by grants or contracts) research, experiments, and demonstrations relating to occupational safety and health, including studies of psychological factors involved, and relating to innovative methods, techniques, and approaches for dealing with occupational safety and health problems. OSH Act of 1970 Section 21(a)-(c). (a) The Secretary of Health and Human services, after consultation with the Secretary and with other appropriate Federal departments and agencies, shall conduct, directly or by grants or contracts– (1) education programs to provide an adequate supply of qualified personnel to carry out the purposes of this Act, and (2) informational programs on the importance of and proper use of adequate safety and health equipment. (b) The Secretary is also authorized to conduct, directly or by grants or contracts, short-term training of personnel engaged in work related to his responsibilities under this	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Act. (c) The Secretary, in consultation with the Secretary of Health and Human Services, shall– (1) provide for the establishment and supervision of programs for the education and training of employers and employees in the recognition, avoidance, and prevention of unsafe or unhealthful working conditions in employments covered by this Act, and (2) consult with and advise employers and employees, and organizations representing employers and employees as to effective means of preventing occupational injuries and illnesses.	
	VIII. 29 CFR 1910.132	**VIII. 29 CFR 1910.132** Application. Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of	**VIII. 29 CFR 1910.132** Personal Protective Equipment: Safety standards subject to federal authority.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		any part of the body through absorption, inhalation or physical contact. (b) Employee-owned equipment. Where employees provide their own protective equipment, the employer shall be responsible to assure its adequacy, including proper maintenance, and sanitation of such equipment. (c) Design. All personal protective equipment shall be of safe design and construction for the work to be performed. (d) Hazard assessment and equipment selection. (1) The employer shall assess the workplace to determine if hazards are present, or are likely to be present, which necessitate the use of personal protective equipment. If such hazards are present, or likely to be present, the employer shall: (i) Select, and have each affected employee use, the types of personal protective equipment that will protect the affected employee from the hazards identified in the hazard assessment; (ii) Communicate selection decisions to each affected employee; and, (iii) Select personal protective equipment that properly fits each affected employee. Note: Non-mandatory Appendix B contains an example of procedures that would comply with the requirement for a hazard assessment. (2) The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment. (e) Defective and damaged equipment. Defective or damaged personal protective equipment shall not be used. (f) Training. (1) The employer shall provide training to each employee who is required by this section to use personal protective equipment. Each such employee shall be trained to know at least the following: (i) When personal protective equipment is necessary; (ii) What personal protective equipment is necessary; (iii) How to properly don, doff, adjust, and wear personal protective equipment; (iv) The limitations of the personal protective equipment; and, (v) The proper care, maintenance, useful life and disposal of the personal protective equipment. Each affected employee shall demonstrate an understanding of the training specified in 29 CFR 1910.132 (f)(1), and the ability to use personal protective equipment properly, before being allowed to perform work requiring the use of personal protective equipment. (3) When the employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required by paragraph (f)(2) of this section, the employer shall retrain each such employee.	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Circumstances where retraining is required include, but are not limited to, situations where: (i) Changes in the workplace render previous training obsolete; or (ii) Changes in the types of personal protective equipment to be used render previous training obsolete; or (iii) Inadequacies in an affected employee's knowledge or use of assigned personal protective equipment indicate that the employee has not retained the requisite understanding or skill. (4) The employer shall verify that each affected employee has received and understood the required training through a written certification that contains the name of each employee trained, the date(s) of training, and that identifies the subject of the certification. (g) Paragraphs (d) and (f) of this section apply only to 29 CFR Sections 1910.133, 1910.135, 1919.136, and 1910.138. Paragraphs (d) and (f) of this section do not apply to 29 CFR Sections 1910.134 and 1910.137.	
When and under what authority can consent requirements be waived? (Centers for Medicare and Medicaid Services?) (Applicable to Facilities, not healthcare providers)	**I. Centers for Medicare and Medicaid Services Conditions of Participations 42 CFR 482.11(a)(b)(c)**	**I. Centers for Medicare and Medicaid Services Conditions of Participations 42 CFR 482.11(a)(b)(c)** 42 CFR Section 482.11 Condition of participation: Compliance with Federal, State and local laws. (a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. (b) The hospital must be—(1) Licensed; or (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing	**I. Centers for Medicare and Medicaid Services Conditions of Participations 42 CFR 482.11(a)(b)(c)** In general, consent requirements, including informed consent, revolve around patient care and the liability for treatment without consent is attached to the healthcare professional. Nonetheless, by regulation, hospitals retain ultimate responsibility for the care provided in the facility. Note however, under Business and Professions

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		hospitals. (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.42 CFR 482.11(c) Hospitals must assure its personnel meet all applicable state and local requirements. This by implication includes the requirement that medical staff obtain informed consent.	Code Section 2397, if an emergency situation in a doctors office or hospital and need for treatment is urgent, providers maybe protected from battery but not for professional negligence.
	II. Patient Bill of Rights, Health and Safety Code Section 1262.8, 1288.4, 1249.60 22 CCR 70707 et seq. and 42 CCR 482.13	**II. Patient Bill of Rights, Health and Safety Code Section 1262.8, 1288.4, 1249.60 22 CCR 70707 et seq. and 42 CCR 482.13** Patient Rights includes the right to make informed decisions	**II. Patient Bill of Rights, Health and Safety Code Section 1262.8, 1288.4, 1249.60 22 CCR 70707 et seq. and 42 CCR 482.13** Patients' Rights: Patients are afforded certain rights. Under this regulation, hospitals and medical staffs are required to adopt a written policy on patient rights and post those patient rights within the hospital. Hospitals are required pursuant to this regulation, to post the patient rights. As it relates to informed consent, they have the right to as much information as they need in order to give informed consent. There is an exception to informed consent in an emergency, meaning the patient is experiencing an emergency medical condition and there is insufficient time to undergo the process of obtaining informed consent without causing additional harm or death. It is unlikely that the Governor would waive the requirement to obtain informed consent by order, however in the event of a catastrophic disaster, if a patient is experiencing an emergency medical condition, the obligation to obtain informed consent is not required to treat that emergency medical condition. Caution should be used, however, to limit treatment without consent to the emergency

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			condition of the patient. Once stable, all consent requirements apply. In the event the intervention is minor (e.g., a flu injection) simple consent may suffice. Simple consent applies if a relatively low risk intervention (i.e., a shot) and the patient knows they are going to get a shot but do not object. Consent is a complicated subject and if in doubt, do what is possible to inform, advise of options and potential risks, and document the circumstances. In general, consent requirements, including informed consent, revolve around patient care and the liability for treatment without consent is attached to the healthcare professional. Nonetheless, by regulation, hospitals retain ultimate responsibility for the care provided in the facility. Note however, under Business and Professions Code Section 2397, if an emergency situation in a doctors office or hospital and need for treatment is urgent, providers maybe protected from battery but not for professional negligence.
	III. Civil Code Section 1714.5. Mass Care Centers; Disaster workers; Civil Code Section 1714.6.	**III. Civil Code Section 1714.5. Mass Care Centers; Disaster workers** Mass Care Centers; Disaster workers. There shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or	**III. Civil Code Section 1714.5. Mass Care Centers; Disaster workers** Flex/Waiver/Alteration Not Necessary - Invoke protections afforded by Civil Code. Liability protections apply if a facility (or alternate care site) is used as a mass care center or temporary annex to treat those injured in under emergency circumstances unless an act or omission is willful.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency.	
	IV. Federal and State Conditions of admission		**IV. Federal and State Conditions of admission** Flex/Waiver/Alteration does not appear necessary - Invoke protections afforded by Civil Code. Statutory protection from a cause of action for negligence or violation of any statute or ordinance if complying with regulations directives or orders by

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			the Governor under the Emergency Services Act.
	V. 22 CCR 70713	**V. 22 CCR 70713** Hospitals are ultimately responsible for the care provided at the facility	**V. 22 CCR 70713** Though certain requirements are subject to flexibility, the hospital professional and administrative responsibility for services rendered.
	VI. 42 CFR 482.13(b)(2)	**VI. 42 CFR 482.13(b)(2)** 42 CFR Section 482.13 Condition of participation: Patients' rights. A hospital must protect and promote each patient's rights. (b) Standard: Exercise of rights. (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.	**VI. 42 CFR 482.13(b)(2)** In general, consent requirements, including informed consent, revolve around patient care and the liability for treatment without consent is attached to the healthcare professional. Nonetheless, by regulation, hospitals retain ultimate responsibility for the care provided in the facility. Note however, under Business and Professions Code Section 2397, if an emergency situation in a doctors office or hospital and need for treatment is urgent, providers maybe protected from battery but not for professional negligence.
What are the liability issues that result when patients are turned away due to overflow or lack of specialty (Emergency Medical Treatment and Active Labor Act)?	**I. Emergency Medical Treatment and Active Labor Act**	**I. Emergency Medical Treatment and Active Labor Act** A medical screening exam and treatment necessary to stabilize within the capability or within the staff and facilities available unless an appropriate transfer is made.	**I. Emergency Medical Treatment and Active Labor Act** There is express authority to waive sanction provisions by the Secretary of Health and Human Services. There is also authority under H.R. 3448 to waive all requirements. Key for compliance

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Additional resources to review: California Hospital Association Emergency Medical Treatment and Active Labor Act Manual	**II. 42 USC Section 1320b-5**	**II. 42 USC Section 1320b-5** To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify application of, with respect to healthcare items and services furnished by a healthcare provider (or classes of healthcare providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations, and regulations thereunder, insofar as they relate to such subchapters), pertaining to: sanctions under 42 USC Section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section if the transfer arises out of the circumstances of the emergency.	includes Documentation of what is within the hospital/staff capabilities. **II. 42 USC Section 1320b-5** The Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response can flex these regulations under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act (pursuant to HR 3448 Section 143).

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Waiver Under Section 1135 of the Social Security Act (#5) – memo from Department of Health and Human Services Secretary, September 4, 2005	**III. Waiver Under Section 1135 of the Social Security Act (#5) – memo from Department of Health and Human Services Secretary, September 4, 2005** Pursuant to 42 USC Section 1135(b) I hereby waive the following requirements of titles XVIII, XIX, or XXI of the Act or regulations thereunder, and the following requirements of Title XI of the Act, and regulations thereunder, insofar as they relate to Titles XVIII, XIX, or XXI of the Act, but in each case, only to the extent necessary to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid and State Children's Health Insurance Program programs and to ensure that healthcare providers that furnish such items and services in good faith, but are unable to comply with one or more of these requirements as a result of the effects of Hurricane Katrina, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud and abuse: Sanctions under 42 USC Section 1395dd (the Emergency Medical Treatment and Labor Act) for the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.	**III. Waiver Under Section 1135 of the Social Security Act (#5) – memo from Department of Health and Human Services Secretary, September 4, 2005** The Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response can flex these regulations under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act (pursuant to HR 3448 Section 143).

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Civil Code Section 1714.6, Compliance with Emergency Orders	**IV. Civil Code Section 1714.6, Compliance with Emergency Orders** Civil Code Section 1714.6 - Compliance with emergency orders. The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.	**IV. Civil Code Section 1714.6, Compliance with Emergency Orders** Flex/Waiver/Alteration Not Necessary - Invoke protections afforded by Civil Code. Statutory protection from a cause of action for negligence or violation of any statute or ordinance if complying with regulations directives or orders by the Governor under the Emergency Services Act. Action must be taken to secure Governor's Orders.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. Health and Safety Code Section1317 (refusal to care for non-emergency patient) **VI. 42 USC Section 1395dd**	**V. Health and Safety Code Section1317 (refusal to care for non-emergency patient)** Health and Safety Code Section 1317. Refusal to render care to non emergency patient - No health facility, its employees, physician, dentist, clinical psychologist or podiatrist shall be liable in any action arising from refusing to render emergency care if based on a determination, exercising reasonable care, the person is not suffering from an emergency medical condition, or the health facility does not have the appropriate facilities or qualified personnel available to render those services. The same applies to any "rescue team" if resuscitation efforts are attempted and in good faith.	**V. Health and Safety Code Section1317 (refusal to care for non-emergency patient)** No liability if refusal to render emergency care is based on a determination that an emergency medical condition does not exist or the facility does not have the appropriate capabilities or qualified personnel. **VI. 42 USC Section 1395dd** The Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response can flex these regulations under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act (pursuant to HR 3448 Section 143).

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VII. 42 CFR 489 **VIII. Burrows v Redbud Community Hospital**		**VII. 42 CFR 489** The Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response can flex these regulations under the National Preparedness for Bioterrorism and Other Public Health Emergencies Act (pursuant to HR 3448 Section 143). **VIII. Burrows v Redbud Community Hospital** California damages limitations do not apply to the Emergency Medical Treatment and Active Labor Act causes of action.
What are the liability issues that result when patients are turned away due to overflow or lack of specialty (Emergency Medical Treatment and Active Labor Act)? (Copy from Previous) Austere Care **Additional resources to review: California Hospital Association Emergency Medical Treatment and Active Labor Act Manual**	**I. Emergency Medical Treatment and Active Labor Act** **II. 42 USC Section 1320b-5**	**I. Emergency Medical Treatment and Active Labor Act** A medical screening exam and treatment necessary to stabilize within the capability or within the staff and facilities available unless an appropriate transfer is made. **II. 42 USC Section 1320b-5** To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify application of, with respect to healthcare items and services furnished by a healthcare provider (or classes of healthcare providers) in any emergency area (or portion	**I. Emergency Medical Treatment and Active Labor Act** There is express authority to waive sanction provisions by the Secretary of Health and Human Services. There is also authority under H.R. 3448 to waive all requirements. Key for compliance includes Documentation of what is within the hospital/staff capabilities. **II. 42 USC Section 1320b-5** There is express authority to waive sanction provisions by the Secretary of Health and Human Services. There is also authority under H.R. 3448 to waive all requirements. Key for compliance includes Documentation of what is within the hospital/staff capabilities.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations, and regulations thereunder, insofar as they relate to such subchapters), pertaining to: sanctions under 42 USC Section 1395dd of this title (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section if the transfer arises out of the circumstances of the emergency.	
	III. Waiver Under 42 USC Section 1320b-5 – memo from Department of Health and Human Services Secretary, September 4, 2005	**III. Waiver Under 42 USC Section 1320b-5 – memo from Department of Health and Human Services Secretary, September 4, 2005** Pursuant to Section 1135(b) of the Social Security Act (the Act) (42 USC 1320b-5) I hereby waive the following requirements of titles XVIII, XIX, or XXI of the Act or regulations thereunder, and the following requirements of Title XI of the Act, and regulations thereunder, insofar as they relate to Titles XVIII, XIX, or XXI of the Act, but in each case, only to the extent necessary to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid and State Children's Health Insurance Program programs and to ensure that	**III. Waiver Under 42 USC Section 1320b-5 – memo from Department of Health and Human Services Secretary, September 4, 2005** There is express authority to waive sanction provisions by the Secretary of Health and Human Services. There is also authority under H.R. 3448 to waive all requirements. Key for compliance includes Documentation of what is within the hospital/staff capabilities.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		healthcare providers that furnish such items and services in good faith, but are unable to comply with one or more of these requirements as a result of the effects of Hurricane Katrina, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud and abuse: Sanctions under Social Security Act Section 1867 (the Emergency Medical Treatment and Labor Act, or EMTALA) for the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances.	
	IV. Civil Code Section 1714.6, Compliance with Emergency Orders	**IV. Civil Code Section 1714.6, Compliance with Emergency Orders** Civil Code Section 1714.6 - Compliance with emergency orders. The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No	**IV. Civil Code Section 1714.6, Compliance with Emergency Orders** Flex/Waiver/Alteration Not Necessary - Invoke protections afforded by Civil Code. Statutory protection from a cause of action for negligence or violation of any statute or ordinance if complying with regulations directives or orders by the Governor under the Emergency Services Act. Action must be taken to secure Governor's Orders.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.	
	V. Health and Safety Code Section 1317 (refusal to care for non-emergency patient)	**V. Health and Safety Code Section 1317 (refusal to care for non-emergency patient)** Refusal to render care to non emergency patient - No health facility, its employees, physician, dentist, clinical psychologist or podiatrist shall be liable in any action arising from refusing to render emergency care if based on a determination, exercising reasonable care, the person is not suffering from an emergency medical condition, or the health facility does not have the appropriate facilities or qualified personnel available to render those services. The same applies to any "rescue team" if resuscitation efforts are attempted and in good faith.	**V. Health and Safety Code Section 1317 (refusal to care for non-emergency patient)** No liability if refusal to render emergency care is based on a determination that an emergency medical condition does not exist or the facility does not have the appropriate capabilities or qualified personnel.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Can Occupational Safety and Health Administration/Hazardous Waste Operations and Emergency Response Standard requirements be flexed?	**I. 29 CFR 1910.120 Hazardous waste operations and emergency response; Corresponding California Occupational Safety and Health Administration reference - 8 CCR 5192**	**I. 29 CFR 1910.120 Hazardous waste operations and emergency response; Corresponding California Occupational Safety and Health Administration reference - 8 CCR 5192** 29 CFR 1910.120(a)(1)(v) This section covers the following operations, unless the employer can demonstrate that the operation does not involve employee exposure or the reasonable possibility for employee exposure to safety or health hazards: Emergency response operations for releases of, or substantial threats of releases of, hazardous substances without regard to the location of the hazard. 29 CFR 1910.120(b)(1) Employers shall develop and implement a written safety and health program for their employees involved in hazardous waste operations. The program shall be designed to identify, evaluate, and control safety and health hazards, and provide for emergency response for hazardous waste operations. 29 CFR 1910.120(b)(4)(i) The site safety and health plan, which must be kept on site, shall address the safety and health hazards of each phase of site operation and include the requirements and procedures for employee protection. 29 CFR 1910.120(b)(4)(ii) The site safety and health plan, as a minimum, shall address the following:	**I. 29 CFR 1910.120 Hazardous waste operations and emergency response; Corresponding California Occupational Safety and Health Administration reference - 8 CCR 5192** Hazardous Materials and Waste: These regulations deal with safety requirements for dealing with hazardous materials including Hazardous Materials teams. Again, these are federal requirements and discuss critical elements of safety plans and requirements. As such, they are not subject to state waivers but would require intervention by the President.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		A safety and health risk or hazard analysis for each site task and operation found in the workplan. Employee training assignments to assure compliance with 29 CFR 1910.120 (e). Personal protective equipment to be used by employees for each of the site tasks and operations being conducted as required by the personal protective equipment program in 29 CFR 1910.120 (g)(5). Medical surveillance requirements in accordance with the program in 29 CFR 1910.120 (f). Frequency and types of air monitoring, personnel monitoring, and environmental sampling techniques and instrumentation to be used, including methods of maintenance and calibration of monitoring and sampling equipment to be used. Site control measures in accordance with the site control program required in 29 CFR 1910.120 (d). Decontamination procedures in accordance with 29 CFR 1910.120 (k). An emergency response plan meeting the requirements of paragraph (l) of this section for safe and effective responses to emergencies, including the necessary	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		personal and protective equipment and other equipment. Confined space entry procedures. A spill containment program meeting the requirements of 29 CFR 1910.120 (j). 29 CFR 1910.120(c)(4) The following information to the extent available shall be obtained by the employer prior to allowing employees to enter a site: Location and approximate size of the site. Description of the response activity and/or the job task to be performed. Duration of the planned employee activity. Site topography and accessibility by air and roads. Safety and health hazards expected at the site. Pathways for hazardous substance dispersion. Present status and capabilities of emergency response teams that would provide assistance to on-site employees at the time of an emergency. Hazardous substances and health hazards involved or expected at the site and their chemical and physical properties. 29 CFR 1910.120(c)(6)	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Monitoring. The following monitoring shall be conducted during initial site entry when the site evaluation produces information which shows the potential for ionizing radiation or immediately dangerous to life or health conditions, or when the site information is not sufficient reasonably to eliminate these possible conditions: Monitoring with direct reading instruments for hazardous levels of ionizing radiation. Monitoring the air with appropriate direct reading test equipment for (i.e., combustible gas meters, detector tubes) for immediately dangerous to life or health and other conditions that may cause death or serious harm (combustible or explosive atmospheres, oxygen deficiency, toxic substances.) Visually observing for signs of actual or potential immediately dangerous to life or health or other dangerous conditions. An ongoing air monitoring program in accordance with 29 CFR 1910.120 (h) shall be implemented after site characterization has determined the site is safe for the start-up of operations. 29 CFR 1910.120(c)(7) Risk identification. Once the presence and concentrations of specific hazardous substances and health hazards have been established, the risks associated with these substances shall be identified. Employees	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		who will be working on the site shall be informed of any risks that have been identified. In situations covered by the Hazard Communication Standard, 29 CFR 1910.1200, training required by that standard need not be duplicated. Risks to consider include, but are not limited to: Exposures exceeding the permissible exposure limits and published exposure levels Immediately Dangerous to Life or Health Concentrations Potential Skin Absorption and Irritation Sources Potential Eye Irritation Sources Explosion Sensitivity and Flammability Ranges Oxygen deficiency 29 CFR 1910.120(g)(5) Personal protective equipment program. A personal protective equipment program, which is part of the employer's safety and health program required in 29 CFR 1910.120 (b) or required in 29 CFR 1910.120 (p)(1) of this section and which is also a part of the site-specific safety and health plan shall be established. The personal protective equipment program shall also address the elements listed below. When elements, such as donning and doffing procedures, are	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		provided by the manufacturer of a piece of equipment and are attached to the plan, they need not be rewritten into the plan as long as they adequately address the procedure or element. Personal protective equipment selection based upon site hazards, Personal protective equipment use and limitations of the equipment, Work mission duration, Personal protective equipment maintenance and storage, Personal protective equipment decontamination and disposal, Personal protective equipment training and proper fitting, Personal protective equipment donning and doffing procedures, Personal protective equipment inspection procedures prior to, during, and after use, Evaluation of the effectiveness of the Personal protective equipment program, and Limitations during temperature extremes, heat stress, and other appropriate medical considerations. 1910.120(k)(2)(i)	

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		A decontamination procedure shall be developed, communicated to employees and implemented before any employees or equipment may enter areas on site where potential for exposure to hazardous substance exists. 29 CFR 1910.120(l)(1)(i) An emergency response plan shall be developed and implemented by all employers within the scope of 29 CFR 1910.120 (a)(1)(i) through (ii) to handle anticipated emergencies prior to the commencement of hazardous waste operations. The plan shall be in writing and available for inspection and copying by employees, their representatives, Occupational Safety and Health Administration personnel and other governmental agencies with relevant responsibilities.	
Can Medicare Conditions of Participation be flexed?	**I. 42 CFR 482.11 Condition of participation: Compliance with Federal, State and local laws**	**I. 42 CFR 482.11 Condition of participation: Compliance with Federal, State and local laws** Compliance with Federal, State and local laws. (a) The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. (b) The hospital must be—(1) Licensed; or (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals. (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.	**I. 42 CFR 482.11 Condition of participation: Compliance with Federal, State and local laws** The conditions of participation may be flexed directly by the Secretary of Health and Human Services or Assistant Secretary of Disasters pursuant to 42 USC 1320b-5 and HR 3448 upon receipt of request by the Governor. Conditions of Participation may also be altered indirectly if such alteration meets the federal threshold criteria and applicable state standards. (42 CFR 482.11c) In other words, id state statute allows program flexibility so long as flexibility is granted the federal requirement would be met

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			based on compliance with applicable state standards. Note, however, some state requirements are not subject to program flexibility.

3.4 Alternate Care Sites

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
There are no known existing laws prescribing minimum criteria to establish an Alternate Care Site. The only known existing statutes that could apply are: I. Emergency Services Act II. Good Samaritan Statutes III. California Government Code, Disaster Service Workers IV. Civil Code Statutes regarding Care in an Emergency	**I. California Emergency Services Act :** • Government Code Section 8550 • Government Code Section 8607 • Government Code Section 8656 • Government Code Section 8659 • Government Code Section 8569 • Government Code Section 8570	**I. California Emergency Services Act:** • Government Code Section 8550. The state has long recognized its responsibility to mitigate the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and the resources of the state, and generally to protect the health and safety and preserve the lives and property of the people of the state. To insure that preparations within the state will be adequate to deal with such emergencies, it is hereby found and declared to be necessary: (a) To confer upon the Governor and upon the chief executives and governing bodies of political subdivisions of this state the emergency powers provided herein; and to provide for state assistance in the organization and maintenance of the emergency programs of such political subdivisions; (b) To provide for a state agency to be known and referred to as the Office of Emergency Services, within the Governor's office; and to prescribe the powers and duties of the director of that office; (c) To provide for the assignment of functions to state agencies to be performed during an emergency and for the coordination and direction of the emergency actions of such agencies; (d) To provide for the rendering of mutual aid by the state government and all its departments and agencies and by the political subdivisions of this state in carrying out the purposes of this chapter; (e) To authorize the establishment of such organizations and the taking of such actions as are necessary and proper to carry out the provisions of this chapter.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		It is further declared to be the purpose of this chapter and the policy of this state that all emergency services functions of this state be coordinated as far as possible with the comparable functions of its political subdivisions, of the federal government including its various departments and agencies, of other states, and of private agencies of every type, to the end that the most effective use may be made of all manpower, resources, and facilities for dealing with any emergency that may occur. Government Code Section 8607. (SEMS) (a) By December 1, 1993, the Office of Emergency Services, in coordination with all interested state agencies with designated response roles in the state emergency plan and interested local emergency management agencies shall jointly establish by regulation a standardized emergency management system for use by all emergency response agencies. The public water systems identified in Government Code Section 8607.2 may review and comment on these regulations prior to adoption. This system shall be applicable, but not limited to, those emergencies or disasters referenced in the state emergency plan. The standardized emergency management system shall include all of the following systems as a framework for responding to and managing emergencies and disasters involving multiple jurisdictions or multiple agency responses: (1) The Incident Command Systems adapted from the systems originally developed by the FIRESCOPE Program, including those currently in use by state agencies. (2) The multi-agency coordination system as developed by the FIRESCOPE Program. (3) The mutual aid agreement, as defined in Government Code Section 8561, and related mutual aid systems such as those used in law enforcement, fire service, and coroners operations. (4) The operational area concept, as defined in Government Code Section 8559.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		(b) Individual agencies' roles and responsibilities agreed upon and contained in existing laws or the state emergency plan are not superseded by this article. (c) By December 1, 1994, the Office of Emergency Services, in coordination with the State Fire Marshal's Office, the Department of the California Highway Patrol, the Commission on Peace Officer Standards and Training, the Emergency Medical Services Authority, and all other interested state agencies with designated response roles in the state emergency plan, shall jointly develop an approved course of instruction for use in training all emergency response personnel, consisting of the concepts and procedures associated with the standardized emergency management system described in Government Code Section 8607 (a). (d) By December 1, 1996, all state agencies shall use the standardized emergency management system as adopted pursuant to Government Code Section 8607 (a), to coordinate multiple jurisdiction or multiple agency emergency and disaster operations. (e) (1) By December 1, 1996, each local agency, in order to be eligible for any funding of response-related costs under disaster assistance programs, shall use the standardized emergency management system as adopted pursuant to Government Code Section 8607to coordinate multiple jurisdiction or multiple agency operations. (2) Notwithstanding paragraph (1), local agencies shall be eligible for repair, renovation, or any other nonpersonnel costs resulting from an emergency. (f) The office shall, in cooperation with involved state and local agencies, complete an after-action report within 120 days after each declared disaster. This report shall review public safety response and disaster recovery activities and shall be made available to all interested public safety and emergency management organizations. • Government Code Section 8656

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		Extraterritorial performance of functions or duties; applicability of all privileges and immunities, exemptions, rights and benefits All of the privileges and immunities from liability; exemptions from laws, ordinances, and rules; all pension, relief, disability, workers' compensation, and other benefits which apply to the activity of officers, agents, or employees of any political subdivision when performing their respective functions within the territorial limits of their respective political subdivisions, shall apply to them to the same degree and extent while engaged in the performance of any of their functions and duties extraterritorially under this chapter. • Government Code Section 8659 Healthcare providers rendering emergency aid immune from liability; exception: Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted not apply in the event of a willful act or omission. • Government Code Section 8569 The Governor shall coordinate the State Emergency Plan and those programs necessary for the mitigation of the effects of an emergency in this state; and he shall coordinate the preparation of plans and programs for the mitigation of the effects of an emergency by the political subdivisions of this state, such plans and programs to be integrated into and coordinated with the State Emergency Plan and the plans and programs of the federal government and of other states to the fullest possible extent.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		• Government Code Section 8570 The Governor may, in accordance with the State Emergency Plan and programs for the mitigation of the effects of an emergency in this state: (a) Ascertain the requirements of the state or its political subdivisions for food, clothing, and other necessities of life in the event of an emergency. (b) Plan for, procure, and pre-position supplies, medicines, materials, and equipment. (c) Use and employ any of the property, services, and resources of the state as necessary to carry out the purposes of this chapter. (d) Provide for the approval of local emergency plans. (e) Provide for mobile support units. (f) Provide for use of public airports. (g) Institute training programs and public information programs. (h) Make surveys of the industries, resources, and facilities, both public and private, within the state, as are necessary to carry out the purposes of this chapter. (i) Plan for the use of any private facilities, services, and property and, when necessary, and when in fact used, provide for payment for that use under the terms and conditions as may be agreed upon. (j) Take all other preparatory steps, including the partial or full mobilization of emergency organizations in advance of an actual emergency; and order those test exercises needed to insure the furnishing of adequately trained and equipped personnel in time of need.
	II. Good Samaritan Statutes: • California Business and Professions Code Section 1627.5 Dentist • California Business and Professions Code Section 2395, 2395.5, 2396, 2398 Physician • California Business and Professions Code Section 2727.5, 2861.5, 3503.5 Nurses/Physician Assistant	**II. Good Samaritan Statutes** • Business and Professions Code Section 1627.5. Dentists No person licensed under this chapter [dentists], who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		• Business and Professions Code Section 2395. Physician and Surgeon No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Government Code Section 8550, Title 2, Division 2, Chapter 7). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission. • Business and Professions Code Section 2727.5. Nurse A person licensed under this chapter [nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent. • Business and Professions Code Section 2861.5. Licensed Vocational Nurse A person licensed under this chapter [licensed vocational nurse]

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of his employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent. • Business and Professions Code Section 3503.5. Physician's Assistant (a) A person licensed under this chapter [physician's assistant] who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. (b) This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. (c) In addition to the immunity specified in subdivision (a), the provisions of Government Code Section 2395, Chapter 5 Article 17 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.
	III. California Government Code, Disaster Service Workers: • Government Code Section 3100. Public Employees as Disaster Service Workers • Government Code Section 3101. Definitions • Government Code Section 3107. Reimbursement Prohibited Absent Oath	**III. Disaster Service Workers** • Government Code Section 3100 It is hereby declared that the protection of the health and safety and preservation of the lives and property of the people of the state from the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and resources is of paramount state importance requiring the responsible efforts of public and private agencies and individual citizens. In furtherance of the exercise of the police power of the state in protection of its citizens and resources, all public employees are hereby declared to be disaster service workers

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		subject to such disaster service activities as may be assigned to them by their superiors or by law. • Government Code Section 3101 For the purpose of this chapter the term “disaster service worker” includes all public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council. The term “public employees” includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed. • Government Code Section 3107 No compensation nor reimbursement for expenses incurred shall be paid to any disaster service worker by any public agency unless such disaster service worker has taken and subscribed to the oath or affirmation required by this chapter. It shall be the duty of the person certifying to public payrolls to ascertain and certify that such disaster service worker has taken such oath or affirmation. Whenever there is more than one officer certifying to public payrolls the governing body of a city or county or school district may designate and make it the duty of a certain officer or officers to ascertain and certify that such disaster service worker has taken such oath or affirmation. The governing body of a city or county or school district may designate and make it the duty of a local disaster service officer to ascertain and certify that each volunteer disaster service worker has taken such oath or affirmation. Nothing in this chapter, however, shall prevent the correction of any technical error or deficiency in an oath taken pursuant to this chapter; provided, such correction is made before the disaster service worker is actually paid or reimbursed.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
	IV. Civil Code Statutes regarding Care in an Emergency • California Civil Code Section 1714.5 • California Civil Code Section 1714.6	**IV. Civil Code Statutes regarding Care in an Emergency** • California Civil Code Section 1714.5 There shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Government Code Section 8558, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

Issue to Address	Current Applicable Statutes, Regulations and Standards	Current Compliance Requirements
		• California Civil Code Section 1714.6 The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.

3.5 Personnel

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Augmenting staffing needed during an emergency: Use of volunteers and Emergency System for Advance Registration of Volunteer Health Professionals, to obtain necessary staff, healthcare professionals and medical staff during an emergency	**I. Health Resources and Services Administration Guidelines for developing an Emergency System for Advance Registration of Volunteer Health Professionals (http://www.hrsa.gov/esarvhp/guidelines/default.htm)**	**I. Health Resources and Services Administration Guidelines for developing an Emergency System for Advance Registration of Volunteer Health Professionals** Emergency System for Advance Registration of Volunteer Health Professionals System is an electronic database of healthcare personnel who volunteer to provide aid in an emergency. An Emergency System for Advance Registration of Volunteer Health Professionals must (1) register health volunteers, (2) apply emergency credentialing standards to registered volunteers, and (3) allow for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency. Health Resources and Services Administration has published Guidelines [including an emergency credentialing process] which are minimally prescriptive and are designed to provide States with options and flexibility to develop an Emergency System for Advance Registration of Volunteer Health Professionals which best meets the States' needs while enabling a national	**I. Health Resources and Services Administration Guidelines for developing an Emergency System for Advance Registration of Volunteer Health Professionals** Implementing Emergency System for Advance Registration of Volunteer Health Professionals is not yet operationalized in CA. Alternatives may exist to waive or flex, for example, credentialing and licensure requirements by order of the Governor under the Emergency Services Act. In the alternative, immunity protection may apply if following orders issued by the Governor.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		system of mutual aid. By the end of the program in December 2006, all States will have an Emergency System for Advance Registration of Volunteer Health Professionals developed in coordination with Health Resources and Service Administration's Emergency System for Advance Registration of Volunteer Health Professionals program, allowing for a national system of mutual assistance of health volunteers within a State's public health structures and hospital systems.	
	II. The Emergency Medical Services Authority's California Emergency System for Advance Registration of Volunteer Health Professionals (http://www.emsa.cahwnet.gov/def_comm/viii092706_a.asp)	**II. The Emergency Medical Services Authority's California Emergency System for Advance Registration of Volunteer Health Professionals** The Emergency Medical Services Authority's California Emergency System for Advance Registration of Volunteer Health Professionals effort has made significant progress during the last six months, and is continuing with procurement and widespread system rollout. The key accomplishments of the last six months include: • A proof-of-concept pilot that registered physicians, registered nurses, paramedics, and pharmacists at www.medicalvolunteer.ca. gov. This pilot registered volunteer health	**II. The Emergency Medical Services Authority's California Emergency System for Advance Registration of Volunteer Health Professionals** Alternatives to Emergency System for Advance Registration of Volunteer Health Professionals may exist to waive or flex, for example, credentialing and licensure requirements by order of the Governor under the Emergency Services Act. In the alternative, immunity protection may apply if following orders issued by the Governor.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		professionals from throughout the state. Additionally, the Emergency Medical Services Authority partnered with San Mateo County and Santa Barbara County to participate as pilot counties and assist in beta testing the system. • Creation of a 30-minute on-line training program for volunteer health professionals. Designed to be delivered prior to deployment, the program answers important questions regarding disaster deployment, and helps prepare volunteers for emergency service. • Development of a detailed and wide-ranging Standardized Emergency Management System-based Principles of Operation, describing how the state's Emergency System for Advance Registration of Volunteer Health Professionals will work at local and state levels. These principles were developed consensually, with input from key stakeholders in county Emergency Medical Services authorities, public health departments, state agencies, and the private sector. • Resolution of critical legal questions regarding professional liability and workers compensation coverage.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		• Reconvening of the state's formal Emergency System for Advance Registration of Volunteer Health Professionals program advisory committee, with explicit approval of Emergency Medical Services Authority overall efforts. • Completion of a survey of county-level Emergency System for Advance Registration of Volunteer Health Professionals efforts. • Development of a marketing and outreach plan for the coming year, designed to recruit volunteers and brief all relevant partners. • Research and development across a wide range of programmatic issues, particularly concerned with privacy, information security, data integrity, and other aspects relevant to maintaining the Emergency System for Advance Registration of Volunteer Health Professionals registry. • Completion of the Emergency Medical Services Authority Feasibility Study Report, necessary for procurement of software for the state system. Currently, the Emergency Medical Services Authority is in the middle of the procurement process for the formal	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(post-pilot) Emergency System for Advance Registration of Volunteer Health Professionals system. Additionally, the Authority is engaged in activities to expand the capacity to manage the Emergency System for Advance Registration of Volunteer Health Professionals program, including hiring new staff. Concurrent with procurement efforts, the Emergency Medical Services Authority is planning for full-fledged implementation of the Emergency System for Advance Registration of Volunteer Health Professionals system. Some of the many activities in this next year will include: codification and refinement of policies and procedures; limited-scope exercises to test operational concepts; extensive marketing, recruitment, and outreach efforts; pilots with key hospital/healthcare system partners; resolution of additional legal and regulatory issues; pursuit of funds for future operations; and training of system administrators. The system launched during the pilot remains active and available for both registration and emergency use. Emergency System for Advance Registration of Volunteer Health Professionals represents a critical resource in providing for surge personnel	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		in the event of a disaster.	
	III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25** *HR.1.25*. Standard: The hospital may assign disaster responsibilities to volunteer practitioners. Rationale: When the disaster plan has been implemented (*see* standard Environment of Care 4.10 for a description of emergency management planning requirements) and the immediate needs of the patients cannot be met, the hospital may implement a modified process for determining qualifications and competence of volunteer practitioners* (*see* EPs 5–8). The volunteer practitioners that are addressed by this standard only include those professionals that are required by law and regulation to have a license, certification, or registration to practice their profession. The usual process to determine the qualifications and competence of these professionals	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25** Joint Commission allows for use of volunteers so long as for disaster plan that is activated. Hospitals must nonetheless assure that volunteers are competent to safely provide care, and verify licensure.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster privileges for volunteer licensed independent practitioners exists at standard MS.4.110. While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of the following two parts of the usual process for determining qualifications and competence must be maintained: 1. Verification of licensure, certification, or registration required to practice a profession. 2. Oversight of the care, treatment, and services provided. This option to assign disaster responsibilities to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. There are a number of state and federal systems engaged in pre-event verification of qualifications that may facilitate the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		assigning of disaster responsibilities to volunteer practitioners at the time of a disaster. Examples of such systems include the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals. It is expected that additional programs will emerge and evolve. Elements of Performance: Disaster responsibilities are assigned only when the following two conditions are present: the emergency management plan has been activated, and the hospital is unable to meet immediate patient needs. 2. The hospital identifies in writing the individual(s) responsible for assigning disaster responsibilities. 3. The hospital describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who are assigned disaster responsibilities. 4. The hospital has a mechanism to identify volunteer practitioners that have been assigned disaster responsibilities. 5. For volunteer practitioners to be assigned disaster responsibilities, the hospital obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		passport) and at least one of the following: A current hospital picture identification card that clearly identifies professional designation. A current license, certification, or registration. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession). Identification indicating that the individual is a member of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications 6. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Note: *In the extraordinary circumstance that primary*	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) *cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.* 7. The hospital oversees the professional practice of volunteer practitioners. 8. The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer practitioner) within 72 hours related to the continuation of the disaster responsibilities initially assigned.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Government Code Section 8599. Plan Government Code Section 8599.2	**IV. Government Code Section 8599. Plan Government Code Section 8599.2** The Office of Emergency Services shall develop a plan for state and local governmental agencies to utilize volunteer resources during a state of emergency proclaimed by the Governor. The office shall consult with appropriate state and local governmental agencies and volunteer organizations in the development of this plan. Government Code Section 8599.2: Statewide Natural Disaster Volunteer Corp. Provides the minimum requirements for the state Office of Emergency Services plan to utilize volunteer resources during a state of emergency. Plan Minimum Requirements: The plan required by Government Code Section 8599 shall address, at a minimum, all of the following issues: (a) A formal system for the utilization of volunteer resources by state and local governmental agencies during a proclaimed state of emergency. (b) A definition of volunteer resources. (c) The identification and listing of volunteer resources in California. (d) An education program for volunteer resources on the needs and use of	**IV. Government Code Section 8599. Plan Government Code Section 8599.2** The State's volunteer registry program is currently in the design stages. In the event of a state of disaster, the Governor may issue orders that suspend, alter or require certain actions, and if acting under that order, certain liability protections and immunities will apply.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		volunteers by state and local governmental agencies during a proclaimed state of emergency. (e) An education program for state and local governmental agencies on the availability and utilization of volunteer resources during a proclaimed state of emergency. (f) The coordination of volunteer resources during a proclaimed state of emergency. (g) Definition and identification of volunteer skills and resources typically required by state and local governmental agencies during a proclaimed state of emergency. (h) A volunteer resources emergency management system for responding to needs of state and local governmental agencies during a proclaimed state of emergency. (i) A notification procedure of volunteer resources for participation in the plan. (j) Communication needs of volunteer resources responding during a proclaimed state of emergency. (k) Predisaster agreements for utilization of volunteer resources by state and local governments during a proclaimed state of emergency.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. Government Code Section 8657 (enrolled or registered volunteers; those impressed into service.	**V. Government Code Section 8657**. (a) Volunteers duly enrolled or registered with the Office of Emergency Services or any disaster council of any political subdivision, or unregistered persons duly impressed into service during a state of war emergency, a state of emergency, or a local emergency, in carrying out, complying with, or attempting to comply with, any order or regulation issued or promulgated pursuant to the provisions of this chapter or any local ordinance, or performing any of their authorized functions or duties or training for the performance of their authorized functions or duties, shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions performing similar work for their respective entities. (b) No political subdivision or other public agency under any circumstances, nor the officers, employees, agents, or duly enrolled or registered volunteers thereof, or unregistered persons duly impressed into service during a state of war emergency, a state of emergency, or a local emergency, acting within the scope of their official duties under this chapter or any local ordinance shall be liable for personal injury or property damage sustained by any duly enrolled or registered volunteer engaged in or	**V. Government Code Section 8657 (enrolled or registered volunteers; those impressed into service.** Immunity protection to those enrolled or registered volunteers, or those unregistered impressed into services by order of the Governor.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		training for emergency preparedness or relief activity, or by any unregistered person duly impressed into service during a state of war emergency, a state of emergency, or a local emergency and engaged in such service. The foregoing shall not affect the right of any such person to receive benefits or compensation which may be specifically provided by the provisions of any federal or state statute nor shall it affect the right of any person to recover under the terms of any policy of insurance. (c) The California Earthquake Prediction Evaluation Council, an advisory committee established pursuant to Government Code Section 8590 of this chapter, may advise the Governor of the existence of an earthquake or volcanic prediction having scientific validity. In its review, hearings, deliberations, or other validation procedures, members of the council, jointly and severally, shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions engaged in similar work in their respective entities. Any person making a presentation to the council as part of the council's validation process, including presentation of a prediction for validation, shall be deemed a member of the council until the council has found	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		the prediction to have or not have scientific validity.	
	VI. Government Code Section 3111	**VI. Government Code Section 3111: Defining volunteer and direct services volunteer**	**VI. Government Code Section 3111** Waiver not applicable. Disaster must be declared to invoke regulation.
	VII. 19 CCR 2570 (Disaster Service Worker Volunteer Program)	**VII. 19 CCR 2570.1** The Legislature has long provided a state-funded program of workers' compensation benefits for disaster service worker volunteers who contribute their services to protect the health and safety and preserve the lives and property of the people of the state. This program was established to protect such volunteers from financial loss as a result of injuries sustained while engaged in disaster service activities and to provide immunity from liability for such disaster service worker volunteers while providing disaster service. 19 CCR 2570.2. Definitions Disaster Service Worker. (a) A disaster service worker is any person registered with a disaster council or the Governor's Office of Emergency Services, or a state agency granted authority to register disaster service workers, for the purpose of engaging in	**VII. 19 CCR 2570 (Disaster Service Worker Volunteer Program)** Provides workers compensation rights to protection to volunteers engaged in disaster services activities. *Appears cannot concurrently serve as a Disaster Service Worker and be on a payroll or otherwise compensated. This is unfortunate because it precludes protections and flexibility afforded to Disaster Service Workers. Option may be to seek order by Governor to temporarily suspend the request to allow Disaster Service Workers to receive compensation with disaster responsibilities and activities.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		disaster service pursuant to the California Emergency Services Act without pay or other consideration. (2) [sic] Disaster service worker includes public employees, and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties. (3) Exclusion: Disaster service worker does not include any member registered as an active fire fighting member of any regularly organized volunteer fire department, having official recognition, and full or partial support of the county, city, town or district in which such fire department is located. (b) Disaster Service. Disaster service means all activities authorized by and carried on pursuant to the California Emergency Services Act, including approved and documented training necessary or proper to engage in such activities. Exclusion. Disaster service does not include any activities or functions performed by a person if the disaster council with which the person is registered receives a fee or other compensation for the performance of	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		that person's activities or functions. (c) Training. For purposes of these regulations, training is a planned activity sponsored by a disaster council (or designated agency or authority) and may include classroom instruction, disaster drills or exercises, or related activities that are designed to enhance the disaster response skills (including safety) of the disaster service worker. (d) Disaster Council. A disaster council is a public agency established by ordinance which is empowered to register and direct the activities of disaster service workers within the area of the county, city, city and county, or any part thereof. In this respect, the disaster council is acting as an instrument of the state in aid of carrying out general state government functions and policy with regard to disaster services. (e) Accredited Disaster Council. A disaster council may become accredited through certification by the California Emergency Council, or the Governor when the Emergency Council is not meeting, when the disaster council agrees to follow and comply with the rules and regulations established by the Emergency Council pursuant to the provisions of the Emergency Services Act. Upon certification, and not before,	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		the disaster council becomes an accredited disaster council. A disaster council remains accredited only while the certification of the California Emergency Council is in effect and is not revoked. (f) Auxiliary Fire Fighter. An auxiliary fire fighter is a person recruited, registered and trained as a supplement or reserve for unusual fire emergencies or disaster situations. Workers' compensation benefits for auxiliary fire fighters may be provided by the state. An auxiliary fire fighter is not a "volunteer fire fighter," who is a person recruited and trained to meet the day-to-day operational requirements of a fire department. Workers' compensation insurance premiums for the volunteer fire fighter are the responsibility of the local government or fire entity. (g) Public Employee. All persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed, are considered to be public employees. (h) Convergent Volunteers. Convergent volunteers are individuals that come forward to offer disaster response and recovery volunteer services, during a healthcare surge. Convergent volunteers are not persons impressed into service at the scene of an incident.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VIII. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency	**VIII. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency** (a) Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the healthcare is provided only during a state of emergency as defined in of Government Code Section 8558 (b) which emergency overwhelms the response capabilities of California healthcare practitioners and only upon the request of the Director of the Emergency Medical Services Authority**.** (b) The director shall be the medical control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. (c) Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. (d) Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority	**VIII. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency** Yes, flexibility exists for this regulation. May utilize out-of-state licensed professionals upon declaration of state of emergency and request of the Emergency Medical Services Authority. (Template request would be recommended.) Once met, Director has authority to delineate professional deployment.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		with verification of licensure upon request. (e) Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659. (f) For the purposes of this chapter, "healthcare practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. (g) For purposes of this chapter, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified Health and Safety Code Section 1797 Division 2.5.	
	IX. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act	**IX. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act** This chapter shall be known and may be cited as the Healthcare Professional Disaster Response Act.	**IX. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act** Provides authority during a disaster to utilize healthcare professionals whose licenses have lapsed or are inactive. This also waives applicable licensure fees.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	X. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters	**X. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters** (a) The Legislature finds and declares the following: (1) In times of national or state disasters, a shortage of qualified healthcare practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. (2) Healthcare practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified healthcare practitioners exists, if licensing requirements were streamlined and fees curtailed. (b) It is, therefore, the intent of the Legislature to address these matters through the provisions of the Healthcare Professional Disaster Response Act.	**X. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters** Business and Professions Code Section 702 provides that the holder of an inactive healing arts license or certificate issued pursuant to this article shall not engage in any activity for which an active license or certificate is required. Business and Professions Code Section 921 states a legislative intent that inactive healthcare professionals could serve as a resource in a disaster. However, Business and Professions Code Section 922 allows only the Medical Board to waive licensing fees with regard to physicians and surgeons. That section imposes other requirements, including continuing education, upon inactive physicians applying for a disaster license. Business and Professions Code Section 922 imposes regulatory provisions which could be suspended under Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency	**XI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency** Nothing in this chapter [on physician licensing] prohibits service in the case of emergency, or the domestic administration of family remedies.	**XI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency** This section provides that the medical practice licensing provisions do not prohibit service in the event of an emergency. In effect, any person, licensed or unlicensed, could during an emergency provide what could be considered medical care. Thus, a disaster service worker who is not licensed as a physician, but is required to provide medical services in response to an emergency, is not prohibited from doing so by the medical practice licensing provisions, and would enjoy the legal immunities afforded to disaster service workers for doing so.
Disaster Service Workers	**I. Labor Code Section 3211.92. Disaster Service Worker**	**I. Labor Code Section 3211.92 Disaster Service Worker** (a) "Disaster service worker" means any natural person who is registered with an accredited disaster council or a state agency for the purpose of engaging in disaster service pursuant to the California Emergency Services Act without pay or other consideration. (b) "Disaster service worker" includes public employees performing disaster work that is outside the course and scope of their regular employment	**I. Labor Code Section 3211.92. Disaster Service Worker** Yes, there is flexibility to waive this regulation. To the extent waiver or flexibility is required, the Local Health Department and Governor may issue orders or take whatever action is required to respond to a disaster that affects the public health. Flexibility or waiver are not required to operationalize the use of Disaster Service Workers. However, the local Board of Supervisors need to delegate authority to issue orders to the local health department. It is also prudent

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		without pay and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties. (c) Persons registered with a disaster council at the time that council becomes accredited need not reregister in order to be entitled to the benefits provided by Labor Code Section 4351 Chapter 10. (d) Employee excluding "any unregistered person performing like services as a Disaster Service Worker without pay or other consideration except as provided by Labor Code 3211.92	that each locality establishes a disaster council so the pre-planning and registration of Disaster Service Workers is accomplished prior to any large scale disaster. The statures do not expressly preclude registration retroactive to the time of disaster, but since immunity protections are afforded, it is prudent to pre-register to ensure maximum flexibility to assist and afford maximum protection from liability.
	II. Labor Code Section 3211.93. Disaster Service	**II. Labor Code Section 3211.93. Disaster Service** "Disaster service" means all activities authorized by and carried on pursuant to the California Emergency Services Act, including training necessary or proper to engage in such activities.	**II. Labor Code Section 3211.93. Disaster Service** Yes, there is flexibility to waive this regulation. To the extent waiver or flexibility is required, the Local Health Department and Governor may issue orders or take whatever action is required to respond to a disaster that affects the public health. Flexibility or waiver are not required to operationalize use of Disaster Service Workers. However, the local Board of Supervisors need to delegate

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			authority to issue orders to the local health department. It is also prudent that each locality establishes a disaster council so the pre-planning and registration of Disaster Service Workers is accomplished prior to any large scale disaster. The statures do not expressly preclude registration retroactive to the time of disaster, but since immunity protections are afforded, it is prudent to pre-register to ensure maximum flexibility to assist and afford maximum protection from liability.
	III. Labor Code Section 3211.93a. Disaster Service; Exclusion of Compensated Performance	**III. Labor Code Section 3211.93a. Disaster Service; Exclusion of Compensated Performance** "Disaster service" does not include any activities or functions performed by a person if the accredited disaster council with which that person is registered receives a fee or other compensation for the performance of those activities or functions by that person.	**III. Labor Code Section 3211.93a. Disaster Service; Exclusion of Compensated Performance** Yes, there is flexibility to waive this regulation, but similar to other disaster provisions this may not be required. Waiver would be required, however, to allow Disaster Service Worker to concomitantly provide services as paid personnel. The policy behind investigating this option is to blanket existing employees or contractors with the liability protections afforded Disaster Service Worker. It appears to do so, the prohibitions against receiving compensation would need to be waived during the acute phase of a disaster.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Labor Code Section 3352.94. Definition of Employee	**IV. Labor Code Section 3352.94. Definition of Employee** "Employee" excludes a disaster service worker while performing services as a disaster service worker except as provided in Chapter 10 of this part. "Employee" excludes any unregistered person performing like services as a disaster service worker without pay or other consideration, except as provided by Labor Code Section 3211.92.	**IV. Labor Code Section 3352.94. Definition of Employee** Law currently creates a distinction between Disaster Service Worker and employer based on whether being compensated. Yes - merging this distinction, if desirable, waiver requires an order by the Governor under the Emergency Powers Act, state of emergency authority. Assessment of risks and benefits to any such merger is required to determine if merging the distinction via order would create additional protections or cause other untoward effects upon those offering assistance during a disaster.
	V. Labor Code Section 3600.6. Coverage of Disaster Service Workers	**V. Labor Code Section 3600.6. Coverage of Disaster Service Workers** Disaster service workers registered by a disaster council while performing services under the general direction of the disaster council shall be entitled to all of the same benefits of this division as any other injured employee, except as provided by Labor Code Section 4351 Part 1Chapter 10. For purposes of this section, an unregistered person impressed into performing service as a disaster service worker during a state of	**V. Labor Code Section 3600.6. Coverage of Disaster Service Workers** Waiver is not required. This provision provides. Note, however, that invoking the Disaster Service Worker provisions requires a declaration of a state or local emergency, and that services are provided without compensation.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties shall also be deemed a disaster service worker and shall be entitled to the same benefits of this division as any other disaster service worker.	
	VI. Labor Code Section 4350. Office of Emergency Services Administration of Compensation for Disaster Service Workers	**VI. Labor Code Section 4350. Office of Emergency Services Administration of Compensation for Disaster Service Workers** The Office of Emergency Services shall administer this chapter as it relates to volunteer disaster service workers.	**VI. Labor Code Section 4350. Office of Emergency Services Administration of Compensation for Disaster Service Workers** Waiver not applicable.
	VII. Labor Code Section 4351. Compensation as Exclusive Remedy	**VII. Labor Code Section 4351. Compensation as Exclusive Remedy** Compensation provided by this division is the exclusive remedy of a disaster service worker, or his or her dependents, for injury or death arising out of, and in the course of, his or her activities as a disaster service worker as against the state, the disaster council with which he or she is registered, and the county or city which has empowered the disaster council to register and direct his or her activities. Liability for compensation provided by this division is in lieu of any	**VII. Labor Code Section 4351. Compensation as Exclusive Remedy** This provision, like any state statute, may be suspended or waived by the Governor. It is not likely that this limitation of Disaster Service Worker remedies would be waived, as it would broaden liability against State or local government.

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		other liability whatsoever to a disaster service worker or his or her dependents or any other person on his or her behalf against the state, the disaster council with which the disaster service worker is registered, and the county or city which has empowered the disaster council to register and direct his or her activities, for any injury or death arising out of, and in the course of, his or her activities as a disaster service worker.	
	VIII. Labor Code Section 4352. Compensation Dependent on Appropriation	**VIII. Labor Code Section 4352. Compensation Dependent on Appropriation** No compensation shall be paid or furnished to disaster service workers or their dependents pursuant to this division except from money appropriated for the purpose of furnishing compensation to disaster service workers and their dependents. Liability for the payment or furnishing of compensation is dependent upon and limited to the availability of money so appropriated. After all money so appropriated is expended or set aside in bookkeeping reserves for the payment or furnishing of compensation and reimbursing the State Compensation Insurance Fund for its services, the payment or furnishing of compensation for an injury to a disaster service worker	**VIII. Labor Code Section 4352. Compensation Dependent on Appropriation** Compensation for Disaster Service Worker is limited to available funds. As above, it is unlikely this would be waived as it broadens liability exposure against the state or local government.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		or his or her dependents is dependent upon there having been a reserve set up for the payment or furnishing of compensation to that disaster service worker or his or her dependents and for that injury, and liability is limited to the amount of the reserve. The excess in a reserve for the payment or furnishing of compensation or for reimbursing the State Compensation Insurance Fund for its services may be transferred to reserves of other disaster service workers for the payment or furnishing of compensation and reimbursing the State Compensation Insurance Fund, or may be used to set up reserves for other disaster service workers.	
	IX. Labor Code Section 4353. Determination of Earnings	**IX. Labor Code Section 4353. Determination of Earnings** If a disaster service worker suffers injury or death while in the performance of duties as a disaster service worker, then, irrespective of his or her remuneration from this or other employment or from both, the average weekly earnings for the purposes of determining temporary and permanent disability indemnity shall be taken at the maximum fixed for each, respectively, in Labor Code Section 4453.	**IX. Labor Code Section 4353. Determination of Earnings** Same as above (VIII), but specific to replacement of wages.

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	X. Labor Code Section 4354. Permanent Disability	**X. Labor Code Section 4354. Permanent Disability** If the injury sustained by a disaster service worker causes permanent disability, the percentage of disability to total disability shall be determined as for the occupation of a laborer of like age by applying the schedule for the determination of the percentages of permanent disabilities prepared and adopted by the administrative director. The amount of the weekly payment for permanent disability shall be the same as the weekly benefit which would be paid for temporary total disability pursuant to Labor Code Section 4353.	**X. Labor Code Section 4354. Permanent Disability** Same as above (VIII), but specific to disability.
	XI. Labor Code Section 4355. Other Available Benefits	**XI. Labor Code Section 4355. Other Available Benefits** (a) Should the United States Government or any agent thereof, in accordance with any federal statute, rule, or regulation, furnish monetary assistance, benefits, or other temporary or permanent relief to disaster service workers or to disaster service workers and their dependents for injuries arising out of and occurring in the course of their activities as disaster service workers, the amount of compensation that any disaster service worker or his or her dependents are otherwise entitled to receive from the State of California	**XI. Labor Code Section 4355. Other Available Benefits** This is an offset provision under the jurisdiction of the federal government. To the extent federal funds are available, accessing these funds may require registration as a Disaster Service Worker, and a declaration of a state or local disaster.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		under this division for any injury shall be reduced by the amount of monetary assistance, benefits, or other temporary or permanent relief the disaster service worker or his or her dependents have received and will receive from the United States or any agent thereof as a result of the injury. (b) If, in addition to monetary assistance, benefits, or other temporary or permanent relief, the United States Government or any agent thereof furnishes medical, surgical, or hospital treatment, or any combination thereof, to an injured disaster service worker, the disaster service worker has no right to receive similar medical, surgical, or hospital treatment under this division. (c) If, in addition to monetary assistance, benefits, or other temporary or permanent relief, the United States Government or any agent thereof will reimburse a disaster service worker or his or her dependents for medical, surgical, or hospital treatment, or any combination thereof, furnished to the injured disaster service worker, the disaster service worker has no right to receive similar medical, surgical, or hospital treatment under this division. (d) If the furnishing of compensation under this division to a disaster service worker or his or her dependents	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		prevents the disaster service worker or his or her dependents from receiving assistance, benefits, or other temporary or permanent relief under a federal statute, rule, regulation, the disaster service worker and his or her dependents shall have no right to, and may not receive, any compensation from the State of California under this division for any injury for which the United States Government or any agent thereof will furnish assistance, benefits, or other temporary or permanent relief in the absence of the furnishing of compensation by the State of California	
Disaster Service Workers - Authority of State to Compel Service	**I. Government Code Section 204.**	**I. Government Code Section 204.** The State may require services of persons, with or without compensation: In military duty; in jury duty; as witnesses; as town officers; in highway labor; in maintaining the public peace; in enforcing the service of process; in protecting life and property from fire, pestilence, wreck, and flood; and in other cases provided by statute.	**I. Government Code Section 204.** Flexibility or waiver is not required.
Disaster Service Workers - Public Employees, Oaths and Compensation	**I. Government Code Section 3100. Public Employees as Disaster Service Workers**	**I. Government Code Section 3100. Public Employees as Disaster Service Workers** It is hereby declared that the protection of the health and safety and preservation of the lives and property of the people of the state from the effects of natural,	**I. Government Code Section 3100. Public Employees as Disaster Service Workers** This law deems all public employees as Disaster Service Worker regardless of compensation. No flexibility or waiver is required, nor is a written declaration.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and resources is of paramount state importance requiring the responsible efforts of public and private agencies and individual citizens. In furtherance of the exercise of the police power of the state in protection of its citizens and resources, all public employees are hereby declared to be disaster service workers subject to such disaster service activities as may be assigned to them by their superiors or by law.	
	II. Government Code Section 3101. Definitions	**II. Government Code Section 3101. Definitions** Government Code Section 3101. For the purpose of this chapter the term "disaster service worker" includes all public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council. The term "public employees" includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed.	**II. Government Code Section 3101. Definitions** This clarifies that Disaster Service Worker includes all public employees and registered volunteers serving during a disaster. No flex is required.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Government Code Section 3102.	**III. Government Code Section 3102.** Government Code Section 3102 (a) All disaster service workers shall, before they enter upon the duties of their employment, take and subscribe to the oath or affirmation required by this chapter. (b) In the case of intermittent, temporary, emergency or successive employments, then in the discretion of the employing agency, an oath taken and subscribed as required by this chapter shall be effective for the purposes of this chapter for all successive periods of employment which commence within one calendar year from the date of that subscription. (c) Notwithstanding Government Code Section 3102 (b), the oath taken and subscribed by a person who is a member of an emergency organization sanctioned by a state agency or an accredited disaster council, whose members are duly enrolled or registered with the Office of Emergency Services, or any accredited disaster council of any political subdivision, shall be effective for the period the person remains a member with that organization.	**III. Government Code Section 3102.** Yes, this oath requirement may be waived by the Governor under a state emergency. Since status as a Disaster Service Worker requires taking this oath, assessment should be made regarding suspending the (registration) and oath requirements until such time as appropriate (e.g. after the acute phase of a disaster).

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Government Code Section 3103. Constitutional Oath.	**IV. Government Code Section 3103. Constitutional Oath.** The oath or affirmation required by this chapter is the oath or affirmation set forth in Section 3 of Article XX of the Constitution of California.	**IV. Government Code Section 3103. Constitutional Oath.** Yes, this oath requirement may be waived by the Governor under a state emergency. Since status as a Disaster Service Worker requires taking this oath, assessment should be made regarding suspending the (registration) and oath requirements until such time as appropriate (e.g. after the acute phase of a disaster).
	V. Government Code Section 3104. Administration of Oath	**V. Government Code Section 3104. Administration of Oath** The oath or affirmation may be taken before any officer authorized to administer oaths. The oath or affirmation of any disaster service worker may be taken before his appointing power or before any person authorized in writing by his appointing power. No fee shall be charged by any person before whom the oath or affirmation is taken and subscribed.	**V. Government Code Section 3104. Administration of Oath** Yes, this oath requirement may be waived by the Governor under a state emergency. Since status as a Disaster Service Worker requires taking this oath, assessment should be made regarding suspending the (registration) and oath requirements until such time as appropriate (e.g. after the acute phase of a disaster).
	VI. Government Code Section 3105. Filing of Oath	**VI. Government Code Section 3105. Filing of Oath** (a) The oath or affirmation of any disaster service worker of the state shall be filed as prescribed by State Personnel Board rule within 30 days of	**VI. Government Code Section 3105. Filing of Oath** Yes, this oath requirement may be waived by the Governor under a state emergency. Since status as a Disaster

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		the date on which it is taken and subscribed. (b) The oath or affirmation of any disaster service worker of any county shall be filed in the office of the county clerk of the county or in the official department personnel file of the county employee who is designated as a disaster service worker. (c) The oath or affirmation of any disaster service worker of any city shall be filed in the office of the city clerk of the city. (d) The oath or affirmation of any disaster service worker of any other public agency, including any district, shall be filed with any officer or employee of the agency that may be designated by the agency. (e) The oath or affirmation of any disaster service worker may be destroyed without duplication five years after the termination of the disaster service worker's service or, in the case of a public employee, five years after the termination of the employee's employment.	Service Worker requires taking this oath, assessment should be made regarding suspending the (registration) and oath requirements until such time as appropriate (e.g. after the acute phase of a disaster).
	VII. Government Code Section 3106. State employees	**VII. Government Code Section 3106. State employees** Compliance with this chapter shall, as to state employees, be deemed full compliance with Government Code Section 3106 Title 2, Division 5, Part 1, Chapter 4, requiring taking of oaths by state employees.	**VII. Government Code Section 3106. State employees** Same as above (VI), to allow for post-disaster administrative requirements.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath	**VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath** No compensation nor reimbursement for expenses incurred shall be paid to any disaster service worker by any public agency unless such disaster service worker has taken and subscribed to the oath or affirmation required by this chapter. It shall be the duty of the person certifying to public payrolls to ascertain and certify that such disaster service worker has taken such oath or affirmation. Whenever there is more than one officer certifying to public payrolls the governing body of a city or county or school district may designate and make it the duty of a certain officer or officers to ascertain and certify that such disaster service worker has taken such oath or affirmation. The governing body of a city or county or school district may designate and make it the duty of a local disaster service officer to ascertain and certify that each volunteer disaster service worker has taken such oath or affirmation. Nothing in this chapter, however, shall prevent the correction of any technical error or deficiency in an oath taken pursuant to this chapter; provided, such correction is made before the disaster	**VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath** Same as above (VI), except to the extent federal funds are available subject to regrets under jurisdiction of the federal government. Careful assessment should be made to determine if securing oaths upon hiring or at some routine interval makes fiscal sense. (See applicable federal disaster funding statutes for requests).

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		service worker is actually paid or reimbursed.	
	IX. Government Code Section 3108. False Oath	**IX. Government Code Section 3108. False Oath** Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he or she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison for two, three, or four years.	**IX. Government Code Section 3108. False Oath** Waiver is not likely, though an option should it be necessary.
	X. Government Code Section 3109. Prohibited Membership	**X. Government Code Section 3109. Prohibited Membership** Every person having taken and subscribed to the oath or affirmation required by this chapter, who, while in the employ of, or service with, the state or any county, city, city and county, state agency, public district, or disaster council or emergency organization advocates or becomes a member of any party or organization, political or otherwise, that advocates the overthrow of the government of the United States by force or violence or other unlawful means, is guilty of a felony, and is punishable by imprisonment in the state prison.	**X. Government Code Section 3109. Prohibited Membership** Not applicable.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Disaster Emergency Planning - Disaster Councils Formation	**I. Labor Code Section 3211.9. Disaster Council Defined.** **II. Labor Code Section 3211.91. Accredited Disaster Council**	**I. Labor Code Section 3211.9. Disaster Council Defined.** "Disaster council" means a public agency established by ordinance which is empowered to register and direct the activities of disaster service workers within the area of the county, city, city and county, or any part thereof, and is thus, because of such registration and direction, acting as an instrumentality of the state in aid of the carrying out of the general governmental functions and policy of the state. **II. Labor Code Section 3211.91. Accredited Disaster Council** "Accredited disaster council" means a disaster council that is certified by the Office of Emergency Services as conforming with the rules and regulations established by the office pursuant to Government Code Section 8610, Title 2, Division 1, Chapter 7, Article 10. A disaster council remains accredited only while the certification of the Office of Emergency Services is in effect and is not revoked.	**I. Labor Code Section 3211.9. Disaster Council Defined.** Yes there is flexibility for this regulation by order of the Governor under the Disaster Services Act. To the extent localities have not pre-established Disaster Councils, but a disaster is in effect, this may require waiver by order of the Governor to ensure the downstream capabilities offered by the Disaster Services Act. **II. Labor Code Section 3211.91. Accredited Disaster Council** Yes, there is flexibility for this regulation by order of the Governor under the Disaster Services Act. To the extent localities have not pre-established Disaster Councils, but a disaster is in effect, this may require waiver by order of the Governor to ensure the downstream capabilities offered by the Disaster Services Act. In addition, assessment should be made to determine if accreditation is required to secure federal or other disaster funding.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Government Code Section 8610. Creation and Duties	**III. Government Code Section 8610. Creation and Duties** Counties, cities and counties, and cities may create disaster councils by ordinance. A disaster council shall develop plans for meeting any condition constituting a local emergency or state of emergency, including, but not limited to, earthquakes, natural or manmade disasters specific to that jurisdiction, or state of war emergency; such plans shall provide for the effective mobilization of all of the resources within the political subdivision, both public and private. The disaster council shall supply a copy of any plans developed pursuant to this section to the Office of Emergency Services. The governing body of a county, city and county, or city may, in the ordinance or by resolution adopted pursuant to the ordinance, provide for the organization, powers and duties, divisions, services, and staff of the emergency organization. The governing body of a county, city and county, or city may, by ordinance or resolution, authorize public officers, employees, and registered volunteers to command the aid of citizens when necessary in the execution of their duties during a state of war emergency, a state of emergency, or a local emergency.	**III. Government Code Section 8610. Creation and Duties** Yes, there is flexibility for this regulation, though flexibility is not required because this stature is affording permission authority to establish a disaster council by ordinance. Once established, though, flexibility may be required to the extent non-permissive request are met pre-disaster but required to secure other dependant.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Counties, cities and counties, and cities may enact ordinances and resolutions and either establish rules and regulations or authorize disaster councils to recommend to the director of the local emergency organization rules and regulations for dealing with local emergencies that can be adequately dealt with locally; and further may act to carry out mutual aid on a voluntary basis and, to this end, may enter into agreements.	
	IV. Government Code Section 8612. Accreditation	**IV. Government Code Section 8612. Accreditation** Any disaster council that both agrees to follow the rules and regulations established by the Office of Emergency Services pursuant to Government Code Section 8585.5 and substantially complies with those rules and regulations shall be certified by the office. Upon that certification, and not before, the disaster council becomes an accredited disaster council.	**IV. Government Code Section 8612. Accreditation** To the extent accreditation of a disaster council is necessary to secure other abilities or benefits, and such extent has not yet been assessed, waiver of this requirement is available to the Governor under his powers.
	V. Government Code Section 8613. Loss of Accreditation	**V. Government Code Section 8613. Loss of Accreditation** Should an accredited disaster council fail to comply with the rules and regulations of the Office of Emergency Services in any material degree, the office may	**V. Government Code Section 8613. Loss of Accreditation** Same as above (IV), but specific to the Office of Emergency Services authority to revoke accreditation.

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		revoke its certification and, upon the act of revocation, the disaster council shall lose its accredited status. It may again become an accredited disaster council in the same manner as is provided for a disaster council that has not previously been accredited.	
	VI. Government Code Section 8614. Local Assistance to Governor	**VI. Government Code Section 8614. Local Assistance to Governor** (a) Each department, division, bureau, board, commission, officer, and employee of each political subdivision of the state shall render all possible assistance to the Governor and to the Director of the Office of Emergency Services in carrying out the provisions of this chapter. (b) The emergency power which may be vested in a local public official during a state of war emergency or a state of emergency shall be subject or subordinate to the powers herein vested in the Governor when exercised by the Governor. (c) Ordinances, orders, and regulations of a political subdivision shall continue in effect during a state of war emergency or a state of emergency except as to any provision suspended or superseded by an order or regulation issued by the Governor.	**VI. Government Code Section 8614. Local Assistance to Governor** Waiver does not appear necessary (Government Code Section 8614. Local Assistance to Governor).

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	VII. 19 CCR 2570.2 - Definitions - Disaster Council	**VII. 19 CCR 2570.2 - Definitions - Disaster Council** (d) A disaster council is a public agency established by ordinance which is empowered to register and direct the activities of disaster service workers within the area of the county, city, city and county, or any part thereof. In this respect, the disaster council is acting as an instrument of the state in aid of carrying out general state government functions and policy with regard to disaster services. (e) Accredited Disaster Council. A disaster council may become accredited through certification by the California Emergency Council, or the Governor when the Emergency Council is not meeting, when the disaster council agrees to follow and comply with the rules and regulations established by the Emergency Council pursuant to the provisions of the Emergency Services Act. Upon certification, and not before, the disaster council becomes an accredited disaster council. A disaster council remains accredited only while the certification of the California Emergency Council is in effect and is not revoked.	**VII. 19 CCR 2570.2 - Definitions - Disaster Council** Waiver does not appear necessary, but to the extent flexibility is required, the Governor has authority to waiver under his executive powers.

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	VIII. 19 CCR 2571. Accredited Disaster Council.	**VIII. 19 CCR 2571. Accredited Disaster Council.** (a) Disaster councils shall be accredited in accordance with Government Code Sections 8581(b) or 8612. (b) When applying for accreditation, disaster councils shall furnish the Governor's Office of Emergency Services with a certified copy of the ordinance which has provided for the following: a) a disaster council; b) a Chairperson or director of the disaster council; c) an Emergency organization; and, d) compliance with the Emergency Services Act. The various classifications of disaster service workers and the general duties of the members of each classification shall be limited to those described below: (a) Animal Rescue, Care and Shelter. Veterinarians, veterinary support staff and animal handlers providing skills in the rescue, clinical treatment, and transportation of all animals, including but not limited to companion animals, livestock, poultry, fish, exhibition	

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		animals, zoo animals, laboratory and research animals, and wildlife; assisting in the procurement of shelters, equipment, and supplies; documenting arrival, sheltering, treatment, and discharge or placement of animals. (b) Communications. Install, operate and maintain various communications systems and perform related service, to assist officials and individuals in the protection of life and property. (c) Community Emergency Response Team Member. Under the direction of emergency personnel or a designated team leader, assist emergency units within their block, neighborhood, or other area assignment; survey area conditions; disseminate information; secure data desirable for emergency preparedness planning; report incidents; and generally assist officials and individuals in the protection of life and property. (d) Finance and Administrative Staff. Perform executive, administrative, technical, financial and clerical functions for the emergency organization. (e) Human Services. Assist in providing food, clothing, bedding, shelter, and rehabilitation aid; register evacuees to promote reuniting families and to support the needs of special populations; compile authoritative lists of deceased	

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		and missing persons; and other phases of emergency human services, such as maintaining morale and administering to the mental health, religious or spiritual needs of persons suffering from the effects of the disaster. (f) Fire. As auxiliary fire fighters or auxiliary wildland fire fighters, assist regular fire fighting forces or fire protection agencies to fight fire, rescue persons, and save property; control forest or wildland fires or fire hazards; instruct residents in fire prevention and property defense methods, methods of detecting fire, and precautions to be observed in reducing fire hazards. (1) For purposes of these regulations only, the ratios between auxiliary fire fighters, volunteer fire fighters, and paid fire fighters shall be one auxiliary for one volunteer and three volunteers for one paid fire fighter. The basis for applying these ratios is that the staffing of an engine company, truck company, or a squad shall not exceed six paid fire fighters, and a salvage and rescue company shall not exceed two paid fire fighters. A fire department that has no volunteer fire fighters is limited to three auxiliary fire fighters for each paid fire fighter in the companies and squads, staffed as above. These staffing standards are based on the number of first line (not reserve) apparatus	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		operated by the fire department. (2) When auxiliary fire fighters are registered with other than an established fire service organization; for example, auxiliary fire fighters in a county or city emergency management services organization, a total number of eligible auxiliary fire fighters shall be computed for that city or unincorporated area. The emergency management services organization is entitled to register auxiliary fire fighters not otherwise registered with other established fire service organizations, and to a number not to exceed the allowable total as indicated in 19 CCR Section 2572.1(f)(1), above. (g) Laborer. Under the direction and supervision of the responding agency, performs general labor services and supports emergency operations. (h) Law Enforcement. As Auxiliaries, assist law enforcement officers and agencies to protect life and property; maintain law and order; perform traffic control duties; guard buildings, bridges, factories, and other facilities; isolate and report unexploded ordnance. (i) Logistics. Under the direction of the emergency organization, assist in procurement, warehousing, and release of supplies, equipment materials, or other resources. Assist in mobilization and utilization of public and private	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		transportation resources required for the movement of persons, materials, and equipment. (j) Medical and Environmental Health. Staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations; maintain or restore environmental sanitation; assist in preserving the safety of food, milk, and water and preventing the spread of disease; perform laboratory analysis to detect the presence and minimize the effects of nuclear, chemical, biological, radiological or other hazardous agents. (k) Safety Assessment Inspector. Survey, evaluate and assess damaged facilities for continued occupancy or use; assist in emergency restoration of facilities for utilities, transportation, and other vital community services; and provide recommendations regarding shoring or stabilization of damaged or unsafe buildings or structures. (l) Search and Rescue. Under the direction of the appropriate authority, perform search and rescue operations in one or more of several areas including: search and rescue; urban search and rescue; or mine and confined space rescue. (m) Utilities. Assist utility personnel in the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		repair and restoration of public utilities damaged by disaster.	
Disaster Service Workers - Public Employees, Oaths and Compensation	**I. Government Code Section 3100. Public Employees as Disaster Service Workers**	**I. Government Code Section 3100. Public Employees as Disaster Service Workers** It is hereby declared that the protection of the health and safety and preservation of the lives and property of the people of the state from the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and resources is of paramount state importance requiring the responsible efforts of public and private agencies and individual citizens. In furtherance of the exercise of the police power of the state in protection of its citizens and resources, all public employees are hereby declared to be disaster service workers subject to such disaster service activities as may be assigned to them by their superiors or by law.	**I. Government Code Section 3100. Public Employees as Disaster Service Workers** Flexibility does not appear to be necessary.
	II. Government Code Section 3101. Definitions	**II. Government Code Section 3101. Definitions** Government Code Section 3101. For the purpose of this chapter the term "disaster service worker" includes all public employees and all volunteers in	**II. Government Code Section 3101. Definitions** Yes, flexibility exists for this regulation by the Governor under his executive authority, and by his powers under the Emergency Services Act. It may be

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		any disaster council or emergency organization accredited by the California Emergency Council. The term "public employees" includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed.	desirable to have a waiver as to compensate persons providing services during a disaster, to invoke other benefits and protections to employees that are available to Disaster Service Workers.
	III. Government Code Section 3102.	**III. Government Code Section 3102.** (a) All disaster service workers shall, before they enter upon the duties of their employment, take and subscribe to the oath or affirmation required by this chapter. (b) In the case of intermittent, temporary, emergency or successive employments, then in the discretion of the employing agency, an oath taken and subscribed as required by this chapter shall be effective for the purposes of this chapter for all successive periods of employment which commence within one calendar year from the date of that subscription. (c) Notwithstanding Government Code Section 3102 (b), the oath taken and subscribed by a person who is a member of an emergency organization sanctioned by a state agency or an accredited disaster council, whose members are duly enrolled or registered with the Office of Emergency Services,	**III. Government Code Section 3102.** Yes, flexibility for this regulation exists by the Governor under his executive authority, and by his powers under the Emergency Services Act. Given the unknown nature of a disaster, waiver may be necessary to eliminate until post-disaster, the administrative request not necessary to respond to the actual disaster.

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		or any accredited disaster council of any political subdivision, shall be effective for the period the person remains a member with that organization.	
	IV. Government Code Section 3103. Constitutional Oath.	**IV. Government Code Section 3103. Constitutional Oath.** The oath or affirmation required by this chapter is the oath or affirmation set forth in Section 3 of Article XX of the Constitution of California.	**IV. Government Code Section 3103. Constitutional Oath.** Waiver not necessary as it addresses the oath process.
	V. Government Code Section 3104. Administration of Oath	**V. Government Code Section 3104. Administration of Oath** The oath or affirmation may be taken before any officer authorized to administer oaths. The oath or affirmation of any disaster service worker may be taken before his appointing power or before any person authorized in writing by his appointing power. No fee shall be charged by any person before whom the oath or affirmation is taken and subscribed.	**V. Government Code Section 3104. Administration of Oath** Waiver not necessary as it addresses the oath process.

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	VI. Government Code Section 3105. Filing of Oath	**VI. Government Code Section 3105. Filing of Oath** (a) The oath or affirmation of any disaster service worker of the state shall be filed as prescribed by State Personnel Board rule within 30 days of the date on which it is taken and subscribed. (b) The oath or affirmation of any disaster service worker of any county shall be filed in the office of the county clerk of the county or in the official department personnel file of the county employee who is designated as a disaster service worker. (c) The oath or affirmation of any disaster service worker of any city shall be filed in the office of the city clerk of the city. (d) The oath or affirmation of any disaster service worker of any other public agency, including any district, shall be filed with any officer or employee of the agency that may be designated by the agency. (e) The oath or affirmation of any disaster service worker may be destroyed without duplication five years after the termination of the disaster service worker's service or, in the case of a public employee, five years after the	**VI. Government Code Section 3105. Filing of Oath** Yes, flexibility for this regulation exists by the Governor under his executive authority, and by his powers under the Emergency Services Act. Given the unknown nature of a disaster, waiver may be necessary to eliminate until post-disaster, the administrative request not necessary to respond to the actual disaster.

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		termination of the employee's employment.	
	VII. Government Code Section 3106. State employees	**VII. Government Code Section 3106. State employees** Compliance with this chapter shall, as to state employees, be deemed full compliance with Chapter 4, Part 1, Division 5, Title 2 of Government Code Section 3106, requiring taking of oaths by state employees.	**VII. Government Code Section 3106. State employees** Yes, flexibility for this regulation exists by the Governor under his executive authority, and by his powers under the Emergency Services Act. Given the unknown nature of a disaster, waiver may be necessary to eliminate until post-disaster, the administrative request not necessary to respond to the actual disaster.
	VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath	**VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath** No compensation nor reimbursement for expenses incurred shall be paid to any disaster service worker by any public agency unless such disaster service worker has taken and subscribed to the oath or affirmation required by this chapter. It shall be the duty of the person certifying to public payrolls to ascertain and certify that such disaster service worker has taken such oath or affirmation. Whenever there is more than one officer certifying to public payrolls the governing body of a city or county or	**VIII. Government Code Section 3107. Reimbursement Prohibited Absent Oath** Yes, flexibility for this regulation exists per authority of the Governor. Given the unknown nature of a disaster, waiver may be necessary to eliminate until post-disaster, the administrative request not necessary to respond to the actual disaster. Note that this subdivision allows for correction of technical errors, which must be made prior to paying or reimbursing a Disaster Service Worker.

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		school district may designate and make it the duty of a certain officer or officers to ascertain and certify that such disaster service worker has taken such oath or affirmation. The governing body of a city or county or school district may designate and make it the duty of a local disaster service officer to ascertain and certify that each volunteer disaster service worker has taken such oath or affirmation. Nothing in this chapter, however, shall prevent the correction of any technical error or deficiency in an oath taken pursuant to this chapter; provided, such correction is made before the disaster service worker is actually paid or reimbursed.	
	IX. Government Code Section 3108. False Oath	**IX. Government Code Section 3108. False Oath** Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he or she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison for two, three, or four years.	**IX. Government Code Section 3108. False Oath** Not necessary or likely to be waived.

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	X. Government Code Section 3109. Prohibited Membership	**X. Government Code Section 3109. Prohibited Membership** Every person having taken and subscribed to the oath or affirmation required by this chapter, who, while in the employ of, or service with, the state or any county, city, city and county, state agency, public district, or disaster council or emergency organization advocates or becomes a member of any party or organization, political or otherwise, that advocates the overthrow of the government of the United States by force or violence or other unlawful means, is guilty of a felony, and is punishable by imprisonment in the state prison.	**X. Government Code Section 3109. Prohibited Membership** Not necessary or likely to be waived.
Augmenting staffing needed during an emergency: Operation of Medical Reserve Corps, Non-licensed Federal Employees	**I. Medical Reserve Corps** **http://www.medicalreservecorps.org**	**I. Medical Reserve Corps; http://www.medicalreservecorps.org** The Medical Reserve Corps program was created after President Bush's 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. The Medical Reserve Corps is comprised of organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. These volunteers assist communities nationwide during emergencies and for ongoing efforts in public health.	**I. Medical Reserve Corps; http://www.medicalreservecorps.org** The Medical Reserve Corps is a federal program to register healthcare professionals, under the control of the federal government. Waiver or flexibility appears not to be necessary. Pre-planning local communications with outside resources including disaster volunteers would be beneficial pre-disaster, and could be crucial during the acute phase of a disaster. Many States have disaster volunteer registrations programs and information on the internet. There are also template mutual aid agreements available on the internet for

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		The need for trained supplemental medical and public health personnel to assist with emergency operations was highlighted after the terrorist attacks of September 11, 2001. Many medical and public health professionals sought to support emergency relief efforts, but there was no organized approach to channel their efforts. The Medical Reserve Corps program provides the structure necessary to deploy medical and public health personnel in response to an emergency, as it identifies specific, trained, credentialed personnel available and ready to respond to emergencies. There is no "typical" Medical Reserve Corps unit. Each unit organizes in response to their area's specific needs. A region's hazard threats, health concerns, and the organization in which the unit is established (health department, faith-based organization, etc.), will dictate what an Medical Reserve Corps "looks like." With community resources and partners that span a spectrum from local voluntary organizations to private corporations, the "face" of each Medical Reserve Corps community is unique. However, the goals of the Medical Reserve Corps are similar; units work toward bettering their local area's public health infrastructure and strengthening their response capabilities in the event of an	guides to tailor locality or facility specific mutual aid agreements.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		emergency. The differences exist in how each community reaches these goals.	
	II. California statutes on Mutual Aid Agreements http://www.pdhealth.mil/reservist/ downloads/GuideForLocalLeaders.pdf	**II. California statutes on Mutual Aid Agreements. http://www.pdhealth.mil/reservist/ downloads/GuideForLocalLeaders.pdf** How a local Medical Reserve Corps unit is utilized will be decided locally. If an emergency situation arises that indicates the need for a local Medical Reserve Corps unit to play a role, the decision to activate the Medical Reserve Corps unit will be made locally. The Medical Reserve Corps unit will decide, preferably in cooperation with appropriate local officials, if and when to activate its members to work to improve public health in the community.	**II. California statutes on Mutual Aid Agreements http://www.pdhealth.mil/reservist/ downloads/GuideForLocalLeaders.pdf** The Medical Reserve Corps is a federal program to register healthcare professionals, under the control of the federal government. Waiver or flexibility appears not to be necessary. Pre-planning local communications with outside resources including disaster volunteers would be beneficial pre-disaster, and could be crucial during the acute phase of a disaster. Many States have disaster volunteer registrations programs and information on the internet. There are also template mutual aid agreements available on the internet for guides to tailor locality or facility specific mutual aid agreements.

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	III. Business and Professions Code Section 715. Practice by Non-licensed Federal Employees	**III. Business and Professions Code Section 715. Practice by Non-licensed Federal Employees** Unless otherwise required by federal law or regulation, no board under this division which licenses dentists, physicians and surgeons, podiatrists, or nurses may require a person to obtain or maintain any license to practice a profession or render services in the State of California if one of the following applies: (a) The person practicing a profession or rendering services does so exclusively as an employee of a department, bureau, office, division, or similarly constituted agency of the federal government, and provides medical services exclusively on a federal reservation or at any facility wholly supported by and maintained by the United States government. (b) The person practicing a profession or rendering services does so solely pursuant to a contract with the federal government on a federal reservation or at any facility wholly supported and maintained by the United States government. (c) The person practicing a profession or	**III. Business and Professions Code Section 715. Practice by Non-licensed Federal Employees** Yes, there is flexibility for this regulation per authority of the Governor. This provision may play a critical component in expanding the pool of listed healthcare providers to those in the military.

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		rendering services does so pursuant to, or as a part of a program or project conducted or administered by a department, bureau, office, division, or similarly constituted agency of the federal government which by federal statute expressly exempts persons practicing a profession or rendering services as part of the program or project from state laws requiring licensure.	
	IV. Business and Professions Code Section 718. Practice by Non-licensed Commissioned Active Duty Officer of Military	**IV. Business and Professions Code Section 718. Practice by Non-licensed Commissioned Active Duty Officer of Military** A physician and surgeon who is not licensed in this state but who is a commissioned officer on active duty in the medical corps of any branch of the armed forces of the United States may engage in the practice of medicine as part of a residency, fellowship, or clinical training program if all the following conditions are met: (a) The residency, fellowship, or clinical training program is conducted by a branch of the armed forces of the United States at a health facility on a federal reservation and limited in enrollment to military physicians on active duty in the medical corps of a branch of the armed	**IV. Business and Professions Code Section 718. Practice by Non-licensed Commissioned Active Duty Officer of Military** Yes, there is flexibility for this regulation per authority of the Governor. This provision may play a critical component in expanding the pool of listed healthcare providers to those physicians still in residency or fellowship training.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		forces of the United States. (b) The residency, fellowship, or clinical training program, as part of its program, contracts with or affiliates with a similar program in or at a health facility not on a federal reservation to offer specific courses or training not available at the facility located on the federal reservation. (c) The officers enrolled in the residency, fellowship, or clinical training program restrict their practice only to patients who are seen as part of their duties in the program. (d) The compensation received by the officers enrolled in the residency, fellowship, or clinical training program is limited to their regular pay and allowances as commissioned officers. (e) The officers enrolled in the training programs or portions of training programs not conducted on a federal reservation shall register with the Division of Licensing of the Medical Board of California on a form provided by the division.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. Business and Professions Code Section 922. Licensing of Physician with Expired License	**V. Business and Professions Code Section 922. Licensing of Physician with Expired License** (a) A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter. (b) To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board, along with the following: (1) Documentation that the applicant has completed the continuing education requirements described in Business and Professions Code Section 2190, Chapter 5, Article 10 for each renewal period during which the applicant was not licensed. (2) A complete set of fingerprints as required by Business and Professions Code Sections 144 and 2082, together with the fee required for processing those fingerprints. (c) An applicant shall not be required to	**V. Business and Professions Code Section 922. Licensing of Physician with Expired License** Yes, there is flexibility for this regulation by executive authority of the Governor and under the Emergency Services Act. Flexibility or waiver of the administrative requirement may facilitate use of recently retired physicians during the acute phase of a disaster.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		pay any licensing, delinquency, or penalty fees for the issuance of a license under this chapter.	
Can staff (licensed and unlicensed professionals) be required to work during a disaster, or in conditions (workplace, hours or safety) not in compliance with current standards?	**I. California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10)**	**I. California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10)** No employee assigned to work a 12-hour shift established pursuant to this order shall be required to work more than 12 hours in any 24-hour period unless the chief nursing officer or authorized executive declares that: • A "healthcare emergency", as defined above, exists in this order; and • All reasonable steps have been taken to provide required staffing; and • Considering overall operational status needs, continued overtime is necessary to provide required staffing. Provided further that no employee shall be required to work more than 16 hours in a 24-hour period unless by voluntary mutual agreement of the employee and the employer, and no employee shall work more than 24 consecutive hours until said employee receives not less	**I. California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10)** All statutes and regulations are subject to modification or waiver under the Governors executive Powers during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		than eight (8) consecutive hours off duty immediately following the 24 consecutive hours of work. Notwithstanding California Industrial Welfare Commission Order No. 4-2001, 3(B)(9), an employee may be required to work up to 13 hours in any 24-hour period if the employee scheduled to relieve the subject employee does not report for duty as scheduled and does not inform the employer more than two (2) hours in advance of that scheduled shift that he/she will not be appearing for duty as scheduled.	
	II. (b) 29 USC Section 654	**II. 29 USC Section 654** (a) Each employer– (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees; (2) shall comply with occupational safety and health standards promulgated under this Act. (b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are	**II. 29 USC Section 654** These provisions of federal law are essentially identical to the provisions of Labor Code Section 6400. Although the Governor could waive the Labor Code provisions, the state cannot waive the provisions of the federal law. Although the U.S. Department of Labor could elect not to enforce these provisions in disaster situations, it is unclear that the requirements can be suspended. However, it should also be noted that disaster service workers, whether volunteers, public employees or impressed into service, have no claim against the public agencies for which they serve.

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		applicable to his own actions and conduct. Occupational Safety and Health Administration requires under its general duty clause that employers protect employees from known dangers.	
Can staff be commandeered and reallocated from an unaffected area and transferred to an affected area?	**I. Government Code Section 8572**	**I. Government Code Section 8572** In the exercise of the emergency powers hereby vested in him during a state of war emergency or state of emergency, the Governor is authorized to commandeer or utilize any private property or personnel deemed by him necessary in carrying out the responsibilities hereby vested in him as Chief Executive of the state and the state shall pay the reasonable value thereof. Notwithstanding the provisions of this section, the Governor is not authorized to commandeer any newspaper, newspaper wire service, or radio or television station, but may, during a state of war emergency or state of emergency, and if no other means of communication are available, utilize any news wire services, and the state shall pay the reasonable value of such use. In so utilizing any such facilities, the Governor shall interfere as little as possible with their use for the transmission of news.	**I. Government Code Section 8572** Yes, there is flexibility for this regulation by order of the Governor during a state of emergency. Commandeering personnel requires the state to pay reasonable compensation. What will be the basis for determining what is reasonable remains to be determined. Also, it is unclear whether commandeering personnel would afford the protection offered to Disaster Service Workers.

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What are the current precedents and guidelines related to required use of personal protective equipment and mandated vaccinations or quarantines for personnel?	**I. Speier Bill 739, codified at Health and Safety Code Section 1288.5**	**I. Speier Bill 739, codified at Health and Safety Code Section 1288.5** The bill would establish the Hospital Infectious Disease Control Program, which would require the State Department of Public Health of health facilities and general acute care hospitals implement various measures relating to disease surveillance and the prevention of healthcare associated infection. By July 1, 2007, the acute care hospitals need to take the following actions: (1) Annually offer on-site influenza vaccines to all employees (2) Institute respiratory hygiene and cough etiquette protocols, develop and implement isolation procedures for influenza patients, and adopt a seasonal influenza plan (3) Revise existing or develop a new disaster plan that includes a pandemic influenza component. The plan should include any actual or recommended collaboration with local, regional and state public health agencies in the event of an influenza pandemic By January 1, 2008, the following actions should be taken by the state department: (1) Implement an healthcare associated infection surveillance and prevention program designed to assess the department's resource needs, educate health facility evaluator nurses in	**I. Speier Bill 739, codified at Health and Safety Code Section 1288.5** Yes, there is flexibility for this regulation. This law requires hospitals to provide for example, flu vaccinations to all employees. The various requirements under this statute, some of which are not yet effective, are subject to waiver by the Governor by his authority in a state of emergency.

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		healthcare associated infections and educate department staff on methods of implementing recommendations for disease prevention (2) Investigate the development of electronic reporting databases (3) Revise existing and adopt new administrative regulations as necessary (4) Require that hospitals develop a process for evaluating the judicious use of antibiotics	
	II. Health and Safety Code Section 120175 - 120250	**II. Health and Safety Code Section 120175 - 120250** Health and Safety Code Section120195. Each health officer shall enforce all orders, rules, and regulations concerning quarantine or isolation prescribed or directed by the department. Health and Safety Code Section 120200. Each health officer, whenever required by the department, shall establish and maintain places of quarantine or isolation that shall be subject to the special directions of the department. Health and Safety Code Section 120205. No quarantine shall be established by a county or city against another county or city without the written consent of the department. Health and Safety Code Section 120210. Whenever in the judgment of the department it is necessary for the	**II. Health and Safety Code Section 120175 - 120250** Yes, there is flexibility for this regulation. This and other quarantine related statutes are subject to waiver by the Governor, and may be subject to waiver by the CDPH authority. By delegation of the government locality, the Local Health Office may execute quarantine orders in addition to enforcing them under this statute.

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		protection or preservation of the public health, each health officer shall, when directed by the department, do the following: (a) Quarantine or isolate and disinfect persons, animals, houses or rooms, in accordance with general and specific instructions of the department. (b) Destroy bedding, carpets, household goods, furnishings, materials, clothing, or animals, when ordinary means of disinfection are considered unsafe, and when the property is, in the judgment of the department, an imminent menace to the public health. When the property is destroyed pursuant to this section, the governing body of the locality where the destruction occurs may make adequate provision for compensation in proper cases for those injured thereby. Health and Safety Code Section 120215. Upon receiving information of the existence of contagious, infectious, or communicable disease for which the department may from time to time declare the need for strict isolation or quarantine, each health officer shall: (a) Ensure the adequate isolation of each case, and appropriate quarantine of the contacts and premises. (b) Follow local rules and regulations, and all general and special rules, regulations, and orders of the department, in carrying out the quarantine or isolation. Health and Safety Code Section 120220.	

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		When quarantine or isolation, either strict or modified, is established by a health officer, all persons shall obey his or her rules, orders, and regulations. Health and Safety Code Section 120225. A person subject to quarantine or strict isolation, residing or in a quarantined building, house, structure, or other shelter, shall not go beyond the lot where the building, house, structure, or other shelter is situated, nor put himself or herself in immediate communication with any person not subject to quarantine, other than the physician, the health officer or persons authorized by the health officer. Health and Safety Code Section 120230. No instructor, teacher, pupil, or child who resides where any contagious, infectious, or communicable disease exists or has recently existed, that is subject to strict isolation or quarantine of contacts, shall be permitted by any superintendent, principal, or teacher of any college, seminary, or public or private school to attend the college, seminary, or school, except by the written permission of the health officer. Health and Safety Code Section 120235. No quarantine shall be raised until every exposed room, together with all personal property in the room, has been adequately treated, or, if necessary,	

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		destroyed, under the direction of the health officer; and until all persons having been under strict isolation are considered noninfectious.	
	III. Health and Safety Code Section 120140 Necessary Measures	**III. Health and Safety Code Section 120140 Necessary Measures** Health and Safety Code Section 120140 Upon being informed by a health officer of any contagious, infectious, or communicable disease the department may take measures as are necessary to ascertain the nature of the disease and prevent its spread. To that end, the department may, if it considers it proper, take possession or control of the body of any living person, or the corpse of any deceased person.	**III. Health and Safety Code Section 120140 Necessary Measures** Yes, there is flexibility for this regulation by authority of the Governor in a state of emergency.
	IV. Government Code Section 202. Authority of State to Confine	**IV. Government Code Section 202. Authority of State to Confine** The state may imprison or confine for the protection of the public peace or health or of individual life or safety.	**IV. Government Code Section 202. Authority of State to Confine** Yes, there is flexibility for this regulation by authority of the Governor in a state of emergency.

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	V. Health and Safety Code Section 120135 Places of Quarantine	**V. Health and Safety Code Section 120135 Places of Quarantine** The department may establish and maintain places of quarantine or isolation.	**V. Health and Safety Code Section 120135 Places of Quarantine** Yes, there is flexibility for this regulation by authority of the Governor in a state of emergency.
	VI. Health and Safety Code Section 120145. Authority to Quarantine and Disinfect	**VI. Health and Safety Code Section 120145. Authority to Quarantine and Disinfect** The department may quarantine, isolate, inspect, and disinfect persons, animals, houses, rooms, other property, places, cities, or localities, whenever in its judgment the action is necessary to protect or preserve the public health.	**VI. Health and Safety Code Section 120145. Authority to Quarantine and Disinfect** Health and Safety Code Sections 120140 and 120150 give CDPH broad authority to take whatever action, including as to persons, necessary to protect or preserve the public place. It is unclear whether this includes the temporary flexing or waiving existing requirements within its jurisdiction, but it is conceivable that should such flexibility be necessary to protect or preserve the public health, it may be appropriate. Otherwise, as with all other statutes and regulations, the Governor has authority, under a state of emergency.

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	VII. Health and Safety Code Section 120150. Destruction of Property	**VII. Health and Safety Code Section 120150. Destruction of Property** The department may destroy such objects as bedding, carpets, household goods, furnishings, materials, clothing, or animals, when ordinary means of disinfection are considered unsafe, and when the property is in its judgment, an imminent menace to the public health.	**VII. Health and Safety Code Section 120150. Destruction of Property** This provision authorizes the Department of Public Health to destroy personal property in the event it cannot be safely or adequately disinfected. It is not relevant to the issue under consideration.
What are the current standards for mandated support services available to staff and dependents during a surge/disaster? a. mental healthcare b. dependent care c. food, shelter, clothing d. pet care	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, 2007, Environment of Care 4.10**	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, 2007, Environment of Care 4.10** Standard: The hospital addresses emergency management. Rationale: An emergency in the hospital or its community could suddenly and significantly affect the need for the hospital's services or its ability to provide those services. Therefore, a hospital needs to have an emergency management plan that comprehensively describes its approach to emergencies in the hospital or in its community. Element of Performance (#10) 10. The plan provides processes for	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, 2007, Environment of Care 4.10** There are no legal requirements for the provision of support to staff or dependents during an emergency.

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		managing the following under emergency conditions: _ Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients) _ Staff support activities (for example, housing, transportation, incident stress debriefing) _ Staff family support activities Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water) _ Security (for example, access, crowd control, traffic control) _ Communication with the news media	
Can staffing ratios be flexed during a disaster?	**I. 22 CCR Section 70217(q)**	**I. 22 CCR Section 70217(q)** A process is in place to allow for the nurse-to-patient ratios to be suspended, assuming that a hospital can demonstrate that efforts were made to maintain the required staffing levels. 22 CCR Section 70217(q). The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is	**I. 22 CCR Section 70217(q)** Yes, CDPH has general flexibility authority. This regulation is also subject to waiver by the Governor during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical intervention and care.	
	II. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23	**II. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23** No guidance could be found as to how the hospitals are to provide this type of documentation. Nor could it be found what the "triggers" are that can set this process in motion. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals Section 482.23 Condition of participation: Nursing services. The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. (a) Standard: Organization. The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the	**II. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23** Yes, there is flexibility for this regulation but because this is a federal statute, it must be waived by the Secretary of Health and Human Services or the Assistant Secretary for Preparedness and Response.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. (b) Standard: Staffing and delivery of care. The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. (1) The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times, except for rural hospitals that have in effect a 24-hour nursing waiver granted under Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals Section 405.1910(c). (2) The nursing service must have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10** Under Joint Commission standards, a hospital should provide an adequate number and mix of staff consistent with the hospital's staffing plan. Additionally, the hospital's plan should encompass the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations, for example, postanesthesia care unit and emergency department areas. This includes the nurse staffing plan. *HR.1.10*. Standard: The hospital provides an adequate number and mix of staff consistent with the hospital's staffing plan. Rationale: An organization must provide appropriate types and numbers of qualified staff necessary to furnish the care, treatment, and services offered by the organization. This can be done either through traditional employer–employee arrangements or through contractual arrangements. See the "Nursing" chapter for additional information regarding the provision of nursing care services.	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.10, LD.3.15, NR.3.10** Joint Commission requires hospitals to address care, flow of patient care and staffing under disaster surge circumstances. It does not provide any formal procedure for doing so, nor does it make any commitment to suspend accreditation requirements during a disaster.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Elements of Performance: The hospital has an adequate number and mix of staff to meet the care, treatment, and service needs of the patients. *LD.3.15*. Standard: The leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital. Rationale: Managing the flow of patients through the hospital is essential to the prevention and mitigation of patient crowding, a problem that can lead to lapses in patient safety and quality of care. The emergency department is particularly vulnerable to experiencing negative effects of inefficiency in the management of this process. While emergency departments have little control over the volume and type of patient arrivals and most hospitals have lost the "surge capacity" that existed at one time to manage the elastic nature of emergency admissions, other opportunities for improvement do exist. Overcrowding has been shown to be primarily a hospitalwide "system problem" and not just a problem for which a solution resides within the emergency department. Opportunities for improvement often exist outside the emergency department. This standard emphasizes the role of assessment and planning for effective and efficient patient flow throughout the hospital. To	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		understand the system implications of the issues, leadership should identify all of the processes critical to patient flow through the hospital system from the time the patient arrives, through admitting, patient assessment and treatment, and discharge. Supporting processes such as diagnostic, communication, and patient transportation are included if identified by leadership as impacting patient flow. Relevant indicators are selected and data is collected and analyzed to enable monitoring and improvement of processes. A key component of the standard addresses the needs of admitted patients who are in temporary bed locations awaiting an inpatient bed. Twelve key elements of care have been identified to ensure adequate and appropriate care for admitted patients in temporary locations. These elements have implications across the hospital and should be considered when planning care and services for these patients. Planning should also address the delivery of adequate care and services to those patients for whom no decision to admit has been made, but who are placed in overflow locations for observation or while awaiting completion of their evaluation. Additionally, the standard calls for indicator results to be made available to	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		those individuals who are accountable for processes that support patient flow. These results should be regularly reported to leadership to support their planning. The hospital should improve inefficient or unsafe processes identified by leadership as essential in the efficient movement of patients through the hospital. Criteria should be defined to guide decisions about ambulance diversion. Elements of Performance: 1. Leaders assess patient flow issues within the hospital, the impact on patient safety, and plan to mitigate that impact. 2. Planning encompasses the delivery of appropriate and adequate care to admitted patients who must be held in temporary bed locations, for example, postanesthesia care unit and emergency department areas. 3. Leaders and medical staff share accountability to develop processes that support efficient patient flow. 4. Planning includes the delivery of adequate care, treatment, and services to non-admitted patients who are placed in overflow locations. 5. Specific indicators are used to measure components of the patient flow process and address the following: Available supply of patient bed space. Efficiency of patient care, treatment, and service areas. Safety of patient care, treatment, and service areas. Support	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		service processes that impact patient flow. 6. Indicator results are available to those individuals who are accountable for processes that support patient flow. 7. Indicator results are reported to leadership on a regular basis to support planning. 8. The hospital improves inefficient or unsafe processes identified by leadership as essential to the efficient movement of patients through the hospital. 9. Criteria are defined to guide decisions about initiating diversion. *NR.3.10.* Standard: The nurse executive establishes nursing policies and procedures, nursing standards, and a nurse staffing plan(s). Elements of Performance: 1. The nurse executive, registered nurses, and other designated nursing staff members write nursing policies and procedures; nursing standards of patient care, treatment, and services; standards of nursing practice; a nurse staffing plan(s); and standards to measure, assess, and improve patient outcomes. 2. The nurse executive is responsible for ensuring that nursing policies, procedures, and standards describe and guide how the nursing staff provides the nursing care, treatment, and services required by all patients and patient populations served by the hospital and as defined in the hospital's plan(s) for	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		providing nursing care, treatment, and services and as required by applicable law and regulation. 3. All nursing policies, procedures, and standards are defined, documented, and accessible to the nursing staff in written or electronic format. 4. The nurse executive or a designee(s) exercises final authority over those associated with providing nursing care, treatment, and services.	
	IV. Health and Safety Code Section 1276.4(l)	**IV. Health and Safety Code Section 1276.4(l)** The department may take into consideration the unique nature of the University of California teaching hospitals as educational institutions when establishing licensed nurse-to-patient ratios. The department shall coordinate with the Board of Registered Nursing to ensure that staffing ratios are consistent with the Board of Registered Nursing approved nursing education requirements. This includes nursing clinical experience incidental to a work-study program rendered in a University of California clinical facility approved by the Board of Registered Nursing provided there will be sufficient direct care registered nurse preceptors available to ensure safe patient care.	**IV. Health and Safety Code Section 1276.4(l)** Yes, there is flexibility for this regulation but specific to rural or university hospitals. Flexing as per other types of licensed facilities depends on the type of unit and flexibility regulations specific to that facility type. In addition, the Governor may waive or flex any statute or regulation during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Can healthcare facility employees be forced to have return to work examinations	**I. 8 CCR 9776.1. Return to Work Coordination.**	**I. 8 CCR 9776.1. Return to Work Coordination.** Employer's generally require some type of return to work release with limitations and/or accommodations defined before returning an employee to work. This can be obtained from the workers compensation approved physician. 8 CCR 9776.1 - A healthcare organization shall maintain a return to work program in conjunction with the employer and claims administrator to facilitate and coordinate returning injured workers to the workplace, to assess the feasibility and availability of modified work or modified duty, and to minimize risk of employee exposure after return to work to risk factors which may aggravate or cause recurrence of injury. The duties of the healthcare organization shall be specified in the contract between the healthcare organization and the claims administrator.	**I. 8 CCR 9776.1. Return to Work Coordination.** Yes, there is flexibility for this regulation by authority of the Governor under the Emergency Services Act.
	II. Workers' compensation final regulations Return to work 8 CCR 10001 - 10003	**II. Workers' compensation final regulations Return to work 8 CCR 10001 - 10003** An injured worker should return to work as soon as it is medically feasible. If the injured worker is unable to immediately engage in his/her usual occupation, the	**II. Workers' compensation final regulations Return to work 8 CCR 10001 - 10003** Yes, there is flexibility for this regulation, but this action and authority will probably not be necessary as in most likelihood, workplace injuries and the requirement of a return-to-work examination will occur

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		injured worker should be returned to modified or alternative work, provided that the work can be practically accommodated by the employer. The treating or evaluating physician should recommend appropriate and specific work restrictions.	post-disaster.
What is the process and criteria for credentialing/privileging healthcare workers (emergency privileging and verification of credentials in California) and how will this process be different in a surge emergency for: • interstate, intrastate and international medical and allied healthcare professionals;	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5**	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** California law qualifies out-of-state licensed professionals to work in California, within scope of practice or licensure. Based on the requirement for hospitals to have Compliance programs, hospitals should have a mechanism in place for background checks. This applies to entities with compliance requirements Individuals not employed by an entity that has compliance requirements will not necessarily have background checks. Government Code Section 178 Article 4. Whenever any person holds a license, certificate or other permit issued by any state evidencing the meeting of qualifications for professional, mechanical or other skills, such person may render aid involving such skill in any party state to meet an emergency or	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** Credentialing and privileging responsibilities are held by the facility, and also the panel of providers held by the payer. During a disaster, certain streamlined accommodations may be invoked under a state of emergency. In addition, existing law recognizes the licensure, credentialing or permit held by a healthcare professional as evidence of qualifications to provide disaster assistance within the scope of service of the provider or healthcare professional. This is part of the Mutual Aid Compact.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		disaster and such state shall give due recognition to such license, certificate or other permit as if issued in the state in which aid is rendered.	
	II. Emergency Management Assistance Compact Government Code Section 179-179.9	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** Yes, there is flexibility for this regulation. By order of the Governor, subject to limitation, this provision provides deemed recognition to healthcare professionals holding a current license, certificate, or other permit issued by another state that is part of the Mutual Aid Compact. By virtue of this deemed status as a licensed healthcare professional, out-of-state volunteers may assist during a disaster without the administrative delay required to verify qualifications of the healthcare professional.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners. Rationale for MS.4.110: When the disaster plan has been implemented (*see* standard Environment of Care 4.10 for a description of emergency management planning requirements) and the immediate needs of the patients [individual or group] cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (*see* EPs 5–8). The usual process to credential and privilege healthcare professionals would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are not independent practitioners exists at standard HR.1.25. While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** Joint Commission requires hospitals to address care, flow of patient care, and staffing under disaster surge circumstances. It does not provide any formal procedure for doing so, nor does it make any commitment to suspend accreditation requirements during a disaster. Given this allowance, flexibility or waiver is not required. Still, hospital providers retain the obligation to verify competency and maintain oversight of the healthcare professionals and care delivered. If primary source verification cannot be verified within 72 hours from the healthcare professional presenting to the provider, the provider must keep records of why it could not under the circumstances do the required verification check.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained: 1. Verification of licensure 2. Oversight of the care, treatment, and services provided. This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a disaster. Examples of such systems include the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals. It is expected that additional programs will emerge and evolve. Elements of Performance for MS.4.110 1. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. 2. As described in the bylaws, the individual(s) responsible for granting disaster	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		privileges is identified. 3. The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges. 4. The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges. 5. In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: A current picture hospital identification card that clearly identifies professional designation. A current license to practice. Primary source verification of the license. Identification indicating that the individual is a member of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		federal, state, or municipal entity). Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Note*: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges*. 7. The medical staff oversees the professional practice of volunteer licensed independent practitioners. 8. The organization makes	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.	
	IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899** Model Compliance Program for Hospitals states ":… hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.[47] The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 USC Section 1320a–7(i), or exclusion action. Pursuant to the compliance program, hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded or otherwise ineligible for participation in Federal healthcare programs…"	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899** Since this is per federal oversight guidance relating in large part to fraud and abuse concerns, it is not within the jurisdiction of the Governor to waive. Existing federal law prohibits providers with a criminal conviction from participants in the Medicare program. Therefore, use of providers with a prior criminal conviction would require waiver by the Secretary of Health and Human Services, or the Assistant Secretary for Preparedness and Response pursuant to HR 3448.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act	**V. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act** This chapter shall be known and may be cited as the Healthcare Professional Disaster Response Act.	**V. Business and Professions Code Section 920. Healthcare Professional Disaster Response Act** This legislation permits use of providers with lapsed or inactive licenses in disaster areas where a shortage exists. The administrative requirements may be prohibitive if time is of the essence, so waiver of these requirements (at Business & Professions Code 922) would assist facilitating use of retired or inactive licenses. The Governor has the authority under his executive powers in a state of emergency.
	VI. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters	**VI. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters** Nothing in this chapter [on physician licensing] prohibits service in the case of emergency, or the domestic administration of family remedies.	**VI. Business and Professions Code Section 921. Use of Inactive Licensees in State Disasters** Yes, there is flexibility for this regulation, though this statute acknowledges that licensure is not a pre-requisite to providing services during a disaster. Despite this, verification of licensure by primary source, and qualification remain, therefore, Governor's orders of waiver may be appropriate, particularly as it relates to liability protections.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What is the process and criteria for credentialing/privileging healthcare workers (emergency privileging and verification of credentials in California) and how will this process be different in a surge emergency for: • licensed healthcare professionals working under flexed scope of practice;	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5**	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** Whenever any person holds a license, certificate or other permit issued by any state evidencing the meeting of qualifications for professional, mechanical or other skills, such person may render aid involving such skill in any party state to meet an emergency or disaster and such state shall give due recognition to such license, certificate or other permit as if issued in the state in which aid is rendered.	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** This provision authorizes licensed healthcare professionals to render aid during a disaster. It does not, however, address liability protections. Therefore, a Governor's order under a state of emergency may be required to invoke certain protections from liability or cancellation by insurers of professional liability coverage if providing services outside the scope of practice. The Governor has such powers in a state of emergency.
	II. Emergency Management Assistance Compact Government Code Section 179-179.9	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** Invoking this authority requires a declaration of a state of emergency by the Governor.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.	
	III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners. Rationale for MS.4.110: When the disaster plan has been implemented (*see* standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the patients [individual or group] cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (*see* EPs 5–8). The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** Joint Commission requires hospitals to address care, flow of patient care, and staffing under disaster surge circumstances. It does not provide any formal procedure for doing so, nor does it make any commitment to suspend accreditation requirements during a disaster. Given this allowance, flexibility or waiver is not required. Still, hospital providers retain the obligation to verify competency and maintain oversight of the healthcare professionals and care delivered. If primary source verification cannot be verified within 72 hours from the healthcare professional presenting to the provider, the provider must keep records of why it could not under the circumstances do the required verification check.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		not independent practitioners exists at standard HR.1.25. While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained: 1. Verification of licensure 2. Oversight of the care, treatment, and services provided. This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a disaster. Examples of such systems include the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals. It is expected that additional programs will emerge and evolve. Elements of Performance for MS.4.110 1. Disaster privileges are granted only when the following two conditions are present: the emergency	

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		management plan has been activated, and the organization is unable to meet immediate patient needs. 2. As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified. 3. The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges. 4. The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges. 5. In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: A current picture hospital identification card that clearly identifies professional designation. A current license to practice. Primary source verification of the license. Identification indicating that the individual is a member of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Note: *In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided*	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		care, treatment, and services under the disaster privileges. 7. The medical staff oversees the professional practice of volunteer licensed independent practitioners. 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.	
	IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899, Section 920-922	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899, Section 920-922** Model Compliance Program for Hospitals states ":… hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.[47] The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 USC Section 1320a, or exclusion action. Pursuant to the compliance program, hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded or	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 899, Section 920-922** Since this is per federal oversight guidance relating in large part to fraud and abuse concerns, it is not within the jurisdiction of the Governor to waive. Existing federal law prohibits providers with a criminal conviction from participants in the Medicare program. Therefore, use of providers with a prior criminal conviction would require waiver by the Secretary of Health and Human Services, or the Assistant Secretary of Planning and Response pursuant to HR 3448.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		otherwise ineligible for participation in Federal healthcare programs…".	
	V. 19 CCR 2572.2 (Scope of Disaster Service Duties)	**V. 19 CCR 2572.2 (Scope of Disaster Service Duties)** Each disaster service worker in any classification shall, without regard to a formal designation or assignment, be considered to be acting within the scope of disaster service duties while assisting any unit of the emergency organization or performing any act contributing to the protection of life or property, or mitigating the effects of an emergency or potential emergency either: (a) under the authorization of a duly constituted superior in the emergency organization; or, (b) under the supervision and direction of the American Red Cross while carrying out its programs in consonance with state and local statements of understanding, or in carrying out a mission assigned to that agency by a responsible state or local authority.	**V. 19 CCR 2572.2 (Scope of Disaster Service Duties)** This protection is subject to a declaration of a state of emergency and deems the disaster service worker to be working/acting within the scope of duties. A declaration of a state or local emergency is required for this deemed status and scope authority.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What is the process and criteria for credentialing/privileging healthcare workers (emergency privileging and verification of credentials in California) and how will this process be different in a surge emergency for: • volunteer healthcare professionals not currently active or on staff (including VA, military);	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5**	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** Whenever any person holds a license, certificate or other permit issued by any state evidencing the meeting of qualifications for professional, mechanical or other skills, such person may render aid involving such skill in any party state to meet an emergency or disaster and such state shall give due recognition to such license, certificate or other permit as if issued in the state in which aid is rendered.	**I. Interstate Civil Defense and Disaster Compact Government Code Section 177-178.5** Credentialing or "citizenship" and privileging, or "permission" to do certain things is a lengthy process that requires primary source verification and validation of qualifications. Under a state of emergency declaration, altered credentialing and privileging standards may be invoked. Still, hospital providers are left exposed to negligent credentialing causes of action if by failure to ensure the education, qualifications and experience, a patient is harmed. There does not exist a remedy or waiver for exposure to negligent credentialing. Thus, it may be optimal to utilize any volunteer assistance under the auspices of disaster service workers by authority of the Emergency Services Act.
	II. Emergency Management Assistance Compact Government Code Section 179-179.9	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** Whenever any person holds a license, certificate, or other permit issued by any state party to the compact evidencing the meeting of qualifications for professional, mechanical, or other skills, and when such assistance is requested	**II. Emergency Management Assistance Compact Government Code Section 179-179.9** By implementing a hospital's disaster plan, credentialing and privileging requirements may be streamlined to facilitate rapid deployment of healthcare providers not currently on the medical staff or payroll. Use of this process is

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		by the receiving party state, such person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the governor of the requesting state may prescribe by executive order or otherwise.	dependent on having a disaster plan in place, and implementing it during a healthcare surge. Still, hospitals must verify primary sources of education and provide oversight of the treatment provided.
	III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners. Rationale for MS.4.110: When the disaster plan has been implemented (*see* standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the patients [individual or group] cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (*see* EPs 5–8). The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for	**III. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), MS.4.110** Pre-event credentialing is recommended, along with exploring the opportunity or availability of credentialing and privileges through outside contracted relationships such as other hospitals or payors having the same requirements.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are not independent practitioners exists at standard HR.1.25. While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained: 1. Verification of licensure 2. Oversight of the care, treatment, and services provided. This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners. There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a disaster. Examples of such systems include the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals. It is expected that	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		additional programs will emerge and evolve. Elements of Performance for MS.4.110 1. Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. 2. As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified. 3. The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges. 4. The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges. 5. In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: A current picture hospital identification card that clearly identifies professional designation. A current license to practice. Primary source verification of the license. Identification indicating that the individual is a member	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. Note: *In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care,*	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges. 7. The medical staff oversees the professional practice of volunteer licensed independent practitioners. 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.	
	IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998** Model Compliance Program for Hospitals states ":… hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.[47] The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 USC Section 1320a, or exclusion action. Pursuant to the compliance program,	**IV. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998** Since this is per federal oversight guideline relating in large part to fraud and abuse concerns, it is not within the jurisdiction of the Governor to waive. Existing federal law prohibits providers with a criminal conviction from participating in the Medicare Program. Therefore, use of providers with a criminal conviction would require waiver by the Secretary of Health and Human Services or the Assistant Secretary of

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded or otherwise ineligible for participation in Federal healthcare programs…"	Planning and Response pursuant to HR 3448.
What is the process and criteria for credentialing/privileging healthcare workers (emergency privileging and verification of credentials in CA) and how will this process be different in a surge emergency for: • unlicensed and non-active licensed professionals (e.g. retired);	**I. Healthcare Professional Disaster Response Act California Business and Professions Code Section 920-922**	**I. Healthcare Professional Disaster Response Act California Business and Professions Code Section 920-922** CA law allows for professionals with retired/inactive license to assist during emergencies, however the process involved (filling out/submitting forms) may be too cumbersome or restrictive. For example, professionals who have been retired for greater than 5 years must complete an application process which must then be approved. Business and Professions Code Section 921 (a)(1) In times of national or state disasters, a shortage of qualified healthcare practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. (2) Healthcare practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified healthcare practitioners exists, if licensing requirements were	**I. Healthcare Professional Disaster Response Act California Business and Professions Code Section 920-922** Healthcare practitioners with inactive or expired licenses are authorized under a state of emergency (Business & Professions Code 900), if the disaster overwhelms the provider capabilities and the assistance is requested by the director. A request can be expressly implied per Government Code Section 8659. Also, the Governor has authority to waive this statute or any of its provisions during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		streamlined and fees curtailed. Business and Professions Code Section 922 (a) A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter. (b) To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board. Additional content in the statute.	
	II. Government Code Section 8659, California Emergency Services Act	**II. Government Code Section 8659, California Emergency Services Act** Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein	**II. Government Code Section 8659, California Emergency Services Act** This provision may be flexed or waived by the Governor, but this is unlikely as this provides liability protections to specified providers. A modification of the type of providers, per Governor's order, to expand to all licensed healthcare professionals would expand these protections to other types of healthcare professionals.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		granted shall not apply in the event of a willful act or omission. Absent an actual declaration, an implied request would be critical to invoke this protection. The statute provides this protection without limitation based on if the licensed healthcare practitioner was providing services that were compensated by some form of reimbursement, during working hours under payroll, or as a volunteer.	
	III. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency	**III. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency** (a) Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the healthcare is provided only during a state of emergency as defined in subdivision (b) of Government Code Section 8558, which emergency overwhelms the response capabilities of California healthcare practitioners and only upon the request of the Director of the Emergency Medical Services Authority. (b) The director shall be the medical	**III. Business and Professions Code Section 900. Practice by Non-licensed Practitioner during State of Emergency** This provision may be flexed or waived by the Governor in a state of emergency. The Director of CDPH has authority to direct providers to designated areas.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. (c) Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. (d) Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. (e) Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659. (f) For the purposes of this chapter, “healthcare practitioner” means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. (g) For purposes of this chapter, “director” means the Director of the Emergency Medical Services Authority who shall have the powers specified in the Health and Safety Code Section	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		1797 Division 2.5.	
	IV. Business and Professions Code Section 702. Inactive Licenses	**IV. Business and Professions Code Section 702. Inactive Licenses** The holder of an inactive healing arts license or certificate issued pursuant to this article shall not engage in any activity for which an active license or certificate is required.	**IV. Business and Professions Code Section 702. Inactive Licenses** This provision may be waived. There are also authorities that allow healthcare professionals with expired or inactive licenses to render assistance during a state of emergency.
	V. Business and Professions Code Section 922. Licensing of Physician with Expired License	**V. Business and Professions Code Section 922. Licensing of Physician with Expired License** (a) The Legislature finds and declares the following: (1) In times of national or state disasters, a shortage of qualified healthcare practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. (2) Healthcare practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified healthcare practitioners exists, if licensing requirements were streamlined and fees curtailed. (b) It is, therefore, the intent of the Legislature to address these matters through the provisions of the Healthcare	**V. Business and Professions Code Section 922. Licensing of Physician with Expired License** This is subject to waiver by the Governor during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Professional Disaster Response Act.	
	VI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency	**VI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency** (a) A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter. (b) To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board, along with the following: (1) Documentation that the applicant has completed the continuing education requirements described in Business and Professions Code Section 2190, Chapter 5 Article 10 for each renewal period during which the applicant was not licensed. (2) A complete set of fingerprints as required by Business and Professions Code Sections 144 and 2082, together with the fee required for processing those fingerprints. (c) An applicant shall not be required to	**VI. Business and Professions Code Section 2058. Lack of License Does Not Prohibit Service in Emergency** This provision may be flexed or waived.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		pay any licensing, delinquency, or penalty fees for the issuance of a license under this chapter.	
	VII. Business and Professions Code Section 2439. Retired Licensee May Not Practice	**VII. Business and Professions Code Section 2439. Retired Licensee May Not Practice** (a) Every licensee is exempt from the payment of the renewal fee and requirement for continuing medical education if the licensee has applied to the Division of Licensing for a retired license. The holder of a retired license may not engage in the practice of medicine or the practice of podiatric medicine. (b) If a physician and surgeon has applied to convert from retired status to active status on or after January 1, 2004, but prior to January 1, 2005, the fee to change license status shall be waived, unless the change in status coincides with the physician and surgeon's license renewal date. The board shall refund any fees paid by a physician and surgeon to change from retired to active status after January 1, 2004, and before January 1, 2005, unless the change in status coincides with the physician and surgeon's license renewal date.	**VII. Business and Professions Code Section 2439. Retired Licensee May Not Practice** This provision may be flexed or waived.

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What is the process and criteria for credentialing/privileging healthcare workers (emergency privileging and verification of credentials in CA) and how will this process be different in a surge emergency for: • not currently employed healthcare workers (e.g. RNs volunteering during surge);	**I. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Section 107**	**I. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Section 107** Volunteers who have registered through the Emergency System for Advance Registration of Volunteer Health Professionals have their licenses verified. However, there is no current, streamlined process to verify licensure of non-pre-registered volunteers (i.e., walk-in volunteers). Based on the requirement for hospitals to have Compliance programs, hospitals should have a mechanism in place for background checks. This applies to entities with compliance requirements. Congress passed the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 in order to facilitate the effective use of volunteer health professionals during public health emergencies. Public Health Security and Bioterrorism Preparedness and Response Act of 2002 Section 107 directs the Health and Human Services Secretary to create a program to develop an Emergency System for Advance Registration of Volunteer Health Professionals. Health Resources and Services Administration is in the process of preparing Technical and Policy Guidelines, and Standards and	**I. Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Section 107** Yes, there is flexibility around this regulation. Volunteer pre-registration is a priority in streamlining requirements to engage them in delivery of care.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Definitions (Guidelines) for the states to use in developing their volunteer registration systems. Each state (and territory) system is to include readily available, verifiable, and up-to-date information regarding the volunteer's identity and licensing, credentialing, accreditation, and privileging in hospitals or other medical facilities that might need volunteers. The establishment of these standardized state systems will give each state the ability to quickly identify and better utilize volunteer health professionals in emergencies and disasters.	
	II. California Medical Volunteer Site	**II. California Medical Volunteer Site** A California nurse, doctor, pharmacist, or paramedic with an active license may volunteer for disaster service by registering through the California Medical Volunteer Site. Registration for mental health and other allied health professionals is not yet available.	**II. California Medical Volunteer Site** Waiver not applicable.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23 b 5-6	**III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23 b 5-6** A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.	**III. Centers for Medicare and Medicaid Services Conditions of Participation for Hospitals, 482.23 b 5-6** Any and all of the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor under a state of emergency.
	IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25** HR.1.25 The hospital may assign disaster responsibilities to volunteer practitioners. When the disaster plan has been implemented (*see* standard Environment of Care 4.10 for a description of emergency management planning requirements) and the immediate needs of the patients cannot be met, the hospital may implement a modified process for determining qualifications and competence of volunteer practitioners* (*see* EPs 5–8). The volunteer practitioners that are addressed by this standard only include those practitioners that are required by	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals: The Official Handbook (2006), HR.1.25** Joint Commission provides for a process to streamline, during a disaster, verification of licensure and qualification of providers.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		law and regulation to have a license, certification, or registration to practice their profession. The usual process to determine the qualifications and competence of these practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster privileges for volunteer licensed independent practitioners exists at standard MS.4.110. While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of the following two parts of the usual process for determining qualifications and competence must be maintained: 1. Verification of licensure, certification, or registration required to practice a profession 2. Oversight of the care, treatment, and services provided. This option to assign disaster responsibilities to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		patients, and on the qualifications of its volunteer practitioners. There are a number of state and federal systems engaged in pre-event verification of qualifications that may facilitate the assigning of disaster responsibilities to volunteer practitioners at the time of a disaster. Examples of such systems include the Medical Reserve Corps and the Emergency System for Advance Registration of Volunteer Health Professionals. It is expected that additional programs will emerge and evolve. 1. Disaster responsibilities are assigned only when the following two conditions are present: the emergency management plan has been activated, and the hospital is unable to meet immediate patient needs. 2. The hospital identifies in writing the individual(s) responsible for assigning disaster responsibilities. 3. The hospital describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who are assigned disaster responsibilities. 4. The hospital has a mechanism to identify volunteer practitioners that have been assigned disaster responsibilities. 5. For volunteer practitioners to be assigned disaster responsibilities, the hospital obtains for each volunteer practitioner at a	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: A current hospital picture identification card that clearly identifies professional designation. A current license, certification, or registration. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession). Identification indicating that the individual is a member of a Disaster Medical Assistance Team, or Medical Reserve Corps, Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity). Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications. 6. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) begins as soon as the immediate situation is under control, and is completed within 72 hours from the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		time the volunteer practitioner presents to the organization. Note: *In the extraordinary circumstance that primary source verification of licensure, certification, or registration* (if required by law and regulation to practice a profession) *cannot be completed in 72 hours (for example, no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure, certification, or registration* (if required by law and regulation to practice a profession) *would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster responsibilities.* 7. The hospital oversees the professional practice of volunteer practitioners. 8. The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer practitioner) within 72 hours related to the continuation of the disaster responsibilities initially assigned.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Introduction to Staffing Effectiveness: Staffing effectiveness is defined as the number, competency, and skill mix of staff in relation to the provision of needed care and treatment. Effective staffing has been linked to positive patient outcomes and improved quality and safety of care. This standard is designed to help healthcare organizations determine and continuously improve the effectiveness of their nurse staffing (including registered nurses, licensed practical nurses, and nursing assistants or aides) through an objective, evidence-based approach. Other types of practitioners may be included if the organization chooses to do so. The described goal relies on the use of relevant clinical/service outcome and human resource screening indicators to monitor for, identify and trigger nursing-related improvement opportunities in the provision of patient care. In its simplest conception, the standard reflects the application of continuous quality improvement methods to the performance of staffing effectiveness. This staffing standard requires healthcare organizations to collect data on relevant human resource and clinical/service screening indicators for a minimum of two units /divisions,* determine the desired performance for	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		each indicator, trend the data over time, and analyze variation from desired performance. It may be appropriate to rotate the units/divisions being monitored over time, after sufficient data have been reviewed to conclude that care on these units is stable. The use of multiple indicators increases the likelihood that existing problems will be identified and appropriately characterized. The use of nursing-sensitive measures makes it likely that problems identified will be staffing-related. However, this will not be universally true—the types of root causes may be identified and will need to be addressed. Many hospitals will find that they are already collecting the types of data contemplated by this standard. Since indicators selected are hospital-specific and part of internal performance improvement activities, and are not designed for comparison with other healthcare organizations, it may be appropriate to rotate indicator selection, after sufficient data have been reviewed to conclude that performance is stable and acceptable. Methods of data collection and tools for data analysis do not need to be sophisticated, and may vary based on the availability of resources. Simple control charts or other graphics to display data may be sufficient. The purpose of collecting data for these indicators is to screen for	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		possible nurse staffing issues and then to analyze underlying causes when the data do not meet performance expectations. Identification of statistical correlations among measure results is not required; however, identified relationships among results may provide clues to underlying causes. The data for each screening indicator are analyzed to identify any variations from desired performance by individual measure. Variations in performance trigger further analysis to determine the causes of the variation and whether staffing effectiveness issues might be affecting outcomes of care. When variation from desired performance is detected in one indicator, other indicator results are reviewed to identify information that may assist in clarifying the potential cause of variation. The organization drills down to determine the cause(s) of variation when data varies from what is expected; the organization then undertakes steps leading to appropriate actions that are likely to remedy identified problems. For example, analysis of the data may indicate the need for evaluation of the organization's staffing practices. If so, the organization take specific actions to improve its performance. Examples of strategies that may be used to address identified staffing issues include the following: Staff recruitment,	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		Education/training, Service curtailment, Increased technology support, Reorganization of work flow, Provision of additional ancillary or support staff, Adjustment of skill mix.	
	V. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998	**V. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998** Model Compliance Program for Hospitals states ":… hospitals should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application.[47] The application should specifically require the applicant to disclose any criminal conviction, as defined by 42 USC Section 1320a–7(i), or exclusion action. Pursuant to the compliance program, hospital policies should prohibit the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded or otherwise ineligible for participation in Federal healthcare programs…".	**V. Office of Inspector General Compliance Program Guidance for hospitals: Federal Register/Vol. 63, No. 35/ Monday, February 23, 1998 pp 8987- 8998** Office of Inspector General Compliance Guidelines are based on oversight of federal requirements. They are not per-se subject to waiver, however, the controlling federal laws are and may be waived or flexed.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VI. Model State Emergency Health Powers Act, 12/2001 Draft, Section 608	**VI. Model State Emergency Health Powers Act, 12/2001 Draft, Section 608** The public health authority may exercise, for such period as the state of public health emergency exists, the following emergency powers regarding licensing and appointment of health personnel. (a) To require in-state healthcare providers to assist in the performance of vaccination, treatment, examination, or testing of any individual as a condition of licensure, authorization, or the ability to continue to function as a healthcare provider in this State. (b)(2) The public health authority may waive any or all licensing requirements, permits, or fees required by the State code and applicable orders, rules, or regulations for healthcare providers from other jurisdictions to practice in this State.	**VI. Model State Emergency Health Powers Act, 12/2001 Draft, Section 608** Yes, this provision may be waived by the Governor or the Director or his or her public health designee under a state of emergency. Waiver of licensure requirements is discretionary and could be invoked to broaden the pool of providers.
Background checks/ immunizations for volunteer workers during emergencies	**I. Speier Bill 739 codified at Health and Safety Code 1288.5**	**I. Speier Bill 739 codified at Health and Safety Code 1288.5** The bill would establish the Hospital Infectious Disease Control Program, which would require the State Department of Public Health of health facilities and general acute care hospitals implement various measures relating to disease surveillance and the prevention of healthcare associated infection. By July 1, 2007, the acute care hospitals need to take the following	**I. Speier Bill 739 codified at Health and Safety Code 1288.5** Yes, this provision may be flexed or waived by the Governor under his executive authority. As written, this statute does not require vaccination of volunteers within hospitals.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		actions: (1) Annually offer on-site influenza vaccines to all employees (2) Institute respiratory hygiene and cough etiquette protocols, develop and implement isolation procedures for influenza patients, and adopt a seasonal influenza plan (3) Revise existing or develop a new disaster plan that includes a pandemic influenza component. The plan should include any actual or recommended collaboration with local, regional and state public health agencies in the event of an influenza pandemic By January 1, 2008, the following actions should be taken by the state department: (1) Implement an healthcare associated infection surveillance and prevention program designed to assess the department's resource needs, educate health facility evaluator nurses in healthcare associated infection and educate department staff on methods of implementing recommendations for disease prevention (2) Investigate the development of electronic reporting databases (3) Revise existing and adopt new administrative regulations as necessary (4) Require that hospitals develop a process for evaluating the judicious use of antibiotics	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	II. Business and Professions Code Section 2082(e)	**II. Business and Professions Code Section 2082(e)** Each application shall include the following: requirements of the school shall have been at the time of granting the diploma in no degree less than those required under this chapter or by any preceding medical practice act at the time that the diploma was granted. In lieu of a diploma, the applicant may submit evidence satisfactory to the Division of Licensing of having possessed the same. (b) An official transcript or other official evidence satisfactory to the division showing each approved medical school in which a resident course of professional instruction was pursued covering the minimum requirements for certification as a physician and surgeon, and that a diploma and degree were granted by the school. (c) Other information concerning the professional instruction and preliminary education of the applicant as the division may require. (d) An affidavit showing to the satisfaction of the division that the applicant is the person named in each diploma and transcript that he or she submits, that he or she is the lawful holder thereof, and that the diploma or transcript was procured in the regular course of professional instruction and examination without fraud or misrepresentation. (e) Either fingerprint	**II. Business and Professions Code Section 2082(e)** Yes, this provision may be flexed or waived by the Governor in a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		cards or a copy of a completed Live Scan form from the applicant in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction, including foreign countries. The information obtained as a result of the fingerprinting of the applicant shall be used in accordance with Penal Code Section 11105, and to determine whether the applicant is subject to denial of licensure under the provisions of Business and Professions Code Section 475 Division 1.5 and Business and Professions Code Section 2221.	
	III. Nursing Practice Act; Business and Professions Code Section 2761	**III. Nursing Practice Act; Business and Professions Code Section 2761** The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following: (a) Unprofessional conduct, which includes, but is not limited to, the following: (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions. (2) A conviction of practicing medicine without a license in violation of Chapter 5 (commencing with Section 2000), in which event the record of conviction shall be conclusive	**III. Nursing Practice Act; Business and Professions Code Section 2761** Yes, there is flexibility for this regulation and consideration of doing so may be desirable to afford licensed professionals added comfort if having to provide limited or austere care which may otherwise constitute unprofessional conduct.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		evidence thereof. (3) The use of advertising relating to nursing which violates Business and Professions Code Section 17500. (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a healthcare professional license or certificate by another state or territory of the United States, by any other government agency, or by another California healthcare professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action. (b) Procuring his or her certificate or license by fraud, misrepresentation, or mistake. (c) Procuring, or aiding, or abetting, or attempting, or agreeing, or offering to procure or assist at a criminal abortion. (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or regulations adopted pursuant to it. (e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What are the guidelines for compensation and reimbursement of expenses for disaster service workers?	**I. Government Code Section 3100 - 3109** **II. Labor Code Section 3600.6** **III. Disaster Service Worker Volunteer Program, Labor Code Section 4351 - 4355** **IV. 19 CCR 2570.1**	**I, II, III, IV.** CA laws allow for compensation and reimbursement of expenses for disaster service workers so long as the worker has taken and subscribed to the oath or affirmation required by this chapter.	**I, II, III, IV.** Yes, this provision may be flexed or waived by the Governor under a state of emergency. Most of the laws applicable to disaster service workers do not allow this designation if any compensation is received. Workers compensation benefits are afforded to disaster service workers (as well as liability protections). Consideration should be made to eliminate from the requirements to be deemed a disaster service worker, a prohibition against receiving compensation.
Is Worker's Compensation affected during a disaster (limited coverage)? *See also - Disaster Service Workers: Public Employees, Oaths and Compensation for additional guidance* **Can current workers' compensation laws be applied for staff and volunteers at an Alternate Care Site?**	**I. Unemployment Insurance Code Section 1253, 1254**	**I. Unemployment Insurance Code Section 1253, 1254** Unemployment Insurance Code Section 1253. An unemployed individual is eligible to receive unemployment compensation benefits with respect to any week only if the director finds that: (a) A claim for benefits with respect to that week has been made in accordance with authorized regulations. (b) He or she has registered for work, and thereafter continued to report, at a public employment office or any other place as the director may approve. Either or both of the requirements of this subdivision may be waived or altered by authorized regulation as to partially employed individuals attached to regular	**I. Unemployment Insurance Code Section 1253, 1254** The Governor's authority to suspend regulatory statutes specifically includes UI Code 1253(d).

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		jobs. (c) He or she was able to work and available for work for that week. (d) He has been unemployed for a waiting period of one week as defined in Unemployment Insurance Code Section 1254, unless this waiting period has been waived pursuant to Government Code Section 8571. (e) He or she conducted a search for suitable work in accordance with specific and reasonable instructions of a public employment office. (f) He or she participated as required by the director in reemployment activities, such as orientation and assessment if the individual has been identified pursuant to an automated profiling system as likely to exhaust regular unemployment benefits unless the individual has shown good cause for failure to participate. Unemployment Insurance Code Section 1254. No week shall be counted as a week of unemployment under subdivision (d) of Unemployment Insurance Code Section 1253: (a) Unless it occurs within the benefit year which includes the week with respect to which he claims payment of unemployment compensation benefits, but this requirement shall not interrupt	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		the payment of such benefits for consecutive weeks of unemployment. The week immediately preceding a benefit year, if part of one uninterrupted period of unemployment which continues into that benefit year shall be deemed, for the purposes of this section only, to be within such benefit year as well as within the preceding benefit year. (b) If unemployment compensation benefits have been paid with respect to that week. (c) Unless the individual was eligible for unemployment compensation benefits with respect thereto in all respects, except for the requirements of subdivision (d) of Unemployment Insurance Code Section 1253 and Section 1281.	
	II. Government Code Section 8571	**II. Government Code Section 8571** Suspension of Regulatory Statutes During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including Unemployment Insurance Code Section 1253 (d), where the Governor determines and declares that strict compliance with any statute, order,	**II. Government Code Section 8571** The Governor does have the authority to suspend regulatory statutes and statutes for the conduct of state business. It must be noted that this falls short of an authorization to suspend any state law. A regulatory statute is a specific kind of statute, enacted for the purpose of protecting public health or safety. It may be enforced by a regulatory agency, or through criminal sanctions which are designed to ensure compliance, as opposed to punishment for anti-social

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.	behavior.
	III. Terrorism Risk Insurance Act of 2002	**III. Terrorism Risk Insurance Act of 2002** The purpose of this title is to establish a temporary Federal program that provides for a transparent system of shared public and private compensation for insured losses resulting from acts of terrorism, in order to (1) protect consumers by addressing market disruptions and ensure the continued widespread availability and affordability of property and casualty insurance for terrorism risk; and (2) allow for a transitional period for the private markets to stabilize, resume pricing of such insurance, and build capacity to absorb any future losses, while preserving State insurance regulation and consumer protections.	**III. Terrorism Risk Insurance Act of 2002** The Terrorism Risk Insurance Act of 2002 renders all existing policy terrorism exclusions null and void, and requires all property and casualty insurers to offer policyholders terrorism insurance for two years (which, at the Treasury Secretary's discretion, may be extended an additional year). The terrorism coverage offered must not "materially differ from the terms, amounts, and other coverage limitations applicable to losses arising from events other than acts of terrorism." The Act establishes a program within the Treasury Department, under which the Federal government shares the risk of loss from future foreign terrorist attacks. This is a federal statute that cannot be flexed by the Governor. There does not appear to be any provision for flexing its requirements in federal law.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Public Employees as Disaster Service Workers Government Code Section 3101. Definitions	**IV. Public Employees as Disaster Service Workers Government Code Section 3101. Definitions** For the purpose of this chapter the term "disaster service worker" includes all public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council. The term "public employees" includes all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed.	**IV. Public Employees as Disaster Service Workers Government Code Section 3101. Definitions** Although this section defines what public employees will be considered "disaster service workers," the provisions providing worker's compensation coverage for disaster service workers are dealt with elsewhere. It is highly unlikely that this provision would be flexed during an emergency. Public employees constitute an important labor pool in the event of a disaster. It is unlikely that worker's compensation falls within the categories of statutes that the Governor can suspend. There is little indication that the legislature intended that worker's compensation be suspended during an emergency. The Disaster Service Worker program is established to ensure that workers during a disaster will receive worker's compensation coverage and benefits if injured. Suspending workers compensation for non-disaster employees would be unlikely to serve the purposes of mitigating the effects of the disaster.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. Government Code Section 3102.	**V. Government Code Section 3102.** (a) All disaster service workers shall, before they enter upon the duties of their employment, take and subscribe to the oath or affirmation required by this chapter. (b) In the case of intermittent, temporary, emergency or successive employments, then in the discretion of the employing agency, an oath taken and subscribed as required by this chapter shall be effective for the purposes of this chapter for all successive periods of employment which commence within one calendar year from the date of that subscription. (c) Notwithstanding subdivision (b), the oath taken and subscribed by a person who is a member of an emergency organization sanctioned by a state agency or an accredited disaster council, whose members are duly enrolled or registered with the Office of Emergency Services, or any accredited disaster council of any political subdivision, shall be effective for the period the person remains a member with that organization.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VI. Government Code Section 3103. Constitutional Oath.	**VI. Government Code Section 3103. Constitutional Oath.** The oath or affirmation required by this chapter is the oath or affirmation set forth in Section 3 of Article XX of the Constitution of California. 3.2.4.1.1	**VI. Government Code Section 3103. Constitutional Oath.** While it may be possible to suspend the oath requirement for disaster service workers, it should be noted that the suspension will only last for the duration of the emergency, and the oath requirement is a condition precedent to receiving compensation, which will likely be given after the emergency. Further, the oath requirement can be fulfilled after the fact, e.g., when the claim for compensation or reimbursement is made. Thus, there appears to be no point in suspending this requirement.
	VII. Government Code Section 3104. Administration of Oath	**VII. Government Code Section 3104. Administration of Oath** The oath or affirmation may be taken before any officer authorized to administer oaths. The oath or affirmation of any disaster service worker may be taken before his appointing power or before any person authorized in writing by his appointing power. No fee shall be charged by any person before whom the oath or affirmation is taken and subscribed.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	VIII. Government Code Section 3105. Filing of Oath	**VIII. Government Code Section 3105. Filing of Oath** (a) The oath or affirmation of any disaster service worker of the state shall be filed as prescribed by State Personnel Board rule within 30 days of the date on which it is taken and subscribed. (b) The oath or affirmation of any disaster service worker of any county shall be filed in the office of the county clerk of the county or in the official department personnel file of the county employee who is designated as a disaster service worker. (c) The oath or affirmation of any disaster service worker of any city shall be filed in the office of the city clerk of the city. (d) The oath or affirmation of any disaster service worker of any other public agency, including any district, shall be filed with any officer or employee of the agency that may be designated by the agency. (e) The oath or affirmation of any disaster service worker may be destroyed without duplication five years after the termination of the disaster service worker's service or, in the case of a public employee, five years after the termination of the employee's employment.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IX. Government Code Section 3106. State employees **X. Government Code Section 3107. Reimbursement Prohibited Absent Oath**	**IX. Government Code Section 3106. State employees** Compliance with this chapter shall, as to state employees, be deemed full compliance with Government Code Section 3106, Chapter 4, Part 1, Division 5, Title 2, requiring taking of oaths by state employees. **X. Government Code Section 3107. Reimbursement Prohibited Absent Oath** No compensation nor reimbursement for expenses incurred shall be paid to any disaster service worker by any public agency unless such disaster service worker has taken and subscribed to the oath or affirmation required by this chapter. It shall be the duty of the person certifying to public payrolls to ascertain and certify that such disaster service worker has taken such oath or affirmation. Whenever there is more than one officer certifying to public payrolls the governing body of a city or county or school district may designate and make it the duty of a certain officer or officers to ascertain and certify that such disaster service worker has taken such oath or affirmation. The governing body of a city or county or school district may designate and make it the duty of a local disaster service officer to ascertain and	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		certify that each volunteer disaster service worker has taken such oath or affirmation. Nothing in this chapter, however, shall prevent the correction of any technical error or deficiency in an oath taken pursuant to this chapter; provided, such correction is made before the disaster service worker is actually paid or reimbursed.	
	XI. Government Code Section 3108. False Oath	**XI. Government Code Section 3108. False Oath** Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he or she knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison for two, three, or four years.	
	XII. Government Code Section 3109. Prohibited Membership	**XII. Government Code Section 3109. Prohibited Membership** Every person having taken and subscribed to the oath or affirmation required by this chapter, who, while in the employ of, or service with, the state or any county, city, city and county, state agency, public district, or disaster council or emergency organization advocates or becomes a member of any party or	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		organization, political or otherwise, that advocates the overthrow of the government of the United States by force or violence or other unlawful means, is guilty of a felony, and is punishable by imprisonment in the state prison.	
	XIII. Labor Code Section 3600.6	**XIII. Labor Code Section 3600.6** Disaster service workers registered by a disaster council while performing services under the general direction of the disaster council shall be entitled to all of the same benefits of this division as any other injured employee, except as provided by Labor Code Section 4351, Part 1, Chapter 10.	
	XIV. Disaster Service Worker Volunteer Program, Labor Code Section 4351 - 4355	**XIV. Disaster Service Worker Volunteer Program, Labor Code Section 4351 - 4355** Compensation provided by this division is the exclusive remedy of a disaster service worker, or his or her dependents, for injury or death arising out of, and in the course of, his or her activities as a disaster service worker as against the state, the disaster council with which he or she is registered, and the county or city which has empowered the disaster council to register and direct his or her activities. Liability for compensation provided by this division is in lieu of any	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		other liability whatsoever to a disaster service worker or his or her dependents or any other person on his or her behalf against the state, the disaster council with which the disaster service worker is registered, and the county or city which has empowered the disaster council to register and direct his or her activities, for any injury or death arising out of, and in the course of, his or her activities as a disaster service worker.	
	XV. 19 CCR 2570.1	**XV. 19 CCR 2570.1** The Legislature has long provided a state-funded program of workers' compensation benefits for disaster service worker volunteers who contribute their services to protect the health and safety and preserve the lives and property of the people of the state. This program was established to protect such volunteers from financial loss as a result of injuries sustained while engaged in disaster service activities and to provide immunity from liability for such disaster service worker volunteers while providing disaster service.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XVI. 19 CCR 2573.3	**XVI. 19 CCR 2573.3** Claims for injuries sustained by disaster service worker are to be filed under the same authorities and guidelines as those filed by paid employees. Must include proof of registration form and oath. (a) Claim Packages. Worker's compensation claims for injuries sustained by disaster service workers while performing disaster service, shall be filed under the same authorities and guidelines as claims filed by paid employees. The claim shall include: 1) the appropriate claim and employer's report of injury forms as prescribed by the State Compensation Insurance Fund; 2) a written narrative account of the incident that may include witness statements; and, 3) a copy of the claimant's current disaster service worker registration form indicating the loyalty oath or affirmation was administered.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XVII. 19 CCR 2573.1. Disaster Service Worker File Retention and Record Keeping (Requirements for Worker's Compensation Claims)	**XVII. 19 CCR 2573.1. Disaster Service Worker File Retention and Record Keeping (Requirements for Worker's Compensation Claims)** (a) Documented proof of the oath or affirmation of any disaster service worker is an integral part of an injury claim for workers' compensation. File retention should follow the same rules as other public personnel records. The oath or affirmation shall be filed as follows: 1) State. File as prescribed by the State Department of Personnel Administration within 30 days of the date it was taken or subscribed; 2) County. File in the office of the county clerk. The oath may also be filed in either the office of the county auditor or in the office of the clerk of the board of supervisors; 3) City. File in the office of the city clerk; 4) Other Agencies or Districts. File with an agency or district designated officer or employee. (b) All registration records shall be available for inspection by any officer or employee of the State Compensation Insurance Fund or of the Governor's Office of Emergency Services. (c) The personnel officer or other individual designated by the disaster council shall be responsible for keeping the registration current, and for the accuracy and safekeeping of the official	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		registration records. (d) The California Emergency Council may prescribe additional registration requirements as it may deem necessary.	
How can scope of practice be flexed, yet still allow for liability and reimbursement and payment of personnel (physicians and clinical staff)?	**I. Government Code Section 8659, Emergency Services Act**	**I. Government Code Section 8659, Emergency Services Act** The Emergency Services Act covers liability protections for any healthcare professional that renders services under an emergency. However, to date, no California-specific laws, federal laws, or profession-specific standards offer explicit guidance on how a licensed healthcare professional may begin to work beyond their usual scope of practice. For example, under what conditions (if any) may a non-pharmacist begin dispensing medications? Government Code Section 8659. Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided,	**I. Government Code Section 8659, Emergency Services Act** Scope of practice is delineated by practitioner type, and may be governed by statute, licensure boards and standards of care in the community (or any combination of these). Scope is complicated and constantly changing. The legislature is reluctant to strictly prescribe scope, in order to allow for changes as advances are made in both education and practice. Scope is further complicated by overlapping and sometimes competing interests of the various provider types (e.g., anesthesiologists and nurse anesthetists). With this in mind, flexing scope is under the auspices and authority of the Governor during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		however, that the immunity herein granted shall not apply in the event of a willful act or omission.	
Scope of practice flexibility: the extent to which existing requirements will be waived or lifted.			Existing scope of practice legal and professional requirements and guidelines may be flexed by the Governor during a state of emergency. This, however, raises issues relating to liability and professional malpractice coverage if an injury occurs to a patient receiving care from a provider whose care is outside his or her scope. Addressing this and other related issues should be considered at the time of flexing scope of practice to ensure liability and malpractice coverage.
What is the specific allowed flexed scope of practice for: military corpsmen, veterinarians, veterinarian technicians, dentists, mid-wives, nurse practitioners, physician assistants, physical therapists, emergency medical technicians, pharmacists, medical and nursing students, family members, licensed pre-certified, unlicensed medical and nursing students, non-	**I. Business and Professions Code Section 715 (For Military, Federal Government personnel)**	**I. Business and Professions Code Section 715 (For Military, Federal Government personnel)** Unless otherwise required by federal law or regulation, no board under this division which licenses dentists, physicians and surgeons, podiatrists, or nurses may require a person to obtain or maintain any license to practice a profession or render services in the State of California if one of the following applies: (a) The person practicing a profession or rendering services does so exclusively as an employee of a department, bureau, office, division, or similarly constituted agency of the federal	**I. Business and Professions Code Section 715 (For Military, Federal Government personnel)** Licensure is not required of military personnel providing services under federal control and in limited circumstances. If outside these circumstances, it appears licensure and verification is required, but the flexibility under the Emergency Services Act mitigates the administrative process to some degree during an active phase of a disaster. Scope, as discussed above, is complicated. Any clear deviations or authority to provide services outside the scope could be effectuated by order of the Governor during a state of

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
traditional sources (if available or outlined from previous experience)?		government, and provides medical services exclusively on a federal reservation or at any facility wholly supported by and maintained by the United States government. (b) The person practicing a profession or rendering services does so solely pursuant to a contract with the federal government on a federal reservation or at any facility wholly supported and maintained by the United States government. (c) The person practicing a profession or rendering services does so pursuant to, or as a part of a program or project conducted or administered by a department, bureau, office, division, or similarly constituted agency of the federal government which by federal statute expressly exempts persons practicing a profession or rendering services as part of the program or project from state laws requiring licensure.	emergency. This, again, raises issues of liability protections and malpractice coverage.
	II. Business and Professions Code Section 900	**II. Business and Professions Code Section 900** (a) Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		healthcare is provided only during a state of emergency as defined in subdivision (b) of Government Code Section 8558, which emergency overwhelms the response capabilities of California healthcare practitioners and only upon the request of the Director of the Emergency Medical Services Authority. (b) The director shall be the medical control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. (c) Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. (d) Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. (e) Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659. (f) For the purposes of this chapter,	

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		"healthcare practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. (g) For purposes of this chapter, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Health and Safety Code Section 1797, Division 2.5.	
What professional liability protections currently exist for healthcare workers during emergency operations?	**I. California Emergency Services Act, Government Code Section 8659**	**I. California Emergency Services Act, Government Code Section 8659** Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.	**I. California Emergency Services Act, Government Code Section 8659** The Governor does have the authority to suspend regulatory statutes and statutes for the conduct of state business. It must be noted that this falls short of an authorization to suspend any state law. A regulatory statute is a specific kind of statute, enacted for the purpose of protecting public health or safety. It is unlikely that the immunity for healthcare workers under the Emergency Services Act falls within this category. Further, it is difficult to conceive any situation in which this statute would hinder, rather than help, the mitigation of the effects of the disaster. Therefore, it does not appear that this provision could be suspended. Moreover, there appears to be no reason why such a suspension would be

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			desirable.
	II. Good Samaritan Statutes, California Business and Professions Code Sections 1627.5 (Dentist), 2395, 2395.5, 2396, 2398 (Physician), 2727.5, 2861.6, 3503.5 (Nurses/Physician Assistant)	**II. Good Samaritan Statutes, California Business and Professions Code Sections 1627.5 (Dentist), 2395, 2395.5, 2396, 2398 (Physician), 2727.5, 2861.6, 3503.5 (Nurses/Physician Assistant)** Business and Professions Code Section 1627.5. Dentists No person licensed under this chapter [dentists], who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care. Business and Professions Code Section 2395. Physician and Surgeon No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil	**II. Good Samaritan Statutes, California Business and Professions Code Sections 1627.5 (Dentist), 2395, 2395.5, 2396, 2398 (Physician), 2727.5, 2861.6, 3503.5 (Nurses/Physician Assistant)** The Good Samaritan statutes apply only to uncompensated care, usually at the scene of an emergency. They are neither regulatory statutes nor statutes for the conduct of state business. Therefore, they cannot be suspended.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act Government Code Section 8550, Title 2, Division 1, Chapter 7. Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission. Business and Professions Code Section 2727.5. Nurse A person licensed under this chapter [nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent. Business and Professions Code Section 2861.5. Licensed Vocational Nurse A person licensed under this chapter [licensed vocational nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of his employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent. Business and Professions Code Section 3503.5. Physician's Assistant (a) A person licensed under this chapter [physician's assistant] who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. (b) This section shall not be construed to	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. (c) In addition to the immunity specified in subdivision (a), the provisions Business and Professions Code Section 2395, Chapter 5, Article 17 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.	
	III. Interstate Civil Defense and Disaster Compact, Government Code Section 177-178.5	**III. Interstate Civil Defense and Disaster Compact, Government Code Section 177-178.5** No party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged, or on account of the maintenance or use of any equipment or supplies in connection therewith.	**III. Interstate Civil Defense and Disaster Compact, Government Code Section 177-178.5** The Governor's suspension authority runs to "statutes". It does not allow the Governor to amend a statute, or suspend parts of statutes. The statute is the whole provision, and the Governor does not appear to have the authority to suspend only portions of the statute. He may issue orders which accomplish this purpose, by suspending a whole statute, at the same time as issuing an order that imposes a portion of that statute. This provision of the Interstate Civil Defense and Disaster Compact applies to the liability of out-of-state disaster workers. It is not a regulatory statute or one for the conduct of state business.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	IV. Emergency Management Assistance Compact, Government Code Section 179-179.9	**IV. Emergency Management Assistance Compact, Government Code Section 179-179.9** Officers or employees of a party state rendering aid in another state pursuant to this compact shall be considered agents of the requesting state for tort liability and immunity purposes. No party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	V. 42 USC Section14503, Volunteer Protection Act of 199, GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - GENERAL TORT LIABILITY	**V. 42 USC Section14503, Volunteer Protection Act of 199, GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - GENERAL TORT LIABILITY** No volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity if: (1) the volunteer was acting within the scope of the volunteer's responsibilities...etc. (2) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities...etc. ***GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - GENERAL TORT LIABILITY***	**V. 42 USC Section14503, Volunteer Protection Act of 199, GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - GENERAL TORT LIABILITY** The Volunteer Protection Act of 1997 provides that a volunteer of a nonprofit organization or government generally will be relieved of liability for harm if the volunteer was acting within the scope of his responsibilities and if he was properly licensed, certified, or authorized for the activities (whenever such licensing, certification, or authorization is appropriate or required). The Act preempts state law, but allows a State to apply its own law exclusively in any case that does not involve out-of-State parties. It does not protect volunteer organizations. This federal provision could not be suspended by the Governor.
	VI. Civil Code Section 43. Right to Protection from Injury	**VI. Civil Code Section 43. Right to Protection from Injury** Besides the personal rights mentioned or recognized in the Government Code, every person has, subject to the qualifications and restrictions provided by law, the right of protection from bodily restraint or harm, from personal insult, from defamation, and from injury to his personal relations.	**VI. Civil Code Section 43. Right to Protection from Injury** Disagree with the statement that all laws can be flexed. The Governor does have the authority to suspend regulatory statutes and statutes for the conduct of state business. It must be noted that this falls short of an authorization to suspend any state law. A regulatory statute is a specific kind of statute, enacted for the

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			purpose of protecting public health or safety.
	VII. Civil Code Section 1708. Obligation to Refrain from Injury	**VII. Civil Code Section 1708. Obligation to Refrain from Injury** Every person is bound, without contract, to abstain from injuring the person or property of another, or infringing upon any of his or her rights.	
	VIII. Civil Code Section 3526. No Responsibility for the Uncontrollable, GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - STANDARDS OF CARE	**VIII. Civil Code Section 3526. No Responsibility for the Uncontrollable, GENERAL AREAS OF LAW AFFECTING HEALTHCARE DELIVERY - STANDARDS OF CARE** No man is responsible for that which no man can control.	
	IX. Civil Code Section n1714. Liability for Want of Ordinary Care	**IX. Civil Code Section n1714. Liability for Want of Ordinary Care** (a) Everyone is responsible, not only for the result of his or her willful acts, but also for an injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person, except so far as the latter has, willfully or by want of ordinary	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		care, brought the injury upon himself or herself. . . . The extent of liability in these cases is defined by the Title on Compensatory Relief. ***IMMUNITIES SECTION***	
	X. Civil Code Section 3526	**X. Civil Code Section 3526** No man is responsible for that which no man can control.	
	XI. Civil Code Section 1714.2. Cardiopulmonary resuscitation	**XI. Civil Code Section 1714.2. Cardiopulmonary resuscitation** (a) In order to encourage citizens to participate in emergency medical services training programs and to render emergency medical services to fellow citizens, no person who has completed a basic cardiopulmonary resuscitation course which complies with the standards adopted by the American Heart Association or the American Red Cross for cardiopulmonary resuscitation and emergency cardiac care, and who, in good faith, renders emergency cardiopulmonary resuscitation at the scene of an emergency shall be liable for any civil damages as a result of any acts or omissions by such person rendering the emergency care.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(b) This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering such emergency care constitutes gross negligence. (c) In order to encourage local agencies and other organizations to train citizens in cardiopulmonary resuscitation techniques, no local agency, entity of state or local government, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of citizens in cardiopulmonary resuscitation shall be liable for any civil damages alleged to result from such training programs. (d) In order to encourage qualified individuals to instruct citizens in cardiopulmonary resuscitation, no person who is certified to instruct in cardiopulmonary resuscitation by either the American Heart Association or the American Red Cross shall be liable for any civil damages alleged to result from the acts or omissions of an individual who received instruction on cardiopulmonary resuscitation by that certified instructor. (e) This section shall not be construed to grant immunity from civil damages to any person who renders such emergency care to an individual with the expectation of receiving compensation from the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		individual for providing the emergency care.	
	XII. Civil Code Section 1714.21. Automatic External Defibrillator	**XII. Civil Code Section 1714.21. Automatic External Defibrillator** (a) For purposes of this section, the following definitions shall apply: (1) "AED" or "defibrillator" means an automated or automatic external defibrillator. (2) "CPR" means cardiopulmonary resuscitation. (b) Any person who, in good faith and not for compensation, renders emergency care or treatment by the use of an automatic external defibrillator at the scene of an emergency is not liable for any civil damages resulting from any acts or omissions in rendering the emergency care. (c) A person or entity who provides cardiopulmonary resuscitation and automatic external defibrillator training to a person who renders emergency care pursuant to subdivision (b) is not liable for any civil damages resulting from any acts or omissions of the person rendering the emergency care. (d) A person or entity that acquires an automatic external defibrillator for emergency use pursuant to this section	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		is not liable for any civil damages resulting from any acts or omissions in the rendering of the emergency care by use of an automatic external defibrillator, if that person or entity has complied with Health and Safety Code Section 1797.196 (b). (e) A physician who is involved with the placement of an automatic external defibrillator and any person or entity responsible for the site where an automatic external defibrillator is located is not liable for any civil damages resulting from any acts or omissions of a person who renders emergency care pursuant to Civil Code Section 1714.21(b), if that physician, person, or entity has complied with all of the requirements of Health and Safety Code Section 1797.196 that apply to that physician, person, or entity. (f) The protections specified in this section do not apply in the case of personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of the person who renders emergency care or treatment by the use of an automatic external defibrillator. (g) Nothing in this section shall relieve a manufacturer, designer, developer, distributor, installer, or supplier of an automatic external defibrillator or	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		defibrillator of any liability under any applicable statute or rule of law.	
	XIII. Civil Code Section 1714.5. Mass Care Centers; Disaster workers	**XIII. Civil Code Section 1714.5. Mass Care Centers; Disaster workers** There shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Government Code Section 8558 shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.	
	XIV. Civil Code Section 1714.6. Compliance with Emergency Orders	**XIV. Civil Code Section 1714.6. Compliance with Emergency Orders** The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XV. Civil Code Section 1714.8. Natural Course of Disease or Condition	**XV. Civil Code Section 1714.8. Natural Course of Disease or Condition** (a) No healthcare provider shall be liable for professional negligence or malpractice for any occurrence or result solely on the basis that the occurrence or result was caused by the natural course of a disease or condition, or was the natural or expected result of reasonable treatment rendered for the disease or condition. This section shall not be construed so as to limit liability for the failure to inform of the risks of treatment or failure to accept treatment, or for negligent diagnosis or treatment or the negligent failure to diagnose or treat. (b) As used in this section, "healthcare provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act, or certified pursuant to Health and Safety Code Section 1440, Division 2, Chapter 2.5, and any clinic, health dispensary, or health facility licensed pursuant to Health and Safety Code Section 1200, Division 2.	**XV. Civil Code Section 1714.8. Natural Course of Disease or Condition** Do not appear to be regulatory statutes or statutes for the conduct of state business. Governor cannot suspend.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XVI. Government Code Section 50086. Search & Rescue Volunteers	**XVI. Government Code Section 50086. Search & Rescue Volunteers** No person who is summoned by a county sheriff, city police department, fire department, park ranger, or other local agency to voluntarily assist in a search or rescue operation, who possesses first aid training equivalent to the Red Cross advanced first aid and emergency care training standards, and who in good faith renders emergency services to a victim prior to or during the evacuation or extrication of the victim, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering such emergency services. For the purposes of this section, “emergency services” includes, but is not limited to, first aid and medical services, rescue procedures, and transportation or other related activities necessary to insure the safety of the victim who is the object of the search or rescue operation.	**XVI. Government Code Section 50086. Search & Rescue Volunteers** Do not appear to be regulatory statutes or statutes for the conduct of state business. Governor cannot suspend.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
	XVII. Health and Safety Code Section 1317. Refusal to Render Care to Non-Emergency Patient	**XVII. Health and Safety Code Section 1317. Refusal to Render Care to Non-Emergency Patient** (c) Neither the health facility, its employees, nor any physician and surgeon, dentist, clinical psychologist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services. (f) No act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised. (g) "Rescue team," as used in this section, means a special group of	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life. (h)This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team. ***EMERGENCY MEDICAL SERVICES IMMUNITY***	
	XVIII. Health and Safety Code Section 1799.100. EMS Training	**XVIII. Health and Safety Code Section 1799.100. EMS Training** In order to encourage local agencies and other organizations to train people in emergency medical services, no local agency, entity of state or local government, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of people, or certifies those people, excluding physicians and surgeons, registered nurses, and	**XVIII. Health and Safety Code Section 1799.100. EMS Training** This provision governs liability alleged to result from training. Flexing this provision could result in a loss of immunity. This does not appear to be regulatory statutes or statutes for the conduct of state business.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		licensed vocational nurses, as defined, in emergency medical services, shall be liable for any civil damages alleged to result from those training programs.	
	XIX. Health and Safety Code Section 1799.102. On-scene Emergency Care	**XIX. Health and Safety Code Section 1799.102. On-scene Emergency Care** No person who in good faith, and not for compensation, renders emergency care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered.	**XIX. Health and Safety Code Section 1799.102. On-scene Emergency Care** The Governor's suspension authority runs to "statutes". It does not allow the Governor to amend a statute, or suspend parts of statutes. The statute is the whole provision, and the Governor does not appear to have the authority to suspend only portions of the statute. He may issue orders which accomplish this purpose, by suspending a whole statute, at the same time as issuing an order that imposes a portion of that statute.
	XX. Health and Safety Code Section 1799.104. Physician/nurse Instructions to Emergency Medical Technician or paramedic	**XX. Health and Safety Code Section 1799.104. Physician/nurse Instructions to Emergency Medical Technician or paramedic** (a) No physician or nurse, who in good faith gives emergency instructions to an emergency medical technician-II or mobile intensive care paramedic at the scene of an emergency, shall be liable for any civil damages as a result of	**XX. Health and Safety Code Section 1799.104. Physician/nurse Instructions to Emergency Medical Technician or paramedic** These provisions limit liability alleged to result from response activities. Flexing these provisions could result in a loss of immunity. These do not appear to be regulatory statutes or statutes for the conduct of state business. Governor

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		issuing the instructions. (b) No emergency medical technician-II or mobile intensive care paramedic rendering care within the scope of his duties who, in good faith and in a nonnegligent manner, follows the instructions of a physician or nurse shall be liable for any civil damages as a result of following such instructions.	cannot suspend.
	XXI. Health and Safety Code Section 1799.106. Firefighters/Law Enforcement On-scene Emergency Care	**XXI. Health and Safety Code Section 1799.106. Firefighters/Law Enforcement On-scene Emergency Care** In addition to the provisions of Health and Safety Code Section 1799.104 and of Civil Code Section 1714.2 and in order to encourage the provision of emergency medical services by firefighters, police officers or other law enforcement officers, emergency medical technician-I, emergency medical technician-II, or emergency medical technician-P, a firefighter, police officer or other law enforcement officer, emergency medical technician-I, emergency medical technician-II, or emergency medical technician-P who renders emergency medical services at the scene of an emergency shall only be liable in civil damages for acts or	**XXI. Health and Safety Code Section 1799.106. Firefighters/Law Enforcement On-scene Emergency Care**

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		omissions performed in a grossly negligent manner or acts or omissions not performed in good faith. A public agency employing such a firefighter, police officer or other law enforcement officer, emergency medical technician-I, emergency medical technician-II, or emergency medical technician-P shall not be liable for civil damages if the firefighter, police officer or other law enforcement officer, emergency medical technician-I, emergency medical technician-II, or emergency medical technician-P is not liable.	
	XXII. Health and Safety Code Section 1799.107. Public Entities and Emergency Rescue Personnel Providing Emergency Services	**XXII. Health and Safety Code Section 1799.107. Public Entities and Emergency Rescue Personnel Providing Emergency Services** (a) The Legislature finds and declares that a threat to the public health and safety exists whenever there is a need for emergency services and that public entities and emergency rescue personnel should be encouraged to provide emergency services. To that end, a qualified immunity from liability shall be provided for public entities and emergency rescue personnel providing emergency services.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(b) Except as provided in Vehicle Code Section 17000, Chapter 1, Division 9, Article 1, neither a public entity nor emergency rescue personnel shall be liable for any injury caused by an action taken by the emergency rescue personnel acting within the scope of their employment to provide emergency services, unless the action taken was performed in bad faith or in a grossly negligent manner. (c) For purposes of this section, it shall be presumed that the action taken when providing emergency services was performed in good faith and without gross negligence. This presumption shall be one affecting the burden of proof. (d) For purposes of this section, "emergency rescue personnel" means any person who is an officer, employee, or member of a fire department or fire protection or firefighting agency of the federal government, the State of California, a city, county, city and county, district, or other public or municipal corporation or political subdivision of this state, or of a private fire department, whether that person is a volunteer or partly paid or fully paid, while he or she is actually engaged in providing emergency services as defined by Health and Safety Code Section 1799.107(e).	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(e) For purposes of this section, "emergency services" includes, but is not limited to, first aid and medical services, rescue procedures and transportation, or other related activities necessary to insure the health or safety of a person in imminent peril.	
	XXIII. Health and Safety Code Section 1799.108. Certificated Personnel for Emergency Field Care	**XXIII. Health and Safety Code Section 1799.108. Certificated Personnel for Emergency Field Care** Any person who has a certificate issued pursuant to this division from a certifying agency to provide prehospital emergency field care treatment at the scene of an emergency, as defined in Health and Safety Code Section 1799.102, shall be liable for civil damages only for acts or omissions performed in a grossly negligent manner or acts or omissions not performed in good faith.	**XXIII. Health and Safety Code Section 1799.108. Certificated Personnel for Emergency Field Care** This section provides a qualified immunity to certificated personnel in emergency field care. Flexing these provisions could result in a loss of immunity. This does not appear to be a regulatory statute or statute for the conduct of state business. Governor cannot suspend.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What professional liability protections currently exist for healthcare workers during emergency operations?	**XXIV. Health and Safety Code Section 1799.110. Standard for Physicians for Emergency Medical Services**	**XXIV. Health and Safety Code Section 1799.110. Standard for Physicians for Emergency Medical Services** (a) In any action for damages involving a claim of negligence against a physician and surgeon arising out of emergency medical services provided in a general acute care hospital emergency department, the trier of fact shall consider, together with all other relevant matters, the circumstances constituting the emergency, as defined herein, and the degree of care and skill ordinarily exercised by reputable members of the physician and surgeon's profession in the same or similar locality, in like cases, and under similar emergency circumstances. (b) For the purposes of this section, "emergency medical services" and "emergency medical care" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death. (c) In any action for damages involving a claim of negligence against a physician and surgeon providing emergency medical coverage for a general acute	**XXIV. Health and Safety Code Section 1799.110. Standard for Physicians for Emergency Medical Services** This section provides a qualified immunity to certificated personnel in emergency field care. Flexing these provisions could result in a loss of immunity. This does not appear to be a regulatory statute or statute for the conduct of state business. Governor cannot suspend.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		care hospital emergency department, the court shall admit expert medical testimony only from physicians and surgeons who have had substantial professional experience within the last five years while assigned to provide emergency medical coverage in a general acute care hospital emergency department. For purposes of this section, "substantial professional experience" shall be determined by the custom and practice of the manner in which emergency medical coverage is provided in general acute care hospital emergency departments in the same or similar localities where the alleged negligence occurred.	
	XXV. Health and Safety Code Section 1799.111. Hospitals; Detention of Mentally Disordered	**XXV. Health and Safety Code Section 1799.111. Hospitals; Detention of Mentally Disordered** (a) A licensed general acute care hospital, as defined by Health and Safety Code Section 1250 (a), licensed professional staff of the hospital, or any physician and surgeon, providing emergency medical services to a person at the hospital shall not be civilly or criminally liable for detaining a person, or for the actions of the person after release from the hospital, if all of the	**XXV. Health and Safety Code Section 1799.111. Hospitals; Detention of Mentally Disordered** This section provides a qualified immunity to certificated personnel in emergency field care. Flexing these provisions could result in a loss of immunity. This does not appear to be a regulatory statute or statute for the conduct of state business. Governor cannot suspend.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		following conditions exist: (1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, “gravely disabled” means an inability to provide for his or her basic personal needs of food, clothing, or shelter. (2) The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person. (3) The person is not detained beyond eight hours. (b) Nothing in this section shall affect the responsibility of a general acute care hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		consent for medical treatment. (c) A person detained under this section shall be credited for the time detained, up to eight hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Welfare and Institutions Code Section 5150.	
Pharmacy Practice Act - Can the regulation be flexed during a surge? If so, to what degree can it be flexed?	**I. Pharmacy Practice Act – Business and Professions Code Section 4052.1, 4052.2**	**I. Pharmacy Practice Act – Business and Professions Code Section 4052.1, 4052.2** Business and Professions Code Section 4052.1. (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions in a licensed healthcare facility in accordance with policies, procedures, or protocols developed by health professionals, including physicians, pharmacists, and registered nurses, with the concurrence of the facility administrator: (1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and biologicals by injection pursuant to a prescriber's	**I. Pharmacy Practice Act – Business and Professions Code Section 4052.1, 4052.2** Under a declared emergency, the pharmacy board has the authority to waive the application of the act if it will aid in the protection of public health or the provision of patient care. (Business and Professions Code Section 4062 (b).)

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		order. (4) Initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's prescriber and in accordance with the policies, procedures, or protocols of the licensed healthcare facility. (b) Prior to performing any procedure authorized by this section, a pharmacist shall have received appropriate training as prescribed in the policies and procedures of the licensed healthcare facility. Business and Professions Code Section 4052.2. (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions as part of the care provided by a healthcare facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed healthcare service plan with regard to the care or services provided to the enrollees of that healthcare service plan, or a physician, in accordance with the policies, procedures, or protocols of that facility, home health agency, licensed clinic, healthcare service plan, or physician, and in accordance with Business and Professions Code Section 4052.2 (c):	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and biologicals by injection pursuant to a prescriber's order. (4) Initiating or adjusting the drug regimen of a patient pursuant to a specific written order or authorization made by the individual patient's treating prescriber, and in accordance with the policies, procedures, or protocols of the healthcare facility, home health agency, licensed clinic, healthcare service plan, or physician. Adjusting the drug regimen does not include substituting or selecting a different drug, except as authorized by the protocol. The pharmacist shall provide written notification to the patient's treating prescriber, or enter the appropriate information in an electronic patient record system shared by the prescriber, of any drug regimen initiated pursuant to this paragraph within 24 hours. (b) A patient's treating prescriber may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the pharmacist.	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		(c) The policies, procedures, or protocols referred to in this subdivision shall be developed by healthcare professionals, including physicians, pharmacists, and registered nurses, and shall, at a minimum, do all of the following: (1) Require that the pharmacist function as part of a multidisciplinary group that includes physicians and direct care registered nurses. The multidisciplinary group shall determine the appropriate participation of the pharmacist and the direct care registered nurse. (2) Require that the medical records of the patient be available to both the patient's treating prescriber and the pharmacist. (3) Require that the procedures to be performed by the pharmacist relate to a condition for which the patient has first been seen by a physician. (4) Except for procedures or functions provided by a healthcare facility, a licensed clinic in which there is physician oversight, or a provider who contracts with a licensed healthcare plan with regard to the care or services provided to the enrollees of that healthcare service plan, require the procedures to be performed in accordance with a written, patient specific protocol approved by the treating or supervising physician. Any change, adjustment, or	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		modification of an approved preexisting treatment or drug therapy shall be provided in writing to the treating or supervising physician within 24 hours. (d) Prior to performing any procedure authorized by this section, a pharmacist shall have done either of the following: (1) Successfully completed clinical residency training. (2) Demonstrated clinical experience in direct patient care delivery.	
Nursing/Medical Practice Act - Can the regulation be flexed during a surge? If so, to what degree can it be flexed?	**I. Nursing/Medical Practice Act – Business and Professions Code Section 2725(b), 2726, 2727, 2727.5**	**I. Nursing/Medical Practice Act – Business and Professions Code Section 2725(b), 2726, 2727, 2727.5** Business and Professions Code Section 2725(b) – Practice of nursing defined. The practice of nursing within the meaning of this chapter means those functions, including basic healthcare, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following: (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease	**I. Nursing/Medical Practice Act – Business and Professions Code Section 2725(b), 2726, 2727, 2727.5** Yes, this provision may be flexed or waived by order of the Governor during a state of emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		prevention and restorative measures. (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Health and Safety Code Section 1316.5. (3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries. (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. Business and Professions Code Section 2726 – Unauthorized Practices. Except as otherwise provided herein, this chapter confers no authority to practice	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		medicine or surgery. Business and Professions Code Section 2727 – Practices not prohibited. This chapter does not prohibit: (a) Gratuitous nursing of the sick by friends or members of the family. (b) Incidental care of the sick by domestic servants or by persons primarily employed as housekeepers as long as they do not practice nursing within the meaning of this chapter. (c) Domestic administration of family remedies by any person. (d) Nursing services in case of an emergency. “Emergency,” as used in this subdivision includes an epidemic or public disaster. (e) The performance by any person of such duties as required in the physical care of a patient and/or carrying out medical orders prescribed by a licensed physician; provided, such person shall not in any way assume to practice as a professional, registered, graduate or trained nurse. Business and Professions Code Section 2727.5 – Liability for emergency care. A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person’s employment shall not be	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.	
	II. Medical Practice Act – Business and Professions Code Section 2058	**II. Medical Practice Act – Business and Professions Code Section 2058** The physician's and surgeon's certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions.	**II. Medical Practice Act – Business and Professions Code Section 2058** This section provides that the licensing requirement for physicians does not prohibit service in an emergency, i.e., someone providing medical assistance in an emergency is not liable for prosecution for not having a license. It is difficult to conceive how this section would hinder the mitigation of the effects of the emergency. Absent this, waiver would not be authorized.
Board of Pharmacy Rules & Regulations - Can the regulation be flexed during a surge? If so, to what degree can it be flexed?	**I. Board of Pharmacy Rules & Regulations – 16 CCR 1793.1**	**I. Board of Pharmacy Rules & Regulations – 16 CCR 1793.1** Only a pharmacist, or an intern pharmacist acting under the supervision of a pharmacist, may: a) Receive a new prescription order orally from a prescriber or other person authorized by law. b) Consult with a patient or his or her agent regarding a prescription, either	**I. Board of Pharmacy Rules & Regulations – 16 CCR 1793.1** In addition to suspension by the Governor, the Pharmacy Board is authorized to waive regulations adopted under the Pharmacy Practice Act if it will aid in the protection of public health or the provision of patient care. (Business and Professions Code Section 4062 (b).)

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		prior to or after dispensing, or regarding any medical information contained in a patient medication record system or patient chart. c) Identify, evaluate and interpret a prescription. d) Interpret the clinical data in a patient medication record system or patient chart. e) Consult with any prescriber, nurse or other healthcare professional or authorized agent thereof. f) Supervise the packaging of drugs and check the packaging procedure and product upon completion. g) Perform all functions which require professional judgment.	
Non-resident Pharmacy Regulations - Can the regulations be flexed during a surge? If so, to what degree can it be flexed?	**I. Non-resident Pharmacy Regulations – Business and Professions Code Section 4112**	**I. Non-resident Pharmacy Regulations – Business and Professions Code Section 4112** (a) Any pharmacy located outside this state that ships, mails, or delivers, in any manner, controlled substances, dangerous drugs, or dangerous devices into this state shall be considered a nonresident pharmacy. (b) All nonresident pharmacies shall register with the board. The board may register a nonresident pharmacy that is organized as a limited liability company	**I. Non-resident Pharmacy Regulations – Business and Professions Code Section 4112** In addition to suspension by the Governor, the Pharmacy Board is authorized to waive regulations adopted under the Pharmacy Practice Act if it will aid in the protection of public health or the provision of patient care. (Business and Professions Code Section 4062 (b).)

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		in the state in which it is licensed. (c) A nonresident pharmacy shall disclose to the board the location, names, and titles of (1) its agent for service of process in this state, (2) all principal corporate officers, if any, (3) all general partners, if any, and (4) all pharmacists who are dispensing controlled substances, dangerous drugs, or dangerous devices to residents of this state. A report containing this information shall be made on an annual basis and within 30 days after any change of office, corporate officer, partner, or pharmacist. (d) All nonresident pharmacies shall comply with all lawful directions and requests for information from the regulatory or licensing agency of the state in which it is licensed as well as with all requests for information made by the board pursuant to this section. The nonresident pharmacy shall maintain, at all times, a valid unexpired license, permit, or registration to conduct the pharmacy in compliance with the laws of the state in which it is a resident. As a prerequisite to registering with the board, the nonresident pharmacy shall submit a copy of the most recent inspection report resulting from an inspection conducted by the regulatory or licensing agency of the state in which it is located. (e) All nonresident pharmacies shall	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		maintain records of controlled substances, dangerous drugs, or dangerous devices dispensed to patients in this state so that the records are readily retrievable from the records of other drugs dispensed. (f) Any pharmacy subject to this section shall, during its regular hours of operation, but not less than six days per week, and for a minimum of 40 hours per week, provide a toll-free telephone service to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patient's records. This toll-free telephone number shall be disclosed on a label affixed to each container of drugs dispensed to patients in this state. (g) The board shall adopt regulations that apply the same requirements or standards for oral consultation to a nonresident pharmacy that operates pursuant to this section and ships, mails, or delivers any controlled substances, dangerous drugs, or dangerous devices to residents of this state, as are applied to an in-state pharmacy that operates pursuant to Business and Profession Code Section 4037 when the pharmacy ships, mails, or delivers any controlled substances, dangerous drugs, or dangerous devices to residents of this state. The board shall not adopt any	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		regulations that require face-to-face consultation for a prescription that is shipped, mailed, or delivered to the patient. The regulations adopted pursuant to this subdivision shall not result in any unnecessary delay in patients receiving their medication. (h) The registration fee shall be the fee specified in Business and Professions Code Section 4400 (a). (i) The registration requirements of this section shall apply only to a nonresident pharmacy that ships, mails, or delivers controlled substances, dangerous drugs, and dangerous devices into this state pursuant to a prescription. (j) Nothing in this section shall be construed to authorize the dispensing of contact lenses by nonresident pharmacists except as provided by Business and Professions Code Section 4124.	

3.6 Supplies, Pharmaceuticals, and Equipment

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
Can standards be flexed for using medications for off-label usage and for expired medications?	**I. 21 USC Section 351, Federal Food, Drug & Cosmetic Act, Chapter V, Subchapter A, Sec. 501(a)(2)(B) - Adulterated Drugs and Devices** **II. 21 USC Section 331, Federal Food, Drug & Cosmetic Act, Chapter III, Section 301 – Prohibited Acts**	**I. 21 USC Section 351, Federal Food, Drug & Cosmetic Act, Chapter V, Subchapter A, Sec. 501(a)(2)(B) - Adulterated Drugs and Devices** A drug or device shall be deemed to be adulterated if it is a drug and the methods used in, or the facilities or controls used for, its manufacture, processing, packing, or holding do not conform to or are not operated or administered in conformity with current good manufacturing practice to assure that such drug meets the requirements of this Act as to safety and has the identity and strength, and meets the quality and purity characteristics, which it purports or is represented to possess. **II. 21 USC Section 331, Federal Food, Drug & Cosmetic Act, Chapter III, Section 301 – Prohibited Acts** The following acts and the causing thereof are hereby prohibited: (a) The introduction or delivery for introduction into interstate commerce of any food, drug, device, or cosmetic that is adulterated or misbranded.	Off-label Use If a drug is being used for off-label use, it means that the drug is approved by Federal Drug Administration, but the physician is using the drug for a use other than the one for which Federal Drug Administration gave the approval. Subsequent to a drug's approval, researchers often notice that the drug has other beneficial uses. Based on this published research, clinicians may prescribe the drug for this other use. Over time, use of the drug for this off-label use can become common practice, and be considered within the standard of care in the community. There is no statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, there is no regulatory requirement to be flexed. The only limitation on such off-label use is the law of medical malpractice. The more a drug is used for off-label purposes, the lower the likelihood that such use will be considered a breach of the standard of care owed to the patient. A proclamation of an emergency could include a provision making the standard of care the prevention of the greatest loss of life, which could allow some off label uses even if not generally accepted by the medical community, but consistent with the goal of saving a life. Expired Drugs Approved drugs are tested for stability and the expiration dates are based on those tests. However, most drugs remain stable far beyond the expiration date, sometimes ten times as long. The manufacturers have no incentive to test

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
			stability for longer periods of time; shorter expiration dates mean higher drug turnover, and testing stability for longer periods of time is expensive. So, they generally don't try to establish longer expiration dates, even if there is data showing that the drug is stable for much longer than they state in their new drug applications. Certain drug products have been qualified for shelf life extension through the Shelf Life Extension Program, which is sponsored by the Department of Defense and performed by the Federal Drug Administration. The life extension program is sponsored by the Department of Defense because of the substantial savings to the government from extending the shelf life of certain antibiotics and other drug products that are stored in Federal stockpiles in large quantities under controlled conditions and are of strategic importance. Absent some approved shelf-life extension for specific drugs, the only way to determine the potency of drug stocks is to test. This is not a requirement that can be flexed by state law from a regulatory perspective. State law would provide some legal protections to the administration of drugs without cost by a physician. However, if the physician charged for the service, those protections would not appear to apply. Any restrictions on pharmacists dispensing expired drugs could be waived by the Pharmacy Board.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What is the liability of using medications, equipment, and supplies beyond the manufacturer's recommended use (e.g., personal protective equipment)?	**I. 21 USC Section 360bbb-3, Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564 - Authorization for Medical Products for Use in Emergencies**	**I. 21 USC Section 360bbb-3, Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564 - Authorization for Medical Products for Use in Emergencies** In General.—(1) Emergency uses.—Notwithstanding Sections 505, 510(k), and 515 of the Federal Food, Drug and Cosmetic Act and 42 USC Section 35, and subject to the provisions of this section, the Secretary may authorize the introduction into interstate commerce, during the effective period of a declaration under subsection (b), of a drug, device, or biological product intended for use in an actual or potential emergency (referred to in this section as an "emergency use"). (2) Approval status of product.—An authorization under paragraph (1) may authorize an emergency use of a product that— (A) is not approved, licensed, or cleared for commercial distribution under a provision of law referred to in such paragraph (referred to in this section as an "unapproved product"); or (B) is approved, licensed, or cleared under such a provision, but which use is not under such provision an approved, licensed, or cleared use of the product (referred to in this section as an "unapproved use of an approved	**I. 21 USC Section 360bbb-3, Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564 - Authorization for Medical Products for Use in Emergencies** With regard to drugs, see the answer to the previous question. With regard to equipment, and supplies, the question is, "liability to whom?" The patients, or the employees? If liability to the patients, using equipment in a manner other than that recommended by the manufacturer can provide a basis for liability except where the use is subject to a claim of immunity. This, in effect, means that their may be liability for any emergency treatment for compensation, i.e., which is not voluntary. It may be possible, through an emergency declaration changing the overall standard of care, to use equipment in a manner not recommended if the purpose is to save the life, and still receive compensation. This may not preclude liability lawsuits, but it could lessen the likelihood of a successful claim. As for employees, and particularly with regard to personal protective equipment, the liability would be for workers compensation benefits. The Labor Code requires that every employer furnish and use safety devices and safeguards, and adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful. It is doubtful that, in an emergency, this requirement would be waived.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		product"). (3) Relation to other uses.--An emergency use authorized under paragraph (1) for a product is in addition to any other use that is authorized for the product under a provision of law referred to in such paragraph. (4) Definitions.—For purposes of this section: (A) The term "biological product" has the meaning given such term in 42 USC Section 351. (B) The term "emergency use" has the meaning indicated for such term in paragraph (1). (C) The term "product" means a drug, device, or biological product. (D) The term "unapproved product" has the meaning indicated for such term in paragraph (2)(A). (E) The term "unapproved use of an approved product" has the meaning indicated for such term in paragraph (2)(B). (b) DECLARATION OF EMERGENCY.— (1) IN GENERAL.—The Secretary may declare an emergency justifying the authorization under this subsection for a product on the basis of— (A) a determination by the Secretary of Homeland Security that there is a	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		domestic emergency, or a significant potential for a domestic emergency, involving a heightened risk of attack with a specified biological, chemical, radiological, or nuclear agent or agents; (B) a determination by the Secretary of Defense that there is a military emergency, or a significant potential for a military emergency, involving a heightened risk to United States military forces of attack with a specified biological, chemical, radiological, or nuclear agent or agents; or (C) a determination by the Secretary of a public health emergency under 42 USC Section 319 that affects, or has a significant potential to affect, national security, and that involves a specified biological, chemical, radiological, or nuclear agent or agents, or a specified disease or condition that may be attributable to such agent or agents. (2) Termination of declaration.— (A) In general.—A declaration under this subsection shall terminate upon the earlier of— (i) a determination by the Secretary, in consultation with the Secretary of Defense, that the circumstances described in paragraph (1) have ceased to exist; or (ii) the expiration of the one-year period beginning on the date on which the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		declaration is made. (B) Renewal.—Notwithstanding subparagraph (A), the Secretary may renew a declaration under this subsection, and this paragraph shall apply to any such renewal. (C) Disposition of product.—If an authorization under this section with respect to an unapproved product ceases to be effective as a result of a termination under subparagraph (A) of this paragraph, the Secretary shall consult with the manufacturer of such product with respect to the appropriate disposition of the product. (3) Advance notice of termination.—The Secretary shall provide advance notice that a declaration under this subsection will be terminated. The period of advance notice shall be a period reasonably determined to provide— (A) in the case of an unapproved product, a sufficient period for disposition of the product, including the return of such product (except such quantities of product as are necessary to provide for continued use consistent with 21 USC Section 360bbb-3 (f)(2)) to the manufacturer (in the case of a manufacturer that chooses to have such product returned); and (B) in the case of an unapproved use of an approved product, a sufficient period for the disposition of any labeling, or any	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		information under 21 USC Section 360bbb-3 (e)(2)(B)(ii), as the case may be, that was provided with respect to the emergency use involved. (4) Publication.—The Secretary shall promptly publish in the Federal Register each declaration, determination, advance notice of termination, and renewal under this subsection.	
What is the liability for Non-Governmental Organizations for the distribution of medical and health supplies?			A non-governmental organization can be held liable in negligence just as any other organization. The liabilities for the distribution of medical and health supplies can be either regulatory (i.e., criminal), or civil (e.g., for damages). Regulatory liabilities would arise where the item distributed is subject to regulatory controls and the non-governmental organization acts in violation of those controls, e.g., prescription drugs. Those controls could be waived by the Board of Pharmacy under Business and Professions Code Section 4062(b). Civil liability for non-governmental organizations during a declared emergency would depend upon whether the non-governmental organization was functioning as a disaster service organization, i.e., all of its employees are functioning as disaster service workers. If so, the employee's would be immune to liability under Civil Code Section 1714.5. Also, the Governor could issue orders that require non-governmental organizations to carry out certain functions, and they would not have liability under Civil Code Section 1714.6.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
What designated personnel are allowed to distribute medications during a surge, and what is their liability?	**I. California Business and Professions Code Section 4051** **II. California Business and Professions Code Section 4052.1**	**I. California Business and Professions Code Section 4051** Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous device, or to dispense or compound any prescription pursuant to Business and Professions Code Section 4040 of a prescriber unless he or she is a pharmacist under this chapter. **II. California Business and Professions Code Section 4052.1** (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions in a licensed healthcare facility in accordance with policies, procedures, or protocols developed by health professionals, including physicians, pharmacists, and registered nurses, with the concurrence of the facility administrator: (1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and	**I. California Business and Professions Code Section 4051** **Business and Professions Code Section 4062(b)** During a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the [Pharmacy] board's opinion, the waiver will aid in the protection of public health or the provision of patient care. **II. California Business and Professions Code Section 4052.1** **Business and Professions Code Section 4062(b)** During a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the [Pharmacy] board's opinion, the waiver will aid in the protection of public health or the provision of patient care.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		biologicals by injection pursuant to a prescriber's order. (4) Initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's prescriber and in accordance with the policies, procedures, or protocols of the licensed healthcare facility. (b) Prior to performing any procedure authorized by this section, a pharmacist shall have received appropriate training as prescribed in the policies and procedures of the licensed healthcare facility.	
	III. California Business and Professions Code Section 4052.2(a)	**III. California Business and Professions Code Section 4052.2(a)** (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions as part of the care provided by a healthcare facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed healthcare service plan with regard to the care or services provided to the enrollees of that healthcare service plan, or a physician, in accordance with the policies,	**III. California Business and Professions Code Section 4052.2(a)** **Business and Professions Code Section 4062(b** During a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the [Pharmacy] board's opinion, the waiver will aid in the protection of public health or the provision of patient care.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		procedures, or protocols of that facility, home health agency, licensed clinic, healthcare service plan, or physician, and in accordance with subdivision (c): (1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and biologicals by injection pursuant to a prescriber's order. (4) Initiating or adjusting the drug regimen of a patient pursuant to a specific written order or authorization made by the individual patient's treating prescriber, and in accordance with the policies, procedures, or protocols of the healthcare facility, home health agency, licensed clinic, healthcare service plan, or physician. Adjusting the drug regimen does not include substituting or selecting a different drug, except as authorized by the protocol. The pharmacist shall provide written notification to the patient's treating prescriber, or enter the appropriate information in an electronic	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Can law be flexed or altered? Are there applicable waivers?
		patient record system shared by the prescriber, of any drug regimen initiated pursuant to this paragraph within 24 hours.	

3.7 Administration

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
To what extent will current provider/ facility reporting requirements remain in effect during a declared disaster (e.g., diseases, births, deaths)?	**I. Disease Reporting/ Notification** 17 CCR 2500(b), (h), (j) Health and Safety Code Sections 120130, 120176, 120185, 120190, 120250	**I. Disease Reporting/ Notification** *17 CCR 2500* (b) It shall be the duty of every healthcare provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed in subsection (j) of this section, to report to the local health officer for the jurisdiction where the patient resides as required in 17 CCR 2500 (h). Where no healthcare provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed in 17 CCR 2500 (j) may make such a report to the local health officer for the jurisdiction where the patient resides. (h) The urgency of reporting is identified by symbols in the list of diseases and conditions in 17 CCR 2500 (j). Those diseases with a diamond (r) are considered emergencies and shall be reported immediately by telephone. Those diseases and conditions with a cross (+) shall be reported by mailing, telephoning or electronically transmitting a report within one (1) working day of identification of the case or suspected case. Those diseases and conditions not otherwise identified by a diamond or a cross shall be reported by mailing a written report, telephoning, or electronically transmitting a report within seven (7) calendar days of the time of identification. (j) Healthcare providers shall submit reports for the following diseases or conditions. [Listed below are all diseases and conditions that have been labeled with a (r)] Anthrax, Botulism (Infant, Foodborne, Wound,	**I. Disease Reporting/ Notification** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) Disease reporting is a regulatory statute. Consequently, it can be waived under Government Code Section 8571. However, it is unlikely that this requirement would be waived. In the aftermath of a disaster, the potential for an outbreak of disease is increased and may be one of the effects of the emergency. Waiving the reporting requirement would frustrate the ability of government to mitigate this effect of the emergency. Consequently, the likelihood that the

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Other), Brucellosis, Cholera, Ciguatera Fish Poisoning, Dengue, Diarrhea of the Newborn-Outbreaks, Diphtheria, Domoic Acid Poisoning (Amnesic Shellfish Poisoning), Escherichia coli O157:H7 Infection, Hantavirus Infections, Hemolytic Uremic Syndrome, Meningococcal Infections, Paralytic Shellfish Poisoning, Plague-Human or Animal, Rabies-Human or Animal, Scombroid Fish Poisoning, Severe Acute Respiratory Infection, Shiga toxin (detected in feces), Smallpox (Variola), Tularemia, Varicella (deaths only), Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Margurg viruses), Yellow fever, Occurrence of any unusual disease, Outbreaks of any disease (including diseases not listed in 17 CCR 2500) *Health and Safety Code Section 120130* (a) The department shall establish a list of reportable diseases and conditions and shall include the urgency of reporting each disease and condition. The list of reportable diseases and conditions may include both communicable and noncommunicable diseases. The list may include those diseases that are either known to be, or suspected of being, transmitted by milk or milk-based products. The list shall also include, but not be limited to, diphtheria, listeria, salmonella, shigella, streptococcal infection in food handlers or dairy workers, and typhoid. The list may be modified at any time by the department, after consultation with the California Conference of Local Health Officers. Modification of the list shall be exempt from the administrative regulation and rulemaking requirements of Government Code Section 11340, Title 2, Division 3, Part 1, Chapter 3.5, and shall be implemented without being adopted as a regulation, except that the revised list shall be filed with the Secretary of State and printed in the California Code of Regulations as required under subdivision (d). Those	Governor's authority to suspend regulatory statutes would used to waive this requirement is extremely low. If circumstances make timely reporting impossible, then it is highly unlikely that healthcare providers would incur any liability for failure to report in a timely manner.

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		diseases listed as reportable shall be properly reported as required to the department by the health officer. (b) The department may from time to time adopt and enforce regulations requiring strict or modified isolation, or quarantine, for any of the contagious, infectious, or communicable diseases, if in the opinion of the department the action is necessary for the protection of the public health. (c) The health officer may require strict or modified isolation, or quarantine, for any case of contagious, infectious, or communicable disease, when this action is necessary for the protection of the public health. (d) The list established pursuant to subdivision (a) and any subsequent modifications shall be published in 17 CCR. (e) Notwithstanding any other provision of law, no civil or criminal penalty, fine, sanction, finding, or denial, suspension, or revocation of licensure for any person or facility may be imposed based upon a failure to provide the notification of a reportable disease or condition that is required under this section, unless the disease or condition that is required to be reported was printed in the California Code of Regulations at least six months prior to the date of the claimed failure to report. *Health and Safety Code Section 120185* In the case of a local epidemic of disease, the health officer shall report at those times as are requested by the department all facts concerning the disease, and the measures taken to abate and prevent its spread. *Health and Safety Code Section 120190* Each health officer shall immediately report by telegraph or telephone to the department every discovered or known case or suspect case of those diseases	

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		designated for immediate reporting by the department. Within 24 hours after investigation each health officer shall make reports as the department may require. *Health and Safety Code Section 120250* All physicians, nurses, clergymen, attendants, owners, proprietors, managers, employees, and persons living with, or visiting any sick person, in any hotel, lodginghouse, house, building, office, structure, or other place where any person is ill of any infectious, contagious, or communicable disease, shall promptly report that fact to the health officer, together with the name of the person, if known, the place where he or she is confined, and the nature of the disease, if known.	
	II. Suspicious Injury Reports Penal Code Section 11160(a)-(d) Penal Code Section 11161 California Hospital Association Consent Manual 2006: Chapter 19 – Assault and Abuse Reporting Requirements	**II. Suspicious Injury Reports** *Penal Code Section 11160(a)-(d)* (a) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows, shall immediately make a report in accordance with subdivision (b): (1) Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm. (2) Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct. (b) Any health practitioner employed in a health facility,	**II. Suspicious Injury Reports** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The suspicious injury reporting requirement is a regulatory statute. Consequently, it can be

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		clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department shall make a report regarding persons described in subdivision (a) to a local law enforcement agency as follows: (1) A report by telephone shall be made immediately or as soon as practically possible. (2) A written report shall be prepared on the standard form developed in compliance with paragraph (4) of this subdivision, and Penal Code Section 11160.2, and adopted by the agency or agencies designated by the Director of Finance pursuant to Penal Code Section 13820, or on a form developed and adopted by another state agency that otherwise fulfills the requirements of the standard form. The completed form shall be sent to a local law enforcement agency within two working days of receiving the information regarding the person. (3) A local law enforcement agency shall be notified and a written report shall be prepared and sent pursuant to paragraphs (1) and (2) even if the person who suffered the wound, other injury, or assaultive or abusive conduct has expired, regardless of whether or not the wound, other injury, or assaultive or abusive conduct was a factor contributing to the death, and even if the evidence of the conduct of the perpetrator of the wound, other injury, or assaultive or abusive conduct was discovered during an autopsy. (4) The report shall include, but shall not be limited to, the following: (A) The name of the injured person, if known. (B) The injured person's whereabouts. (C) The character and extent of the person's injuries. (D) The identity of any person the injured person alleges	waived under Government Code Section 8571. However, it is unlikely that this requirement would be waived. In the aftermath of a disaster, the potential for a breakdown in social order, including an increased number of criminal assaults and homicides, is high. Reports of suspicious injuries by healthcare providers may be the only way for law enforcement to become aware that a crime has been committed in their jurisdiction, and to commence an appropriate investigation to apprehend offenders. Consequently, the likelihood that the Governor's authority to suspend regulatory statutes would used to waive this requirement is extremely low. If circumstances make timely reporting impossible, then it is highly unlikely that healthcare providers would incur any liability for failure to report in a timely manner.

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		inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person. (c) For the purposes of this section, “injury” shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug. (d) For the purposes of this section, “assaultive or abusive conduct” shall include any of the following offenses: (1) Murder, in violation of Penal Code Section 187. (2) Manslaughter, in violation of Penal Code Section 192 or 192.5. (3) Mayhem, in violation of Penal Code Section 203. (4) Aggravated mayhem, in violation of Penal Code Section 205. (5) Torture, in violation of Penal Code Section 206. (6) Assault with intent to commit mayhem, rape, sodomy, or oral copulation, in violation of Penal Code Section 220. (7) Administering controlled substances or anesthetic to aid in commission of a felony, in violation of Penal Code Section 222. (8) Battery, in violation of Penal Code Section 242. (9) Sexual battery, in violation of Penal Code Section 243.4. (10) Incest, in violation of Penal Code Section 285. (11) Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, in violation of Penal Code Section 244. (12) Assault with a stun gun or taser, in violation of	

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		Penal Code Section 244.5. (13) Assault with a deadly weapon, firearm, assault weapon, or machinegun, or by means likely to produce great bodily injury, in violation of Penal Code Section 245. (14) Rape, in violation of Penal Code Section 261. (15) Spousal rape, in violation of Penal Code Section 262. (16) Procuring any female to have sex with another man, in violation of Penal Code Section 266, 266a, 266b, or 266c. (17) Child abuse or endangerment, in violation of Penal Code Section 273a or 273d. (18) Abuse of spouse or cohabitant, in violation of Penal Code Section 273.5. (19) Sodomy, in violation of Penal Code Section 286. (20) Lewd and lascivious acts with a child, in violation of Penal Code Section 288. (21) Oral copulation, in violation of Penal Code Section 288a. (22) Sexual penetration, in violation of Penal Code Section 289. (23) Elder abuse, in violation of Penal Code Section 368. (24) An attempt to commit any crime specified in paragraphs (1) to (23), inclusive. Penal Code Section 11161 Notwithstanding Penal Code Section 11160, the following shall apply to every physician or surgeon who has under his or her charge or care any person	

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		described in Penal Code Section 11160 (a): (a) The physician or surgeon shall make a report in accordance with Penal Code Section 11160 (b) to a local law enforcement agency. (b) It is recommended that any medical records of a person about whom the physician or surgeon is required to report pursuant to Penal Code Section 11160 (a) include the following: (1) Any comments by the injured person regarding past domestic violence, as defined in Penal Code Section 13700, or regarding the name of any person suspected of inflicting the wound, other physical injury, or assaultive or abusive conduct upon the person. (2) A map of the injured person's body showing and identifying injuries and bruises at the time of the healthcare. (3) A copy of the law enforcement reporting form. It is recommended that the physician or surgeon refer the person to local domestic violence services if the person is suffering or suspected of suffering from domestic violence, as defined in Penal Code Section 13700. California Hospital Association Consent Manual 2006: Chapter 19 – Assault and Abuse Reporting Requirements *A. Who Must Report.* Reports must be made by (1) any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department, and (2) a physician who has an injured patient under his or her charge or care. The reporting duties under this law are individual, provided that when two or more persons who	

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		are required to report are present and jointly have knowledge of a reportable event, they may agree among themselves to report as a team. The team may mutually select a member of the team to make a report by telephone and a single written report. The written report must be signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so must thereafter make the report. No supervisor or administrator may impede or inhibit the reporting duties required under law and no person making a report may be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established consistent with the above. The internal procedures must not require any employee required to make a report to disclose his or her identity to the employer. *B. Reports Required to Be Made.* A report must be made when a health practitioner, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows: 1. A person suffering from any wound or other physical injury where the injury is by means of a firearm, whether inflicted by the patient him/herself or by another person. 2. A person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct [Penal Code Section 11160]. The duty to report arises where the health practitioner provides medical services to a patient for any physical condition, not just the condition or injury arising from the assault, battery or firearm incident. A report must also be made by every physician who has such a person under his or her charge or care [Penal	

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		Code Section 11161(a)].	
	III. Crime Scene/Evidence Collection Requirements (Disclosing Information to Law Enforcement) – 45 CFR 164.512(f)(3), (5), (6)	**III. Crime Scene/Evidence Collection Requirements (Disclosing Information to Law Enforcement)** 45 CFR 164.512(f)(3), (5), (6) *(3) Permitted disclosure: victims of a crime.* Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if: (i) The individual agrees to the disclosure; or (ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that: (A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim. (B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and (C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment. (5) *Permitted disclosure: crime on premises.* A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity. (6) *Permitted disclosure: reporting crime in*	**III. Crime Scene/Evidence Collection Requirements** This requirement is based on federal law and could not be waived by the Governor. However, it appears to be within the authority of the federal Health and Human Services Secretary to waive under 42 U.S.C. 1320b-5, which authorizes, among other things, a waiver of certain HIPAA requirements. However, this appears to fall far short of a complete waiver of HIPAA. Although, by waiving HIPAA requirements, the Secretary may be foregoing his/her ability to seek civil money penalties, a person or receiving hospital harmed by an unlawful transfer would still have its ability to seek relief.

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		emergencies. (i) A covered healthcare provider providing emergency healthcare in response to a medical emergency, other than such emergency on the premises of the covered healthcare provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to: (A) The commission and nature of a crime; (B) The location of such crime or of the victim(s) of such crime; and (C) The identity, description, and location of the perpetrator of such crime.	
	IV. Reportable "Unusual Occurrences" 22 CCR 70737 and 71535	**IV. Reportable "Unusual Occurrences"** All cases of reportable diseases shall be reported to the local health officer in accordance with 17 CCR 2500, Chapter 4, Subchapter 4, Article 1. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require.	**IV. Reportable "Unusual Occurrences"** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) Disease reporting is a regulatory statute. Consequently, it can be waived under

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			Government Code Section 8571. However, it is unlikely that this requirement would be waived. In the aftermath of a disaster, the potential for an outbreak of disease is increased and may be one of the effects of the emergency. Waiving the reporting requirement would frustrate the ability of government to mitigate this effect of the emergency. Consequently, the likelihood that the Governor's authority to suspend regulatory statutes would used to waive this requirement is extremely low. If circumstances make timely reporting impossible, then it is highly unlikely that healthcare providers would incur any liability for failure to report in a timely manner.
	V. Crime Reporting/Law Enforcement – Each subsection below contains a reference to California law as well as reference to the California Hospital Association Consent Manual 2006 i) *Violence Against Hospital Personnel* – California Health and Safety Code Section 1257.7(d) ii) *Violence Against Community Healthcare Worker* – California Labor Code Section 6332 iii) *Child Abuse and Neglect* – Penal Code Section 11164-11174.3 (select sections	**V. Crime Reporting/ Law Enforcement** *Violence Against Hospital Personnel – Health and Safety Code Section 1257.7(d)* Any act of assault, as defined in Penal Code Section 240, or battery, as defined in Penal Code Section 242 , that results in injury or involves the use of a firearm or other dangerous weapon, against any on-duty hospital personnel shall be reported to the local law enforcement agency within 72 hours of the incident. Any other act of assault, as defined in Penal Code Section 240, or battery as defined in Penal Code Section 242, against any on-duty hospital personnel may be reported to the local law enforcement agency within 72 hours of the incident. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery pursuant to this section shall be civilly or criminally liable for any report required by this	**V. Crime Reporting/Law Enforcement** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate

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	included in Summary) iv) *Abuse of Elders and Dependent Adults* – Welfare and Institutions Code Section 15600-15659 v) *Injury or Condition in a Patient Received From a Licensed Health Facility Resulting from Neglect or Abuse* – Penal Code Section 11161.8	section. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery that is authorized, but not required, by this section, shall be civilly or criminally liable for the report authorized by this section unless it can be proven that a false report was made and the health facility or its employee knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any health facility or employee of a health facility who makes a report known to be false or with reckless disregard of the truth or falsity of the report shall be liable for any damages caused. Any individual knowingly interfering with or obstructing the lawful reporting process shall be guilty of a misdemeanor. "Dangerous weapon," as used in this section, means any weapon the possession or concealed carrying of which is prohibited by Penal Code Section 12020. *Violence Against Community Healthcare Worker – Labor Code Section 6332* (a) For purposes of this section, the following terms have the following meanings: (1) "Community healthcare worker" means an individual who provides healthcare or healthcare-related services to clients in home settings. (2) "Employer" means a person or entity that employs a community healthcare worker. "Employer" does not include an individual who is a recipient of home-based services and who is responsible for hiring his or her own community healthcare worker. (3) "Violence" means a physical assault or a threat of a physical assault. (b) Every employer shall keep a record of any violence committed against a community healthcare worker and shall file a copy of that record with the Division of Labor Statistics and Research in the form and detail and within the time limits prescribed by the Division of Labor Statistics and	4th 1416, 143435.) The violence against hospital personnel or community health worker reporting requirement is a regulatory statute. Consequently, it can be waived under Government Code Section 8571. Whether it is waived may depend upon whether this is what the healthcare community wants. In the aftermath of a disaster, the potential for violent behavior against medical staff is increased. Hospitals and clinics may possess resources that others may be desperate to acquire. Reports of violence against hospital healthcare providers or community health workers is for the benefit of the providers. Consequently, the likelihood that the Governor's authority to suspend regulatory statutes would used to waive this requirement is extremely low absent an indication from all parties that suspension is necessary to mitigate the effects of the emergency. Similarly, suspension of the requirement for reports of suspected child or elder abuse seems unlikely. If circumstances make timely reporting impossible, then it is highly unlikely that healthcare providers would incur any liability for failure to report in a timely manner.

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		Research. *Child Abuse and Neglect – Penal Code Section 11164-11174.3* Penal Code Section 11165.7(a)(21)-(28). As used in this article, "mandated reporter" is defined as any of the following: (21) A physician, surgeon, psychiatrist, psychologist, dentist, hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Business and Professions Code Section 500, Division 2; (22) Any emergency medical technician I or II, paramedic, or other person certified pursuant to Health and Safety Code Section 1797, Division 2.5; (23) A psychological assistant registered pursuant to Business and Professions Code Section 2913; (24) A marriage, family, and child therapist trainee, as defined in subdivision (c) of the Business and Professions Code Section 4980.03; (25) An unlicensed marriage, family, and child therapist trainee, as defined in subdivision (c) of the Business and Professions Code Section 4980.44; (26) A state or county public health employee who treats a minor for venereal disease or any other condition; (27) A coroner; (28) A medical examiner, or any other person who performs autopsies. *Penal Code Section 11165.9.* Reports of suspected child abuse or neglect shall be made by mandated reports, or in the case of reports pursuant to Penal Code Section 11166.05, may be made, to any police department or sheriff's department, not including a school district police or security department, county probation department, if designated by the county to receive mandated reports, or the county welfare department. Any of those agencies shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person, or referred by	

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		another agency, even if the agency to whom the report is being made lacks subject matter or geographical jurisdiction to investigate the reported case, unless the agency can immediately electronically transfer the call to an agency with proper jurisdiction. When an agency takes a report about a case of suspected child abuse or neglect in which that agency lacks jurisdiction, the agency shall immediately refer the case by telephone, fax, or electronic transmission to an agency with proper jurisdiction. Agencies that are required to receive reports of suspected child abuse or neglect from a mandated reporter or another person unless otherwise authorized pursuant to this section, and shall maintain a record of all reports received. *Penal Code Section 11166(a)(2).* Except as provided in subdivision (d), and in Penal Code Section 11166.05, a mandated reporter shall make a report to an agency specified in Penal Code Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make an initial report to the agency immediately or as soon as is practicably possible by telephone and the mandated reporter shall prepare and send, fax, or electronically transmit a written follow-up report thereof within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any nonprivileged documentary evidence the mandated reporter possesses relating to the incident. *Penal Code Section 11166(b).* The agency shall be notified and a report shall be prepared and sent, faxed, or electronically transmitted even if the child has expired, regardless of whether or not the possible abuse	

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		was a factor contributing to the death, and even if suspected child abuse was discovered during an autopsy. *Penal Code Section 11166(b)(5).* Nothing in this section shall supersede the requirement that a mandated reporter first attempt to make a report via telephone, or that agencies specified in Section 11165.9 accept reports from mandated reporters and other persons as required. *Penal Code Section 11166(c).* Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that imprisonment and fine. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until an agency specified in Section 11165.9 discovers the offense. *Penal Code Section 11166.01(b).* Notwithstanding Penal Code Section 11162 or subdivision (c) of Penal Code Section 11166, any mandated reporter who willfully fails to report abuse or neglect, or any person who impedes or inhibits a report of abuse or neglect, in violation of this article, where that abuse or neglect results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment. *Penal Code Section 11166.2.* In addition to the reports required under Penal Code Section 11166, any agency specified in Penal Code Section 11165.9 shall immediately or as soon as practically possible report by	

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		telephone, fax, or electronic transmission to the appropriate licensing agency every known or suspected instance of child abuse or neglect when the instance of abuse or neglect occurs while the child is being cared for in a child day care facility, involves a child day care licensed staff person, or occurs while the child is under the supervision of a community care facility or involves a community care facility licensee or staff person. The agency shall also send, fax, or electronically transmit a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it makes a telephone report under this subdivision. The agency shall send the licensing agency a copy of its investigation report and any other pertinent materials. *Abuse of Elders and Dependent Adults – Welfare and Institutions Code Section 15600-15659* *Penal Code 15630(b)(1).* Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Penal Code Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall repot the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days, as follows: (A) If the abuse has occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the report shall be made to the local ombudsperson or the local law enforcement agency. Except in an emergency, the local ombudsperson and the local law enforcement agency shall, as soon as	

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		practicable, do all of the following: (i) Report to the State Department of Public Health any cause of known or suspected abuse occurring in a long-term healthcare facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code. (ii) Report to the State Department of Social Services any case of known or suspected abuse occurring in a residential care facility for the elderly, as defined in Health and Safety Code Section 1569.2, or in an adult day care facility, as defined in paragraph (2) of subdivision (a) of Health and Safety Code Section 1502. (iii) Report to the State Department of Public Health and the California Department of Aging any case of known or suspected abuse occurring in an adult day healthcare center, as defined in subdivision (b) of Health and Safety Code Section 1570.7. (iv) Report to the Bureau of Medi-Cal Fraud and Elder Abuse any case of known or suspected criminal activity. (B) If the suspected or alleged abuse occurred in a state mental hospital or a state developmental center, the report shall be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services, or to the local law enforcement agency. Except in an emergency, the local law enforcement agency shall, as soon as practicable, report any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse. (C) If the abuse has occurred any place other than one described in subparagraph (A), the report shall be made to the adult protective services agency or the local law enforcement agency *Penal Code Section 15630(b)(3).* (A) A mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report, pursuant to paragraph (1), an incident where all of the	

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		following conditions exist: (i) The mandated reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, as defined in Welfare and Institutions Code Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect. (ii) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred. (iii) The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia. (iv) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Evidence Code Section 1010, reasonably believes that the abuse did not occur. *Penal Code Section 15630(h).* Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Welfare and Institutions Code Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment. Any mandated reporter of, physical abuse, as defined in Welfare and Institutions Code Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment. If a mandated reporter intentionally conceals his or her failure to report and incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency	

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		specified in paragraph (1) of subdivision (b) of Welfare and Institutions Code Section 15630 discovers the offense. *Injury or Condition in a Patient Received From a Licensed Health Facility Resulting from Neglect or Abuse* Every person, firm, or corporation conducting any hospital in the state, or the managing agent thereof, or the person managing or in charge of such hospital, or in charge of any ward or part of such hospital, who receives a patient transferred from a health facility, as defined in Health and Safety Code Section 1250 or from a community care facility, as defined in Health and Safety Code Section 1502, who exhibits a physical injury or condition which, in the opinion of the admitting physician, reasonably appears to be the result of neglect or abuse, shall report such fact by telephone and in writing, within 36 hours, to both the local police authority having jurisdiction and the county health department. Any registered nurse, licensed vocational nurse, or licensed clinical social worker employed at such hospital may also make a report under this section, if, in the opinion of such person, a patient exhibits a physical injury or condition which reasonably appears to be the result of neglect or abuse. Every physician and surgeon who has under his charge or care any such patient who exhibits a physical injury or condition which reasonably appears to be the result of neglect or abuse shall make such report. The report shall state the character and extent of the physical injury or condition. No employee shall be discharged, suspended, disciplined, or harassed for making a report pursuant to this section. No person shall incur any civil or criminal liability as a result of making any report authorized by this section.	

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	VI. Office of Statewide Health Planning and Development Reporting http://www.oshpd.ca.gov/oshpdKEY/SubmitData.htm Office of Statewide Health Planning and Development Accounting and Reporting Manual for California Hospitals: Appendix C: Extension Procedure	**VI. Office of Statewide Health Planning and Development Reporting** The Office of Statewide Health Planning and Development mandates eight (8) reports for healthcare facilities. These include: 1. Annual Financial – Hospitals are required to submit a Hospital Annual Disclosure Report within 4 months of the hospital's fiscal year end. The report contains: type of ownership and inventory of provided services; number of beds and corresponding utilization patient statistics by payer; balance sheet and income statement; revenues by payer and revenue center; expenses by natural classification and cost center; and productive hours and average hourly rates by employee classification and cost center. 2. Annual Utilization (Automated Licensing Information and Report Tracking System) – Contains license and utilization data information of healthcare facilities in California. 3. Coronary Artery Bypass Graft Surgeries – The California Coronary Artery Bypass Graft Outcomes Reporting Program collects clinical data from hospital cardiac units and reports risk-adjusted outcomes annually at the hospital level and bi-annually at the surgeon level . 4. Chargemaster – Makes certain pricing information available to the public. This report is submitted annually and required by Assembly Bill 1045 (Chapter 532, Statutes of 2005) and Assembly Bill 1627 (Chapter 582, Statutes of 2003) 5. Community Benefits – Private nonprofit hospitals are required to conduct a community needs assessment every 3 years to develop a community benefit plan in consultation with the community and annually submit a copy of its plan to the Office of Statewide Health Planning and Development. 6. Medical Information Reporting for California – Inpatient Discharges – Semi-annual report. Healthcare	**VI. Office of Statewide Health Planning and Development Reporting** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 143435.) The Office of Statewide Health Planning and Development reporting requirement is a regulatory statute. Consequently, it can be waived under Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		facilities are required to submit Patient Discharge data to include: patient demographic information, diagnostic information, The International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis codes, Diagnosis-Related Group and MDC groupings, treatment information, The International Classification of Diseases, Ninth Revision, Clinical Modification procedure codes, external cause of injury codes (E-codes), and total charges with expected principal source of payment. 7. Medical Information Reporting for California – Emergency Department Data – Section Health and Safety Code 128736 requires hospital emergency care data records for each patient encounter to be reported to the Office of Statewide Health Planning and Development. 8. Medical Information Reporting for California – Ambulatory Surgery Data – Health and Safety Code Section 128737 requires ambulatory surgery data records from hospitals and freestanding ambulatory surgery clinics to be reported to the Office of Statewide Health Planning and Development. 9. Quarterly Financial (internet Hospital Quarterly Reporting System) – This report is to be submitted 45 days after the end of each calendar quarter and contains data on capacity and utilization summary income statements; revenue and expenses by payer; and capital expenditures and fixed assets. The Office of Statewide Health Planning and Development allows for “reasonable flexibility of report due dates to account for disasters or other situations that could not have been anticipated. Extensions are available to health facilities that are unable to complete or correct their disclosure reports by the prescribed dates.” Extensions are available to health facilities that are unable to complete or correct their disclosure reports by the prescribed dates.	

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	VII. Birth & Death Reporting Birth Reporting – Health and Safety Code Sections 102400-102415 Death Reporting – Health and Safety Code Section 102775 California Health and Safety Code Sections 103450(b), (c), 103451, 103465, 103466, 103490(b)	**VII. Birth & Death Reporting** Birth Reporting Health and Safety Code Section 102400. Each live birth shall be registered with the local registrar of births and deaths for the district in which the birth occurred within 10 days following the date of the emergency. Health and Safety Code Section 102405. For live births that occur in a hospital, or a state-licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Health and Safety Code Section 1204, the administrator of the hospital or center or a representative designated by the administrator in writing may sign the birth certificate certifying the fact of birth instead of the attending physician and surgeon, certified nurse midwife, or principal attendant if the physician and surgeon, certified nurse midwife, or principal attendant is not available to sign the certificate; and shall be responsible for registering the certificate with the local registrar within the time specified in Health and Safety Code Section 102400. Health and Safety Code Section 102410. For those live births occurring in a hospital, and upon a parent's request, a footprint shall be taken of the child prior to discharge from the facility and shall be made available to the parents. The footprint shall be placed on a sheet of paper that is separate from the birth certificate, shall only be prepared for the parents prior to discharge from the hospital, and need not be retained or kept on file. Health and Safety Code Section 102415. For live births that occur outside of a hospital or outside of a state-licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Health and Safety Code Section 1204, the physician in attendance at the birth or,	**VII. Birth & Death Reporting** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The birth and death reporting requirement is a regulatory statute. Consequently, it can be waived under Government Code section 8571. However, it is unlikely that this requirement would be waived in its entirety. In the aftermath of a disaster, there will likely be many deaths and the county clerk's registry of births and deaths will play a vital role in determining which persons have died, for purposes of notifying next of kin. Also, some record of births seems essential to ensure that newborns are included in disaster relief, and can subsequently enjoy a provable identity. Consequently, the likelihood that the Governor's authority to suspend

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		in the absence of a physician, the professionally licensed midwife in attendance at the birth or, in the absence of a physician or midwife, either one of the parents shall be responsible for entering the information on the certificate, securing the required signatures, and for registering the certificate with the local registrar. Death Reporting Health and Safety Code Section 102775. Each death shall be registered with the local registrar of births and deaths in the district in which the death was officially pronounced or the body was found, within eight calendar days after death and prior to any disposition of the human remains. Health and Safety Code Section 103450(b). In the event of a mass fatalities incident, a verified petition may be filed by a coroner, medical examiner, or any beneficially interested person with the clerk of the superior court in and for (1) the county in which the death is alleged to have occurred, or (2) the county in which the person was domiciled at the date of death for an order to judicially establish the fact of, and the time and place of, a death that is not registered or for which a certified copy of the death certificate is not obtainable. Health and Safety Code Section 103451. For purposes of this chapter, “mass fatalities incident” means a situation in which any of the following conditions exist: (1) There are more dead bodies than can be handled using local resources. (2) Numerous persons are known to have died, but no bodies were recovered from the site of the incident. (3) Numerous persons are known to have died, but the recovery and identification of the bodies of those persons is impracticable or impossible. (b) The county coroner or medical examiner may make the determination that a condition described in	regulatory statutes would used to waive this requirement is extremely low, although it may be possible to extend the period of time in which reports must be made. If circumstances make timely reporting impossible, then it is highly unlikely that healthcare providers would incur any liability for failure to report in a timely manner.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		subdivision (a) exists. Health and Safety Code Section 103465. Upon the filing of the petition a hearing shall be fixed by the clerk and at the convenience of the court set at a time not less than five nor more than 10 days after the filing of the petition. The hearing may be held in chambers. The court, for good cause, may continue the hearing beyond the 10-day period. Health and Safety Code Section 103466. Notwithstanding Health and Safety Code Section 103465, upon the filing of a petition for a determination of the fact of death in the event of a mass fatalities incident, the clerk shall set a hearing no later than 15 days from the date the petition was filed. The petitioner shall make a reasonable effort to provide notice of the hearing to the known heirs of the deceased up to the second degree of relationship. Failure to provide the notice specified in this section shall not invalidate the judicial proceedings regarding the determination of the fact of death. Health and Safety Code Section 103490(b). In the event of a mass fatalities incident, the State Registrar, without delay, shall send certified copies of the court order delayed death certificate to the local registrar and the county recorder of the county in which the incident occurred and in whose offices copies of records of the year of occurrence of the incident are on file. The State Registrar, without delay, also shall send a certified copy of the court order delayed death certificate to the spouse or next of kin of the decedent, if there is no spouse, provided the spouse or next of kin's name and address information are included in the court order or on the application form submitted by the spouse, next of kin, coroner, or medical examiner. However, if the incident occurred outside the state, a certified copy shall	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		be sent only to the county recorder of the county in which the decedent was domiciled at the date of death.	
To what extent will current provider/ facility reporting requirements remain in effect during a declared disaster (e.g., diseases, births, deaths)?	**VIII. Cancer Registry** Health and Safety Code Section 103885(a)(2)	**VIII. Cancer Registry** Health and Safety Code Section 103885. (a) The director shall establish a statewide system for the collection of information determining the incidence of cancer, using population-based cancer registries modeled after the Cancer Surveillance Program of Orange County. As of the effective date of this section the director shall begin phasing in the statewide cancer reporting system. By July 1, 1988, all county or regional registries shall be implemented or initiated. By July 1, 1990, the statewide cancer reporting system shall be fully operational. Within 60 days of the effective date of this section, the director shall submit an implementation and funding schedule to the Legislature. (2) Any physician and surgeon, dentist, podiatrist, or other healthcare practitioner diagnosing or providing treatment for cancer patients shall report each cancer case to the department or the authorized representative of the department except for those cases directly referred to a treatment facility or those previously admitted to a treatment facility for diagnosis or treatment of that instance of cancer.	**VIII. Cancer Registry** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The cancer registry reporting requirement is a regulatory statute. Consequently, it can be waived under Government Code Section 8571.
	IX. Reporting Adverse Reactions to Vaccinations 42 USC Section 300aa-25, 42 USC Section 300aa-14 http://www.vaers.hhs.gov/	**IX. Reporting Adverse Reactions to Vaccinations** *42 USC Section 300aa-25(b).* (1) Each healthcare provider and vaccine manufacturer shall report to the Secretary – (A) the occurrence of any event set forth in the Vaccine Injury Table, including the events set forth in 42 USC Section 300aa-14(b) which occur within 7 days of the administration of any vaccine set forth in the Table or within such longer period as is specified in the	**IX. Reporting Adverse Reactions to Vaccinations** This requirement is based on federal law and could not be waived by the Governor. In addition, it does not appear that a waiver of this requirement is authorized under 42 U.S.C. 1320b-5.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Table or section, (B) the occurrence of any contraindicating reaction to a vaccine which is specified in the manufacturer's package insert, and (C) such other matters as the Secretary may by regulation require. Reports of the matters referred to in subparagraphs (A) and (B) shall be made beginning 90 days after December 22, 1987. The Secretary shall publish in the Federal Register as soon as practicable after such date a notice of the reporting requirement. (2) A report under paragraph (1) respecting a vaccine shall include the time periods after the administration of such vaccine within which vaccine-related illnesses, disabilities, injuries, or conditions, the symptoms and manifestations of such illnesses, disabilities, injuries, or conditions, or deaths occur, and the manufacturer and lot number of the vaccine. (3) The Secretary shall issue the regulations referred to in paragraph (1)(C) within 180 days of December 22, 1987. *US 42 300aa-14(a)-(b).* (a) Initial table The following is a table of vaccines, the injuries, disabilities, illnesses, conditions, and deaths resulting from the administration of such vaccines, and the time period in which the first symptom or manifestation of onset or of the significant aggravation of such injuries, disabilities, illnesses, conditions, and deaths is to occur after vaccine administration for purposes of receiving compensation under the Program: The Vaccine Adverse Event Reporting System (VAERS) This Web site provides a nationwide mechanism by which adverse events following immunization may be reported, analyzed and made available to the public. The Vaccine Adverse Event Reporting System Web site also provides a vehicle for disseminating vaccine safety-related information to parents/guardians, healthcare	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		providers, vaccine manufacturers, state vaccine programs, and other constituencies. VACCINE INJURY TABLE I. DTP; P; DTP/Polio Combination; or Any Other Vaccine Containing Whole Cell Pertussis Bacteria, Extracted or Partial Cell Bacteria, or Specific Pertussis Antigen(s). Illness, disability, injury, or condition covered: — Time period for first symptom or manifestation of onset or of significant aggravation after vaccine administration:	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements		Analysis
		A. Anaphylaxis or anaphylactic shock	24 hours	
		B. Encephalopathy (or encephalitis)	3 days	
		C. Shock-collapse or hypotonic-hyporesponsive collapse	3 days	
		D. Residual seizure disorder in accordance with subsection (b)(2)	3 days	
		E. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose	Not applicable	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements		Analysis
		within the time period prescribed		
		II. Measles, mumps, rubella, or any vaccine containing any of the foregoing as a component; DT; Td; or Tetanus Toxoid.		
		A. Anaphylaxis or anaphylactic shock	24 hours	
		B. Encephalopathy (or encephalitis)	15 days (for mumps, rubella, measles, or any vaccine containing any of the foregoing as a component). 3 days (for DT, Td, or tetanus toxoid).	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements		Analysis
		C. Residual seizure disorder in accordance with subsection (b)(2)	15 days (for mumps, rubella, measles, or any vaccine containing any of the foregoing as a component). 3 days (for DT, Td, or tetanus toxoid).	
		D. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed	Not applicable	
		III. Polio Vaccines (other than Inactivated Polio Vaccine).		

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements		Analysis
		A. Paralytic polio		
		—in a non-immunodeficient recipient	30 days	
		—in an immunodeficient recipient	6 months	
		—in a vaccine-associated community case	Not applicable	
		B. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed	Not applicable	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		IV. Inactivated Polio Vaccine. A. Anaphylaxis or anaphylactic shock — 24 hours B. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed — Not applicable (b) Qualifications and aids to interpretation The following qualifications and aids to interpretation shall apply to the Vaccine Injury Table in subsection (a) of this section: (1) A shock-collapse or a hypotonic-hyporesponsive collapse may be evidenced by indicia or symptoms such as decrease or loss of muscle tone, paralysis (partial or complete), hemiplegia or hemiparesis, loss of color or turning pale white or blue, unresponsiveness to environmental stimuli, depression of consciousness, loss of consciousness, prolonged	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		sleeping with difficulty arousing, or cardiovascular or respiratory arrest. (2) A petitioner may be considered to have suffered a residual seizure disorder if the petitioner did not suffer a seizure or convulsion unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit before the first seizure or convulsion after the administration of the vaccine involved and if— (A) in the case of a measles, mumps, or rubella vaccine or any combination of such vaccines, the first seizure or convulsion occurred within 15 days after administration of the vaccine and 2 or more seizures or convulsions occurred within 1 year after the administration of the vaccine which were unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit, and (B) in the case of any other vaccine, the first seizure or convulsion occurred within 3 days after administration of the vaccine and 2 or more seizures or convulsions occurred within 1 year after the administration of the vaccine which were unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit. (3) (A) The term “encephalopathy” means any significant acquired abnormality of, or injury to, or impairment of function of the brain. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting at least 6 hours in level of consciousness, with or without convulsions. The neurological signs and symptoms of encephalopathy may be temporary with complete recovery, or may result in various degrees of permanent impairment. Signs and symptoms such as high pitched and unusual screaming, persistent unconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		wave activity on an electroencephalogram. (B) If in a proceeding on a petition it is shown by a preponderance of the evidence that an encephalopathy was caused by infection, toxins, trauma, or metabolic disturbances the encephalopathy shall not be considered to be a condition set forth in the table. If at the time a judgment is entered on a petition filed under section 300aa–11 of this title for a vaccine-related injury or death it is not possible to determine the cause, by a preponderance of the evidence, of an encephalopathy, the encephalopathy shall be considered to be a condition set forth in the table. In determining whether or not an encephalopathy is a condition set forth in the table, the court shall consider the entire medical record. (4) For purposes of paragraphs (2) and (3), the terms "seizure" and "convulsion" include grand mal, petit mal, absence, myoclonic, tonic-clonic, and focal motor seizures and signs. If a provision of the table to which paragraph (1), (2), (3), or (4) applies is revised under subsection (c) or (d) of this section, such paragraph shall not apply to such provision after the effective date of the revision unless the revision specifies that such paragraph is to continue to apply.	
	X. Reports Under the Safe Medical Device Act of 1990 21 USC Section 360(i)(b), 21 CFR 803.10, 803.22, 803.19, 803.33	**X. Reports Under the Safe Medical Device Act of 1990** *21 USC Section 360(i)(b)*. (b) User reports (1) (A) Whenever a device user facility receives or otherwise becomes aware of information that reasonably suggests that a device has or may have caused or contributed to the death of a patient of the facility, the facility shall, as soon as practicable but not later than 10 working days after becoming aware of the information, report the information to the Secretary and, if the identity of the manufacturer is known, to the manufacturer of the	**X. Reports Under the Safe Medical Device Act of 1990** This requirement is based on federal law and could not be waived by the Governor. In addition, it does not appear that a waiver of this requirement is authorized under 42 U.S.C. 1320b-5.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		device. In the case of deaths, the Secretary may by regulation prescribe a shorter period for the reporting of such information. (B) Whenever a device user facility receives or otherwise becomes aware of—(i) information that reasonably suggests that a device has or may have caused or contributed to the serious illness of, or serious injury to, a patient of the facility, or (ii) other significant adverse device experiences as determined by the Secretary by regulation to be necessary to be reported, the facility shall, as soon as practicable but not later than 10 working days after becoming aware of the information, report the information to the manufacturer of the device or to the Secretary if the identity of the manufacturer is not known. (C) Each device user facility shall submit to the Secretary on an annual basis a summary of the reports made under subparagraphs (A) and (B). Such summary shall be submitted on January 1 of each year. The summary shall be in such form and contain such information from such reports as the Secretary may require and shall include— (i) sufficient information to identify the facility which made the reports for which the summary is submitted, (ii) in the case of any product which was the subject of a report, the product name, serial number, and model number, (iii) the name and the address of the manufacturer of such device, and (iv) a brief description of the event reported to the manufacturer. (D) For purposes of subparagraphs (A), (B), and (C), a device user facility shall be treated as having received or otherwise become aware of information with respect to a device of that facility when medical personnel who are employed by or otherwise formally affiliated with the facility receive or otherwise become aware of information with respect to that device in the course of their duties. (2) The Secretary may not disclose the identity of a device user facility which	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		makes a report under paragraph (1) except in connection with— (A) an action brought to enforce 21 USC Section 331(q), or (B) a communication to a manufacturer of a device which is the subject of a report under paragraph (1). This paragraph does not prohibit the Secretary from disclosing the identity of a device user facility making a report under paragraph (1) or any information in such a report to employees of the Department of Health and Human Services, to the Department of Justice, or to the duly authorized committees and subcommittees of the Congress. (3) No report made under paragraph (1) by—(A) a device user facility, (B) an individual who is employed by or otherwise formally affiliated with such a facility, or (C) a physician who is not required to make such a report, shall be admissible into evidence or otherwise used in any civil action involving private parties unless the facility, individual, or physician who made the report had knowledge of the falsity of the information contained in the report. (4) A report made under paragraph (1) does not affect any obligation of a manufacturer who receives the report to file a report as required under subsection (a) of this section. (5) With respect to device user facilities: (A) The Secretary shall by regulation plan and implement a program under which the Secretary limits user reporting under paragraphs (1) through (4) to a subset of user facilities that constitutes a representative profile of user reports for device deaths and serious illnesses or serious injuries. (B) During the period of planning the program under subparagraph (A), paragraphs (1) through (4) continue to apply. (C) During the period in which the Secretary is providing for a transition to the full implementation of the program, paragraphs (1) through (4) apply except to the extent that the Secretary determines otherwise. (D) On and after the date on which the program is fully	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		implemented, paragraphs (1) through (4) do not apply to a user facility unless the facility is included in the subset referred to in subparagraph (A). (E) Not later than 2 years after November 21, 1997, the Secretary shall submit to the Committee on Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report describing the plan developed by the Secretary under subparagraph (A) and the progress that has been made toward the implementation of the plan. (6) For purposes of this subsection: (A) The term “device user facility” means a hospital, ambulatory surgical facility, nursing home, or outpatient treatment facility which is not a physician’s office. The Secretary may by regulation include an outpatient diagnostic facility which is not a physician’s office in such term. (B) The terms “serious illness” and “serious injury” mean illness or injury, respectively, that—(i) is life threatening, (ii) results in permanent impairment of a body function or permanent damage to a body structure, or (iii) necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure. *21 CFR 803.10* (a) If you are a device user facility, you must submit reports as follows: (1) Submit reports of individual adverse events no later than 10 work days after the day that you become aware of a reportable event: (i) Submit reports of device-related deaths to us and to the manufacturer, if known; or (ii) Submit reports of device-related serious injuries to the manufacturers or, if the manufacturer is unknown, submit reports to us. (2) Submit annual reports (described in 21 CFR 803.33) to us. (b) If you are an importer, you must submit reports (described in subpart D of this part), as follows: (1)	

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		Submit reports of individual adverse events no later than 30 calendar days after the day that you become aware of a reportable event: (i) Submit reports of device-related deaths or serious injuries to us and to the manufacturer; or (ii) Submit reports of device-related malfunctions to the manufacturer. (2) [Reserved] (c) If you are a manufacturer, you must submit reports (described in subpart E of this part) to us, as follows: (1) Submit reports of individual adverse events no later than 30 calendar days after the day that you become aware of a reportable death, serious injury, or malfunction. (2) Submit reports of individual adverse events no later than 5 work days after the day that you become aware of: (i) A reportable event that requires remedial action to prevent an unreasonable risk of substantial harm to the public health, or (ii) A reportable event for which we made a written request. (3) Submit annual baseline reports. (4) Submit supplemental reports if you obtain information that you did not submit in an initial report. *21 CFR 803.22* What are the circumstances in which I am not required to file a report? (a) If you become aware of information from multiple sources regarding the same patient and same reportable event, you may submit one medical device report. (b) You are not required to submit a medical device report if: (1) You are a user facility, importer, or manufacturer, and you determine that the information received is erroneous in that a device-related adverse event did not occur. You must retain documentation of these reports in your MDR files for the time periods specified in 21 CFR 803.18. (2) You are a manufacturer or importer and you did not manufacture or import the device about which you have adverse event information. When you receive reportable event information in error, you must forward this information to	

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		us with a cover letter explaining that you did not manufacture or import the device in question. *21 CFR 803.19* Are there exemptions, variances, or alternative forms of adverse event reporting requirements? (a) We exempt the following persons from the adverse event reporting requirements in this part: (1) A licensed practitioner who prescribes or administers devices intended for use in humans and manufactures or imports devices solely for use in diagnosing and treating persons with whom the practitioner has a “physician-patient’’ relationship; (2) An individual who manufactures devices intended for use in humans solely for this person’s use in research or teaching and not for sale. This includes any person who is subject to alternative reporting requirements under the investigational device exemption regulations (described in 21 CFR 812, which require reporting of all adverse device effects; and (3) Dental laboratories or optical laboratories. (b) If you are a manufacturer, importer, or user facility, you may request an exemption or variance from any or all of the reporting requirements in this part. You must submit the request to us in writing. Your request must include information necessary to identify you and the device; a complete statement of the request for exemption, variance, or alternative reporting; and an explanation why your request is justified. (c) If you are a manufacturer, importer, or user facility, we may grant in writing an exemption or variance from, or alternative to, any or all of the reporting requirements in this part and may change the frequency of reporting to quarterly, semiannually, annually or other appropriate time period. We may grant these modifications in response to your request, as described in paragraph (b) of this section, or at our discretion. When we grant modifications to the reporting requirements, we may	

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		impose other reporting requirements to ensure the protection of public health. (d) We may revoke or modify in writing an exemption, variance, or alternative reporting requirement if we determine that revocation or modification is necessary to protect the public health. (e) If we grant your request for a reporting modification, you must submit any reports or information required in our approval of the modification. The conditions of the approval will replace and supersede the regular reporting requirement specified in this part until such time that we revoke or modify the alternative reporting requirements in accordance with paragraph (d) of this section. *21 CFR 803.33* If I am a user facility, what must I include when I submit an annual report? (a) You must submit to us an annual report on Food and Drug Administration Form 3419, or electronic equivalent as approved by us under 21 CFR 803.14. You must submit an annual report by January 1, of each year. You must clearly identify your annual report as such. Your annual report must include: (1) Your Centers for Medicare and Medicaid Services provider number used for medical device reports, or the number assigned by us for reporting purposes in accordance with 21 CFR 803.3; (2) Reporting year; (3) Your name and complete address; (4) Total number of reports attached or summarized; (5) Date of the annual report and report numbers identifying the range of medical device reports that you submitted during the report period (e.g., 1234567890-2004-0001 through 1000); (6) Name, position title, and complete address of the individual designated as your contact person responsible for reporting to us and whether that person is a new contact for you; and (7) Information for each	

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		reportable event that occurred during the annual reporting period including: (i) Report number; (ii) Name and address of the device manufacturer; (iii) Device brand name and common name; (iv) Product model, catalog, serial and lot number; (v) A brief description of the event reported to the manufacturer and/or us; and (vi) Where the report was submitted, i.e., to the manufacturer, importer, or us. (b) In lieu of submitting the information in paragraph (a)(7) of this section, you may submit a copy of Food and Drug Administration Form 3500A, or an electronic equivalent approved under 21 CFR 803.14, for each medical device report that you submitted to the manufacturers and/or to us during the reporting period. (c) If you did not submit any medical device reports to manufacturers or us during the time period, you do not need to submit an annual report.	
	XI. Medication Errors 16 CCR 1711(a) and (b), Business and Professions Code Section 4125	**XI. Medication Errors** *16 CCR 1711(a) and (b)* (a) Each pharmacy shall establish or participate in an established quality assurance program which documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors. (b) For purposes of this section, "medication error" means any variation from a prescription or drug order not authorized by the prescriber, as described in 16 CCR 1716. Medication error, as defined in the section, does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law. *California Business and Professions Code Section 4125*	**XI. Medication Errors** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (See

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		(a) Every pharmacy shall establish a quality assurance program that shall, at a minimum, document medication errors attributable, in whole or in part, to the pharmacy or its personnel. The purpose of the quality assurance program shall be to assess errors that occur in the pharmacy in dispensing or furnishing prescription medications so that the pharmacy may take appropriate action to prevent a recurrence. (b) Records generated for and maintained as a component of a pharmacy's ongoing quality assurance program shall be considered peer review documents and not subject to discovery in any arbitration, civil, or other proceeding, except as provided hereafter. That privilege shall not prevent review of a pharmacy's quality assurance program and records maintained as part of that system by the board as necessary to protect the public health and safety or if fraud is alleged by a government agency with jurisdiction over the pharmacy. Nothing in this section shall be construed to prohibit a patient from accessing his or her own prescription records. Nothing in this section shall affect the discoverability of any records not solely generated for and maintained as a component of a pharmacy's ongoing quality assurance program. (c) This section shall become operative on January 1, 2002.	People v. Davis (2005) 126 California Appellate 4th 1416, 1434-35.) The medication error reporting requirement is a regulatory statute with underlying regulations. Consequently, it can be waived under Government Code Section 8571. It is possible that strict compliance with this section could hinder mitigating the effects of the emergency due to the burden of maintaining accurate pharmacy records and detecting and reporting errors. This would have to be demonstrated. In addition, under the Business & Professions Code Section 4062 (b) , during a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the [Pharmacy] board's opinion, the waiver will aid in the protection of public health or the provision of patient care. It is unclear how waiving this requirement would aid in protection of the public health.
	XII. Occupational Injuries and Illnesses Labor Code Section 6409, 8 CCR 14003	**XII. Occupational Injuries and Illnesses** *California Labor Code Section 6409* (a) Every physician as defined in California Labor Code Section 3209.3 who attends any injured employee shall file a complete report of every occupational injury or occupational illness to the employee with the employer, or if insured, with the employer's insurer, on forms prescribed for that purpose by the Division of Labor	**XII. Occupational Injuries and Illnesses** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section

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		Statistics and Research. A portion of the form shall be completed by the injured employee, if he or she is able to do so, describing how the injury or illness occurred. The form shall be filed within five days of the initial examination. Inability or failure of an injured employee to complete his or her portion of the form shall not affect the employee's rights under this code, and shall not excuse any delay in filing the form. The employer or insurer, as the case may be, shall file the physician's report with the Department of Industrial Relations, through its Division of Labor Statistics and Research, within five days of receipt. Each report of occupational injury or occupational illness shall indicate the social security number of the injured employee. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall also file a complete report, which need not include the affidavit required pursuant to this section, with the Division of Labor Statistics and Research, and within 24 hours of the initial examination shall file a complete report with the local health officer by facsimile transmission or other means. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall not be compensated for the initial diagnosis and treatment unless the report is filed with the employer, or if insured, with the employer's insurer, and includes or is accompanied by a signed affidavit which certifies that a copy of the report was filed with the local health officer pursuant to the requirements of this section. (b) As used in this section, "occupational illness" means any abnormal condition or disorder caused by exposure to environmental factors associated with employment, including acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion, or direct contact.	8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The occupational illness reporting requirement is a regulatory statute with underlying regulations. Consequently, it can be waived under Government Code Section 8571. It is possible that strict compliance with this section could hinder mitigating the effects of the emergency due to the burden of reporting large numbers of disaster-related injuries occurring in the workplace. Suspension of this provision could depend on the nature of the emergency and the extent to which it causes injuries in the workplace.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		8 CCR 14003 (a) Every physician, as defined in Labor Code Section 3209.3, who attends an injured employee shall file, within five days after initial examination, a complete report of every occupational injury or occupational illness to such employee, with the employer's insurer, or with the employer, if self-insured. The injured or ill employee, if able to do so, shall complete a portion of such report describing how the injury or illness occurred. Unless the report is transmitted on computer input media, the physician shall file the original signed report with the insurer or self-insured employer. (b) If treatment is for pesticide poisoning or for a condition suspected to be pesticide poisoning, the physician shall also file a complete report directly with the Division within five days after initial treatment. In no case shall treatment administered for pesticide poisoning or suspected pesticide poisoning be deemed to be first aid treatment. (c) The reports required by this Section shall be made on Form 5021, Rev. 4, Doctor's First Report of Occupational Injury or Illness (sample forms may be secured from the Division), upon a form reproduced in accordance with 8 CCR 14007, or by use of computer input media prescribed by the Division and compatible with the Division's computer equipment. However, reports may be submitted on Revision 3 of Form 5021 until June 30, 1993.	
	XIII. Burns and Smoke Inhalation Injuries Health and Safety Code Section 13110.7	**XIII. Burns and Smoke Inhalation Injuries** *California Health and Safety Code Section 13110.7* The State Fire Marshal shall establish and maintain a registry of burn injuries and deaths, and shall annually compile a statistical report of such injuries and deaths. The director of every burn center which examines,	**XIII. Burns and Smoke Inhalation Injuries** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent,

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		treats, or admits a person with a burn or smoke inhalation injury or a person who suffers a burn-related death shall file a report with the State Fire Marshal describing the injury or death at the end of the examination or treatment or at the time the patient is discharged from the burn center or at the time of the patient's death. As used in this section, the term "burn center" means an intensive care unit in which there are specially trained physicians, nursing and supportive personnel and the necessary monitoring and therapeutic equipment needed to provide specialized medical and nursing care to burned patients. The State Fire Marshall shall, in cooperation with the burn centers, develop the form to be used in reporting information to the State Fire Marshal under this section.	hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The burn and smoke inhalation injury registry reporting requirement is a regulatory statute with underlying regulations. Consequently, it can be waived under Government Code Section 8571. It is possible that strict compliance with this section could hinder mitigating the effects of the emergency due to the burden of reporting large numbers of fire-related injuries. Suspension of this provision could depend on the nature of the emergency and the extent to which it causes injuries in the workplace.
	XIV. Reporting Transfers of Patients Health and Safety Code Section 1317.4(a) and (b)	**XIV. Reporting Transfers of Patients** *Health and Safety Code Section 1317.4(a) and (b)* (a) All hospitals shall maintain records of each transfer made or received, including the "Memorandum of Transfer" described in Health and Safety Code Section 1317.2 (f), for a period of three years. (b) All hospitals making or receiving transfers shall file with the state department annual reports on forms prescribed by the department which shall describe the aggregate number	**XIV. Reporting Transfers of Patients** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		of transfers made and received according to the person's insurance status and reasons for transfers. (c) The receiving hospital, and all physicians, other licensed emergency room health personnel, and certified prehospital emergency personnel at the receiving hospital who know of apparent violations of this article or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence. The state department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency, unless the state department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the state department concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report.	8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The hospital transfer record-keeping and reporting requirement is a regulatory statute with underlying regulations. Consequently, it can be waived under Government Code Section 8571. It is possible that strict compliance with this section could hinder mitigating the effects of the emergency due to the burden of reporting large numbers of fire-related injuries. Suspension of this provision could depend on the nature of the emergency and the extent to which it causes injuries in the workplace. However, it seems unlikely that the requirement for record-keeping would be suspended.

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	XV. Inventories of Medical Supplies Health and Safety Code Section 120176	**XV. Inventories of Medical Supplies** *California Health and Safety Code Section 120176* During an outbreak of communicable disease, or upon the imminent and proximate threat of communicable disease outbreak or epidemic that threatens the public's health, all healthcare providers, clinics, healthcare service plans, pharmacies, their suppliers, distributors, and other for-profit and nonprofit entities shall, upon request of the local health officer, disclose to the local health officer inventories of, critical medical supplies, equipment, pharmaceuticals, vaccines, or other products that may be used for the prevention of, or may be implicated in the transmission of communicable disease. The local health officer shall keep this proprietary information confidential.	**XV. Inventories of Medical Supplies** Whether a statute can be waived during a State of Emergency depends upon whether it is a "regulatory statute," and upon a determination and declaration by the Governor that "strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency." (Government Code Section 8571.) A regulatory statute is one designated to protect public health and safety. The intent of such statutes is to accomplish government's objective by mandating certain affirmative acts. Although criminal sanctions are relied upon, the primary purpose of the statute is regulation rather than punishment or correction. (*See People v. Davis* (2005) 126 California Appellate 4th 1416, 1434-35.) The requirement to report inventories of critical supplies and pharmaceuticals is limited to an outbreak or imminent and proximate threat of an outbreak of communicable disease. It is unlikely that such a requirement would be suspended during an emergency. The Food and Drug Branch of CDPH will likely assume control of all wholesale pharmaceutical and medical supply stocks under standby order No. 2. Outbreaks of disease can be commonplace in the aftermath of disasters, and local health officers and emergency response officials may need to know what retail medical supply stocks are on hand.

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	XVI. Joint Commission Sentinel Event Reporting Joint Commission Comprehensive Accreditation Manual for Hospitals	**XVI. Joint Commission Sentinel Event Reporting** Accredited organizations are expected to identify and respond appropriately to all sentinel events (as defined by the organization in accordance with the preceding paragraph) occurring in the organization or associated with services that the organization provides, or provides for. Appropriate response includes conducting a timely, thorough, and credible root cause analysis; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements.	**XVI. Joint Commission Sentinel Event Reporting** This reporting requirement is imposed by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), which is a US-based non-profit organization with a mission to maintain and elevate the standards of healthcare delivery through evaluation and accreditation of healthcare organizations. Joint Commission requirements do not qualify as a regulatory statute for purposes of suspension by the Governor, nor as a federal law for purposes of the waiver provisions granted to the Health and Human Services Secretary.
To what extent will HIPAA requirements for providers/ facilities remain in effect during a declared disaster?	**I. 45 CFR 164.308(a)(7)(ii)(b)(c), 45 CFR 164.310(a)(2)(i)**	**I. 45 CFR 164.308(a)(7)(ii)(b)(c), 45 CFR 164.310(a)(2)(i)** Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information. 1) Disaster Recovery Plan – Establish (and implement as needed) procedures to restore any loss of data. 2) Emergency mode operation plan – Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of protected health information while operating in emergency mode. Establish (and implement as needed) procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency.	**I. 45 CFR 164.308(a)(7)(ii)(b)(c), 45 CFR 164.310(a)(2)(i)** This is a federal requirement for pre-disaster planning and implementation of procedures and policies. Therefore, it cannot be suspended by the Governor. It does not appear to be subject to waiver under federal law.

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	II. 45 CFR 164.510(b)(4)	**II. 45 CFR 164.510(b)(4)** A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.	**II. 45 CFR 164.510(b)(4)** This federal regulation under HIPAA allows providers to disclose health information to a patient's relatives during a disaster, but makes a qualified requirement that the providers obtain the patient's consent. It appears that the Health and Human Services Secretary may waive the consent requirement under 42 U.S.C. Section 1320b-5.
	III. Department of Health and Human Services Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations	**III. Department of Health and Human Services Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations** On September 2, 2005, the Health and Human Services Secretary issued the Hurricane Katrina Bulletin: Disclosures in Emergency Situations. The bulletin states that: In the case of a severe disaster, providers and health plans covered by the HIPAA Privacy Rule can share patient information in all of the following ways: (1) Treatment: Healthcare providers can share information as necessary to provide treatment. (2) Notification: Healthcare providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death. (3) Imminent Danger: Providers can share patient information with anyone as necessary to prevent or lessen a serious imminent threat to the health and safety of a person or the public - consistent with applicable law and the provider's standards of ethical	**III. Department of Health and Human Services Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations** This bulletin does not constitute federal law for purposes of disasters other than Hurricane Katrina.

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		conduct. (4) Facility Directory: Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individuals whether the individual is at the facility, their location in the facility, and general condition.	
	IV. http://www.hhs.gov/ocr/hipaa/decisiontool/EmergencyPrepDisclose.pdf	**IV. http://www.hhs.gov/ocr/hipaa/decisiontool/EmergencyPrepDisclose.pdf** On July 6, 2006, Department of Health and Human Services Office for Civil Rights published an emergency preparedness planning tool that guides emergency preparedness and recovery planners through a series of questions regarding how the HIPAA Privacy Rule applies to a particular disclosure.	**IV. http://www.hhs.gov/ocr/hipaa/decisiontool/EmergencyPrepDisclose.pdf** This is a guidance document for emergency preparedness planning. It is not something that can be waived during the emergency.
	V. Hurricane Katrina Bulletin #2: HIPAA Privacy Rule Compliance Guidance and Enforcement Statement For Activities in Response to Hurricane Katrina	**V. Hurricane Katrina Bulletin #2: HIPAA Privacy Rule Compliance Guidance and Enforcement Statement For Activities in Response to Hurricane Katrina** Business associates that are managing such personal health information on behalf of covered entities may make disclosures to the extent permitted by their business associate agreements with the covered entities, as provided in the Privacy Rule. For example, a business associate agreement may broadly permit the business associate to make disclosures the covered entity is permitted to make, or may otherwise permit the business associate to make treatment or other disclosures as permitted by the Privacy Rule.	**V. Hurricane Katrina Bulletin #2: HIPAA Privacy Rule Compliance Guidance and Enforcement Statement For Activities in Response to Hurricane Katrina** This bulletin does not constitute federal law for purposes of disasters other than Hurricane Katrina.

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	VI. 42 USC Section 1320b-5, Waiver Under Section 1135 of the Social Security Act	**VI. 42 USC Section 1320b-5, Waiver Under Section 1135 of the Social Security Act** Under 42 USC Section 1320d-5, Health and Human Services may not impose a civil money penalty where the failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period. Health and Human Services has the authority to extend the period within which a covered entity may cure the noncompliance "based on the nature and extent of the failure to comply."….Further , the Office of Civil Rights advises that, in the exercise of its enforcement discretion, where a complaint is filed arising from uses and disclosures of protected health information by a covered entity, its business associate or agent of a business associate, that would have been permissible had there been a business associate agreement as required by the Rule, the Office of Civil Rights will not take enforcement action or seek to impose civil money penalties where, due to the urgency of the circumstances arising from Hurricane Katrina, a covered entity, its business associates or their agents, are unable to formalize such agreements as required by the Rule in sufficient time to meet the immediate needs of the evacuees, but appropriately execute the required agreements as soon as practicable.	**VI. 42 USC Section 1320b-5, Waiver Under Section 1135 of the Social Security Act** This section would apply where a waiver is not available, but compliance has been rendered impossible by circumstances, and the failure is cured. It is a flexing provision, and is not something providers would want flexed in an emergency.
	VII. Definition of "Covered Entity" – 45 CFR 160.103	**VII. Definition of "Covered Entity" – 45 CFR 160.103** *Covered entity* means: (1) A health plan. (2) A healthcare clearinghouse. (3) A healthcare provider who transmits any health information in electronic form in connection with a	**VII. Definition of "Covered Entity" – 45 CFR 160.103** This provision of HIPAA is not subject to waiver under 42 U.S.C. 1320b-5.

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		transaction covered by this subchapter.	
	VIII. Requirement to Distribute Notice - 45 CFR 164.520; 42 USC Section 1320b-5(b)(7)(B)	**VIII. Requirement to Distribute Notice - 45 CFR 164.520; 42 USC Section 1320b-5(b)(7)(B)** Secretarial authority; To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX, or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to such subchapters), pertaining to - (7) sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) - (B) section 164.520 of such title, relating to the requirement to distribute a notice.	**VIII. Requirement to Distribute Notice - 45 CFR 164.520; 42 USC Section 1320b-5(b)(7)(B)** This HIPAA regulation requires covered entities to provide to patients with notice of privacy practices that include information on the uses and disclosures of protected health information that may be made, the individual's rights, and the covered entity's legal duties. There is an exception to the notice requirement for emergency treatment situations, when notice of privacy practices must be provided as soon as reasonably practicable. The Secretary of Health and Human Services is authorized to waive any existing laws at Chapters XVIII, XIX and XXI of the Social Security Act pursuant to authority at 42 USC Section 1320b-5.
	IX. Patients Right to Request Privacy Restrictions and Confidential Communications - 45 CFR 164.522; 42 USC Section 1320b-5(b)(7)(C)	**IX. Patients Right to Request Privacy Restrictions and Confidential Communications - 45 CFR 164.522; 42 USC Section 1320b-5(b)(7)(C)** Secretarial authority; To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes	**IX. Patients Right to Request Privacy Restrictions and Confidential Communications - 45 CFR 164.522; 42 USC Section 1320b-5(b)(7)(C)** This regulation provides patients with the right to request privacy protection for protected health information, including permitted disclosures. Restricted protected health information may be disclosed to a health care

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX, or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations thereunder, insofar as they relate to such subchapters), pertaining to - (7) sanctions and penalties that arise from noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) - (C) section 164.522 of such title, relating to - (i) the patient's right to request privacy restrictions; and (ii) the patient's right to request confidential communications.	provider for emergency treatment, but the covered entity must request that the health care provider not further use or disclose the information. As with all HIPAA requirements, this is subject to waiver by the US Secretary of Health and Human Services during a catastrophic emergency under authority at 42 USC Section 1320b-5.
	X. Work-Related Fatalities Reporting – 8 CCR 342	**X. Work-Related Fatalities Reporting – 8 CCR 342** (a) Every employer shall report immediately by telephone or telegraph to the nearest District Office of the Division of Occupational Safety and Health any serious injury or illness, or death, of an employee occurring in a place of employment or in connection with any employment. Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident. Serious injury or illness is defined in section 330(h), Title 8, California Administrative Code. (b) Whenever a state, county, or local fire or police agency is called to an accident involving an employee covered by this part in which a serious injury, or illness, or death occurs, the nearest office of the Division of	**X. Work-Related Fatalities Reporting – 8 CCR 342** This is an occupational safety and health regulation that requires employers to immediately report any employee serious injury, illness or death that occurred as a result or at a place of employment. If exigent circumstances exist – and may include a catastrophic disaster – the report must be made as soon as reasonably able within 24 hours after the incident. The Governor may suspend or waive this regulatory requirement pursuant to authority in the Emergency Services Act.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Occupational Safety and Health shall be notified by telephone immediately by the responding agency. (c) When making such report, whether by telephone or telegraph, the reporting party shall include the following information, if available: (1) Time and date of accident. (2) Employer's name, address and telephone number. (3) Name and job title, or badge number of person reporting the accident. (4) Address of site of accident or event. (5) Name of person to contact at site of accident. (6) Name and address of injured employee(s). (7) Nature of injury. (8) Location where injured employee(s) was (were) moved to. (9) List and identity of other law enforcement agencies present at the site of accident. (10) Description of accident and whether the accident scene or instrumentality has been altered. (d) The reporting in (a) and (b) above, is in addition to any other reports required by law and may be made by any person authorized by the employers, state, county, or local agencies to make such reports.	

3.8 Funding Sources

This chart presents, by payer type, an overview of the various issues associated with payments for healthcare services. The table provides a general overview of where the payments come from and how they are administered, details of enrollment, conditions, payment provisions for ineligible providers and other pertinent rules.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
How are Hospitals Funded?	Hospital inpatient services are paid out of the Medicare Hospital Trust Fund (Part A). Inpatient Part A benefits are limited to 90 days per spell of illness [+ 60 days lifetime reserve]. Most hospitals are paid on a Prospective Payment System basis. Payment for operating and capital—related costs	Medi-Cal contracts with selected hospitals for inpatient services. These contracts are negotiated by the California Medical Assistance Commission. Different payment provisions apply depending on whether a hospital is a contract or a non-contract hospital. Not all regions of the state are contracted; in non-contracted regions hospitals are exempt from the contracting	County Medical Services Program operates pursuant to Welfare and Institutions Code Section 16809 et seq. County Medical Services Program payments are set by County Medical Services Program Governing Board as a percentage of Medi-Cal fee for service. Providers may negotiate and contract for different rates; without a contract, the rates are set by rule of the County Medical Services Program Governing Board. County Medical Services	**Health Plans/Health Maintenance Organizations; Medicare + Choice Health Maintenance Organizations; Medi-Cal Managed Care** Facilities enter into contracts with third party payors to provide services within the scope of plan benefits to plan patients. Contracts divide payment responsibility (risk) between facility and plan, based on a division of financial responsibility. Noncontracted providers may provide emergency services within the scope of plan benefits and be paid [standard billed charges, subject to usual, customary and reasonable?]; responsibility for payment is based on the division of financial	Uninsured patients obligate themselves to pay by contract [via signing facility's conditions of admission form] Emergency services Other • facilities can charge under implied contract • facilities can sue in quantum

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	is made on the basis of prospectively determined rates, paid on a per discharge basis. Payment for other costs (organ acquisition, Certified Registered Nurse Anesthetist, nursing and Allied Health Professional education) are paid on a reasonable cost basis. Payment for medical education is on a per resident basis. Additional payments for outliers, bad debt, indirect medical education, and serving a disproportionate share of low-income patients. Non-prospective payment system	requirements. Contract hospitals are paid at contracted rates. Sometimes these are per diem rates; sometimes they are per discharge rate [sometimes this only applies to certain types of discharges]. Typically, some services may be excepted from the all-inclusive rates and paid at an agreed-upon fee. All services, except routing Obstetric deliveries, require prior authorization. Noncontracted hospitals in closed areas must receive prior authorization for all services. If a Medi-Cal recipient is	Program rules are not included in the Code of California Regulations; thus the info below is from authorizing statute, the County Medical Services Program website [County Medical Services Programcounties.org], and the Blue Cross Life & Health Insurance Company Provider Operations Manual for County Medical Services Program [Blue Cross administers the County Medical Services Program], available at provideraccess.bluecrossca.com. Note: County Medical Services Program is funded exclusively by Realignment revenue (motor vehicle license fees and sales tax) and county general revenue. Currently 34 counties meet their obligations to provide care to indigents via the County Medical Services Program.	responsibility. Generally, the contracts provide for stop-loss to pick up costs in excess of a contracted limit. For Medi-Cal managed care, there is a risk limit established by regulation [Welfare and Institutions Code Section 14463]. Emergency defined by contract [relating to patient condition, not general state of emergency or disaster]. **Preferred Provider Organizations** Facilities enter into contracts with plans [and/or networks that contract with plans] to provide services within the scope of plan benefits at discounted rates; noncontracted hospitals are paid even less, or not at all (except in emergency [emergency relating to patient condition, not general state of emergency]). **Indemnity Insurers** Contract is between the patient and the insurer; facility may bill insurer directly [as accommodation to patient] or patient may pay and seek reimbursement; payment is	meruit for the reasonable value of services provided • individuals may qualify for charity care • unpaid charges → bad debt

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	hospitals and certain specialty hospitals [psychiatric, rehab, children's, long-term care, hospitals located outside the US, and nonparticipating hospitals furnishing emergency services] are paid based on a cost-based reimbursement system. Hospital outpatient services are paid out of the Medicare Supplementary Medical Insurance Trust Fund, Part B. Outpatient services are now paid on a prospective payment system per ambulatory payment classification groups.	admitted to a non-contract hospital for delivery services, she must be transported, when stable, to a contracting facility for all remaining services, if stable.		limited to services within scope of insured benefits.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Skilled nursing facilities and home health agencies are now paid using a prospective payment methodology.				
How does facility qualify to get paid? I. Retroactive qualification II. Special surge rules	42 CFR 489.10, 489.11., 489.12., 489.13 Eligible provider must enroll by completing a Centers for Medicare and Medicaid Services Form 855A, and upon approval, enter into a Provider Agreement per 42 USC Section 1395cc; 42 CFR Section 489.10, 489.12, 489.53. To be eligible, must be licensed or approved	22 CCR 51000.30 Provider enrollee must meet Standards of Participation in Welfare and Institutions Code Section 14000, Chapter 7 and Welfare and Institutions Code Section 14200, Chapter 8, and be certified by Department of Health Care Services as a Medical provider as a:	Provider must be part of the County Medical Services Program/Blue Cross Life & Health provider network. Also must be enrolled as a Medi-Cal provider. [County Medical Services Program website.] Facility must enter into a contract with County Medical Services Program. **1. Retroactivity qualification** No information about retroactive contracting identified.	**Health Plans/Health Maintenance Organizations; Medicare + Choice Health Maintenance Organizations; Medi-Cal Managed Care** Facility contracts with Plan. **Preferred Provider Organization** Facility contracts with Plan or with Network. **Indemnity Insurers** No particular rules for Insurance eligibility (other than general compliance with law [including licensing]). Note: Except as otherwise provided via the contract division of financial	Individuals who appear at the hospital sign, except in emergency, a conditions of admission form obligating them [or other responsible person] to pay for services rendered. In cases of emergency, there is generally deemed an implied contract to pay for

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	by State licensing agency, and meet applicable Conditions of Participation. 42 CFR 409.3. Conditions of Participation compliance is achieved by State Agency survey, or via "deemed status" for accredited (Joint Commission or other approved accrediting agency) facilities. 42 CFR 482 – Conditions of Participation for hospitals. 42 CFR 483 – for Long Term Care Facilities (Skilled Nursing Facilities). 42 CFR 483.410 – Conditions of	• Clinic licensed (or exempt) per Health and Safety Code Section 1200. • Licensed health facility per Health and Safety Code Section 1250. • Adult day healthcare provider licensed per Health and Safety Code Section 1570. • Home health agency licensed per Health and Safety Code Section 1725. • Hospice licensed per Health and Safety Code	**2. Special surge rules** None found.	responsibility, facilities that accept financial responsibility per the division of financial responsibility [e.g., capitation] will need to pay for care provided by noncontracted providers. 28 CCR 1300.67 (g)(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in 28 CCR 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious	services rendered. Additionally, the hospital could sue under a quantum meruit claim for the reasonable value of services rendered.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Participation for Intermediate Care Facilities for the Mentally Retarded. 42 CFR 484 - Conditions of Participation for Home Health Agencies. 42 CFR 485.54 – Conditions of Participation for Comprehensive Outpatient Rehabilitation Facilities. 42 CFR 485.606 – designation and Conditions of Participation for Critical Access Hospitals. 42 CFR 485.707 – Conditions of Participation for Clinics, Rehab	Section 1745. [or] complete an application per 22 CCR 51000.35 and 51000.45. [Note: despite wording of regulations, Medi-Cal requires provider enrollment applications for all provider applicants, including those enrolled in Medicare.] 22 CCR 51000.45 - Also must enter into a Medical Provider Agreement – Department of Health Care Services 6208. Services may be subject to Treatment Authorization Request requirements per 22 CCR 51003.		deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area. See also 28 CCR 1300.71.4 Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Healthcare Services. 28 CCR 1300.71 (a)(2) "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" as defined by section (a)(10), "information necessary to determine payer liability" as defined in section (a)(11) and: (A) For emergency services and care provider claims as defined by section Health and Safety Code Section	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Agencies, and Public Health Agencies a providers of outpatient Physical Therapy and Speech-Language Services. **1. Retroactive qualification** 42 CFR 489.13(2) – Retro effective date if: a provider or supplier meets the requirements of 42 CFR 489.13 (d)(1) [accreditation] and (d)(1)(i) [compliance with additional requirements, then effective on date of compliance] or (d)(1)(ii) [if no additional requirements, then effective date is date	Treatment authorization requests may be extended when further acute care is needed [based on patient condition – not based on facility needs]. Noncontracting and exempt hospitals must receive treatment authorization requests to provide services to Medi-Cal pts. 22 CCR 51008 – bills must be submitted within 6 months of service (unless good cause per 21 CCR 51008.5). • 22 CCR 51207 Hospitals must be certified for Medicare (or meet requirements for		1371.35(j): (i) the information specified in section Health and Safety Code 1371.35(c); and (ii) any state-designated data requirements included in statutes or regulations. 28 CCR 1300.71(a)(3) "Reimbursement of a Claim" means: (A) For contracted providers with a written contract, including in-network point-of-service and preferred provider organizations: the agreed upon contract rate; (B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the healthcare services rendered based upon statistically credible information that is updated at least annually and takes into consideration:(1) the provider's training, qualifications, and length of time in	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	of initial request for participation], the effective date may be retro for up to 1 year. **2. Special surge rules?** 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.	Medicare certification); be licensed • 22 CCR 51212 – Intermediate Care Facility standards. • 22 CCR 51213 – Rehabilitation Center standards. • 22 CCR 51215 – Skilled Nursing Facilities standards. • 22 CCR 51216 – Home Health Aid standards. • 22 CCR 51250 – Hospice standards. In many areas, hospitals must contract with Medi-Cal to provide services.		practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and (C) For non-emergency services provided by non-contracted providers to preferred provider organization and point of service enrollees: the amount set forth in the enrollee's Evidence of Coverage. **2. Special Surge Rules** 28 CCR 1300.67.05. Acts of War Exclusions (a) No healthcare service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude healthcare services based on a determination that the need for the healthcare service arose as a result of an Act of War.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		Welfare and Institutions Code Section 14081. 22 CCR 51541 – Hospital reimbursed per Negotiated Contracts (with California Medical Assistance Commission). 22 CCR 51541(c)(6) – noncontracted hospitals not eligible to service Medi-Cal beneficiaries, except under one of the following: • provision of services per Welfare and Institutions Code Section 14087: [(a) Providing stabilizing services		(1) The term "contract" includes but is not limited to healthcare service plan contracts with subscribers and healthcare service providers. (2) The term "Act of War" includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization. (b) This regulation does not preclude a health plan from coordinating coverage of benefits with other entities. (c) Nothing in this section shall prevent the Director from finding any exclusion or limitation of healthcare service or other services covered by the contract objectionable on grounds other than those set forth herein.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		as required to program beneficiaries located in a closed health facility planning area who are in a life threatening or emergency situation before the beneficiary may be transported to a contracting hospital. (b) If a beneficiary is located in a closed health facility planning area and experiencing a life threatening or emergency situation but cannot be stabilized sufficiently to			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		facilitate a transfer to a contracting facility, those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to significant disability or death. (c) Providing services to beneficiaries who are also eligible for benefits under the federal program of hospital insurance			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		for the aged and disabled. (d) Providing services to beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the department, if the hospital providing services is closer than a contract hospital]. • provision of services to beneficiary where travel time from home to contract hospital exceeds the normal practice for the community or 30 minutes (whichever is			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		greater) and the noncontracting hospital is closer. • provision of services to a Medicare cross-over pt, subsequent to exhaustion of M-Care benefits and pts in a life threatening or emergency situation which could result in permanent impairment. 2. **Special surge rules** 22 CCR 51550 – process for revisions to provider's cost-based allowable reimbursement. —			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		among the possible reasons: (c)(5) – extraordinary and unusual events.			
What happens when a qualified facility is not in compliance due to surge?	A facility that has Joint Commission "deemed status" could lose deemed status if out of compliance with Joint Commission standards there is an extensive period of survey, correction activities and hearing and appeal rights that precede loss of accreditation. [See Joint Commission Manual, Accreditation Process.] If that occurs, Centers for Medicare and Medicaid Services is notified and, pursuant to 42 CFR 488.7, the	22 CCR 51000.53 Loss of license, federal [Medicare] certification or other certification/approval [i.e., State approval for non-Medicare providers] triggers loss of Medi-Cal certification. Provider may appeal per Welfare and Institutions Code Section 14043.65. Note: since Medi-Cal is a State/Federal program, the Secretary of Health and Human Services might not appear to have complete	No information available. To extent lack of compliance is as to a provision that can be waived by Secretary or by Governor, those waivers should suffice for County Medical Services Program. However, further analysis required to assess whether Governor has authority to waive County Medical Services Program rules.	Noncompliance with licensing standards, for example, could be a basis for finding a facility in breach of contract; possibly resulting in termination of contract and/or nonpayment for services.	Noncompliance with law could serve as basis for individual to claim no duty to pay for services. Also, noncompliance could serve as basis for per se liability claim in event of mishap.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	State Agency conducts a validation survey for compliance with the Conditions of Participation. 42 CFR 488.10- Non-accredited facilities must undergo State Agency survey for compliance with Conditions of Participation. 42 CFR 489.53 - If found out of compliance [42 CFR 488.24] the facility can be terminated by Centers for Medicare and Medicaid Services – normally this is a 90-day termination process [during which the facility may correct compliance and retain certification]; but in case of "immediate	authority to waive requirements during national emergencies [per 42 USC Section 1320b-5]. However, if the Secretary were to have waived compliance with Medicare Conditions of Participation, such that Medicare Certification is not withdrawn, then that should suffice to meet the certification requirement for those facilities that are Medicare certified. State waiver would be necessary for state licensing, or for entities that are not Medicare providers.			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	jeopardy" this is shortened to 23 days. 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				
When can a non-qualified health facility get paid? I. Special surge rules	42 CFR 424.103 Medicare pays for emergency services in nonparticipating hospital. Emergency defined at 42 CFR 424.101 (inpatient or outpatient hospital services necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible	22 CCR 51207 A hospital not meeting all the requirements may be paid for services furnished to eligible beneficiaries on an emergency basis per 22 CCR 51056 – only until such time as the patient may be moved safely to an institution that meets the requirements. 22 CCR 51056 – (a) emergency services	Emergency services performed inside California are County Medical Services Program benefit. Contract and non-contract payment rates apply. Emergency services performed inside designated border-state areas of Arizona, Nevada, and Oregon are County Medical Services Program benefits. Contract and non-contract payment rates apply. Emergency services performed outside of California and the designated boarder states [above] are not covered.	**Health Plans/Health Maintenance Organizations; Medicare + Choice Health Maintenance Organizations; Medi-Cal Managed Care** Services general limited to emergency, as defined by regulation. 28 CCR 1300.67 (g)(2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis… [See above] 28 CCR 1300.71.4. Emergency Medical Condition and Post-Stabilization Responsibilities for	Individuals who appear at the hospital sign, except in emergency, a conditions of admission form obligating them [or other responsible person] to pay for services rendered. In cases of emergency, there is generally deemed an implied contract to pay for

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	hospital available and equipped to furnish those services). 42 CFR 424.105 – determination of emergency requires (a) emergency exists re patient's condition; (b) hospital qualified emergency services hospital; (c) hospital substantially more accessible from the site of the emergency than the nearest participating hospital. Note: above provisions relate to patient emergencies, not general state of emergency.	mean services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. (b) for purposes of treating eligible aliens – it means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in	[County Medical Services Program Provider Operations Manual, Emergency Services.]	Medically Necessary Healthcare Services. The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary healthcare services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized healthcare service plan contract that does not provide for medically necessary healthcare services following stabilization of an emergency condition. (a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary healthcare services, a healthcare service plan shall pay for all medically necessary healthcare services rendered to an enrollee. (b) In the case when an enrollee is	services rendered. Additionally, the hospital could sue under a quantum meruit claim for the reasonable value of services rendered.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	1. Special surge rules 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.	any of the following: • placing the pt's health in serious jeopardy. • serious impairment to bodily functions. • serious dysfunction of any bodily organ or part.		stabilized but the healthcare provider believes that the enrollee requires additional medically necessary healthcare services and may not be discharged safely, the following applies: (1) A healthcare service plan shall approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request. (2) If a healthcare service plan fails to approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the healthcare service plan shall have the authority to disapprove payment for (A) the delivery of	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the healthcare service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				(3) Notwithstanding the provisions of Subsection (b) of this rule, a healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer or the enrollee is discharged. (c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another healthcare provider, the following applies: (1) When a healthcare service plan responds to a healthcare provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another healthcare provider, the plan shall effectuate the transfer of	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				the enrollee as soon as possible. (2) A healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer. (d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary healthcare services shall be fully documented. All provision of medically necessary healthcare services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the healthcare provider making the request, and the name of the plan representative responding to the request.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				Health Plans/Health Maintenance Organizations; Medicare + Choice Health Maintenance Organizations; Medi-Cal Managed Care 28 CCR 1300.71(a)(3) "Reimbursement of a Claim" means: (C) For non-emergency services provided by non-contracted providers to preferred provider organization and point of service enrollees: the amount set forth in the enrollee's Evidence of Coverage. **Medi-Cal Managed Care** Welfare and Institutions Code Section 14454. (a) The [Medi-Cal] prepaid health plan shall be liable for all in-area and out-of-area emergency services which are required by the contract and rendered by a nonprepaid health plan provider. Payment for such services shall include treatment of emergency conditions and shall continue until such time as the enrollee may be transferred to any provider of the prepaid health plan.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				Preferred Provider Organizations Depends on contract – typically higher co-pay does not apply if use noncontract providers in an emergency. Indemnity Licensed providers should be able to be reimbursed for all covered services.	
What, if any, payment rules apply to an Alternate Care Site? I. Must the Alternate Care Site be linked to a licensed facility? II. Can an Alternate Care Site be linked to more than one licensed facility?	42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies. 1. Must the Alternate Care Site be linked to a licensed facility? 2. Can an Alternate Care Site be linked to more than one licensed facility?	22 CCR 51470(c) – services provided by a substitute provider shall be considered to have been provided by the billing provider if all the following conditions are met: • services provided during temporary absence of the billing provider. • substitute is also a qualified Medi-Cal	No provisions found that could be construed to address this.	No provisions found that could be construed to address this.	Individual could claim no duty to pay for services in unlicensed setting.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	No rules found – probably need to rely on general waiver.	provider. • substitute has agreement to provide services in provider's absence; and not to independently bill for same service. • claim clearly identifies provider. Query: could above provision be used for Alternate Care Site? Would a hospital that is shut down due to emergency qualify as "temporar[il]y absence?			
Are there special provisions for sole community hospitals?	42 USC Section 1395ww(d) and 42 CFR 412.90(a) and 412.92.	Nothing specific located.	Nothing specific located.	Nothing specific located.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Hospital applies for sole community provider classification; effective date is 30 days after Centers for Medicare and Medicaid approval; this classification entitles facility to special payment rates determined per 42 CFR 412.63. There does not appear to be provision for retroactive designation. 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies – may this be used to permit retro sole				

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	community provider status?				
Are there special provisions for rural facilities?	42 USC 1395ww(d) and 42 CFR 412.90(a) and 412.92 412.90 – Centers for Medicare and Medicaid may adjust payment rates due to isolated location, weather conditions, travel conditions, or absence of other hospital services. 42 CFR 488.54 - Rural hospitals found out of compliance with one or more conditions of participation may request a temporary waiver of certain conditions if waiver would not jeopardize or adversely affect health and safety of		General rules should apply.	General rules should apply.	General rules should apply.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	patients; up to 1 year retro. 42 CFR 488.56 – Rural skilled nursing facilities out of compliance may request temporary waiver of 7-day registered nurse or Med Dir requirements.				
Are there special provisions for Disproportionate Share Hospital hospitals?	42 CFR 412.106 – this is a payment adjustment based on actual numbers of beds and Medicare and Medicaid patients. Non-acute care beds are excluded. Thus if a surge hospital has to use nonacute care beds for inpatients, may need a waiver to obtain appropriate disproportionate share	42 CFR 412.106 – this is an adjustment based on actual numbers of beds and Medicare and Medicaid patients. Non-acute care beds are excluded. Thus if a surge hospital has to use nonacute care beds for inpatients, may need a waiver to obtain appropriate disproportionate share	Nothing located.	N/A	N/A

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	hospital adjustment. 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.	hospital adjustment. 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies 22 CCR 51557 – disproportionate share payments paid in accordance with the State Plan.			
Are there special provisions for Critical Access Hospitals	42 USC Section 1395ww(d), and 42 CFR 413.70		Nothing specific located.	N/A	N/A
Are there special provisions for Rural Referral Centers	42 USC Section1395ww(d), and 42 CFR 412.96. Centers for Medicare and Medicaid may		N/A	N/A	N/A

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	adjust the payment rate for hospitals with at least 275 beds and at least 50% of its Medicare patients are referred from other hospitals and at least 60% of the hospital's Medicare patients live more than 25 miles from the hospital [or other alternative criteria re case mix, discharges, or medical staff]. Surge may change eligibility for this status.				
Are there special provisions for Medicare-Dependent Hospitals	42 USC Section 1395ww(d), and 42 CFR 412.90(j) and 412.108 – this is a payment adjustment for small rural hospitals who are not		N/A	N/A	N/A

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	sole community providers whose patient base is at least 60% Medicare. This is based on a calculation using discharges from acute care and swing beds, but not from other non-prospective payment system units of the hospital. If a Medicare-Dependent Hospital needs to use nonacute/ nonswing beds, may need a waiver to obtain appropriate disproportionate share hospital adjustment.				
What are reimbursement rules for out of state facilities?	Since Medicare is a federal program, Medicare beneficiaries who are not enrolled in Medicare+Choice programs should be able receive services	22 CCR 51006 – Medi-Cal pays for necessary out-of-state medical care in following circumstances:	Emergency services performed inside designated border-state areas of Arizona, Nevada, and Oregon are County Medical Services Program benefits. Contract and non-contract	**Health Plans/Health Maintenance Organizations Medi-Cal Managed Care** Plan out of network provisions would apply. **Medicare + Choice Health**	Individual obligation to pay for care rendered would apply out-of-state. Also, to extent out-

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	in any state and same rules as for in-state facilities should apply.	• emergency arises from accident, injury, or illness; or • where individual health would be endangered if care were postponed until feasible for pt to return to California; or • where individual health would be endangered if pt undertook return travel to California; or • when customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or	payment rates apply. [Blue Cross County Medical Services Program Provider Operations Manual, Emergency Services]	**Maintenance Organizations** Plan out of network provisions would apply. **Medi-Cal Managed Care** Plan out of network provisions would apply. **Preferred Provider Organizations** Plan out of network provisions may result in higher co-payments. **Indemnity Insurers** Regular indemnity insurance benefits should apply.	of-state care is not a covered benefit, individuals who have third party coverage for healthcare may incur individual responsibility for [noncovered] services rendered.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		• when an out-of-state treatment plan has been authorized – and only when proposed treatment is not available from in-state resources. Prior authorization required for all out-of-state services except in emergency (per 22 CCR 51056) or where it is customary to go out of state.			
Are foreign facilities eligible for reimbursement?	42 CFR 413.74 and section 1814(f) of the Act – payment for the reasonable cost of emergency and nonemergency inpatient hospital services – may only be paid to hospitals in	22 CCR 51006 – no services are covered outside of the US, except for emergency services requiring hospitalization in Canada or Mexico.	Not covered. [Blue Cross County Medical Services Program Provider Operations Manual, Emergency Services.]	Nothing specific located – would depend on the plan or insurance contract.	Individuals would likely be financially responsibility for foreign healthcare services.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Canada and Mexico.				
What are the reimbursement requirements for Religious Nonmedical Healthcare Institutions?	42 CFR 403.720 Religious Nonmedical Healthcare Institutions must: • meet conditions of participation for religious nonmedical healthcare institutions at 42 CFR 403.730 to 403.746. • entering into a provider agreement per 42 CFR 489 → for payment purposes RNCHI is classified as an extended care hospital. • beneficiaries must elect treatment by	22 CCR 51207(c) – Hospitals operated by First Church of Christ Scientist, Boston, Mass. are eligible to participate if they conform to governmental requirements re housing, fire protection, safety, and sanitation. 22 CCR 51312 – Prayer or spiritual healing services are limited to those allowed under Title 18 of the Social Security Act (Medicare).	Nothing specific located.	Nothing specific located.	Individuals who appear at the facility sign, except in emergency, a conditions of admission form obligating them [or other responsible person] to pay for services rendered. In cases of emergency, there is generally deemed an implied contract to pay for services rendered. Additionally, the facility could sue under a quantum meruit claim for the reasonable value of services rendered.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	religious nonmedical healthcare institutions per 42 CFR 403.724.				
What are the reimbursement requirements for Skilled Nursing Facilities?	Essentially the same analysis as for hospitals.	Essentially the same analysis as for hospitals.	Not covered. [Blue Cross County Medical Services Program Provider Operations Manual, Emergency Services.]	Essentially the same analysis as for hospitals.	Individuals with available Medicare benefits, Med-Cal benefits or private insurance are liable for the cost of skilled nursing facility care.
Clinic Funding General Overview California has the following categories of licensed clinics: community clinic free clinic surgical clinic					

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
chronic dialysis clinic rehabilitation clinic alternative birth center psychology clinic Additionally, California permits other clinics to operate without a license: • surgery clinics operated as part of a MD's office • clinic's operated by US government • clinics operated by Indian tribes • clinics operated by [medical schools or other learning institutions] • physician clinics • student clinics • nonprofit speech and					

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
hearing centers • diagnostic imaging and magnetic resonance imaging clinics • medical foundations • community mental health center • and a few other unique categories of clinics					
How does clinic qualify to get paid? I. Retroactive payment? II. Special surge rules	Provider must enroll in Medicare program. For some services, Conditions of Participation apply. **2. Special surge rules?** 42 USC 1320b-5 – Secretary authority to waive requirements	22 CCR 51000.30 – Provider enrollee must meet Standards of Participation in Welfare and Institutions Code Section 14000, Chapter 7 and Welfare and Institutions Code Section 14200, Chapter 8, and be	See above for health facilities.	See above for health facilities.	See above for health facilities.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	during national emergencies.	certified by Division of Health Care Services as a Medical provider as a: • Clinic licensed (or exempt) per Health and Safety Code Section 1200. [or] complete an application per 22 CCR 51000.35 and 51000.45. [Note: despite wording of regulations, Medi-Cal requires provider enrollment applications for all provider applicants, including those enrolled in Medicare.] 22 CCR 51000.45 - Also must enter into a Medical Provider Agreement – Division			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		of Health Care Services 6208.			
What happens when a qualified clinic is not in compliance due to surge?	42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.	Same analysis as for health facilities.	Same analysis as for health facilities.	Same analysis as for health facilities.	Same analysis as for health facilities.
When can a non-qualified clinic get paid? I. Special surge rules?	Since clinics are unlikely to be providing emergency services, anticipate that an unqualified clinic could not get paid.	Since clinics are unlikely to be providing emergency services, anticipate that an unqualified clinic could not get paid.	Since clinics are unlikely to be providing emergency services, anticipate that an unqualified clinic could not get paid.	**Health Plans/Health Maintenance Organizations; Medicare + Choice Health Maintenance Organizations; Medi-Cal Managed Care** Since clinics are unlikely to be providing emergency services, anticipate that an unqualified clinic could not get paid. **Preferred Provider Organizations** Payment would depend on plan contract; generally expect lower plan payment for non-preferred provider organization	Same analysis as for health facilities.

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
				provider. **Indemnity Insurers** Should not affect patient's right to be reimbursed for services that are insured benefits.	
What are reimbursement requirements for Rural Health Clinics?	42 CFR 405.2402 – Rural Health Clinics must be certified by State Agency and accepted by the Secretary; Centers for Medicare and Medicaid and Rural Health Center enter into 1 year agreement, renewable annually by mutual consent. 42 CFR 405.2403 – RHC must comply with Conditions of Participation at 42 CFR 481.	22 CCR 51211.5 – Standards for Participation a) Each rural health clinic shall: (1) Be licensed or exempt from licensure (2) Be located in a rural shortage area at the time of initial certification [or other area previously certified as rural]. (3) Be certified and continue to meet the standards for certification as a rural health clinic established by the Secretary,			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		Department of Health and Human Services. (4) Provide that a physician or nonphysician medical practitioner be available to furnish patient care services at all hours of clinic operation. A nonphysician medical practitioner shall be available to furnish patient care services at least 60 percent of the hours of clinic operation. (5) Execute a provider participation agreement with the Director containing, but not limited to, the following provisions: 22 CCR 51003 –rural health centers are not subject to treatment			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		authorization request.			
What are the reimbursement requirements for Federally Qualified Health Centers?	42 CFR 405.2430 – Must meet requirements of 42 CFR 405.2401(b) and be recommended by Public Health Service; and 42 CFR 405.2434 must enter into agreement with Centers for Medicare and Medicaid Services. Effective date of agreement is date Centers for Medicare and Medicaid Services accepts the signed agreement assuring compliance. 42 CFR 405.2436 - Federally Qualified Health Centers may be terminated if fail to	22 CCR 51003 – Federally Qualified Health Centers are not subject to treatment authorization request.			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	meet requirements.				
What are the reimbursement requirements for Physicians?	Physicians are paid out of the Medicare Trust Fund, Part B. Payment is based on Resource-Based Relative Value Scale & Fee Schedules.				
How does Physician qualify to get paid? I. Retroactive qualification II. Special surge rules?	42 USC Section 1395u (h) – Physician enters into participating physician agreement with Secretary to accept payment on assignment basis for all items and services provided during that year. Participating physicians must be licensed or otherwise authorized to provide services in		Physicians must contract with the Blue Cross County Medical Services Program Provider Network. **1. Retroactivity?** Nothing located. **2. Special surge rules?** Nothing located.		

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	accordance with State law. Physician must enroll by completing a form Centers for Medicare and Medicaid Services 855B. **Retroactivity and Special surge rules** 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				
What if qualified Physician is not in compliance due to surge?	42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
When can a non-qualified Physician get paid? I. Special surge rules	Centers for Medicare and Medicaid Publication 100-4 – nonparticipating providers' fee schedule may not exceed 95% of [payment to participating providers] – this is to be factored with the "limiting charge" rule at 42 CFR 414.48(b) which says that nonparticipating providers may not be paid more than 115% of the fee schedule → limiting charge is 109.25% of the participating fee schedule amount.				

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	1. Special surge rules? 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				
How does Supplier qualify to get paid? I. Retroactive qualification II. Special surge rules	Suppliers are paid out of the Medicare Trust Fund, Part B, for their reasonable charges. 42 USC Section 1395u (h) – Supplier enters into participating supplier agreement with Secretary to accept payment on assignment basis for all items and services provided during that year.	22 CCR 51320 – Medical supplies covered when prescribe by licensed practitioner. 22 CCR 51321(c)(6) – rendering provider must have Medi-Cal provider number. 22 CCR 51323 – medical transportation and ambulance services – for lowest cost type of medical transport that is adequate and			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	1. Retroactivity? **2. Special surge rules** 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.	available – to nearest facility capable of meeting pt's medical needs.			
What if qualified Supplier is not in compliance due to surge?	42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				
When can a non-qualified Supplier get paid? I. Special surge rules	**1. Special surge rules** 42 USC Section 1320b-5 – Secretary authority to waive requirements during national emergencies.				

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
Special Programs I. End Stage Renal Disease	**1. End Stage Renal Disease** 42 CFR 405.2110 – Centers for Medicare and Medicaid Services designates end stage renal disease networks of facilities. End stage renal disease facilities must meet end stage renal disease conditions of participation (42 CFR 405.2130 – 405.2171).	**1. End Stage Renal Disease** 22 CCR 51218 – Renal Dialysis Center, Community Hemodialysis Units, Renal Homotransplantation Center standards.			
What are the reimbursement requirements for Pharmacy Benefits?	Seniors may enroll in Medicare Part D for payment of prescription drug costs. The amount of the benefit depends on the particular plan chosen by the enrollee.	22 CCR 51313 – Drugs on Medi-Cal list of Contract Drugs are covered when prescribed by a licensed practitioner; not to exceed 100 day supply (with exceptions). Drugs not on List		**Health Plans/Health Maintenance Organizations** Most health plans provide a prescription drug benefit. Generally a patient co-payment is required. **Medi-Cal Managed Care** Most preferred provider organization plans provide for lower co-pays with participating providers and/or generic	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
		require prior authorization. Drugs in skilled nursing facilities, intermediate care facilities, and other settings subject to additional requirements. Drugs in hospital acute or extended care and discharge medications [10-day supply] are covered per hospital formulary. 22 CCR 51313.3 – limitation on coverage of drugs.		drugs **Preferred Provider Organizations** Depends on Insurance Policy.	
What are the general enrollment requirements for Beneficiaries [Patients]?	Medicare beneficiaries may Individuals enroll for • Part A benefits [hospital, skilled nursing facilities,	Medi-Cal beneficiaries must Individuals Enroll based on categorical need or medical need. Mandatory services for categorically needy			

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	Home Health, Hospice] • Part B benefits [outpatient] • Part C benefits [Medicare + Choice] • Part D benefits [Pharmacy] Monthly premiums may be assessed, based on income. Deductibles and co-insurance may apply.	include [in relevant part] • inpatient/outpatient hospital • physician • nursing facility • home health • Rural health Clinic and Federally Qualified Health Clinic.			
How does a patient qualify to get paid? I. Retro? II. Special surge rules?	42 CFR 410.10 - Automatic enrollment in Part A if (i) entitled to Part B [Social Security, Railroad Retirement Act retirement or disability, or end stage renal disease], unless	To enroll individuals must meet both financial and categorical requirements. Financial eligibility requires income and resources below a certain level. Eligible	Patient must meet eligibility standards established by the [County Medical Services Program Governing Board/counties?] Detailed standards are set out on the County Medical Services Program Eligibility Manual available on County Medical	**Health Plans/Health Maintenance Organizations** Plan contract between enrollee [or family member] and payer. **Medicare + Choice Health Maintenance Organizations** 42 USC Section 1395w-21(a)(1)(B) M-	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	decline coverage; (ii) has attained age 65 and is a citizen or lawfully admitted alien; (iii) has received disability benefits for 25 months. Part B is optional and must be paid for separately by beneficiaries through monthly premiums. Persons who are not automatically entitled to Medicare can enroll in the program voluntarily if they pay the monthly Part A premium and also enroll in Part B, *[2007 CCH Medicare and Medicaid Benefits].* Inpatient hospital coverage expires after 90 days of benefits per spell of illness [+	categories include: families and children; aged, blind, or disabled; and pregnant women. These are referred to as "categorically needy." Also individuals who are "medically needy." **(a) Retroactive enrollment** Yes, subject to establishing eligibility as of requested date of enrollment.	Services Program website www.County Medical Services Programcounties.org. **a) Retroactive enrollment** No retroactive enrollment. County Medical Services Program Eligibility Manual § 3-015.	Care beneficiary elects M+C enrollment. **Preferred Provider Organization** Preferred provider organization contract between enrollee [or family member] and preferred provider organization plan. **Indemnity Insurers** Insurance contract between insured [or family member] and indemnity insurer. 28 CCR 1300.67 (g)(1) Emergency healthcare services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the healthcare service plan area. Emergency healthcare services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Healthcare Service Plan. (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	60 lifetime reserve days]. Beneficiaries must pay a separate inpatient hospital deductible for each spell of illness [$992 in 2007]; co-payment for nursing home stays is $124/day for the 21st thru 100th day]. Requirement for Part A premium depends on Medicare-covered employment qualification. There may be a 10% surcharge depending on time of enrollment. Part B generally requires a 20% co-charge.			provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. “Urgently needed services” are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan’s service area. “Urgently needed services” includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee’s fetus, based on the enrollee’s reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan’s service area.	

Issue to Address	Medicare	Medi-Cal	County Medical Services Program	Health Plans/Health Maintenance Organizations Medicare + Choice Health Maintenance Organizations Medi-Cal Managed Care Preferred Provider Organizations Indemnity Insurers	Individuals
	1. Retroactive enrollment? Yes, subject to establishing eligibility as of requested date of enrollment.				
Other funding source/provisions					
Disaster relief	42 USC Section 5195b – Director may make financial contributions to States for State and local emergency preparedness personnel and administrative expenses – up to ½ of total cost.	42 USC Section 5195b – Director may make financial contributions to States for State and local emergency preparedness personnel and administrative expenses – up to ½ of total cost.			
www.homeland.ca.gov/pdf/CDHSLOCALASSISTANCESUMMARYPAGES.pdf					

3.9 Populations Rights

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
Population Care – Resource Allocation	**I. Health and Safety Code Section 1317**	**I. Health and Safety Code Section 1317** Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care. If hospital does not maintain an emergency department and is not Medicare participating must (1) exercise reasonable care to determine whether an emergency exists; (2) direct the person to a nearby facility that can render the needed services; and (3) assist, including transportation, in every reasonable way under the circumstances. No discrimination in provision of emergency services based on or affected by, race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay…except in circumstances such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care.	**I. Government Code Section 8571. Governor's authority to waive a "regulatory statute."** During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Unemployment Insurance Code Section 1253, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	II. Emergency Medical Treatment and Active Labor Act – 42 USC Section1395dd(e)(1); 42 CFR 489.24(b)	**II. Emergency Medical Treatment and Active Labor Act – 42 USC Section1395dd(e)(1); 42 CFR 489.24(b)** A Medicare participating hospital that maintains a dedicated emergency department must provide medical screening exam and stabilizing treatment or appropriate transfer. [Extensive rules relating to screening exam and appropriate transfer; responsibilities of hospitals with specialized capabilities or facilities – e.g., burn, trauma, neonatal, regional referral, etc.].	**II. 42 USC Section 1320b-5. Secretary Health and Human Services authority to waive Medicare certification requirements.** To the extent necessary to accomplish the purpose specified in subsection (a) of this section, the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify application of, with respect to healthcare items and services furnished by a healthcare provider (or classes of healthcare providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of subchapters XVIII, XIX or XXI of this chapter, or any regulation thereunder (and the requirements of this subchapter other than this section, and regulations, and regulations thereunder, insofar as they relate to such subchapters), pertaining to: sanctions under 42 USC Section 1395dd (relating to examination and treatment for emergency medical conditions and women in labor) for a transfer of an individual who has not been stabilized in violation of subsection (c) of this section if the transfer arises out of the circumstances of the emergency.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	III. Civil Code Section 51-53	**III. Civil Code Section 51-53** Prohibits discrimination by any business, including one that provides medical services, on basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status or sexual orientation.	**III. Civil Code Section 51-53** May be waived per Government Code Section 8571.
Patient Confidentiality and Patient Rights	**I. HIPAA – 45 CFR 160 and 164**	**I. HIPAA – 45 CFR 160 and 164** General Summary: Protected Health Information may only be disclosed with patient consent, except as required for treatment, payment, or healthcare operations. Extensive regulations regarding Notice of Privacy Practices, permitted disclosures, business associate agreement requirements, security of personal health information.	**I. HIPAA – 45 CFR 160 and 164** 42 USC Section 1320b-5. Secretary Health and Human Services authority to waive Medicare certification requirements.
	II. Confidentiality of Medical Information Act – Civil Code Section 56.	**II. Confidentiality of Medical Information Act – Civil Code Section 56.** General Summary: No provider of healthcare, healthcare service plan, or contractor shall disclose medical information regarding a patient, except as follows: [list of mandatory disclosure circumstances including court order, administrative adjudication, subpoena, arbitrator order, search warrant, patient consent, coroner; and permissive disclosure including among healthcare providers, plans, and contractors for diagnosis or treatment of patient, for payment purposes, billing and claims management, peer review committees, licensing or accrediting bodies, public agencies, etc.]	**II. Confidentiality of Medical Information Act – Civil Code Section 56.** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	III. Patient Rights 22 CCR 70707 [hospitals] and 72527 [skilled nursing facilities]	**III. Patient Rights 22 CCR 70707 [hospitals] and 72527 [skilled nursing facilities]** (a) Hospitals and medical staffs shall adopt a written policy on patients' rights. (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to: (1) Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care. (2) Considerate and respectful care. (3) Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and nonphysicians who will see the patient. (4) Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand. (5) Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment. (6) Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment. (7) Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are	**III. Patient Rights 22 CCR 70707 [hospitals] and 72527 [skilled nursing facilities]** May be waived per Government Code Section 8571. Patients' Rights: Patients are afforded certain rights. Under this regulation, hospitals and medical staffs are required to adopt a written policy on patient rights and post those patient rights within the hospital. Hospitals are required pursuant to this regulation, to post the patient rights. As it relates to informed consent, they have the right to as much information as they need in order to give informed consent. There is an exception to informed consent in an emergency, meaning the patient is experiencing an emergency medical condition and there is insufficient time to undergo the process of obtaining informed consent without causing additional harm or death. It is unlikely that the Governor would waive the requirement to obtain informed consent by order, however in the event of a catastrophic disaster, if a patient is experiencing an emergency medical condition, the obligation to obtain informed consent is not required to treat that emergency medical condition. Caution should be used, however, to limit treatment without consent to the emergency condition of the patient. Once stable, all consent requirements apply. In the event the intervention is minor (e.g., a flu injection) simple consent may suffice. Simple consent applies if a relatively low risk intervention (i.e., a shot) and the patient knows

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual. (8) Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care. (9) Reasonable responses to any reasonable requests made for service. (10) Leave the hospital even against the advice of physicians. (11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care. (12) Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects. (13) Be informed of continuing healthcare requirements following discharge from the hospital. (14) Examine and receive an explanation of the bill regardless of source of payment. (15) Know which hospital rules and policies apply to the patient's conduct while a patient. (16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. (17) Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless: (A) No visitors are allowed. (B) The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility. (C) The patient has indicated to the health facility staff that the patient no longer wants this person to visit. (18) Have the patient's wishes considered for purposes	they are going to get a shot but do not object. Consent is a complicated subject and if in doubt, do what is possible to inform, advise of options and potential risks, and document the circumstances.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household. (19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. (c) A procedure shall be established whereby patient complaints are forwarded to the hospital administration for appropriate response. (d) All hospital personnel shall observe these patients' rights.	
	IV. Welfare and Institutions Code Section 5325 – mental health patient rights	**IV. Welfare and Institutions Code Section 5325 – mental health patient rights** Each person involuntarily detained for evaluation or treatment under provisions of this part, each person admitted as a voluntary patient for psychiatric evaluation or treatment to any health facility, as defined in Health and Safety Code Section 1250, in which psychiatric evaluation or treatment is offered, and each mentally retarded person committed to a state hospital pursuant to Article 5 (commencing with Health and Safety Code Section 6500, Division 6, Part 2, Chapter 2, Article 5 shall have the following rights, a list of which shall be prominently posted in the predominant languages of the community and explained in a language or modality accessible to the patient in all facilities providing such services and otherwise brought to his or her attention by such additional means as the Director of Mental Health may designate by regulation: (a) To wear his or her own clothes; to keep and use his or her own personal possessions including his or her toilet articles; and to	**IV. Welfare and Institutions Code Section 5325 – mental health patient rights** May be waived per Government Code Section 8571. [some of these may be constitutionally-based rights.]

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases. (b) To have access to individual storage space for his or her private use. (c) To see visitors each day. (d) To have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them. (e) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence. (f) To refuse convulsive treatment including, but not limited to, any electroconvulsive treatment, any treatment of the mental condition which depends on the induction of a convulsion by any means, and insulin coma treatment. (g) To refuse psychosurgery. Psychosurgery is defined as those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of any of the following: (1) Modification or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain. (2) Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior. (3) Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior. Psychosurgery does not include prefrontal sonic treatment wherein there is no destruction of brain tissue. The Director of Mental Health shall promulgate appropriate regulations to assure adequate protection of patients' rights in such treatment. (h) To see and receive the services of a patient advocate who has no direct or indirect clinical or	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		administrative responsibility for the person receiving mental health services. (i) Other rights, as specified by regulation. Each patient shall also be given notification in a language or modality accessible to the patient of other constitutional and statutory rights which are found by the State Department of Mental Health to be frequently misunderstood, ignored, or denied. Upon admission to a facility each patient shall immediately be given a copy of a State Department of Mental Health prepared patients' rights handbook. The State Department of Mental Health shall prepare and provide the forms specified in this section and in Welfare and Institutions Code Section 5157. The rights specified in this section may not be waived by the person's parent, guardian, or conservator.	
	V. Welfare and Institutions Code Section 5328-5328.9 – medical records pertaining to LPS patients [mental health / developmental disabilities]	**V. Welfare and Institutions Code Section 5328-5328.9 – medical records pertaining to LPS patients [mental health / developmental disabilities]**	**V. Welfare and Institutions Code Section 5328-5328.9 – medical records pertaining to LPS patients [mental health / developmental disabilities]** May be waived per Government Code Section 8571. [some of these may be constitutionally-based rights]
	VI. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.130	**VI. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.130** Standard: The hospital respects the needs of patients for confidentiality, privacy, and security. Rationale: This standard and its EPs allow flexibility in how a hospital can accomplish this requirement. Privacy, safety, and security can be demonstrated in	**VI. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.130**

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		various ways, for example, via policies and procedures, practices, or the design of the environment. Elements of Performance: I. The hospital protects confidentiality of information about patients. II. The hospital respects the privacy of patients. III. Patients who desire private telephone conversations have access to space and telephones appropriate to their needs and the care, treatment, and services provided. IV. The hospital provides for the safety and security of patients and their property.	
	VII. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.170	**VII. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.170** Standard: Patients have a right to access protective and advocacy services. Elements of Performance: I. When the hospital services a population of patients who often need protective services (that is, guardianship and advocacy services, conservatorship, and child or protective services), it provides resources to help the family and the courts determine the patient's needs for such services. II. When appropriate, the hospital maintains a list of names, addresses, and telephone numbers of pertinent state client advocacy groups such as the state authority and the protection and advocacy network.	**VII. & RI.2.170** No specific provision located re waiver of Joint Commission standards. However, via the Secretary Health and Human Services waiver authority, the jeopardy to Medicare participation can be ameliorated.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		III. The list is given to patients when requested. IV. The hospital develops and implements policies and procedures for the above requirements.	
	VIII. 42 CFR 482.13 – Medicare Conditions of Participation – Patients Rights	**VIII. 42 CFR 482.13 – Medicare Conditions of Participation – Patients Rights** A hospital must protect and promote each patient's rights. (a) Standard: Notice of rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: (i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. (ii) The grievance process must specify time frames for review of the grievance and the provision of a response. (iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance,	**VIII. 42 CFR 482.13 – Medicare Conditions of Participation – Patients Rights** 42 USC Section 1320b-5 [Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response per HR 3448 upon request of the Governor.]

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		the results of the grievance process, and the date of completion. (b) Standard: Exercise of rights. (1) The patient has the right to participate in the development and implementation of his or her plan of care. (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. (3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with Sec. 489.100 of this part (Definition), Sec. 489.102 of this part (Requirements for providers), and Sec. 489.104 of this part (Effective dates). (4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital. (c) Standard: Privacy and safety. (1) The patient has the right to personal privacy. (2) The patient has the right to receive care in a safe setting. (3) The patient has the right to be free from all forms of abuse or harassment. (d) Standard: Confidentiality of patient records. (1) The patient has the right to the confidentiality of his or her clinical records. (2) The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its recordkeeping system permits. (e) Standard: Restraint for acute medical and surgical care. (1) The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. The term ``restraint'' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. (2) A restraint can only be used if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective. (3) The use of a restraint must be—(i) Selected only when other less restrictive measures have been found to be ineffective to protect the patient or others from harm; (ii) In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order a restraint. This order must—(A) Never be written as a standing or on an as needed basis (that is, pro re nata); and (B) Be followed by consultation with the patient's treating physician, as soon as possible, if the restraint is not ordered by the patient's treating physician; (iii) In accordance with a written modification to the patient's plan of care; (iv) Implemented in the least restrictive manner possible;	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		(v) In accordance with safe and appropriate restraining techniques; and (vi) Ended at the earliest possible time. (4) The condition of the restrained patient must be continually assessed, monitored, and reevaluated. (5) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of restraints. (f) Standard: Seclusion and restraint for behavior management. (1) The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term ``restraint'' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. (2) Seclusion or a restraint can only be used in emergency situations if needed to ensure the patient's physical safety and less restrictive interventions have been determined to be ineffective. (3) The use of a restraint or seclusion must be—(i) Selected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; (ii) In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint. The following requirements will be superseded by existing State laws that are more	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		restrictive: (A) Orders for the use of seclusion or a restraint must never be written as a standing order or on an as needed basis (that is, pro re nata). (B) The treating physician must be consulted as soon as possible, if the restraint or seclusion is not ordered by the patient's treating physician. (C) A physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention. (D) Each written order for a physical restraint or seclusion is limited to 4 hours for adults; 2 hours for children and adolescents ages 9 to 17; or 1 hour for patients under 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician or licensed independent practitioner (if allowed under State law) must see and assess the patient before issuing a new order. (iii) In accordance with a written modification to the patient's plan of care; (iv) Implemented in the least restrictive manner possible; (v) In accordance with safe appropriate restraining techniques; and (vi) Ended at the earliest possible time. (4) A restraint and seclusion may not be used simultaneously unless the patient is—(i) Continually monitored face-to-face by an assigned staff member; or (ii) Continually monitored by staff using both video and audio equipment. This monitoring must be in close proximity the patient. (5) The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated. (6) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion. (7) The	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		hospital must report to the Centers for Medicare and Medicaid Services any death that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion.	
Informed Consent	**I. California Business and Professions Code Section 2397**	**I. California Business and Professions Code Section 2397** A licensee shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the licensee's office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure where the failure to inform is caused by any of the following: - The patient was unconscious. - The medical procedure was undertaken without the consent of the patient because the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient. - A medical procedure was performed on a person legally incapable of giving consent, and the licensee reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient.	
	II. Cobbs v Grant, supra, 8 Cal.3d 229, 245	**II. Cobbs v Grant, supra, 8 Cal.3d 229, 245** The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the	**II. Cobbs v Grant, supra, 8 Cal.3d 229, 245**

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		patient's decision.	
	III. Truman v. Thomas, 27 Cal.3d 285,291 (1980)	**III. Truman v. Thomas, 27 Cal.3d 285,291 (1980)** [T]hat which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended procedure…To be material, a fact must also be one that is not commonly appreciated…If the physician knows or should know of a patient's unique concern or lack of familiarity with medical procedures, this may expand the scope of required disclosure.	**III. Truman v. Thomas, 27 Cal.3d 285,291 (1980)** Lack of informed consent is a basis for legal liability; while the duty of care is somewhat circumstantial (such that failure to perform in accordance with a prevailing [nonemergency] standard of care may be taken into account in determining negligence, there may still be exposure to liability for failure to obtain sufficient informed consent. To the extent that informed consent laws are based on constitutional principles, the Governor's authority to waive a regulatory statute [per Government Code Section 8571 is questionable. It may be that a statutory waiver would be more effective [e.g., along the lines of, but expanding, the statutory exceptions of Business and Professions Section 2397].
	IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.40	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.40** Standard: Informed consent is obtained. Rationale: The goal of the informed consent process is to establish a mutual understanding between the patient and the physician or other licensed independent practitioner who provides the care, treatment, and services about the care, treatment, and services that the patient receives. This process allows	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.40** No specific provision located re waiver of Joint Commission standards. However, via the Secretary Health and Human Services waiver authority, the jeopardy to Medicare participation can be ameliorated.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		each patient to fully participate in decisions about his or her care, treatment, and services. Elements of Performance: 1. The hospital's policies describe the following: a) Which, if any, procedures or care, treatment, and services provided require informed consent. b) The process used to obtain informed consent. c) How informed consent is to be documented in the record. d) When a surrogate decision maker, rather than the patient, may give informed consent. e) When procedures or care, treatment, and services normally requiring informed consent may be given without informed consent. 2. Informed consent is obtained and documented in accordance with the hospital's policy. 3. A complete informed consent process includes a discussion of the following elements: a) The nature of the proposed care, treatment, services, medications, interventions, or procedures. b) Potential benefits, risks, or side effects, including potential problems that might occur during recuperation. c) The likelihood of achieving goals. d) Reasonable alternatives. e) The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		services. f) When indicated, any limitations on the confidentiality of information learned from or about the patient.	
	V. 22 CCR 70707(b)(5) [general IC requirement]	**V. 22 CCR 70707(b)(5) [general IC requirement]** Patient right to: receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.	**V. 22 CCR 70707(b)(5) [general IC requirement]** May be waived per Government Code Section 8571. Patients' Rights: Patients are afforded certain rights. Under this regulation, hospitals and medical staffs are required to adopt a written policy on patient rights and post those patient rights within the hospital. Hospitals are required pursuant to this regulation, to post the patient rights. As it relates to informed consent, they have the right to as much information as they need in order to give informed consent. There is an exception to informed consent in an emergency, meaning the patient is experiencing an emergency medical condition and there is insufficient time to undergo the process of obtaining informed consent without causing additional harm or death. It is unlikely that the Governor would waive the requirement to obtain informed consent by order, however in the event of a catastrophic disaster, if a patient is experiencing an emergency medical condition, the obligation to obtain informed consent is not required to treat that emergency medical condition. Caution should be used, however, to limit treatment without consent to the emergency condition of the patient. Once

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
			stable, all consent requirements apply. In the event the intervention is minor (e.g., a flu injection) simple consent may suffice. Simple consent applies if a relatively low risk intervention (i.e., a shot) and the patient knows they are going to get a shot but do not object. Consent is a complicated subject and if in doubt, do what is possible to inform, advise of options and potential risks, and document the circumstances.
Advanced Directive	**I. Assembly Bill 891 (Chapter 658, Statutes of 1999) codified at Probate Code Section 4600-4805**	**I. Assembly Bill 891 (Chapter 658, Statutes of 1999) codified at Probate Code Section 4600-4805** A healthcare provider or institution must comply with a patient's advance directive or instructions from an agent or surrogate to the same extent as if the decision had been made by the patient. - The supervising healthcare provider must document all pertinent information about the existence or revocation of an advance healthcare direction or any oral communication about preferences in the healthcare record. - The primary physician who determines (or is informed of a determination) that a patient lacks capacity or has recovered capacity must record such in the healthcare record. - Before implementing a healthcare decision for a patient, the supervising healthcare provider must inform the patient of the decision and the identity of the person who made it.	**I. Assembly Bill 891 (Chapter 658, Statutes of 1999) codified at Probate Code Section 4600-4805** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	II. Probate Code Section 4740 **III. Probate Code Section 4734**	**II. Probate Code Section 4740** A healthcare provider or healthcare institution acting in good faith and in accordance with generally accepted healthcare standards applicable to the healthcare provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division, including, but not limited to, any of the following conduct: - Declining to comply with an individual healthcare instruction or healthcare decision, in accordance with Sections 4734 to 4736, inclusive. **III. Probate Code Section 4734** (a) A healthcare provider may decline to comply with an individual healthcare instruction or healthcare decision for reasons of conscience. (b) A healthcare institution may decline to comply with an individual healthcare instruction or healthcare decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make healthcare decisions for the patient.	**II. Probate Code Section 4740** May be waived per Government Code Section 8571. **III. Probate Code Section 4734** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.80	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.80** Standard: The hospital addresses the wishes of the patient relating to end-of-life decisions. Elements of Performance: I. Policies, in accordance with law and regulation, address advance directives and the framework for forgoing or withdrawing life-sustaining treatment and withholding resuscitative services. II. Adults are given written information about their right to accept or refuse medical or surgical treatment, including forgoing or withdrawing life-sustaining treatment or withholding resuscitative services. III. The existence or lack of an advance directive does not determine an individual's access to care, treatment and services. IV. Documentation indicates whether or not the patient has signed an advance directive. V. The patient has the option to review and revise advance directives. VI. Appropriate staff are aware of the advance directive if one exists. VII. The hospital helps or refers the patients for assistance in formulating advance directives upon request. VIII. The hospital has a mechanism for healthcare professionals and designated representatives to honor advance directives within the limits of the law and the hospital's capabilities. IX. The hospital documents and honors the patient's	**IV. Joint Commission Comprehensive Accreditation Manual for Hospitals, RI.2.80** No specific provision located re waiver of Joint Commission standards. However, via the Secretary Health and Human Services waiver authority, the jeopardy to Medicare participation can be ameliorated.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		wishes concerning organ donation within the limits of the law or hospital capacity. X. For Outpatient Hospital Settings: The hospital's policies address advance directives and specify whether the hospital will honor the directives. XI. For Outpatient Hospital Settings: The policies are communicated to patients and families when asked about or as appropriate to the care, treatment, and services provided. XII. For Outpatient Hospital Settings: Upon request, the hospital helps patients formulate medical advance directives or refers them for assistance. XIII. The policies are consistently implemented.	
Special Needs Population	**I. Meeting the needs of Vulnerable People in Times of Disaster: Guide for Emergency Managers (from CA Office of Emergency Services)**	**I. Meeting the needs of Vulnerable People in Times of Disaster: Guide for Emergency Managers (from CA Office of Emergency Services)** [Although this reference does not constitute law or statute, it provides a definition for "special needs populations".] In disaster preparedness, the terms "vulnerable" or "special needs" people or populations are used to define groups whose needs are not fully addressed by the traditional service providers. It also includes groups that may feel they cannot comfortably or safely access and use the standard resources offered in disaster preparedness, response, and recovery. This includes, but is not limited to, those who are physically and/or mentally disabled (blind, cognitive disorders, mobility limitations), limited or non-English speaking, geographically or culturally isolated, medically or chemically dependent, homeless, Deaf and hard-of-hearing, frail elderly, and children.	**I.** N/A

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	II. Americans with Disabilities Act compliance	**II. Americans with Disabilities Act compliance** American with Disabilities Act provisions re nondiscrimination in services, access, etc. [need to get summary of requirements]	**II. Americans with Disabilities Act compliance** Would not appear to be within the jurisdiction of Health and Human Services Secretary.
Isolation/ Quarantine	**I. CCR Title 17 Public Health, Division 1, Chapter 4, Subchapter 1, Article 2, Section 2520**	**I. CCR Title 17 Public Health, Division 1, Chapter 4, Subchapter 1, Article 2, Section 2520** Quarantine is defined as the limitation of freedom of movement of persons or animals that have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease, in such manner as to prevent effective contact with those not so exposed. If the disease is one requiring quarantine of the contacts in addition to isolation of the case, the local health officer shall determine the contacts who are subject to quarantine, specify the place to which they shall be quarantined, and issue instructions accordingly. He shall insure that provisions are made for the medical observation of such contacts as frequently as necessary during the quarantine period.	**I. CCR Title 17 Public Health, Division 1, Chapter 4, Subchapter 1, Article 2, Section 2520** May be waived per Government Code Section 8571.
	II. Health and Safety Code, Section 20145	**II. Health and Safety Code, Section 20145** The department may quarantine, isolate, inspect, and disinfect persons, animals, houses, rooms, other property, places, cities, or localities, whenever in its judgment the action is necessary to protect or preserve the public health.	**II. Health and Safety Code, Section 20145** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	III. 42 USC Section 264	**III. 42 USC Section 264** The Surgeon General, with the approval of the Secretary, is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the Surgeon General may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary.	**III. 42 USC Section 264** Need to research whether there is a waiver and by whom. Would not appear to be within the jurisdiction of the Health and Human Services Secretary.
What is the protocol regarding execution of post-mortem care?	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, PC.8.70**	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, PC.8.70** Standard: Comfort and dignity are optimized during end-of-life care. Rationale: The patient at or near the end of his or her life has the right to physical and psychological comfort. The hospital provides care that optimizes the dying patient's comfort and dignity and addresses the patient's and his or her family's psychosocial and spiritual needs. Elements of Performance: 1. To the extent possible, as appropriate to the patient's and family's needs and the hospital's services, interventions address patient and family comfort, dignity, and psychosocial, emotional, and spiritual needs, as appropriate, about death and grief. 2. Staff is educated about the unique needs of dying	**I. Joint Commission Comprehensive Accreditation Manual for Hospitals, PC.8.70** No specific provision located re waiver of Joint Commission standards. However, via the Secretary Health and Human Services waiver authority, the jeopardy to Medicare participation can be ameliorated.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		patients and their families and caregivers.	
	II. Health and Safety Code Section 102795 and 102825 – Death Certificates	**II. Health and Safety Code Section 102795 and 102825 – Death Certificates** Health and Safety Code Section 102795. The medical and health section data and the time of death shall be completed and attested to by the physician and surgeon last in attendance, or in the case of a patient in a skilled nursing or intermediate care facility at the time of death, by the physician and surgeon last in attendance or by a licensed physician assistant under the supervision of the physician and surgeon last in attendance if the physician and surgeon or licensed physician assistant is legally authorized to certify and attest to these facts, and if the physician assistant has visited the patient within 72 hours of the patient's death. In the event the licensed physician assistant certifies the medical and health section data and the time of death, then the physician assistant shall also provide on the document the name of the last attending physician and surgeon and provide the coroner with a copy of the certificate of death. However, the medical health section data and the time of death shall be completed and attested to by the coroner in those cases in which he or she is required to complete the medical and health section data and certify and attest to these facts. Health and Safety Code Section 102825. The physician and surgeon last in attendance, or in the case of a patient in a skilled nursing or intermediate care facility at the time of death, the physician and surgeon last in attendance or a licensed physician assistant under the supervision of the physician and surgeon last in attendance, on a deceased person	**II. Health and Safety Code Section 102795 and 102825 – Death Certificates** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		shall state on the certificate of death the disease or condition directly leading to death, antecedent causes, other significant conditions contributing to death and any other medical and health section data as may be required on the certificate; he or she shall also specify the time in attendance, the time he or she last saw the deceased person alive, and the hour and day on which death occurred, except in deaths required to be investigated by the coroner. The physician and surgeon or physician assistant shall specifically indicate the existence of any cancer as defined in subdivision (e) of Section 103885, of which the physician and surgeon or physician assistant has actual knowledge. A physician and surgeon may designate, one or more other physicians and surgeons who have access to the physician and surgeon' s records, to act as agent for the physician and surgeon for purposes of the performance of his or her duties under this section, provided that any person so designated acts in consultation with the physician and surgeon.	
	III. Health and Safety Code Section 102800 – Coroner's cases	**III. Health and Safety Code Section 102800 – Coroner's cases** The medical and health section data and the physician's or coroner's certification shall be completed by the attending physician within 15 hours after the death, or by the coroner within three days after examination of the body. The physician shall within 15 hours after the death deposit the certificate at the place of death, or deliver it to the attending funeral director at his or her place of business or at the office of the physician.	**III. Government Code Section 27491.43 – Right of coroner to perform autopsy restricted per religious beliefs**

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	IV. Health and Safety Code Section 102950 – certificate of fetal death	**IV. Health and Safety Code Section 102950 – certificate of fetal death** Each fetal death in which the fetus has advanced to or beyond the twentieth week of uterogestation shall be registered with the local registrar of births and deaths of the district in which the fetal death was officially pronounced within eight calendar days following the event and prior to any disposition of the fetus.	**IV. Health and Safety Code Section 7113 – authority of licensed hospital to perform autopsy** May be waived per Government Code Section 8571.
	V. Government Code Section 27491 – coroner's duty to investigate violent, sudden, or unusual deaths	**V. Government Code Section 27491 – coroner's duty to investigate violent, sudden, or unusual deaths** It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths; unattended deaths; deaths wherein the deceased has not been attended by a physician in the 20 days before death; deaths related to or following known or suspected self-induced or criminal abortion; known or suspected homicide, suicide, or accidental poisoning; deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent; deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, or where the suspected cause of death is sudden infant death syndrome; death in whole or in part occasioned by criminal means; deaths associated with a known or alleged rape or crime against nature; deaths in prison or while under sentence; deaths known or suspected as due to contagious disease and constituting a public	**V. 42 USC Section 274 – nationwide organ procurement and transplantation network** No waiver located [this does not appear to be within the scope of the waiver per 42 USC Section 1320b-5].

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		hazard; deaths from occupational diseases or occupational hazards; deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of Mental Health; deaths of patients in state hospitals serving the developmentally disabled and operated by the State Department of Developmental Services; deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and any deaths reported by physicians or other persons having knowledge of death for inquiry by coroner. Inquiry pursuant to this section does not include those investigative functions usually performed by other law enforcement agencies. In any case in which the coroner conducts an inquiry pursuant to this section, the coroner or a deputy shall personally sign the certificate of death. If the death occurred in a state hospital, the coroner shall forward a copy of his or her report to the state agency responsible for the state hospital. The coroner shall have discretion to determine the extent of inquiry to be made into any death occurring under natural circumstances and falling within the provisions of this section, and if inquiry determines that the physician of record has sufficient knowledge to reasonably state the cause of a death occurring under natural circumstances, the coroner may authorize that physician to sign the certificate of death. For the purpose of inquiry, the coroner shall have the right to exhume the body of a deceased person when necessary to discharge the responsibilities set forth in this section. Any funeral director, physician, or other person who has charge of a deceased person's body, when death	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		occurred as a result of any of the causes or circumstances described in this section, shall immediately notify the coroner. Any person who does not notify the coroner as required by this section is guilty of a misdemeanor.	
	VI. Government Code Section 27491.43 – Right of coroner to perform autopsy restricted per religious beliefs	**VI. Government Code Section 27491.43 – Right of coroner to perform autopsy restricted per religious beliefs** (a) (1) Notwithstanding any other provision of law, except as otherwise provided in this section in any case in which the coroner, before beginning an autopsy, dissection, or removal of corneal tissue, pituitary glands, or any other organ, tissue, or fluid, has received a certificate of religious belief, executed by the decedent as provided in subdivision (b), that the procedure would be contrary to his or her religious belief, the coroner shall not perform that procedure on the body of the decedent.	**VI. Health and Safety Code Section 7150 – 7156.5 – California Uniform Anatomical Gift Act [see especially Health and Safety Code Section 7152.5(e) - failure to discharge obligation to search for evidence of anatomical gift may be subject to administrative sanctions]** May be waived per Government Code Section 8571.
	VII. Health and Safety Code Section 7113 – authority of licensed hospital to perform autopsy	**VII. Health and Safety Code Section 7113 – authority of licensed hospital to perform autopsy** A cemetery authority or licensed funeral director or a licensed hospital or its authorized personnel may permit or assist, and a physician may perform, an autopsy of any remains in its or his custody if the decedent, prior to his death, authorizes an autopsy in his will or other written instrument, or upon the receipt of a written authorization, telegram, or a verbal authorization obtained by telephone and recorded on tape or other recording device, from a person representing himself to be any of the following:	**VII. 42 CFR 482.45 – Medicare Conditions of Participation re organ, tissue, and eye procurement** 42 USC Section 1320b-5 [Any and all the Conditions of Participation may be flexed, directly by the Secretary of Health and Human Services or Assistant Secretary of Preparedness and Response (ASPR) per HR 3448 upon request of the Governor.]

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		(a) The surviving spouse; (b) a surviving child or parent; (c) a surviving brother or sister; (d) any other kin or person who has acquired the right to control the disposition of the remains; (e) a public administrator; (f) a coroner or any other duly authorized public officer. A cemetery authority or a licensed funeral director or a licensed hospital or its authorized personnel is not liable for permitting or assisting, and a physician is not liable for performing, an autopsy pursuant to such authorization unless he or it has actual notice that such representation is untrue at the time the autopsy is performed. If such authorization is contained in a will, the autopsy may be performed regardless of the validity of the will in other respects or of the fact that the will may not be offered for or admitted to probate until a later date. This section shall not authorize the obtaining of a verbal authorization by telephone and recorded on tape or other recording device for an autopsy of a deceased person if it is made known to the physician who is to perform the autopsy that the deceased was, at the time of his death, a member of a religion, church, or denomination which relies solely upon prayer for the healing of disease.	
	VIII. 42 USC Section 274 – nationwide organ procurement and transplantation network	**VIII. 42 USC Section 274 – nationwide organ procurement and transplantation network** The Secretary shall by contract provide for the establishment and operation of an Organ Procurement and Transplantation Network which meets the requirements of subsection (b) of this section. The amount provided under such contract in any fiscal year may not exceed $2,000,000. Funds for such contracts shall be made available from funds available to the	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		Public Health Service from appropriations for fiscal years beginning after fiscal year 1984.	
	IX. Health and Safety Code Section 7150 – 7156.5 – California Uniform Anatomical Gift Act [see especially Health and Safety Code Section 7152.5(e) - failure to discharge obligation to search for evidence of anatomical gift may be subject to administrative sanctions]	**IX. Health and Safety Code Section 7150 – 7156.5 – California Uniform Anatomical Gift Act [see especially Health and Safety Code Section 7152.5(e) - failure to discharge obligation to search for evidence of anatomical gift may be subject to administrative sanctions]** Health and Safety Code Section 7152.5(e). A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but is subject to appropriate administrative sanctions.	
	X. 42 CFR 482.45 – Medicare Conditions of Participation re organ, tissue, and eye procurement	**X. 42 CFR 482.45 – Medicare Conditions of Participation re organ, tissue, and eye procurement** The hospital must have and implement protocols that: (1) incorporate an agreement with an organ procurement organization designated under part 486 of this chapter, under which it must notify, in a timely manner, the or a third party designated by the organ procurement organization of individuals whose death is imminent or who have died in the hospital. The organ procurement organization determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the organ procurement organization determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this	

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		purpose.	
	XI. Health and Safety Code Section 7104(a) – unclaimed dead	**XI. Health and Safety Code Section 7104(a) – unclaimed dead** When no provision is made by the decedent, or where the estate is insufficient to provide for interment and the duty of interment does not devolve upon any other person residing in the state or if such person can not after reasonable diligence be found within the state the person who has custody of the remains may require the coroner of the county where the decedent resided at time of death to take possession of the remains and the coroner shall inter the remains in the manner provided for the interment of indigent dead.	**XI. Health and Safety Code Section 7104(a) – unclaimed dead** May be waived per Government Code Section 8571.
	XII. Health and Safety Code Section 1797.188 – notification to funeral director of reportable disease or condition [and 17 CCR 2500 re reportable diseases]	**XII. Health and Safety Code Section 1797.188 – notification to funeral director of reportable disease or condition [and 17 CCR 2500 re reportable diseases]** In the event of the demise of the person afflicted with the reportable disease or condition, the health facility or county health officer shall notify the funeral director, charged with removing the decedent from the health facility, of the reportable disease prior to the release of the decedent from the health facility to the funeral director.	**XII. Health and Safety Code Section 1797.188 – notification to funeral director of reportable disease or condition [and 17 CCR 2500 re reportable diseases]** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
	XIII. Probate Code Section 330 and 13104(d) – disposition of personal property of decedent	**XIII. Probate Code Section 330 and 13104(d) – disposition of personal property of decedent** Probate Code Section 330. (a) Except as provided in subdivision (b), a public administrator, government official, law enforcement agency, the hospital or institution in which a decedent died, or the decedent's employer, may, without the need to wait 40 days after death, deliver the tangible personal property of the decedent in its possession, including keys to the decedent's residence, to the decedent's surviving spouse, relative, or conservator or guardian of the estate acting in that capacity at the time of death. (b) A person shall not deliver property pursuant to this section if the person knows or has reason to believe that there is a dispute over the right to possession of the property. (c) A person that delivers property pursuant to this section shall require reasonable proof of the status and identity of the person to whom the property is delivered, and may rely on any document described in subdivision (d) of Probate Code Section 13104 as proof of identity. (d) A person that delivers property pursuant to this section shall, for a period of three years after the date of delivery of the property, keep a record of the property delivered and the status and identity of the person to whom the property is delivered. (e) Delivery of property pursuant to this section does not determine ownership of the property or confer any greater rights in the property than the recipient would otherwise have and does not preclude later proceedings for administration of the decedent's estate. If proceedings for administration of the decedent's estate are commenced, the person holding	**XIII. Health and Safety Code Section 7104(a) – unclaimed dead** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		the property shall deliver it to the personal representative on request by the personal representative. (f) A person that delivers property pursuant to this section is not liable for loss or damage to the property caused by the person to whom the property is delivered. Probate Code Section 13104(d). If the affidavit or declaration is executed in the presence of the holder, the holder may reasonably rely on any of the following as reasonable proof of identity for the purposes of this section: (1) An identification card or driver's license issued by the Department of Motor Vehicles of this state that is current or was issued during the preceding five years. (2) A passport issued by the Department of State of the United States that is current or was issued during the preceding five years.	
Grievances	**I. Health and Safety Code Section 1368** **II. 28 CCR 1300.68.Health plan grievance requirements**	**I. Health and Safety Code Section 1368** Extensive grievance procedures specified by statute and reg. **II. 28 CCR 1300.68.Health plan grievance requirements** The plan's grievance system shall track and monitor grievances received by the plan, or any entity with delegated authority to receive or respond to grievances. The system shall: (1) Monitor the number of grievances received and resolved; whether the grievance was resolved in favor	**I. Health and Safety Code Section 1368** May be waived per Government Code Section 8571. **II. 28 CCR 1300.68.Health plan grievance requirements** May be waived per Government Code Section 8571.

Issue to Address	Current Applicable Legislation, Statute, Law	Current Compliance Requirements	Analysis
		of the enrollee or plan; and the number of grievances pending over 30 calendar days. The system shall track grievances under categories of Commercial, Medicare and Medi-Cal/other contracts. The system shall indicate whether an enrollee grievance is pending at: (1) the plan's internal grievance system; (2) the Department's consumer complaint process; (3) the Department's Independent Medical Review system; (4) an action filed or before a trial or appellate court; or (5) other dispute resolution process. Additionally, the system shall indicate whether an enrollee grievance has been submitted to: (1) the Medicare review and appeal system; (2) the Medi-Cal fair hearing process; or (3) arbitration. (2) The system shall be able to indicate the total number of grievances received, pending and resolved in favor of the enrollee at all levels of grievance review and to describe the issue or issues raised in grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care and (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.	

3.10 California Healing Arts: Professional Scope of Practice[1]

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
1. Acupuncture	**Business and Professions Code Section 4927.** As used in this chapter, unless the context otherwise requires: (a) "Board" means the Acupuncture "Board". (b) "Person" means any individual, organization, or corporate body, except that only individuals may be licensed under this chapter. (c) "Acupuncturist" means an individual to whom a license has been issued to practice acupuncture pursuant to this chapter, which is in effect and is not suspended or revoked. (d) "Acupuncture" means the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion. **Business and Professions Code Section 4937**. An acupuncturist's license authorizes the holder thereof: (a) To engage in the practice of acupuncture. (b) To perform or prescribe the use of Asian massage, acupressure, breathing techniques, exercise, heat, cold, magnets, nutrition, diet, herbs, plant, animal, and mineral products, and dietary supplements to promote, maintain, and restore health. Nothing in this section prohibits any person who does not possess an acupuncturist's license or another license as a healing arts practitioner from performing, or prescribing the use of any modality listed in this subdivision. (c) For purposes of this section, a "magnet" means a mineral or metal that produces a magnetic field without the application of an electric current. (d) For purposes of this section, "plant, animal, and mineral products" means naturally occurring substances of plant, animal, or mineral origin, except that it does not include synthetic compounds, controlled substances or dangerous drugs as defined in Business and Professions Code Sections 4021 and 4022, or a controlled substance listed in Health and Safety Code Section 11053 Division 10 Chapter 2. (e) For purposes of this section, "dietary supplement" has the same meaning as defined in 21 USC Section 321 (ff), except that dietary supplement does not include controlled substances or dangerous drugs as defined in Business and Professions Code Section 4021 or 4022, or a controlled substance listed in Health and Safety Code Section 11053 Division 10 Chapter 2.

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	Business and Professions Code Section 4947. (a) Nothing in this chapter shall be construed to prevent the practice of acupuncture by a person licensed as a dentist or a podiatrist, within the scope of their respective licenses, if the licensee has received a course of instruction in acupuncture. This course material shall be approved by the licensing board having jurisdiction over the licensee. The board shall assist the licensing boards in providing information as requested by the individual licensing boards. (b) The course requirement set forth in subdivision (a) shall not apply to a podiatrist or dentist who has completed a course in acupuncture, including a continuing education course, and has utilized acupuncture prior to July 1, 1982.
2. Board of Behavioral Sciences	**Business and Professions Code Section 4990.18.** It is the intent of the Legislature that the board employ its resources for each and all of the following functions: (a) The licensure of marriage and family therapists, clinical social workers, and educational psychologists. **Marriage and Family Therapists:** **Business and Professions Code Section 4980.02.** For the purposes of this chapter, the practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied pyschotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Business and Professions Code Sections 4980.37, 4980.40, and 4980.41. Business and Professions Code Section 4980.37. (a) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program which meets the educational qualifications for licensure shall include all of the following: (1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders. (2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships. (3) Train students specifically in the application of marriage and family relationship counseling principles and methods. (4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
	as integrity, sensitivity, flexibility, insight, compassion, and personal presence. (5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships. (6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists. (7) Prepare students to be familiar with crosscultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans. (b) Educational institutions are encouraged to design the practicum required by Business and Professions Code Section 4980.40 (b) to include marriage and family therapy experience in low-income and multicultural mental health settings. **Business and Professions Code Section 4980.40.** To qualify for a license, an applicant shall have all the following qualifications: (a) Applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau for Private Postsecondary and Vocational Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this subdivision, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. The instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment. The coursework shall include all of the following areas: (1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment. (2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups. (3) Developmental issues and life events from infancy to old age and their effect upon individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, and

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	geropsychology. (4) A variety of approaches to the treatment of children. The board shall, by regulation, set forth the subjects of instruction required in this subdivision. (b) (1) In addition to the 12 semester or 18 quarter units of coursework specified above, the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic techniques, assessment, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist. (2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups. (3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement. (c) As an alternative to meeting the qualifications specified in subdivision (a), the board shall accept as equivalent degrees, those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education. (d) All applicants shall, in addition, complete the coursework or training specified in Business and Professions Code Section 4980.41. (e) All applicants shall be at least 18 years of age. (f) All applicants shall have at least two years of experience that meet the requirements of Business and Professions Code Section 4980.43. (g) The applicant shall pass a board administered written or oral examination or both types of examinations, except that an applicant who passed a written examination and who has not taken and passed an oral examination shall instead be required to take and pass a clinical vignette written examination. (h) The applicant shall not have committed acts or crimes constituting grounds for denial of licensure under Business and Professions Code Section 480. The board shall not issue a registration or license to any person who has been convicted of a crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Penal Code Section 290 or the equivalent in another state or territory. (i) (1) An applicant applying for intern registration who, prior to December 31, 1987, met the qualifications for registration, but who failed to apply or qualify for intern registration may be granted an intern registration if the applicant meets all of the following criteria: (A) The applicant possesses a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, counseling with an emphasis in marriage, family, and child counseling, or social work with an emphasis in clinical social work obtained from a school, college, or

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	university currently conferring that degree that, at the time the degree was conferred, was accredited by the Western Association of Schools and Colleges, and where the degree conferred was, at the time it was conferred, specifically intended to satisfy the educational requirements for licensure by the Board of Behavioral Sciences. (B) The applicant's degree and the course content of the instruction underlying that degree have been evaluated by the chief academic officer of a school, college, or university accredited by the Western Association of Schools and Colleges to determine the extent to which the applicant's degree program satisfies the current educational requirements for licensure, and the chief academic officer certifies to the board the amount and type of instruction needed to meet the current requirements. (C) The applicant completes a plan of instruction that has been approved by the board at a school, college, or university accredited by the Western Association of Schools and Colleges that the chief academic officer of the educational institution has, pursuant to subparagraph (B), certified will meet the current educational requirements when considered in conjunction with the original degree. (2) A person applying under this subdivision shall be considered a trainee, as that term is defined in Business and Professions Code Section 4980.03, once he or she is enrolled to complete the additional coursework necessary to meet the current educational requirements for licensure. (j) An applicant for licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is equivalent to a degree earned from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau of Private Postsecondary and Vocational Education. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES), and shall provide any other documentation the board deems necessary. **Business and Professions Code Section 4980.41**. All applicants for licensure shall complete the following coursework or training in order to be eligible to sit for the licensing examinations as specified in Business and Professions Code Section 4980.40 (g): (a) A two semester or three quarter unit course in California law and professional ethics for marriage and family therapists, which shall include, but not be limited to, the following areas of study: (1) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice. (2) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law. (3) The current legal patterns and trends in the mental health profession.

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	(4) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent. (5) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics. This course may be considered as part of the 48 semester or 72 quarter unit requirements contained in Business and Professions Code Section 4980.40. (b) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Business and Professions Code Section 28 and any regulations promulgated thereunder. (c) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Business and Professions Code Section 25, and any regulations promulgated thereunder. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Business and Professions Code Section 4980.40. (d) For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Business and Professions Code Section 4980.40. (e) For persons who began graduate study during the period commencing on January 1, 1995, and ending on December 31, 2003, a master's or doctor's degree qualifying for licensure shall include coursework in spousal or partner abuse assessment, detection, and intervention. For persons who began graduate study on or after January 1, 2004, a master's or doctor's degree qualifying for licensure shall include a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. The requirement for coursework shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation. (f) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychological testing. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Business and Professions Code Section 4980.40. (g) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychopharmacology. When coursework in a master's or doctor's

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	degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Business and Professions Code Section 4980.40. (h) The requirements added by subdivisions (f) and (g) are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended in any way to expand or restrict the scope of licensure for marriage and family therapists. **Clinical Social Workers** **Business and Professions Code Section 4996.9.** The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work. Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. **Business and Professions Code Section 4996.** (a) Only individuals who have received a license under this article may style themselves as "Licensed Clinical Social Workers." Every individual who styles himself or herself or who holds himself or herself out to be a licensed clinical social worker, or who uses any words or symbols indicating or tending to indicate that he or she is a licensed clinical social worker, without holding his or her license in good standing under this article, is guilty of a misdemeanor. (b) It is unlawful for any person to engage in the practice of clinical social work unless at the time of so doing such person holds a valid, unexpired, and unrevoked license under this article. (c) A clinical social worker licensed under this chapter is a licentiate for purposes of paragraph (2) of Business and Professions Code Section 805 (a), and thus is a healthcare practitioner subject to the provisions of Business and

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	Professions Code Section 2290.5 (b). **Business and Professions Code Section 4996.1.** The board shall issue a clinical social worker license to each applicant who qualifies pursuant to this article and successfully passes a board administered written or oral examination or both examinations. An applicant who has successfully passed a previously administered written examination may be subsequently required to take and pass another written examination. **Business and Professions Code Section 4996.2.** Each applicant shall furnish evidence satisfactory to the board that he or she complies with all of the following requirements: (a) Is at least 21 years of age. (b) Has received a master's degree from an accredited school of social work. (c) Has had two years of supervised post-master's degree experience, as specified in Business and Professions Code Section 4996.20, 4996.21, or 4996.23. (d) Has not committed any crimes or acts constituting grounds for denial of licensure under Business and Professions Code Section 480. The board shall not issue a registration or license to any person who has been convicted of any crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Penal Code Section 290 the equivalent in another state or territory. (e) Has completed adequate instruction and training in the subject of alcoholism and other chemical substance dependency. This requirement applies only to applicants who matriculate on or after January 1, 1986. (f) Has completed instruction and training in spousal or partner abuse assessment, detection, and intervention. This requirement applies to an applicant who began graduate training during the period commencing on January 1, 1995, and ending on December 31, 2003. An applicant who began graduate training on or after January 1, 2004, shall complete a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. This requirement for coursework shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation. (g) Has completed a minimum of 10 contact hours of training or coursework in human sexuality as specified in 16 CCR 1807. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

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	(h) Has completed a minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in 16 CCR 1807.2. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. **Educational Psychologists** **Business and Professions Code Section 4989.12.** The Board of Behavioral Sciences shall administer and enforce the provisions of this chapter. For the purposes of this chapter it shall be designated as the board. **Business and Professions Code Section 4989.14.** The practice of educational psychology is the performance of any of the following professional functions pertaining to academic learning processes or the educational system or both: (a) Educational evaluation. (b) Diagnosis of psychological disorders related to academic learning processes. (c) Administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors. (d) Interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors. (e) Providing psychological counseling for individuals, groups, and families. (f) Consultation with other educators and parents on issues of social development and behavioral and academic difficulties. (g) Conducting psychoeducational assessments for the purposes of identifying special needs. (h) Developing treatment programs and strategies to address problems of adjustment. (i) Coordinating intervention strategies for management of individual crises. **Business and Professions Code Section 4989.20.** (a) The board may issue a license as an educational psychologist if the applicant satisfies, with proof satisfactory to the board, the following requirements: (1) Possession of, at minimum, a master's degree in psychology, educational psychology, school psychology, or counseling and guidance. This degree shall be obtained from an educational institution approved by the board according to the regulations adopted under this chapter. (2) Attainment of 18 years of age. (3) No commission of an act or crime constituting grounds for denial of licensure under Business and Professions Code Section 480. (4) Successful completion of 60 semester hours of postgraduate work in pupil personnel services. (5) Completion of three years of full-time experience as a credentialed school psychologist in the public schools. At

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	least one year of the experience required by this paragraph shall be supervised professional experience in an accredited school psychology program or obtained under the direction of a licensed psychologist or a licensed educational psychologist. The applicant shall not be credited with experience obtained more than six years prior to filing the application for licensure. (6) Passage of an examination specified by the board.
3. Committee on Dental Auxiliaries	**Business and Professions Code Section 1750.** (a) A dental assistant is a person who may perform basic supportive dental procedures as authorized by this article under the supervision of a licensed dentist and who may perform basic supportive procedures as authorized pursuant to Business and Professions Code Section 1751(b) under the supervision of a registered dental hygienist in alternative practice. (b) This section shall become inoperative on December 31, 2007, and, as of January 1, 2008, is repealed, unless a later enacted statute, that is enacted before January 1, 2008, deletes or extends the dates on which it becomes inoperative and is repealed. **Business and Professions Code Section 1750.** (a) A dental assistant is an individual who, without a license, may perform basic supportive dental procedures, as authorized by this article and by regulations adopted by the board, under the supervision of a licensed dentist. "Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to precipitate potentially hazardous conditions for the patient being treated. These basic supportive dental procedures may be performed under general supervision. These basic supportive dental procedures do not include those procedures authorized in Business and Professions Code Section 1750.3 or Business and Professions Code Section 1753.1, or by the board pursuant to Business and Professions Code Section 1751 for registered assistants. (b) The supervising licensed dentist shall be responsible for determining the competency of the dental assistant to perform the basic supportive dental procedures authorized pursuant to subdivision (a). (c) The supervising licensed dentist shall be responsible for assuring that each dental assistant, registered orthodontic assistant, registered surgery assistant, registered restorative assistant, registered restorative assistant in extended functions, registered dental assistant, and registered dental assistant in extended functions, who is in his or her continuous employ for 120 days or more, has completed both of the following within a year of the date of employment: (1) Board-approved courses in infection control and California law. (2) A course in basic life support offered by the American Red Cross, the American Heart Association, or any other course approved by the board as equivalent. (d) Prior to operating radiographic equipment or applying for licensure as a registered dental assistant under Business

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	and Professions Code Section 1752.5, an auxiliary described in subdivision (c) shall successfully complete a radiation safety course approved by the board. (e) This section shall become operative on January 1, 2008. **Business and Professions Code Section 1750.1.** (a) The practice of dental assisting does not include any of the following procedures: (1) Diagnosis and comprehensive treatment planning. (2) Placing, finishing, or removing permanent restorations, except as provided in Business and Professions Code Section 1753.1. (3) Surgery or cutting on hard and soft tissue including, but not limited to, the removal of teeth and the cutting and suturing of soft tissue. (4) Prescribing medication. (5) Starting or adjusting local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other and except as otherwise provided in this article. (b) This section shall become operative on January 1, 2008. **Business and Professions Code Section 1750.2.** (a) On and after January 1, 2008, the board shall license as a "registered orthodontic assistant," "registered surgery assistant," or "registered restorative assistant" any person who does either of the following: (1) Submits written evidence of satisfactory completion of a course or courses approved by the board pursuant to subdivision (b) that qualifies him or her in one of these specialty areas of practice and obtains a passing score on both of the following: (A) A written examination developed, for the specialty category for which the person is seeking licensure, by the Dental Assisting National Board (DANB) and approved by the board. (B) A practical examination for the specialty category for which the person is seeking licensure that is approved by the board. (2) Completes a work experience pathway to licensure that meets the requirements set forth in Business and Professions Code Section 1750.4. This section permits the work experience pathway to licensure only for those assistants described in this subdivision and does not apply to dentists or dental hygienists. (b) The board shall adopt regulations for the approval of specialty registration courses in the specialty areas specified in this section. The board shall also adopt regulations for the approval and recognition of required prerequisite courses and core courses that teach basic dental science, when these courses

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	are taught at secondary institutions, regional occupational centers, or through regional occupational programs. The regulations shall define the minimum education and training requirements necessary to achieve proficiency in the procedures authorized for each specialty registration, taking into account the combinations of classroom and practical instruction, clinical training, and supervised work experience that are most likely to provide the greatest number of opportunities for improving dental assisting skills efficiently. (c) The board may approve specialty registration courses referred to in this section prior to January 1, 2008, and the board shall recognize the completion of these approved courses prior to January 1, 2008, but no specialty registrations shall be issued prior to January 1, 2008. (d) The board may approve a course for the specialty registration listed in subdivision (b) that does not include instruction in coronal polishing. (e) The board may approve a course that only includes instruction in coronal polishing as specified in Business and Professions Code Section 1750.3 (b)(8). (f) A person who holds a specialty registration pursuant to this section shall be subject to the continuing education requirements established by the board pursuant to Business and Professions Code Section 1645 and the renewal requirements of Business and Professions Code Section 1715 Article 6. **Business and Professions Code Section 1750.3.** (a) A registered orthodontic assistant may perform all of the following dental procedures, as well as those authorized by board regulations adopted pursuant to Business and Professions Code Section 1751: (1) Any duties that a dental assistant may perform. (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth. (3) Placing metal orthodontic separators. (4) Placing ligatures and arch wires. (5) Taking orthodontic impressions. (6) Sizing, fitting, cementing, and removal of orthodontic bands. (7) Selecting, prepositioning, curing in a position approved by the supervising dentist, and removal of orthodontic brackets. (8) Coronal polishing. (9) Preparing teeth for bonding. (10) Applying bleaching agents and activating bleaching agents with nonlaser, light-curing devices. (11) Removal of excess cement from coronal surfaces of teeth under orthodontic treatment by means of a hand

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	instrument or an ultrasonic scaler. (12) Taking facebow transfers and bite registrations for diagnostic models for case study only. (b) A registered surgery assistant may perform the following dental procedures, as well as those authorized by board regulations adopted pursuant to Business and Professions Code Section 1751: (1) Any duties that a dental assistant may perform. (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth. (3) Monitoring of patients during the preoperative, intraoperative, and postoperative phases. (A) For purposes of this paragraph, patient monitoring includes the following: (i) Selection and validation of monitoring sensors, selecting menus and default settings and analysis for electrocardiogram, pulse oximeter and capnograph, continuous blood pressure, pulse, and respiration rates. (ii) Interpretation of data from noninvasive patient monitors including readings from continuous blood pressure and information from the monitor display for electrocardiogram waveform, carbon dioxide and end tidal carbon dioxide concentration, respiratory cycle data, continuous noninvasive blood pressure data, and pulse arterial oxygen saturation measurements, for the purpose of evaluating the condition of the patient during preoperative, intraoperative, and postoperative treatment. (B) For purposes of this paragraph, patient monitoring does not include the following: (i) Reading and transmitting information from the monitor display during the intraoperative phase of surgery for electrocardiogram waveform, carbon dioxide and end tidal carbon dioxide concentrations, respiratory cycle data, continuous noninvasive blood pressure data, or pulse arterial oxygen saturation measurements, for the purpose of interpretation and evaluation by a licensed dentist who shall be at chairside during this procedure. (ii) Placing of sensors. (4) Taking impressions for surgical splints and occlusal guards. (5) Placement of surgical dressings . (6) Adding drugs, medications, and fluids to intravenous lines using a syringe, provided that a licensed dentist is present at the patient's chairside. (7) Removal of intravenous lines. (8) Coronal polishing, provided that evidence of satisfactory completion of a board-approved course in this function has been submitted to the board prior to the performance thereof. (c) A registered restorative assistant may perform all of the following dental procedures, as well as those authorized by board regulations adopted pursuant to Business and Professions Code Section 1751: (1) Any duties that a dental assistant may perform. (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and

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	missing teeth. (3) Sizing, fitting, adjusting, intraorally fabricating, temporarily cementing, and removing temporary crowns and other temporary restorations. (4) Placing bases and liners on sound dentin. (5) Removing excess cement from supragingival surfaces of teeth with a hand instrument or an ultrasonic scaler. (6) Taking facebow transfers and bite registrations for diagnostic models for case study only. (7) Taking impressions for space-maintaining appliances and occlusal guards. (8) Coronal polishing. (9) Applying pit and fissure sealants. (10) Applying bleaching agents and activating bleaching agents with nonlaser, light-curing devices. (11) Placement of surgical dressings. (d) The supervising dentist shall be responsible for determining the level of supervision required for assistants registered pursuant to this section. (e) This section shall become operative on January 1, 2008.
4. Dental Board of CA	**Business and Professions Code Section 1625.** Dentistry is the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation. Without limiting the foregoing, a person practices dentistry within the meaning of this chapter who does any one or more of the following: (a) By card, circular, pamphlet, newspaper or in any other way advertises himself or represents himself to be a dentist. (b) Performs, or offers to perform, an operation or diagnosis of any kind, or treats diseases or lesions of the human teeth, alveolar process, gums, jaws, or associated structures, or corrects malposed positions thereof. (c) In any way indicates that he will perform by himself or his agents or servants any operation upon the human teeth, alveolar process, gums, jaws, or associated structures, or in any way indicates that he will construct, alter, repair, or sell any bridge, crown, denture or other prosthetic appliance or orthodontic appliance. (d) Makes, or offers to make, an examination of, with the intent to perform or cause to be performed any operation on the human teeth, alveolar process, gums, jaws, or associated structures. (e) Manages or conducts as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed.

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	Business and Professions Code Section 1626. It is unlawful for any person to engage in the practice of dentistry in the state, either privately or as an employee of a governmental agency or political subdivision, unless the person has a valid, unexpired license or special permit from the board. The following practices, acts and operations, however, are exempt from the operation of this chapter: (a) The practice of oral surgery by a physician and surgeon licensed under the Medical Practice Act. (b) The operations, in dental schools approved by the board, of bona fide students of dentistry or dental hygiene in the school's clinical departments or laboratories or in a dental extension program approved by the board or in an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board. (c) The practice of dentistry by licensed dentists of other states or countries while appearing and operating as bona fide clinicians or instructors in dental colleges approved by the Dental Board of California. (d) The practice of dentistry by licensed dentists of other states or countries in conducting or making a clinical demonstration before any bona fide dental or medical society, association, or convention; provided, however, the consent of the Dental Board of California to the making and conducting of the clinical demonstration shall be first had and obtained. (e) The construction, making, verification of shade taking, alteration or repairing of bridges, crowns, dentures, or other prosthetic appliances, or orthodontic appliances, when the casts or impressions for this work have been made or taken by a licensed dentist, but a written authorization signed by a licensed dentist shall accompany the order for the work or it shall be performed in the office of a licensed dentist under his or her supervision. The burden of proving written authorization or direct supervision is upon the person charged with the violation of this chapter. It is unlawful for any person acting under the exemption of this subdivision to represent or hold out to the public in any manner that he or she will perform or render any of the services exempted by this subdivision that are rendered or performed under the provisions of this chapter by a licensed dentist, including the construction, making, alteration or repairing of dental prosthetic or orthodontic appliances. (f) The manufacture or sale of wholesale dental supplies. (g) The practice of dentistry or dental hygiene by applicants during a licensing examination conducted in this state by the licensing agency of another state which does not have a dental school; provided, however, that the consent of the board to the conducting of the examination shall first have been obtained and that the examination shall be conducted in a dental college accredited by the board. (h) The practice by personnel of the Air Force, Army, Coast Guard, or Navy or employees of the United States Public Health Service, Veterans' Administration, or Bureau of Indian Affairs when engaged in the discharge of official duties.

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	Business and Professions Code Section 1626.2. A dentist licensed under this chapter is a licentiate for purposes of Business and Professions Code Section 805 (2)(a), and thus is a healthcare practitioner subject to the provisions of Business and Professions Code Section 2290.5 (b). **Business and Professions Code Section 1626.5.** (a) A licensed dentist, or group of dentists, or dental corporation shall not share in any fee charged by a person for performing acupuncture or receive anything of value from or on behalf of such acupuncturist for any referral or diagnosis. (b) A licensed dentist shall not employ more than one person to perform acupuncture services. (c) A group of dentists or a dental corporation shall not employ more than one person to perform acupuncture services for every 20 dentists in such group or corporation. **Business and Professions Code Section 1627.5.** No person licensed under this chapter, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care. **Business and Professions Code Section 1627.7**. (a) A dentist shall not be liable for damages for injury or death caused in an emergency situation occurring in the dentist's office or in a hospital on account of a failure to inform a patient of the possible consequences of a dental procedure where the failure to inform is caused by any of the following: (1) The patient was unconscious. (2) The dental procedure was undertaken without the consent of the patient because the dentist reasonably believed that a dental procedure should be undertaken immediately and that there was insufficient time to fully inform the patient. (3) A dental procedure was performed on a person legally incapable of giving consent, and the dentist reasonably believed that a dental procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give such consent for the patient. (b) This section is applicable only to actions for damages for injuries or death arising because of a dentist's failure to inform, and not to actions for such damages arising because of a dentist's negligence in rendering or failing to render treatment. (c) As used in this section:

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	(1) "Dentist" means a person licensed as a dentist pursuant to this chapter. (2) "Emergency situation occurring in a hospital" means a situation occurring in a hospital, whether or not it occurs in an emergency room, requiring immediate services for alleviation of severe pain or immediate diagnosis and treatment of unforeseeable dental conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death. (3) "Hospital" means a licensed general acute care hospital as defined in Health and Safety Code Section 1250 (a). (4) "Emergency situation occurring in the dentist's office" means a situation occurring in an office, other than a hospital, used by the dentist for the examination or treatment of patients, requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.
5. Medical Board	**Business and Professions Code Section 2051**. The physician's and surgeon's certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions. **Business and Professions Code Section 2052**. (a) Notwithstanding Business and Professions Code Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment. (b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision. (c) The remedy provided in this section shall not preclude any other remedy provided by law. **Business and Professions Code Section 2053.5**. (a) Notwithstanding any other provision of law, a person who complies with the requirements of Business and Professions Code Section 2053.6 shall not be in violation of Business and Professions Code Section 2051 or 2052 unless that person does any of the following: (1) Conducts surgery or any other procedure on another person that punctures the skin or harmfully invades the body. (2) Administers or prescribes X-ray radiation to another person. (3) Prescribes or administers legend drugs or controlled substances to

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	another person. (4) Recommends the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner. (5) Willfully diagnoses and treats a physical or mental condition of any person under circumstances or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death. (6) Sets fractures. (7) Treats lacerations or abrasions through electrotherapy. (8) Holds out, states, indicates, advertises, or implies to a client or prospective client that he or she is a physician, a surgeon, or a physician and surgeon. (b) A person who advertises any services that are not unlawful under Business and Professions Code Section 2051 or 2052 pursuant to subdivision (a) shall disclose in the advertisement that he or she is not licensed by the state as a healing arts practitioner. **Business and Professions Code Section 2053.6**. (a) A person who provides services pursuant to Business and Professions Code Section 2053.5 that are not unlawful under Business and Professions Code Section 2051 or 2052 shall, prior to providing those services, do the following: (1) Disclose to the client in a written statement using plain language the following information: (A) That he or she is not a licensed physician. (B) That the treatment is alternative or complementary to healing arts services licensed by the state. (C) That the services to be provided are not licensed by the state. (D) The nature of the services to be provided. (E) The theory of treatment upon which the services are based. (F) His or her educational, training, experience, and other qualifications regarding the services to be provided. (2) Obtain a written acknowledgment from the client stating that he or she has been provided with the information described in paragraph (1). The client shall be provided with a copy of the written acknowledgement, which shall be maintained by the person providing the service for three years. (b) The information required by subdivision (a) shall be provided in a language that the client understands. (c) Nothing in this section or in Business and Professions Code Section 2053.5 shall be construed to do the following: (1) Affect the scope of practice of licensed physicians and surgeons. (2) Limit the right of any person to seek relief for negligence or any other civil remedy against a person providing services subject to the requirements of this section.
6. Optometry Board	**Business and Professions Code Section 3040.** It is unlawful for a person to engage in the practice of optometry or to display a sign or in any other way to advertise or hold himself or herself out as an optometrist without having first obtained a certificate of registration from the board under the provisions of this chapter or under the provisions of any former act relating to the practice of optometry. The practice of optometry includes the performing or controlling of any acts set forth in Business and Professions Code Section 3041. In any prosecution for a violation of this section, the use of test cards, test lenses, or of trial frames is prima facie evidence of the practice of optometry.

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	Business and Professions Code Section 3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and is the doing of any or all of the following: (1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively. (2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition. (3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics. (4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses which may be classified as drugs or devices by any law of the United States or of this state. (5) The use of topical pharmaceutical agents for the sole purpose of the examination of the human eye or eyes for any disease or pathological condition. The topical pharmaceutical agents shall include mydriatics, cycloplegics, anesthetics, and agents for the reversal of mydriasis. (b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Business and Professions Code Section 3041.3, may also diagnose and exclusively treat the human eye or eyes, or any of its appendages, for all of the following conditions: (A) Through medical treatment, infections of the anterior segment and adnexa, excluding the lacrimal gland, the lacrimal drainage system and the sclera. Nothing in this section shall authorize any optometrist to treat a person with Acquired Immune Deficiency Syndrome for ocular infections. (B) Ocular allergies of the anterior segment and adnexa. (C) Ocular inflammation, nonsurgical in cause, limited to inflammation resulting from traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis in patients over the age of 18. Unilateral nongranulomatous idiopathic iritis recurring within one year of the initial occurrence shall be referred to an ophthalmologist. An optometrist shall consult with an ophthalmologist if a patient has a recurrent case of episcleritis within one year of the initial occurrence. An optometrist shall consult with an ophthalmologist if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence. (D) Traumatic or recurrent conjunctival or corneal abrasions and erosions. (E) Corneal surface disease and dry eyes. (F) Ocular pain, not related to surgery, associated with conditions optometrists are authorized to treat.

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	(G) Pursuant to subdivision (f), primary open angle glaucoma in patients over the age of 18. (2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision (e). (c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Business and Professions Code Section 3041.3, may use all of the following therapeutic pharmaceutical agents exclusively: (1) All of the topical pharmaceutical agents listed in paragraph (5) of subdivision (a) as well as topical miotics for diagnostic purposes. (2) Topical lubricants. (3) Topical antiallergy agents. In using topical steroid medication for the treatment of ocular allergies, an optometrist shall do the following: (A) Consult with an ophthalmologist if the patient's condition worsens 72 hours after diagnosis. (B) Consult with an ophthalmologist if the inflammation is still present three weeks after diagnosis. (C) Refer the patient to an ophthalmologist if the patient is still on the medication six weeks after diagnosis. (D) Refer the patient to an ophthalmologist if the patient's condition recurs within three months. (4) Topical antiinflammatories. In using topical steroid medication for: (A) Unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 72 hours after the diagnosis, or if the patient's condition has not resolved three weeks after diagnosis. If the patient is still receiving medication for these conditions six weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (B) Peripheral corneal inflammatory keratitis, excluding Moorens and Terriens diseases, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 48 hours after diagnosis. If the patient is still receiving the medication two weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (C) Traumatic iritis, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 72 hours after diagnosis and shall refer the patient to an ophthalmologist if the patient's condition has not resolved one week after diagnosis. (5) Topical antibiotic agents. (6) Topical hyperosmotics. (7) Topical antiglaucoma agents pursuant to the certification process defined in subdivision (f). (A) The optometrist shall not use more than two concurrent topical medications in treating the patient for primary open angle glaucoma. A single combination medication that contains two pharmacological agents shall be considered as two medications.

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	(B) The optometrist shall refer the patient to an ophthalmologist if requested by the patient, if treatment goals are not achieved with the use of two topical medications or if indications of narrow angle or secondary glaucoma develop. (C) If the glaucoma patient also has diabetes, the optometrist shall consult in writing with the physician treating the patient's diabetes in developing the glaucoma treatment plan and shall notify the physician in writing of any changes in the patient's glaucoma medication. The physician shall provide written confirmation of such consultations and notifications. (8) Nonprescription medications used for the rational treatment of an ocular disorder. (9) Oral antihistamines. In using oral antihistamines for the treatment of ocular allergies, the optometrist shall refer the patient to an ophthalmologist if the patient's condition has not resolved two weeks after diagnosis. (10) Prescription oral nonsteroidal antiinflammatory agents. The agents shall be limited to three days' use. If the patient's condition has not resolved three days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (11) The following oral antibiotics for medical treatment as set forth in subparagraph (A) of paragraph (1) of subdivision (b): tetracyclines, dicloxacillin, amoxicillin, amoxicillin with clavulanate, erythromycin, clarythromycin, cephalexin, cephadroxil, cefaclor, trimethoprim with sulfamethoxazole, ciprofloxacin, and azithromycin. The use of azithromycin shall be limited to the treatment of eyelid infections and chlamydial disease manifesting in the eyes. (A) If the patient has been diagnosed with a central corneal ulcer and the condition has not improved 24 hours after diagnosis, the optometrist shall consult with an ophthalmologist. If the central corneal ulcer has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If the patient is still receiving antibiotics 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (B) If the patient has been diagnosed with preseptal cellulitis or dacryocystitis and the condition has not improved 72 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If a patient with preseptal cellulitis or dacryocystitis is still receiving oral antibiotics 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (C) If the patient has been diagnosed with blepharitis and the patient's condition does not improve after six weeks of treatment, the optometrist shall consult with an ophthalmologist. (D) For the medical treatment of all other medical conditions as set forth in subparagraph (A) of paragraph (1) of subdivision (b), if the patient's condition worsens 72 hours after diagnosis, the optometrist shall consult with an ophthalmologist. If the patient's condition has not resolved 10 days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (12) Topical antiviral medication and oral acyclovir for the medical treatment of the following: herpes simplex viral keratitis, herpes simplex viral conjunctivitis and periocular herpes simplex viral dermatitis; and varicella zoster viral

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	keratitis, varicella zoster viral conjunctivitis and periocular varicella zoster viral dermatitis. (A) If the patient has been diagnosed with herpes simplex keratitis or varicella zoster viral keratitis and the patient's condition has not improved seven days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If a patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (B) If the patient has been diagnosed with herpes simplex viral conjunctivitis, herpes simplex viral dermatitis, varicella zoster viral conjunctivitis or varicella zoster viral dermatitis, and if the patient's condition worsens seven days after diagnosis, the optometrist shall consult with an ophthalmologist. If the patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist. (C) In all cases, the use of topical antiviral medication shall be limited to three weeks, and the use of oral acyclovir shall be limited to 10 days. (13) Oral analgesics that are not controlled substances. (14) Codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Health and Safety Code Section 11000 et seq.) and the United States Uniform Controlled Substances Act (21 USC Section 801 et seq.). The use of these agents shall be limited to three days, with a referral to an ophthalmologist if the pain persists. (d) In any case where this chapter requires that an optometrist consult with an ophthalmologist, the optometrist shall maintain a written record in the patient's file of the information provided to the ophthalmologist, the ophthalmologist's response and any other relevant information. Upon the consulting ophthalmologist's request, the optometrist shall furnish a copy of the record to the ophthalmologist. (e) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Business and Professions Code Section 3041.3 may also perform all of the following: (1) Mechanical epilation. (2) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, and urinalysis. (3) Punctal occlusion by plugs, excluding laser, cautery, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter. (4) The prescription of therapeutic contact lenses. (5) Removal of foreign bodies of the cornea, eyelid, and conjunctiva. Corneal foreign bodies shall be nonperforating, be no deeper than the anterior stroma, and require no surgical repair upon removal. Within the central three millimeters of the cornea, the use of sharp instruments is prohibited. (6) For patients over the age of 12 years, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The State Board of Optometry shall certify an optometrist to perform this procedure after completing 10 of the

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	procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. (7) No injections other than the use of an auto-injector to counter anaphylaxis. (f) The State Board of Optometry shall grant a certificate to an optometrist certified pursuant to Business and Professions Code Section 3041.3 for the treatment of primary open angle glaucoma in patients over the age of 18 only after the optometrist meets the following requirements: (1) Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological and other treatment and management of glaucoma. The 24-hour glaucoma curriculum shall be developed by an accredited California school of optometry. Any applicant who graduated from an accredited California school of optometry on or after May 1, 2000, shall be exempt from the 24-hour didactic course requirement contained in this paragraph. (2) After completion of the requirement contained in paragraph (1), collaborative treatment of 50 glaucoma patients for a period of two years for each patient under the following terms: (A) After the optometrist makes a provisional diagnosis of glaucoma, the optometrist and the patient shall identify a collaborating ophthalmologist. (B) The optometrist shall develop a treatment plan that considers for each patient target intraocular pressures, optic nerve appearance and visual field testing for each eye, and an initial proposal for therapy. (C) The optometrist shall transmit relevant information from the examination and history taken of the patient along with the treatment plan to the collaborating ophthalmologist. The collaborating ophthalmologist shall confirm or refute the glaucoma diagnosis within 30 days. To accomplish this, the collaborating ophthalmologist shall perform a physical examination of the patient. (D) Once the collaborating ophthalmologist confirms the diagnosis and approves the treatment plan in writing, the optometrist may begin treatment. (E) The optometrist shall use no more than two concurrent topical medications in treating the patient for glaucoma. A single combination medication that contains two pharmacologic agents shall be considered as two medications. The optometrist shall notify the collaborating ophthalmologist in writing if there is any change in the medication used to treat the patient for glaucoma. (F) Annually after commencing treatment, the optometrist shall provide a written report to the collaborating ophthalmologist about the achievement of goals contained in the treatment plan. The collaborating ophthalmologist shall acknowledge receipt of the report in writing to the optometrist within 10 days. (G) The optometrist shall refer the patient to an ophthalmologist if requested by the patient, if treatment goals are not achieved with the use of two topical medications, or if indications of secondary glaucoma develop. At his or her discretion, the collaborating ophthalmologist may periodically examine the patient. (H) If the glaucoma patient also has diabetes, the optometrist shall consult in writing with the physician treating the patient's diabetes in preparation of the treatment plan and shall notify the physician in writing if there is any change in

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	the patient's glaucoma medication. The physician shall provide written confirmation of the consultations and notifications. (l) The optometrist shall provide the following information to the patient in writing: nature of the working or suspected diagnosis, consultation evaluation by a collaborating ophthalmologist, treatment plan goals, expected follow-up care, and a description of the referral requirements. The document containing the information shall be signed and dated by both the optometrist and the ophthalmologist and maintained in their files. (3) When the requirements contained in paragraphs (1) and (2) have been satisfied, the optometrist shall submit proof of completion to the State Board of Optometry and apply for a certificate to treat primary open angle glaucoma. That proof shall include corroborating information from the collaborating ophthalmologist. If the ophthalmologist fails to respond within 60 days of a request for information from the State Board of Optometry, the board may act on the optometrist's application without that corroborating information. (4) After an optometrist has treated a total of 50 patients for a period of two years each and has received certification from the State Board of Optometry, the optometrist may treat the original 50 collaboratively treated patients independently, with the written consent of the patient. However, any glaucoma patients seen by the optometrist before the two-year period has expired for each of the 50 patients shall be treated under the collaboration protocols described in this section. (g) Notwithstanding any other provision of law, an optometrist shall not treat children under one year of age with therapeutic pharmaceutical agents. (h) Any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge. (i) Notwithstanding any other provision of law, the practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means in a manner not specifically authorized by this act. Nothing in the act amending this section shall limit an optometrist's authority, as it existed prior to the effective date of the act amending this section, to utilize diagnostic laser and ultrasound technology. (j) All collaborations, consultations, and referrals made by an optometrist pursuant to this section shall be to an ophthalmologist located geographically appropriate to the patient. Business and Professions Code 3041.1. With respect to the practices set forth in Business and Professions Code Section 3041 (b), (d), and (e), optometrists diagnosing or treating eye disease shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held.

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	Business and Professions Code Section 3041.2. (a) The State Board of Optometry shall by regulation, establish educational and examination requirements for licensure to insure the competence of optometrists to practice pursuant to Business and Professions Code Section 3041(a). Satisfactory completion of the educational and examination requirements shall be a condition for the issuance of an original certificate of registration under this chapter, on and after January 1, 1980. Only those optometrists who have successfully completed educational and examination requirements as determined by the State Board of Optometry shall be permitted the use of pharmaceutical agents specified by Business and Professions Code Section 3041(a). (b) Nothing in this section shall authorize an optometrist issued an original certificate under this chapter before January 1, 1996, to use or prescribe therapeutic pharmaceutical agents specified in Business and Professions Code Section 3041(d) without otherwise meeting the requirements of Business and Professions Code Section 3041.3. **Business and Professions Code Section 3041.3.** (a) In order to be certified to use therapeutic pharmaceutical agents and authorized to diagnose and treat the conditions listed in Professions Code Section 3041(b), (d), and (e), an optometrist shall apply for a certificate from the board and meet all requirements imposed by the board. (b) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who graduated from a California accredited school of optometry prior to January 1, 1996, is licensed as an optometrist in California, and meets all of the following requirements: (1) Satisfactorily completes a didactic course of no less than 80 classroom hours in the diagnosis, pharmacological, and other treatment and management of ocular disease provided by either an accredited school of optometry in California or a recognized residency review committee in ophthalmology in California. (2) Completes a preceptorship of no less than 65 hours, during a period of not less than two months nor more than one year, in either an ophthalmologist's office or an optometric clinic. The training received during the preceptorship shall be on the diagnosis, treatment, and management of ocular, systemic disease. The preceptor shall certify completion of the preceptorship. Authorization for the ophthalmologist to serve as a preceptor shall be provided by an accredited school of optometry in California, or by a recognized residency review committee in ophthalmology, and the preceptor shall be licensed as an ophthalmologist in California, board-certified in ophthalmology, and in good standing with the Medical Board of California. The individual serving as the preceptor shall schedule no more than three optometrist applicants for each of the required 65 hours of the preceptorship program. This paragraph shall not be construed to limit the total number of optometrist applicants for whom an individual may serve as a preceptor, and is intended only to ensure the quality of the preceptorship by requiring that the ophthalmologist preceptor schedule the training so that each applicant optometrist completes each of the 65 hours of the preceptorship while scheduled with no more than two other optometrist applicants. (3) Successfully completes a minimum of 20 hours of self-directed education.

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	(4) Passes the National Board of Examiners in Optometry's "Treatment and Management of Ocular Disease" examination or, in the event this examination is no longer offered, its equivalent, as determined by the State Board of Optometry. (5) Passes the examination issued upon completion of the 80-hour didactic course required under paragraph (1) and provided by the accredited school of optometry or residency program in ophthalmology.
7. Osteopathic Medical Board	**Business and Professions Code Section 2099.5.** Notwithstanding any other provision of law, an originating license for an osteopathic physician's and surgeon's certificate issued by the Osteopathic Medical Board of California shall require a written examination that is either prepared or selected by the Osteopathic Medical Board of California. The written examination shall include osteopathic principles and practices and all applicable provisions of Business and Professions Code Section 2080 Article 4. An applicant shall successfully complete the written examination, as determined by the board.
8. Pharmacy Board	**Business and Professions Code Section 4050.** (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession. (b) Pharmacy practice is a dynamic patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities. **Business and Professions Code Section 4051**. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous drug or dangerous device, or to dispense or compound any prescription pursuant to Business and Professions Code Section 4040 of a prescriber unless he or she is a pharmacist under this chapter. (b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Business and Professions Code Section 4052, and otherwise provide clinical advice or information or patient consultation if all of the following conditions are met: (1) The clinical advice or information or patient consultation is provided to a healthcare professional or to a patient. (2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice. (3) Access to the information described in paragraph (2) is secure from unauthorized access and use. **Business and Professions Code Section 4052.** (a) Notwithstanding any other provision of law, a pharmacist may: (1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

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	(2) Transmit a valid prescription to another pharmacist. (3) Administer, orally or topically, drugs and biologicals pursuant to a prescriber's order. (4) Perform procedures or functions in a licensed healthcare facility as authorized by Business and Professions Code Section 4052.1. (5) Perform procedures or functions as part of the care provided by a healthcare facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed healthcare service plan with regard to the care or services provided to the enrollees of that healthcare service plan, or a physician, as authorized by Business and Professions Code Section 4052.2. (6) Manufacture, measure, fit to the patient, or sell and repair dangerous devices or furnish instructions to the patient or the patient's representative concerning the use of those devices. (7) Provide consultation to patients and professional information, including clinical or pharmacological information, advice, or consultation to other healthcare professionals. (8) Furnish emergency contraception drug therapy as authorized by Business and Professions Code Section 4052.3. (9) Administer immunizations pursuant to a protocol with a prescriber. (b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration. (c) Nothing in this section shall affect the requirements of existing law relating to maintaining the confidentiality of medical records. (d) Nothing in this section shall affect the requirements of existing law relating to the licensing of a healthcare facility. **Business and Professions Code Section 4052.1.** (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions in a licensed healthcare facility in accordance with policies, procedures, or protocols developed by health professionals, including physicians, pharmacists, and registered nurses, with the concurrence of the facility administrator: (1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and biologicals by injection pursuant to a prescriber's order. (4) Initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's prescriber and in accordance with the policies, procedures, or protocols of the licensed healthcare facility. (b) Prior to performing any procedure authorized by this section, a pharmacist shall have received appropriate training as prescribed in the policies and procedures of the licensed healthcare facility.

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	Business and Professions Code Section 4052.2. (a) Notwithstanding any other provision of law, a pharmacist may perform the following procedures or functions as part of the care provided by a healthcare facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed healthcare service plan with regard to the care or services provided to the enrollees of that healthcare service plan, or a physician, in accordance with the policies, procedures, or protocols of that facility, home health agency, licensed clinic, healthcare service plan, or physician, and in accordance with subdivision (c): (1) Ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. (2) Ordering drug therapy-related laboratory tests. (3) Administering drugs and biologicals by injection pursuant to a prescriber's order. (4) Initiating or adjusting the drug regimen of a patient pursuant to a specific written order or authorization made by the individual patient's treating prescriber, and in accordance with the policies, procedures, or protocols of the healthcare facility, home health agency, licensed clinic, healthcare service plan, or physician. Adjusting the drug regimen does not include substituting or selecting a different drug, except as authorized by the protocol. The pharmacist shall provide written notification to the patient's treating prescriber, or enter the appropriate information in an electronic patient record system shared by the prescriber, of any drug regimen initiated pursuant to this paragraph within 24 hours. (b) A patient's treating prescriber may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the pharmacist. (c) The policies, procedures, or protocols referred to in this subdivision shall be developed by healthcare professionals, including physicians, pharmacists, and registered nurses, and shall, at a minimum, do all of the following: (1) Require that the pharmacist function as part of a multidisciplinary group that includes physicians and direct care registered nurses. The multidisciplinary group shall determine the appropriate participation of the pharmacist and the direct care registered nurse. (2) Require that the medical records of the patient be available to both the patient's treating prescriber and the pharmacist. (3) Require that the procedures to be performed by the pharmacist relate to a condition for which the patient has first been seen by a physician. (4) Except for procedures or functions provided by a healthcare facility, a licensed clinic in which there is physician oversight, or a provider who contracts with a licensed healthcare plan with regard to the care or services provided to the

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	enrollees of that healthcare service plan, require the procedures to be performed in accordance with a written, patient-specific protocol approved by the treating or supervising physician. Any change, adjustment, or modification of an approved preexisting treatment or drug therapy shall be provided in writing to the treating or supervising physician within 24 hours. (d) Prior to performing any procedure authorized by this section, a pharmacist shall have done either of the following: (1) Successfully completed clinical residency training. (2) Demonstrated clinical experience in direct patient care delivery. **Business and Professions Code Section 4052.3.** (a) Notwithstanding any other provision of law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following: (1) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice. (2) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American College of Obstetricians and Gynecologists, the California Pharmacist Association, and other appropriate entities. Both the board and the Medical Board of California shall have authority to ensure compliance with this clause, and both boards are specifically charged with the enforcement of this provision with respect to their respective licensees. Nothing in this clause shall be construed to expand the authority of a pharmacist to prescribe any prescription medication. (b) Prior to performing a procedure authorized under this paragraph, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy. (c) A pharmacist, pharmacist's employer, or pharmacist's agent may not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this paragraph, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this subparagraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a healthcare service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay co-payments pursuant to the terms and conditions of their coverage. The provisions of this subparagraph shall cease to be operative for dedicated emergency contraception drugs when these drugs are reclassified as over-the-

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	counter products by the federal Food and Drug Administration. (d) A pharmacist may not require a patient to provide individually identifiable medical information that is not specified in 16 CCR 1707.1 before initiating emergency contraception drug therapy pursuant to this section. (e) For each emergency contraception drug therapy initiated pursuant to this section, the pharmacist shall provide the recipient of the emergency contraception drugs with a standardized factsheet that includes, but is not limited to, the indications for use of the drug, the appropriate method for using the drug, the need for medical follow-up, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American College of Obstetricians and Gynecologists, the California Pharmacists Association, and other healthcare organizations. The provisions of this section do not preclude the use of existing publications developed by nationally recognized medical organizations. **Business and Professions Code Section 4052.4.** Notwithstanding Business and Professions Code Section 2038 or any other provision of law, a pharmacist may perform skin puncture in the course of performing routine patient assessment procedures or in the course of performing any procedure authorized under Business and Professions Code Section 1206.5. For purposes of this section, "routine patient assessment procedures" means: (a) procedures that a patient could, with or without a prescription, perform for himself or herself, or (b) clinical laboratory tests that are classified as waived pursuant to the federal Clinical Laboratory Improvement Amendments of 1988 (42 USC Section 263a) and the regulations adopted thereunder by the federal Healthcare Financing Administration, as authorized by Business and Professions Code Section 1206.5 (a)(11). A pharmacist performing these functions shall report the results obtained from a test to the patient and any physician designated by the patient. Any pharmacist who performs the service authorized by this section shall not be in violation of Business and Professions Code Section 2052. **Business and Professions Code Section 4052.5.** (a) In addition to the authority allowed under Business and Professions Code Section 4073, a pharmacist filling a prescription order for a drug product may select a different form of medication with the same active chemical ingredients of equivalent strength and duration of therapy as the prescribed drug product when the change will improve the ability of the patient to comply with the prescribed drug therapy. (b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in his or her own handwriting, "Do not substitute" or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "Do not substitute" if the prescriber personally initials the box or checkmark. (c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The pharmacist who selects the drug product to be dispensed pursuant to this section shall assume the same

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	responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product using the prescribed form of medication. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. (d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Welfare and Institutions Code Section 14000, Division 9, Part 3, Chapter 7. (e) When a substitution is made pursuant to this section, the use of the different form of medication shall be communicated to the patient, and the name of the dispensed drug product shall be indicated on the prescription label, unless the prescriber orders otherwise. (f) This section shall not permit substitution between long-acting and short-acting forms of a medication with the same chemical ingredients or between one drug product and two or more drug products with the same chemical ingredients. **Business and Professions Code Section 4052.7.** (a) A pharmacy may, at a patient's request, repackage a drug previously dispensed to the patient or to the patient's agent pursuant to a prescription. (b) Any pharmacy providing repackaging services shall have in place policies and procedures for repackaging these drugs and shall label the repackaged prescription container with the following: (1) All the information required by Business and Professions Code Section 4076. (2) The name and address of the pharmacy repackaging the drug and the name and address of the pharmacy that initially dispensed the drug to the patient. (c) The repackaging pharmacy and the pharmacy that initially dispensed the drug shall only be liable for its own actions in providing the drug to the patient or the patient's agent.
9. Physical Therapy Board	**Business and Professions Code Section 2620.** (a) Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease. (b) Nothing in this section shall be construed to restrict or prohibit other healing arts practitioners licensed or registered

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	under this division from practice within the scope of their license or registration. **Business and Professions Code Section 2620.3.** A physical therapist licensed pursuant to this chapter may apply topical medications as part of the practice of physical therapy as defined in Business and Professions Code Section 2620 if he or she complies with regulations duly adopted by the board pursuant to this section and the Administrative Procedure Act. The board shall adopt regulations implementing this section after meeting and conferring with the Medical Board of California and the California State Board of Pharmacy specifying those topical medications applicable to the practice of physical therapy and protocols for their use. Nothing in this section shall be construed to authorize a physical therapist to prescribe medications. **Business and Professions Code Section.** A physical therapist may, upon specified authorization of a physician and surgeon, perform tissue penetration for the purpose of evaluating neuromuscular performance as a part of the practice of physical therapy, as defined in Business and Professions Code Section 2620, provided the physical therapist is certified by the board to perform the tissue penetration and evaluation and provided the physical therapist does not develop or make diagnostic or prognostic interpretations of the data obtained. Any physical therapist who develops or makes a diagnostic or prognostic interpretation of this data is in violation of the Medical Practice Act (Business and Professions Code Section 2000 Division 2 Chapter 5), and may be subject to all of the sanctions and penalties set forth in that act. The board, after meeting and conferring with the Division of Licensing of the Medical Board of California, shall do all of the following: (a) Adopt standards and procedures for tissue penetration for the purpose of evaluating neuromuscular performance by certified physical therapists. (b) Establish standards for physical therapists to perform tissue penetration for the purpose of evaluating neuromuscular performance. (c) Certify physical therapists meeting standards established by the board pursuant to this section. **Business and Professions Code Section 2620.7.** (a) A physical therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record. (b) A physical therapist shall document the care actually provided to a patient in the patient record. (c) A physical therapist shall sign the patient record legibly. (d) Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years.

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	Business and Professions Code Section 2630. It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter. Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 Business and Professions Code Section 2655 Article 4.5 or Business and Professions Code Section 3500 Chapter 7.7. A physical therapist licensed pursuant to this chapter may utilize the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record. The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section. **Business and Professions Code 2632**. All licenses for the practice of physical therapy in this state shall be issued by the board, and all applications for the licenses shall be filed with the board. Excepting as otherwise required by the director pursuant to Business and Professions Code Section 164, the license issued by the board shall describe the licensee as a "physical therapist licensed by the Physical Therapy Board of California." Each application shall be accompanied by the application fee prescribed by Business and Professions Code Section 2688, shall be signed by the applicant, and shall contain a statement under oath of the facts entitling the applicant to receive a license without examination or to take an examination. **Business and Professions Code 2633.** (a) A person holding a license as a physical therapist issued by the board may use the title "physical therapist" or the letters "P.T." or any other words, letters, or figures that indicate that the person using same is a licensed physical therapist. No other person shall be so designated or shall use the term

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	licensed or registered physical therapist, licensed or registered physiotherapist, licensed or registered physical therapy technician, or the letters "L.P.T.," "R.P.T.," or "P.T.". (b) A licensed physical therapist who has received a doctoral degree in physical therapy (DPT) or, after adoption of the regulations described in subdivision (d), a doctoral degree in a related health science may do the following: (1) In a written communication, use the initials DPT, PhD, or EdD, as applicable, following the licensee's name. (2) In a written communication, use the title "Doctor" or the abbreviation "Dr." preceding the licensee's name, if the licensee's name is immediately followed by an unabbreviated specification of the applicable doctoral degree held by the licensee. (3) In a spoken communication while engaged in the practice of physical therapy, use the title "doctor" preceding the person's name, if the speaker specifies that he or she is a physical therapist. (c) A doctoral degree described in subdivision (b) shall be granted by an institution accredited by the Western Association of Schools and Colleges or by an accrediting agency recognized by the National Commission on Accrediting or the United States Department of Education that the board determines is equivalent to the Western Association of Schools and Colleges. (d) The board shall define, by regulation, the doctoral degrees that are in a related health science for purposes of subdivision (b).
10. Physician Assistant Committee	**Business and Professions Code Section 3500.5**. This chapter shall be known and cited as the Physician Assistant Practice Act. **Business and Professions Code Section 3501.** As used in this chapter: (a) "Board" means the Division of Licensing of the Medical Board of California. (b) "Approved program" means a program for the education of physician assistants which has been formally approved by the committee. (c) "Trainee" means a person who is currently enrolled in an approved program. (d) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the committee. (e) "Supervising physician" means a physician and surgeon licensed by the board or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant. (f) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant. (g) "Committee" or "examining committee" means the Physician Assistant Committee. (h) "Regulations" means the rules and regulations as contained in 16 CCR 1399.500 Chapter 13.8. (i) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

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	Business and Professions Code Section 3502. (a) Notwithstanding any other provision of law, a physician assistant may perform those medical services as set forth by the regulations of the board when the services are rendered under the supervision of a licensed physician and surgeon or of physicians and surgeons approved by the board, except as provided in Business and Professions Code Section 3502.5. (b) Notwithstanding any other provision of law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon. The supervising physician and surgeon shall be physically available to the physician assistant for consultation when such assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine. (c) No medical services may be performed under this chapter in any of the following areas: (1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof. (2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics. (3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye. (4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Business and Professions Code Section 1600 Chapter 4. (d) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Business and Professions Code Section 3501. **Business and Professions Code Section 3502.1.** (a) In addition to the services authorized in the regulations adopted by the board, and except as prohibited by Business and Professions Code Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d). (1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

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	(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. The drugs listed shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon. (b) "Drug order" for purposes of this section means an order for medication which is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of 21 CFR 1306.02. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code. (c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols described in subdivision (a) or shall be approved by the supervising physician before it is filled or carried out. (1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist. (2) A physician assistant may not administer, provide or issue a drug order for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for the particular patient. (3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice. (d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and phone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant. The requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's

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	prescription blank to show the name, license number, and if applicable, the federal controlled substances number of the physician assistant, and shall be signed by the physician assistant. When using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon. (e) The medical record of any patient cared for by a physician assistant for whom the supervising physician and surgeon's Schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven days. (f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA). (g) The committee shall consult with the Medical Board of California and report during its sunset review required by Business and Professions Code Section 473 Division 1.2 the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient. **Business and Professions Code Section 3502.5.** Notwithstanding any other provision of law, a physician assistant may perform those medical services permitted pursuant to Business and Professions Code Section 3502 during any state of war emergency, state of emergency, or state of local emergency, as defined in Business and Professions Code Section 8558 of the Government Code, and at the request of a responsible federal, state, or local official or agency, or pursuant to the terms of a mutual aid operation plan established and approved pursuant to the California Emergency Services Act (Government Code 8550, Title 2, Division 1, Chapter 7), regardless of whether the physician assistant's approved supervising physician is available to supervise the physician assistant, so long as a licensed physician is available to render the appropriate supervision. "Appropriate supervision" shall not require the personal or electronic availability of a supervising physician if that availability is not possible or practical due to the emergency. The local health officers and their designees may act as supervising physicians during emergencies without being subject to approval by the board. At all times, the local health officers or their designees supervising the physician assistants shall be licensed physicians and surgeons. Supervising physicians acting pursuant to this section shall not be subject to the limitation on the number of physician assistants supervised under Business and Professions Code Section 3516. No responsible official or mutual aid operation plan shall invoke this section except in the case of an emergency that endangers the health of individuals. Under no circumstances shall this section be invoked as the result of a labor dispute or other dispute concerning collective bargaining.

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11. Podiatric Medicine	**Business and Professions Code Section 2472.** (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine. (b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. (c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed healthcare practitioner who is authorized to administer the required anesthetic within the scope of his or her practice. (d) (1) A doctor of podiatric medicine who is ankle certified by the board on and after January 1, 1984, may do the following: (A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e). (B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine. (C) Perform a partial amputation of the foot no further proximal than the Chopart's joint. (2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice. (e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations: (1) A licensed general acute care hospital, as defined in Health and Safety Code Section 1250. (2) A licensed surgical clinic, as defined in Health and Safety Code Section 1204, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical clinic. (3) An ambulatory surgical center that is certified to participate in the Medicare Program under Title XVIII (42 USC Section 1395) of the federal Social Security Act, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical center. (4) A freestanding physical plant housing outpatient services of a licensed general acute care hospital, as defined in Health and Safety Code Section 1250, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1). For purposes of this section, a "freestanding physical plant" means any building that is not physically attached to a building where inpatient services are provided. (5) An outpatient setting accredited pursuant to Health and Safety Code Section 1248.1 (g). (f) A doctor of podiatric medicine shall not perform an admitting history and physical examination of a patient in an

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	acute care hospital where doing so would violate the regulations governing the Medicare program. (g) A doctor of podiatric medicine licensed under this chapter is a licentiate for purposes of Business and Professions Code Section 805 (a)(2), and thus is a healthcare practitioner subject to the provisions of Business and Professions Code Section 2290.5 (b). **Business and Professions Code Section 2484**. In addition to any other requirements of this chapter, before a certificate to practice podiatric medicine may be issued, each applicant shall show by evidence satisfactory to the board, submitted directly to the board by the sponsoring institution, that he or she has satisfactorily completed at least two years of postgraduate podiatric medical and podiatric surgical training in a general acute care hospital approved by the Council of Podiatric Medical Education. **Business and Professions Code Section 2486.** The division shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine if the applicant meets all of the following requirements: (a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Business and Professions Code Section 2483. (b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States. (c) The applicant has satisfactorily completed the postgraduate training required by Business and Professions Code Section 2484. (d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence. (e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Business and Professions Code Section 475 Division 1.5. (f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence. (g) A disciplinary databank report regarding the applicant has been directly presented to the board from the Federation of Podiatric Medical Boards.

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12. Board of Psychology	**Business and Professions Code Section 2902**. As used in this chapter, unless the context clearly requires otherwise and except as in this chapter expressly otherwise provided the following definitions apply: (a) "Licensed psychologist" means an individual to whom a license has been issued pursuant to the provisions of this chapter, which license is in force and has not been suspended or revoked. (b) "Board" means the Board of Psychology. (c) A person represents himself or herself to be a psychologist when the person holds himself or herself out to the public by any title or description of services incorporating the words "psychology," "psychological," "psychologist," "psychology consultation," "psychology consultant," "psychometry," "psychometrics" or "psychometrist," "psychotherapy," "psychotherapist," "psychoanalysis," or "psychoanalyst," or when the person holds himself or herself out to be trained, experienced, or an expert in the field of psychology. (d) "Accredited," as used with reference to academic institutions, means the University of California, the California State University, or an institution that is accredited by a national or an applicable regional accrediting agency recognized by the United States Department of Education. (e) "Approved," as used with reference to academic institutions, means an institution having "approval to operate", as defined in Education Code Section 94718. **Business and Professions Code Section 2903.** No person may engage in the practice of psychology, or represent himself or herself to be a psychologist, without a license granted under this chapter, except as otherwise provided in this chapter. The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations. The application of these principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups. Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive. As used in this chapter, "fee" means any charge, monetary or otherwise, whether paid directly or paid on a prepaid or capitation basis by a third party, or a charge assessed by a facility, for services rendered. **Business and Professions Code Section 2903.1**. A psychologist licensed under this chapter may use biofeedback

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	instruments which do not pierce or cut the skin to measure physical and mental functioning. **Business and Professions Code Section 2904.** The practice of psychology shall not include prescribing drugs, performing surgery or administering electroconvulsive therapy. **Business and Professions Code Section 2904.5.** A psychologist licensed under this chapter is a licentiate for purposes of Business and Professions Code Section 805 (a)(2), and thus is a healthcare practitioner subject to the provisions of Business and Professions Code Section 2290.5 (b). **Business and Professions Code Section 2905.** The practice of psychology shall be as defined as in Business and Professions Code Section 2903, any existing statute in the State of California to the contrary notwithstanding.
13. Board of Registered Nursing	**Business and Professions Code Section 2725**. (a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized healthcare systems that provide for collaboration between physicians and registered nurses. These organized healthcare systems include, but are not limited to, health facilities licensed pursuant to Health and Safety Code Section 1250, Division 2, Chapter 2, clinics, home health agencies, physicians' offices, and public or community health services. (b) The practice of nursing within the meaning of this chapter means those functions, including basic healthcare, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following: (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures. (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Health and Safety Code Section

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	1316.5. (3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries. (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. (c) "Standardized procedures," as used in this section, means either of the following: (1) Policies and protocols developed by a health facility licensed pursuant to Health and Safety Code Section 1250 Division 2 Chapter 2 through collaboration among administrators and health professionals including physicians and nurses. (2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized healthcare system which is not a health facility licensed pursuant to Health and Safety Code Section 1250, Division 2, Chapter 2. The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing. (d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing. (e) No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute. "State agency" includes every state office, officer, department, division, bureau, board, authority, and commission. **Business and Professions Code Section 2725.1.** Notwithstanding any other provision of law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon if the nurse is functioning within a licensed clinic as defined in Business and Professions Code Section 1204 (a)(1) and (2) of, or within a clinic as defined in Health and Safety Code Section 1206 (b) or (c). No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Business and Professions Code Section

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	2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Business and Professions Code Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Health and Safety Code Section 11000 Division 10). Nothing in this section shall exempt a clinic from the provisions of Business and Professions Code Section 4180 Chapter 9 Article 13. **Business and Professions Code Section 2725.3**. (a) A health facility licensed pursuant to Health and Safety Code Section 1250 (a), (b) or (f) shall not assign unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills, including, but not limited to, any of the following: (1) Administration of medication. (2) Venipuncture or intravenous therapy. (3) Parenteral or tube feedings. (4) Invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning. (5) Assessment of patient condition. (6) Educating patients and their families concerning the patient's healthcare problems, including postdischarge care. (7) Moderate complexity laboratory tests. (b) This section shall not preclude any person from performing any act or function that he or she is authorized to perform pursuant to Business and Professions Code Section 500 Division 2 or pursuant to existing statute or regulation as of July 1, 1999.
14. Respiratory Care Board	**Business and Professions Code Section 3702.** Respiratory care as a practice means a healthcare profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following: (a) Direct and indirect pulmonary care services that are safe, aseptic, preventative, and restorative to the patient. (b) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a physician and surgeon. (c) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and (1) determination of whether such signs, symptoms, reactions, behavior or general response exhibit abnormal characteristics; (2) implementation based on observed abnormalities of appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a

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	physician and surgeon or the initiation of emergency procedures. (d) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions. (e) The transcription and implementation of the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory care. "Respiratory care protocols" as used in this section means policies and protocols developed by a licensed health facility through collaboration, when appropriate, with administrators, physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed healthcare practitioners. **Business and Professions Code Section 3703.** (a) The settings in which respiratory care may be practiced include licensed healthcare facilities, hospitals, clinics, ambulatory or home healthcare, physicians' offices, and public or community health services. Respiratory care may also be provided during the transportation of a patient, and under any circumstances where an emergency necessitates respiratory care. (b) The practice of respiratory care shall be performed under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to respiratory care protocols as specified in Business and Professions Code Section 3702. **Business and Professions Code Section 3740.** (a) Except as otherwise provided in this chapter, all applicants for licensure under this chapter shall have completed an education program for respiratory care that is accredited by the Commission on Accreditation of Allied Health Education Programs and been awarded a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education. (b) Notwithstanding subdivision (a), meeting the following qualifications shall be deemed equivalent to the required education: (1) Enrollment in a baccalaureate degree program in an institution or university accredited by a regional accreditation

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
	agency or association recognized by the United States Department of Education. (2) Completion of science, general academic, and respiratory therapy coursework commensurate with the requirements for an associate degree in subdivision (a). (c) An applicant whose application is based on a diploma issued to the applicant by a foreign respiratory therapy school or a certificate or license issued by another state, district, or territory of the United States that does not meet the requirements in Business and Professions Code Section 3740 (a) or (b), shall enroll in an advanced standing and approved respiratory educational program for evaluation of his or hereducation and training and furnish documentary evidence, satisfactory to the board, that he or she satisfies all of the following requirements: (1) Holds an associate degree or higher level degree equivalent to that required in subdivision (a) or (b). (2) Completion of a respiratory therapy educational program equivalent to that required in subdivision (a) or (b). (3) Possession of knowledge and skills to competently and safely practice respiratory care in accordance with national standards. (d) Notwithstanding subdivision (c), an applicant whose application is based on education provided by a Canadian institution or university that does not meet the requirements in subdivision (a) or (b) shall furnish documentary evidence, satisfactory to the board, that he or she satisfies both of the following requirements: (1) Holds a degree equivalent to that required in subdivision (a) or (b). (2) Completion of a respiratory therapy educational program recognized by the Canadian Board of Respiratory Care. (e) A school shall give the director of a respiratory care program adequate release time to perform his or her administrative duties consistent with the established policies of the educational institution. (f) Satisfactory evidence as to educational qualifications shall take the form of certified transcripts of the applicant's college record mailed directly to the board from the educational institution. However, the board may require an evaluation of educational credentials by an evaluation service approved by the board. (g) At the board's discretion, it may waive its educational requirements if evidence is presented and the board deems it as meeting the current educational requirements that will ensure the safe and competent practice of respiratory care. This evidence may include, but is not limited to: (1) Work experience. (2) Good standing of licensure in another state. (3) Previous good standing of licensure in the State of California. h) Nothing contained in this section shall prohibit the board from disapproving any respiratory therapy school, nor from denying the applicant if the instruction, including modalities and advancements in technology, received by the

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	applicant or the courses were not equivalent to that required by the board.
15. Veterinary Medical Board	**Business and Professions Code Section 4826.** Any person practices veterinary medicine, surgery, and dentistry, and the various branches thereof, when he or she does any one of the following: (a) Represents himself or herself as engaged in the practice of veterinary medicine, veterinary surgery, or veterinary dentistry in any of its branches. (b) Diagnoses or prescribes a drug, medicine, appliance, application, or treatment of whatever nature for the prevention, cure or relief of a wound, fracture, bodily injury, or disease of animals. (c) Administers a drug, medicine, appliance, application, or treatment of whatever nature for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals, except where the drug, medicine, appliance, application, or treatment is administered by a registered veterinary technician or an unregistered assistant at the direction of and under the direct supervision of a licensed veterinarian subject to Business and Professions Code Section 4832 Article 2.5. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the board. (d) Performs a surgical or dental operation upon an animal. (e) Performs any manual procedure for the diagnosis of pregnancy, sterility, or infertility upon livestock or Equidae. (f) Uses any words, letters or titles in such connection or under such circumstances as to induce the belief that the person using them is engaged in the practice of veterinary medicine, veterinary surgery, or veterinary dentistry. This use shall be prima facie evidence of the intention to represent himself or herself as engaged in the practice of veterinary medicine, veterinary surgery, or veterinary dentistry.
16. Vocational Nursing & Psychiatric Technicians	**Vocational Nursing** **Business and Professions Code Section 2860.5.** A licensed vocational nurse when directed by a physician and surgeon may do all of the following: (a) Administer medications by hypodermic injection. (b) Withdraw blood from a patient, if prior thereto such nurse has been instructed by a physician and surgeon and has demonstrated competence to such physician and surgeon in the proper procedure to be employed when withdrawing blood, or has satisfactorily completed a prescribed course of instruction approved by the board, or has demonstrated competence to the satisfaction of the board. (c) Start and superimpose intravenous fluids if all of the following additional conditions exist: (1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
	demonstrated competence to the satisfaction of the board. (2) The procedure is performed in an organized healthcare system in accordance with the written standardized procedures adopted by the organized healthcare system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. "Organized healthcare system," as used in this section, includes facilities licensed pursuant to Health and Safety Code Section 1250, clinics, home health agencies, physician's offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs. **Business and Professions Code Section 2860.7.** (a) A licensed vocational nurse, acting under the direction of a physician may perform: (1) tuberculin skin tests, coccidioidin skin tests, and histoplasmin skin tests, providing such administration is within the course of a tuberculosis control program, and (2) immunization techniques, providing such administration is upon standing orders of a supervising physician, or pursuant to written guidelines adopted by a hospital or medical group with whom the supervising physician is associated. (b) The supervising physician under whose direction the licensed vocational nurse is acting pursuant to subdivision (a) shall require such nurse to: (1) Satisfactorily demonstrate competence in the administration of immunizing agents, including knowledge of all indications and contraindications for the administration of such agents, and in the recognition and treatment of any emergency reactions to such agents which constitute a danger to the health or life of the person receiving the immunization; and (2) Possess such medications and equipment as required, in the medical judgment of the supervising physician and surgeon, to treat any emergency conditions and reactions caused by the immunizing agents and which constitute a danger to the health or life of the person receiving the immunization, and to demonstrate the ability to administer such medications and to utilize such equipment as necessary. (c) Nothing in this section shall be construed to require physical presence of a directing or supervising physician, or the examination by a physician of persons to be tested or immunized. **Business and Professions Code Section 2866**. An applicant for a licensed vocational nurse license shall comply with each of the following: (a) Be at least 17 years of age. (b) Have successfully completed at least an approved course of study through the 12th grade or the equivalent thereof as specified by the board. (c) Have successfully completed the prescribed course of study in an accredited school of vocational nursing or have

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
	graduated from a school which, in the opinion of the board, maintains and gives a course which is equivalent to the minimum requirements for an accredited school of vocational nursing in this state. (d) Not be subject to denial of licensure under Business and Professions Code Section 480. **Psychiatric Technicians** **Business and Professions Code Section 4502.** As used in this chapter, "psychiatric technician" means any person who, for compensation or personal profit, implements procedures and techniques which involve understanding of cause and effect and which are used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or mentally retarded persons and who has one or more of the following: (a) Direct responsibility for administering or implementing specific therapeutic procedures, techniques, treatments, or medications with the aim of enabling recipients or patients to make optimal use of their therapeutic regime, their social and personal resources, and their residential care. (b) Direct responsibility for the application of interpersonal and technical skills in the observation and recognition of symptoms and reactions of recipients or patients, for the accurate recording of such symptoms and reactions, and for the carrying out of treatments and medications as prescribed by a licensed physician and surgeon or a psychiatrist. The psychiatric technician in the performance of such procedures and techniques is responsible to the director of the service in which his duties are performed. The director may be a licensed physician and surgeon, psychiatrist, psychologist, rehabilitation therapist, social worker, registered nurse, or other professional personnel. Nothing herein shall authorize a licensed psychiatric technician to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of the law. **Business and Professions Code Section 4502.1.** A psychiatric technician, working in a mental health facility or developmental disability facility, when prescribed by a physician and surgeon, may administer medications by hypodermic injection. **Business and Professions Code Section 4502.2.** A psychiatric technician, when prescribed by a physician and surgeon, may withdraw blood from a patient with a mental illness or developmental disability if the psychiatric technician has received certification from the board that the psychiatric technician has completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board. **Business and Professions Code Section 4502.3.** (a) A psychiatric technician, when prescribed by a physician and surgeon, may perform the following activities on a patient with a mental illness or developmental disability:

Profession/Board/Specialty	California Business and Professions Code Scope of Practice Description
	(1) Tuberculin, coccidioidin, and histoplasmin skin tests, providing the administration is within the course of a tuberculosis control program. (2) Immunization techniques, providing the administration is upon the standing orders of a supervising physician and surgeon or pursuant to written guidelines adopted by a hospital or medical group with whom the supervising physician and surgeon is associated. (b) In performing activities pursuant to subdivision (a), the psychiatric technician shall satisfactorily demonstrate competence in all of the following: (1) Administering the testing or immunization agents, including knowledge of all indications and contraindications for the administration of the agents. (2) Recognizing any emergency reactions to the agent that constitute a danger to the health or life of the patient. (3) Treating those emergency reactions by using procedures, medication, and equipment within the scope of practice of the psychiatric technician. **Business and Professions Code Section 4511.** An applicant for a psychiatric technician's license shall have the following qualifications: (a) Be at least 18 years of age. (b) Have successfully completed an approved general education course of study through the 12th grade or the equivalent thereof as determined by the board. (c) Have successfully completed (1) a prescribed course of study and training in a school accredited by the board, which course of study and training shall combine the nursing knowledge and skills necessary for the care of any ill person and in addition those special skills necessary for the care of the mentally disabled and the developmentally disabled, or (2) a course of study and training which, together with previously acquired training or experience, is determined by a school accredited by the board to be equivalent in academic credits to its regular program for psychiatric technician training, or (3) have completed a course of study and training which in the opinion of the board is equivalent to the minimum requirements of an accredited program for psychiatric technicians in the state. Clinical inpatient experience shall be an integral part of any such prescribed or equivalent course of study and training. (d) Have committed no act which, if committed by a licensed psychiatric technician, would be ground for disciplinary action.

1 California Business and Professions Code, http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=bpc&codebody=&hits=20

4. Applying the Incident Command System to the Hospital

During any emergency, a hospital must be prepared to transition from a day-to-day organizational structure to an incident specific management system that focuses on emergency operations, employs systems to manage and effectively address the incident and its impact on the hospital, minimizes risks, maintains mission critical services and patient care, focuses on recovering from the incident and returning to readiness or "normal operations". As strategic principles of the Incident Command System are applied to hospital command, management of emergency incidents is through the use of the Hospital Incident Command System (HICS).

Since its inception in the late 1980s, the Hospital Emergency Incident Command System has been implemented in hospitals across the United States, employed as the management tool of choice during an incident or emergency situation. Recognizing the value and importance of using a hospital-based incident management system, not only in emergency situations but also in preplanned events and non-emergent situations; and, to ensure compliance with regulatory mandates, Hospital Emergency Incident Command System has evolved to become HICS, a comprehensive incident management system to assist hospitals to better and more effectively prepare, respond, and recover from incidents. HICS provides for common organizational structures, communications, resource management, incident action planning, and provides for a more effective incident response and recovery. Standardization among responders also facilitates mitigation, planning and preparedness.

HICS is consistent with the regulations and requirements of California's Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS), Element 2 of the *NIMS Implementation Activities for Hospitals and Healthcare Providers* (September 2006) requires hospitals to "Manage all emergency incidents, exercises and preplanned (recurring/special) events in accordance with Incident Command System organizational structures, doctrine, and procedures, as defined in NIMS"[1].

While HICS is the management tool used by hospitals to manage emergency response and recovery a surge event, it is not the Emergency Operations Plan or the surge plan. In developing the hospital's Emergency Operations Plan and surge plan, HICS is incorporated into the command and management structure, supported by hospital plans, policies and procedures for a surge event. The Hospital Emergency Management Coordinator and others developing the Emergency Operation Plan and surge plans should be familiar with the principles of NIMS, SEMS, Incident Command System, HICS and local community response partner surge plans to ensure continuity of response.

This chapter is not intended to be a primer on HICS, but an overview of HICS in relationship to a patient surge event. The HICS Guidebook and HICS tools can be found at www.emsa.ca.gov/hics/hics.asp. This chapter outlines the role and application of HICS in a catastrophic emergency that results in a patient surge. For these purposes, "healthcare surge"

is defined as follows: “A healthcare surge is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment, determines, subsequent to a significant catastrophic emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services.”

4.1. Incident Management Functions

As described in Incident Command System, every incident requires specific management functions and activities be conducted. The management functions include:

- **Incident Command**. A qualified and trained individual assumes the role of Incident Commander for the internal hospital response and recovery operations and maintains overall responsibility for managing the hospital’s incident or event by setting the incident objectives, strategies and priorities, using the hospital Emergency Operation Plan to guide these decisions.
- **Operations** conducts the tactical operations and manages tactical resources to carry out the hospital’s incident action plan.
- **Planning** collects and evaluates information for decision support, maintains resource status, prepares and documents the hospital’s Incident action Plan) and maintains incident documentation.
- **Logistics** provides support, resources and all other essential services to meet the hospital’s operational objectives.
- **Finance/Administration** monitors the hospital’s costs related to the incident while providing accounting, procurement, time recording and cost analysis.

Management by objectives or **Incident Action Planning** is essential in achieving an effective hospital’s response and recovery. The four-step management approach for incident action planning[2] includes:

- Establishing overarching measurable objectives
- Developing and issuing assignments
- Implementing plans, procedures, and protocols, and directing efforts to meet the hospital’s overarching objectives
- Documenting results to measure performance and facilitate corrective action.

HICS incorporates the management functions and describes each function, position, role and responsibility within the hospital incident management structure. Functions and positions are activated according to the type and magnitude of the event, the impact of the event on the

hospital, with resources available. The size and structure of the HICS incident management team is based on what is needed to meet and support the incident and hospital objectives.

4.2. The Hospital Emergency Operations Plan and Incident Command System

The hospital must develop and maintain a written Emergency Operations Plan which describes an "all-hazards" command structure for coordinating six critical response areas (communications, resources and assets, safety and security, staffing responsibilities, utilities management, and patient clinical and support activities) within the organization during an emergency[3]. The Emergency Operation Plan must also identify to whom staff report in the incident command structure[4].

HICS provides the management structure to assist hospitals to address and coordinate critical response and recovery issues, to delineate the command structure, and designate the chain of command.

4.3. Hospital Incident Action Planning

Planning is essential for effective management, response and recovery. Incident action planning is a key principle element of Incident Command System and is described in the Emergency Operation Plan, incorporated and exercised in the hospitals emergency management activities within the Hospital Command Center (the hospital's incident command post). Incident action planning is an important element of response and recovery. It maximizes the use of resources, reduces duplication, improves communications and reduces costs.

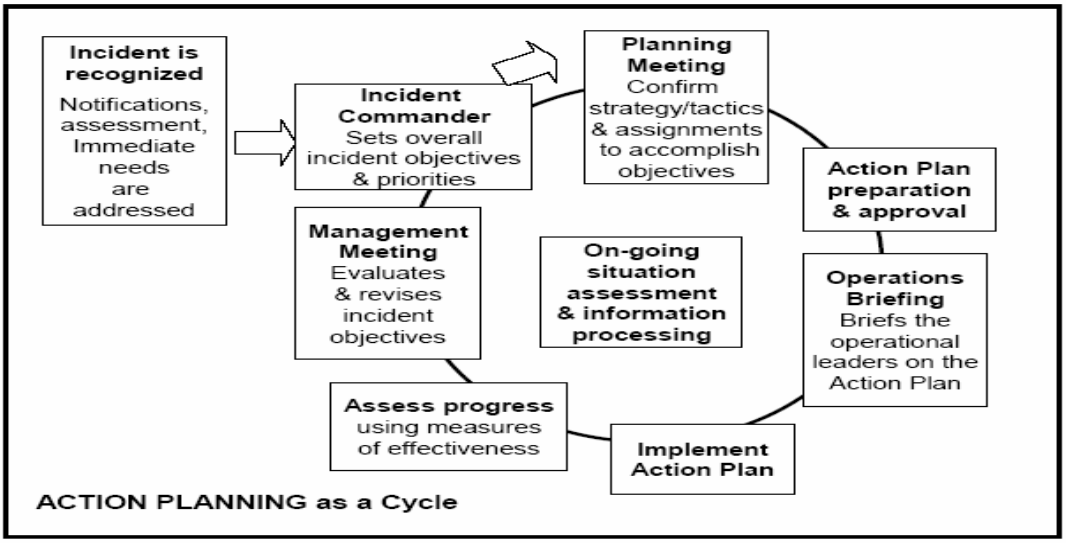
As defined in Incident Command System, the steps to incident action planning include:

- **Understanding organizational policy and procedures.** The incident action plan (Incident Action Plan) plan must be formed by personnel who understand the Emergency Operation Plan, the mission, hospital capabilities, and the hospital's overarching policies on response and recovery. The Emergency Operation Plan defines this for the organization.
- **Setting the operational period.** An operational period is a period of time scheduled for accomplishing a given set of tactical actions in the Incident Action Plan. The operational period is set by the Incident Commander based on the type, size and magnitude of the incident and the impact on the hospital.
- **Determining overall priorities** and set control objectives.
- **Establishing specific measurable and attainable objectives** for the operational period.

- **Setting strategies and tactics** to achieve the operational objectives, including activation of support plans (i.e., safety plans, communications plans, policies, procedures).
- **Identifying the resources** needed to accomplish the objectives.
- **Issuing assignments** to personnel, including Hospital Command Center positions.
- **Monitoring and evaluating** activities and outcomes.
- **Documenting results.**

Incident action planning is an ongoing process throughout the hospital's response and recovery, and is based in established operational periods. The incident action plan is formed by the Command Staff (Incident Commander, Public Information Officer, Liaison Officer, Safety Officer, and Medical/Technical Specialists) and the General Staff (Operations, Planning, Logistics, and Finance/Administration Section Chiefs). The Incident Action Plan is disseminated to the incident management team in the Hospital Command Center. Key components of the Incident Action Plan may be disseminated to external response agencies (i.e., local emergency management, local public health department). The processes and flow of incident action planning is depicted below in the Action Planning as a Cycle diagram[5].

Action Planning as a Cycle



Source: Action Planning as a Cycle from Emergency Management Principles and Practices, Veteran's Administration

4.4. The Incident Command System Structure for Managing Surge Events

The HICS incident management team chart illustrates the hospital management functions, positions, and lines of reporting and authority within the hospital incident management structure. The position titles are standardized with Incident Command System terminology and customized to the unique hospital environment. The Incident Management Team titles do not mirror the day-to-day titles and administrative structure; but rather signal the transition to emergency operations and decrease role confusion when assuming a position in the Hospital Command Center. The Incident Management Team chart reflects a reasonable span of control to help ensure the number of individuals one person can effectively manage is maintained.

The HICS organizational structure is flexible and develops in a top-down, modular fashion based on the size and complexity of the incident, as well as the specifics of the hazard environment created by the incident. As incident complexity increases, the Incident Management Team expands from the top down as functional responsibilities are delegated. As the HICS Incident Management Team expands, the number of management positions activated also expands to adequately address the requirements of the incident. In HICS, as in Incident Command System, only those functions or positions necessary for a particular incident will be filled.

Roles, responsibilities and essential duties for each position within the Incident Management Team (78 positions) are described in the HICS Job Action Sheets. The Job Action Sheet provides actions and options to consider when acting in the position, and note the appropriate HICS forms to be implemented by the position. The Job Action Sheets are designed to be customized by hospitals to meet the unique response and recovery priorities and considerations. The Job Action Sheet can also serve as the form for initial documentation of actions and activities.

The Incident Commander is responsible for building the hospital's Incident Management Team according to the scope and magnitude of the event, potential/real impact to the hospital, available resources and any special response needs (i.e., Hazardous Materials, biological, radiological, etc.) which might be needed. Once Section Chiefs and Branch Directors are appointed, they in turn appoint appropriate, event specific subordinate positions within their Section or Branch.

Activation of the Hospital Command Center

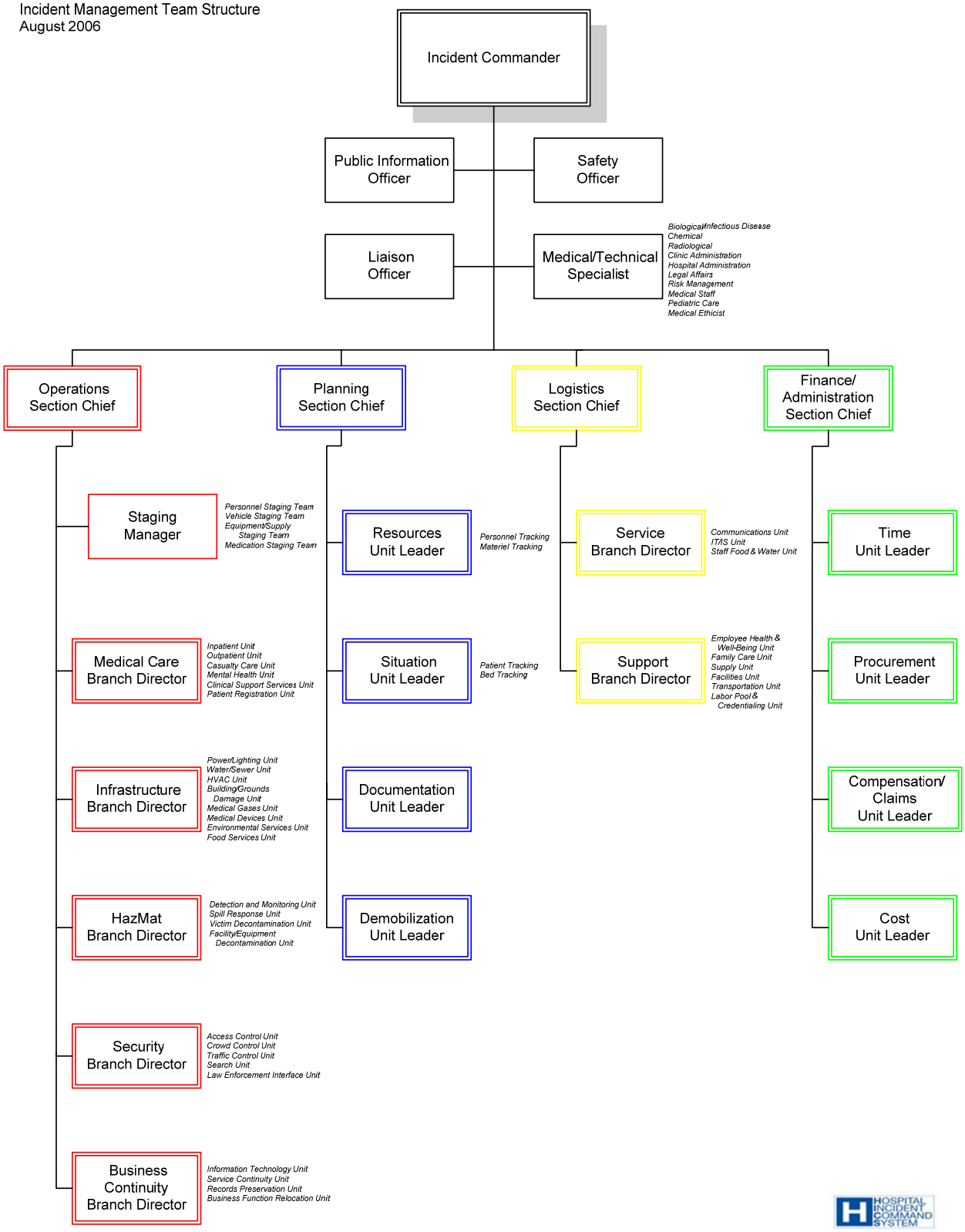
Every incident has certain activities or stages identified in the "lifecycle" of an incident, and are applicable to surge events. The processes for each of these activities or stages should be described in the hospital's Emergency Operation Plan, policies, procedures and supporting plans.

The first stage is **event recognition** and is the time when the hospital becomes aware of or is notified of an incident. Once the event is recognized, a situation analysis is conducted to determine the impact of the incident on the hospital and the need to activate the HICS structure and Hospital Command Center. The Incident Commander is responsible to conduct the initial assessment of the incident, including the location, magnitude, possible duration and impact on the hospital.

Once the event is recognized and evaluated, the Incident Commander determines the need for **activation of the Incident Command System structure** (HICS) and the Emergency Operation Plan. Appropriate management staff and hospital leadership are notified and personnel assuming activated positions are **mobilized to the Hospital Command Center**.

The hospital must maintain mission critical/essential services and business continuity operations while responding to and recovering from an incident. The Incident Command System structure of the hospital, the HICS Incident Commander is responsible for managing the incident, but not the entire hospital. Therefore, collaboration between the incident commander and the agency executive (Chief Executive Officer) is essential to integrate hospital operations and incident operations.

Hospital Incident Command System
Incident Management Team Structure
August 2006



Hospital Incident Operations are managed through the HICS structure. Incident Action planning is conducted as operational objectives are identified, resources assigned and assignments made to conduct incident operations.

Throughout the hospital response and recovery, evaluation for and consideration of **demobilizing** of any Incident Command System position(s) which are no longer needed to meet incident needs should be performed.

At a point in the response, there is a **transition from response to recovery operations**, or a return to "normal" or "new-normal" operations. Hospitals must actively plan for recovery during the response period to ensure critical services are delivered and financial recovery and restoration is achieved.

Once the hospital returns to normal activities and the response has ended, there must be a **return to readiness**. This process includes post-incident evaluation, debriefing, development of an after-action report and a corrective improvement plan. When the corrective improvement plan is implemented, the Emergency Operation Plan and emergency management program are improved.

4.5. Activation of HICS Positions during a Surge Event

During a surge event, the hospital's mission and overall objectives are to:

- Provide safe and appropriate ongoing patient care
- Facilitate appropriate triage of presenting patients and determine appropriate location for care
- Safely manage limited hospital bed capacity and capability
- Manage and allocate critical/scarce resources (i.e., personnel, equipment, supplies, pharmaceuticals, vehicles, services)
- Maintain consistent internal and external communications
- Ensure safety of personnel and assets.

The following Incident Management Team positions[6] are activated to manage the response to the surge event. While there are a total of 78 positions on the HICS Incident Management Team, specific HICS positions are only activated as needed given the magnitude, scope, and impact of the incident on the hospital. The HICS positions described below should be considered for activation during a surge event and assigned through the Hospital Command Center. Key positions are described, however any of the HICS Incident Management Team positions could be activated to maintain the span of control (the number of positions that one person can effectively manage is recommended to be no more than three to seven reports per supervisor) and more effectively manage the incident.

Key HICS Positions Activated during a Surge Event

- **Incident Commander**
  - Position Mission:
    - Activate, organize and direct the Hospital Command Center
    - Provide overall strategic direction for hospital incident management and support activities for response and recovery
    - Communicate incident status to hospital leadership and governing board
  - Role in a Surge Event:
    - Establish the operational period, initial incident objectives and action plan
    - Ensure regular and timely incident action planning and the development of the Incident Action Plan. Approve the Incident Action Plan before distribution
    - Communicate hospital status and critical response issues to hospital leadership, Board of Directors and other appropriate authorities
    - Approve all staff and public information messages before dissemination
    - Ensure the appropriate and timely use of consultants and medical/technical specialists (i.e., legal, bioethicist, risk management) to advise on Hospital Command Center operations
    - Approve the implementation of altered standards of care, in consultation with hospital leadership, Hospital Command Center management team and others, according to pre-event policies and procedures and decision-making appropriate to the incident
    - Ensure business continuity and continuation of essential services
  - Internal and External Key Contacts:

    Internal
    - Hospital Chief Executive Officer, leadership and Board of Directors
    - Command and General Staff
    - Medical/Technical Specialists/consultants

    External
    - Incident commanders in other responding organizations for information sharing
    - Political or government officials

- **Public Information Officer**
  - Position Mission:
    - Serve as the conduit for information to internal and external stakeholders, including hospital personnel, volunteers, patients, visitors, families, and the news media
    - Coordinate and collaborate with the local Emergency Operations Center-Joint Information Center in developing risk and public information messages
  - Role in a Surge Event:
    - Develop regular internal updates on event and hospital situation status for hospital personnel, volunteers, patients, families and visitors
    - Activate/maintain the media staging area, provide regular briefings, and schedule updates
    - Establish a patient information center, if applicable, to provide information to families unable to present at the hospital
    - Consider dispatching a hospital Public Information Officer to the local Joint Information Center for interface and collaboration
  - Internal and External Key Contacts

    Internal
    - Security Branch Director for media staging area security
    - Mental Health Unit Leader or behavioral health consultant to assist with development of briefings and messages
    - Liaison Officer for current external agency information
    - Resources Unit Leader for personnel and resource status information
    - Situation Unit Leader for patient, bed information or status, and current hospital situation status
    - Finance/Administration for response/recovery cost information
    - Public Affairs department staff

    External
    - Other hospital/healthcare provider Public Information Officers
    - Local Joint Information Center
    - News media and media outlets

- **Liaison Officer**
  - Position Mission:
    - Serve as the contact person to the Hospital Command Center for representatives from agencies participating in the incident response (i.e., local Emergency Operations Center, Emergency Medical Services, Fire, Law

Enforcement, area hospitals and healthcare providers, etc.) to gather information from outside agencies and communicate hospital situation status, current issues and resource needs

- Role in a Surge Event:
  - Establish and maintain communications with the local Emergency Operations Center to report activation of the Hospital Command Center, hospital situation status, critical issues, and needed resources. Gather external information to report to Hospital Command Center personnel
  - Contact local or regional licensing authority (i.e., California Department of Public Health Licensing and Certification) for potential or actual request for temporary permission to exceed staffing ratios or patient care delivery areas in regulations or statutes
  - Communicate with area and out-of-area hospitals to determine, if appropriate, situation status, surge capacity, patient transfer/bed availability, capacity to loan needed resources (i.e., personnel, equipment, supplies, pharmaceuticals, etc.)
- Internal and External Key Contacts:

  Internal
  - Resources Unit Leader for personnel and resource information
  - Situation Unit Leader for patient and bed status
  - Medical Care Branch Director for patient status, alternate sites of care activated and critical resource needs
  - Logistics Section Chief for resource needs and critical issues
  - Labor Pool and Credentialing Unit Leader for information on convergent volunteers and assist in credentialing

  External
  - Local Emergency Operations Center Medical and Health Branch
  - Medical and Health Operational Area Coordinator
  - Local public health department/health officer
  - Response partners (i.e., Emergency Medical Services, Fire, Law Enforcement, Coroner, etc.)
  - Area and out-of-area hospitals
  - Other healthcare providers (i.e., long-term care facilities, clinics, established community-based alternate care sites, etc.)

- **Safety Officer**
  - Position Mission:
    - Ensure safety of staff, patients and visitors

- Monitor and correct hazardous conditions
- Halt any operation which poses an immediate threat to life and health

o Role in a Surge Event:

- Conduct an ongoing analysis of existing response activities for health and safety issues related to hospital personnel, volunteers, patients, visitors, and facility.
- Implement corrective actions to address safety issues
- Ensure non-traditional patient care areas and other services are safe and hazard free
- Assess the situation and recommend appropriate personal protective equipment to protect hospital personnel and others from exposure to the hazard (i.e., chemical, biological, etc.)
- Assist with determining safe areas and practices for cohorting or isolating patients

o Internal and External Key Contacts:

Internal

- Section Chiefs (i.e., Operations, Planning, Logistics, Finance Administration) for current section status and activities
- Medical Care Branch Director for patient care safety issues
- Infrastructure Branch Director for facility safety or functional issues
- Hazardous Materials Branch Director for situation status and safety issues
- Security Branch Director for security and safety issues
- Business Continuity Branch Director for safety issues if relocating services or records
- Support Branch Director for employee physical or mental health needs or injuries sustained
- Claims/Compensation Unit Leader to follow up on facility or personnel safety issues or instances
- Safety and/or engineering departmental personnel to perform safety rounds and site checks and report to Hospital Command Center

External

- Local environmental health department
- Local hazmat teams or agencies
- Vendors and suppliers on safety of products or goods
- Other hospital safety officers for ongoing safety issues and status

- **Medical/Technical Specialists**
  - Medical/Technical Specialist roles:
    - Biological/Infectious disease
    - Chemical
    - Radiological
    - Clinic Administration
    - Hospital Administration
    - Legal affairs
    - Risk management
    - Medical Staff
    - Pediatric Care
    - Medical Ethicist
  - Position Mission:
    - This is a category of Incident Management Team personnel with specialized expertise, activated according to the type of incident or event
    - Primarily provide consultation to the Incident Management Team personnel, but may be assigned responsibility or oversight for specific activities (e.g., decontamination operations)
    - May be assigned to any position within the Incident Management Team to provide expert consultation or advice
    - May activate more than one specialist at a time
    - Hospital may develop additional specialist roles according to the unique capabilities of the facility
    - Medical/Technical Specialists may be internal or external personnel and may be activated and physically in the Hospital Command Center, or contacted virtually (i.e., phone/landline, computer, etc.) to provide the technical expertise
  - Role in a Surge Event and Key Contacts:
    - Depending on the type of catastrophic surge event, the Medical/Technical Specialist would be activated accordingly.
    - **Biological/Infectious Disease Specialist** may be an Infectious Disease physician assigned to the Operations Section, Medical Care Branch Director, Safety Officer or Incident Commander to provide consultation on epidemiology of the agent, proper treatment, prophylaxis, and staff personal protection. They may also assist the Liaison Officer with reporting surveillance and case information to the local public health department

- **Chemical Specialist** may be an Internal Medicine physician with experience in chemical exposures, a hazmat specialist, external environmental health provider, or safety officer. They may be assigned to the Operations Section, Hazardous Material Branch Director, Medical Care Branch Director, Safety Officer or report to the Incident Commander to provide consultation and advice on the chemical agent, staff personal protection levels, decontamination, treatment, and follow up. They may also assist the Liaison Officer with reporting agent and victim information to the local public health department or environmental health department
- **Radiological Specialist** may be a physicist, radiation physician, manager of radiology or other internal or external personnel with radiation expertise. They may be assigned to the Operations Section, Hazardous Material Branch Director, Medical Care Branch Director, Planning Section Chief, Safety Officer or report to the Incident Commander to provide consultation and advice on the radiological agent, staff personal protection levels, decontamination, treatment, and follow up. They may assist the Liaison Officer with reporting agent and victim information to the local public health department, environmental health department or other governmental agencies
- **Clinic Administration Specialist** may be the Administrator, director or manager of a hospital-based clinic to provide the Hospital Command Center with the clinic's capabilities, status, services, resource needs, and advise on issues related to clinic operations. They may report to the Operations Section Chief or the Incident Commander
- **Hospital Administration Specialist** may be the Hospital Chief Executive Officer or Administrator, Chief Nursing Officer, or Chief Operating Officer to ensure integration of incident response into hospital operations and to modify hospital operations as appropriate to meet the surge capacity and capability of the incident. It must be noted, the Incident Commander is responsible for the management of the areas impacted and involved in incident operations, but is not necessarily managing all hospital operations. The Hospital Administration Specialist provides information and collaboration between operations and can advise on sustaining critical services during response and recovery operations. They may report to the Incident Commander or Operations Section Chief.
- **Legal Affairs Specialist** may be the hospital attorney or legal affairs to provide legal advice on issues related to incident action planning, response and recovery. During a surge event, this Specialist would research legal issues and authorities, regulations, statutes and mandates relating to hospital management and activities, possible legal options and consequences and participate in incident action planning. They may report to the Incident Commander or Planning Section Chief.

- **Risk management Specialist** may be the hospital risk manager, quality improvement/management department or legal affairs to recommend changes to risk management and loss-prevention program policies to comply with emergency safety legislation and industry practices. They may advise on the most cost effective plans to minimize asset liability. They may report to the Finance/Administration Section Chief, Claims/Compensation Unit Leader (for investigation of incidences of potential/actual asset loss), Planning Section Chief or Incident Commander. They may assist the Liaison Officer with communication and collaboration with attorneys, insurance companies, and individuals.
- **Medical Staff Specialist** may be the Chief of Staff, Chief of Trauma, or Chief of Medicine as appropriate to the incident to advise on issues related to the medical staff (i.e., staffing, procedures, etc.) It may also be filled by the non-physician manager of the Medical Staff department, with consultation as needed from chief of service. They may report to the Incident Commander, Operations Section Chief, Medical Care Branch Director or Planning Section. They collaborate closely with the Labor Pool and Credentialing Unit Leader for physician staffing and credentialing processes and with the Resources Unit Leader/Personnel Tracking Manager.
- **Pediatric Care Specialist** may be the Chief of Pediatrics, a pediatrician, or pediatric nurse specialist to advise on issues related to a pediatric emergency response. They may report to the Operations Section Chief, Medical Care Branch Director, Planning Section Chief, or Incident Commander
- **Medical Ethicist Specialist** may be a bioethicist or clergy with training in ethical issues to manage surge issues with ethical implications (i.e., allocation of scarce resources, altered standards of care, discontinuation of care, etc.). They may report to the Incident Commander, Operations Section Chief or Medical Care Branch Director.

- **Operations Section Chief**
  - Position Mission:
    - Develop and implement strategies and tactics to carry out the hospital's objectives established by the Incident Commander and Incident Action Plan
    - Organize, assign and supervise Staging, Medical Care, Infrastructure, Security, Hazardous Materials, and Business Continuity Branch personnel and resources
  - Role in a Surge Event:
    - Activate the hospital's surge capacity plan, policies and procedures, including patient care and security plans
    - Assess tactical operations and participate in Incident Action Planning

- Assess current staffing and project staffing needs/shortages for the next operational period and 96 hours out and report to Planning Section
- Recommend triage and allocation of scarce resource strategies to Command and General Staff for possible implementation
- Supervises: Inpatient, Outpatient, Casualty Care, Mental Health, Clinical Support Services, and Patient Registration Unit Leaders

o Internal and External Key Contacts:

Internal

- Command Staff and Section Chiefs for resource needs and incident action planning
- Medical Technical Specialists activated for incident expertise
- Operations Section/Branch Unit Leaders for current situation status, critical issues, and resource needs
- Liaison Officer for communications to external agencies

External

- Operations Chiefs from other hospitals to arrange patient transfers

- **Staging Manager**
  - o Position Mission:
    - Staging is activated to organize and distribute resources (personnel, vehicles, equipment, supplies and pharmaceuticals) currently available in the hospital and waiting for assignment
    - Staging **does not** procure the resources, or determine the allocation or use of resources, but responds to requests by Section Chiefs or Branch Directors and deploys the resources appropriately
    - Supervises: Personnel, Vehicle, Equipment and Supplies, and Medications Staging Team Leaders, activated according to the incident and resource needs
  - o Role in a Surge Event:
    - In a surge event, when large numbers of resources are available and waiting for deployment, staging areas may be used.
    - Staging areas may not be needed (and therefore not activated) if the resources are small in number and able to be managed in existing departments (i.e., medications in the pharmacy, supplies in materials management, etc.)
    - Vehicle Staging maintains all vehicle resources until deployed (i.e., ambulances, buses, vans, etc.)
  - o Internal and External Key Contacts:

Internal

- Section Chiefs for formal requests for deployment of resources
- Operations Section Branch Directors to receive requests for deployment of available resources
- Labor Pool and Credentialing Unit Leader for procurement of personnel resources
- Supply Unit Leader for procurement of equipment, supply and pharmaceutical resources
- Service Branch Director (Staff Food and Water Unit Leader) for nutritional support of incident personnel
- Resource Unit Leader (Personnel and Material Tracking Managers) to report resource deployment and location

- **Medical Care Branch Director**
  - Position Mission:
    - Organize and manage the delivery of inpatient, outpatient, casualty care (emergency department), and clinical support (laboratory, pharmacy, radiology, etc.) services
    - Provide mental health support and intervention to inpatients and their families
    - Ensure rapid and accurate patient registration
    - Supervises: Inpatient, Outpatient, Casualty Care, Mental Health, Clinical Support Services, and Patient Registration Unit Leaders
  - Role in a Surge Event:
    - Identify inpatients for early discharge or transfer to other facilities and direct staff to expedite discharges
    - Review all non-essential patient care services (i.e., elective surgery, outpatient testing and procedures, etc.) for cancellation and/or rescheduling
    - Consider extending critical outpatient services (i.e., radiology, laboratory, pharmacy, etc.) to meet the surge needs
    - Establish a discharge “holding” area to free beds until patient can be transported out of the hospital (i.e., home, long-term care, etc.)
    - Activate and establish alternate care sites, as appropriate
    - Establish prioritization and triage of laboratory testing, if indicated
    - Ensure implementation of emergency patient registration and identification procedures (Patient Registration Unit Leader)
    - Provide mental health support to patients, visitors and families (Mental Health Unit Leader)

- Establish morgue services and implement temporary morgue surge capacity plans and procedures (Clinical Support Services Unit Leader)

- Internal and External Key Contacts:

  Internal

  - Operations Section Chief to report status and needs and recommend alternatives to Section and Command Staff
  - Hospital personnel, physicians clinical support personnel delivering care to ascertain patient status, critical issues and needed resources (through the Inpatient, Outpatient and Casualty Care Unit Leaders)
  - Public Information Officer to assist with communications on clinical care procedures, allocations and/or prioritization to patient care personnel
  - Labor Pool and Credentialing Unit Leader for additional personnel

  External

  - None

- **Infrastructure Branch Director**
  - Position Mission:
    - Organize and manage the services required to sustain and repair the hospital's infrastructure
    - Supervises Power/Lighting, Water/Sewer, Heating Ventilation Air Control, Buildings and Grounds Damage, Medical Gasses, Medical Devices, Environmental Services and Food Services Unit Leaders
  - Role in a Surge Event:
    - Ensure the rapid cleaning and turn over of patient care beds and areas to expedite admissions (Environmental Services Unit Leader)
    - Inventory, prioritize and allocate food and water supplies for patients (Patient Food and Water Unit Leader)
    - Maintain power and lighting to the hospital and campus facilities and ensure back-up generator operation, if applicable (Power/Lighting Unit Leader)
    - Evaluate and monitor the potency of existing water, sewage, and sanitation systems (Water/Sewage Unit Leader)
    - Maintain heating and air conditioning to the hospital and campus facilities (Heating Ventilation Air Control Unit Leader)
    - Organize and manage the services required to sustain and repair the hospital's buildings and grounds, if applicable (Buildings/Grounds Damage Unit Leader)
  - Internal and External Key Contacts:

    Internal

- Safety Officer to ensure facility and patient care delivery safety
- Logistics Section's Supply and Facilities Unit Leaders for procurement of supplies, food, water, and equipment to ensure facility infrastructure to provide services
- Finance/Administration Section Procurement Unit Leader to activate existing contracts or agreements with vendors and suppliers to provide infrastructure services
- Medical Care Branch Director to assess and ascertain patient care needs and potential impacts of lack of or non-functional infrastructure

External

- Outside service providers (i.e., repair, construction, etc.) services to maintain or repair infrastructure

- **Hazardous Material Branch Director**
  - Position Mission:
    - Organize and direct hazardous materials incident response activities
    - Supervises: Detection and Monitoring, Spill Response, Victim Decontamination, and Facility/Equipment Decontamination Unit Leaders
  - Role in a Surge Event:
    - Ensure the appropriate allocation and use of personal protection equipment by hospital personnel
    - Direct decontamination operations
  - Internal and External Key Contacts:

    Internal
    - Safety Officer to ensure staff safety, recommend appropriate personal protective equipment, safe decontamination, and clean up operations
    - Medical Care Branch Director for patient care considerations
    - Labor Pool and Credentialing Unit Leader for additional personnel
    - Employee Health and Well Being Unit Leader for staff screening, medical evaluation and follow up pre- and post-decontamination operations
    - Logistics Section/Liaison Officer to request additional Personal Protective Equipment from other hospitals or providers

    External
    - Local Environmental Health Department
    - Local hazardous materials response teams
    - Poison Control Center

- **Security Branch Director**
  - Position Mission:
    - Coordinate all activities related to personnel and facility security
    - Manage internal and external security resources
    - Liaison with responding law enforcement agencies
    - Supervises: Access Control, Crowd Control, Traffic Control, Search, and Law Enforcement Interface Unit Leaders
  - Role in a Surge Event:
    - Implement security plan, crowd and traffic control
    - Secure the perimeter of the facility to maintain access control
    - Provide hospital personnel, patient, and visitor security
    - Secure critical assets (i.e., pharmaceuticals, equipment, supplies, morgue, etc.)
    - Liaison and coordinate with local, state and federal (i.e., Federal Bureau of Investigation) law enforcement in the response to the facility, investigation and follow up of security issues (i.e., terrorism events) and evidence collection. Coordinate the release of patient information and records according to hospital policy and applicable local, state and/or federal statutes
  - Internal and External Key Contacts:

    Internal
    - Operations Section Chief to report security status and approve security strategies and measures to implement during a surge event
    - Operations Section and Logistics Section Branch Directors to ascertain critical security needs
    - Labor Pool and Credentialing Unit Leader for additional staffing resources
    - Planning Section to ascertain current situation status and project future security needs

    External
    - Local, state and federal law enforcement agencies
    - Local, regional or state-level resources to augment security forces (i.e., Volunteers in Police Service)
    - Private and contracted security companies

- **Business Continuity Branch Director**
  - Position Mission:

- Ensure business functions are maintained, restored or augmented to deliver essential services are provided during the incident with limited interruptions in continuity of operations
- This position would be activated if business functions are impacted by the event (i.e., loss of Information Technology and electronic medical records) and support movement of essential clinical, support or business functions
- Supervises: Information Technology, Service Continuity, Records Preservation, and Business Function Relocation Unit Leaders

o Role in a Surge Event:

- This position would be activated to organize and manage activities if the facility is impacted by the catastrophic event, clinical, support or business functions need to be repaired, re-established or relocated to maintain essential services
- Implement down time procedures for Information Technology systems, if applicable

o Internal and External Key Contacts:

Internal

- Command and General Staff for prioritization of service restoration activities
- Hospital department managers to coordinate repair, augment restore or move essential services or business functions
- Finance/Administration Section for activation of agreements and contracts to repair, augment, restore or move services

External

- Contractors, vendors and suppliers of services

- **Planning Section Chief**

o Position Mission:

- Oversee all hospital incident-related data gathering and analysis for incident operation and assigned resources
- Develop alternatives for hospital tactical operations
- Facilitate hospital incident action planning and prepare the Incident Action Plan
- Collect, organize and archive all hospital-related incident documentation
- Supervises: Resources, Situation, Documentation and Demobilization Unit Leaders

o Role in a Surge Event:

- Institute patient, bed, personnel and materials tracking

        - Project critical issues and resource needs for the next operational period through 96 hours out
        - Facilitate the documentation of actions, decisions, activities
        - Maintain hospital situation status throughout the incident
        - Collect and organize documentation
        - Plan for demobilization of positions, response activities, and system recovery
        - Conduct and facilitate incident action planning prior to each operational period and as needed
        - Conduct staff debriefings throughout the response during shift change and upon demobilization
    - Internal and External Key Contacts:

      Internal
        - Command Staff, Section Chiefs and Branch Directors for current status and projections of activities, needed resources and action planning
        - Public Information Officer and Liaison Officer for incident information
        - All Hospital Command Center personnel for current status

      External
        - News media and other resources for event information (Planning Section Personnel monitor media reports, etc.)

- **Resources Unit Leader**
    - Position Mission:
        - Maintain current information on the status, location, and availability of resources (i.e., personnel, facilities, supplies and major equipment) assigned to incident operations
        - Supervises the Personnel and Materials Tracking Managers
    - Role in a Surge Event:
        - Track and report on resources assigned to the incident
        - Project personnel and materials resources needs for the next operational period and 96 hours out
    - Internal and External Key Contacts:
        - Logistics Section positions
        - Operations Section, especially Staging Manager, if activated, to record deployed resources

- **Situation Unit Leader**
    - Position Mission:

        - Collect, process, and organize ongoing situation information, prepare situation summaries, and develop projections and forecasts of future events related to the incident
        - Supervises the Patient and Bed Tracking Managers
    - Role in a Surge Event:
        - Maintain current patient census and location information and track the status of occupied and available beds
        - Project patient census and surge capacity (beds and alternate patient care areas) needs for the next operational period and 96 hours out
        - Gather and prepare an event information and hospital status report for dissemination to Hospital Command Center personnel on a periodic and regular basis
        - Monitor media reports and prepare information for dissemination
        - Contribute information to the incident planning process
    - Internal and External Key Contacts:

      Internal
        - Section Chiefs and Branch Directors for current situation status
        - Public Information Officer and Liaison Officer for event information and status of external agencies

- **Documentation Unit Leader**
    - Position Mission:
        - Maintain accurate and complete incident files, including Hospital Command Center response and recovery actions and decisions, and store incident files for legal, analytical, reporting and historical purposes
        - This position is essential to organize and manage all incident documentation and may require the assignment of additional clerical support personnel to effectively perform position activities
    - Role in a Surge Event:
        - Organize, manage and archive all documentation related to the incident response and recovery, and does not include patient medical records
        - Assist in preparing incident reports
    - Internal and External Key Contacts:

      Internal
        - All Hospital Command Center personnel will submit documentation to this position

- **Demobilization Unit Leader**
  - Position Mission:
    - Develop and coordinate the hospital Incident Demobilization Plan
  - Role in a Surge Event:
    - This position may not be activated in the immediate phase of response, but should be activated early in the response to plan for demobilization throughout the incident.
    - Assess the status of the incident and recommend deactivation of positions and personnel as the magnitude of the incident decreases
    - Attend incident action planning meeting and briefings
  - Internal and External Key Contacts:

    Internal
    - All Hospital Command Center staff positions for current status
    - Public Information Officer, Liaison and Situation Unit Leader for current event and community response agency status
    - Command and General Staff for approval of demobilization plan
    - Department managers and other internal responders for possible deactivation of activities or positions

- **Logistics Section Chief**
  - Position Mission:
    - Support the delivery of patient care and essential services
    - Maintain the facility physical environment
    - Provide human resources, materials, and services to support incident activities
    - Supervises Service and Support Branch Directors
  - Role in a Surge Event:
    - Assess for and recommend the cancellation and/or closure of non-patient care and non-essential services (i.e., closure of gift shop, cancellation of conferences or educational sessions, public events, etc.)
    - Project the current and future need for supplies, equipment, pharmaceuticals and personnel and procure these resources as appropriate
    - Ensure communication and IT system operations
    - Assist the Operations Section, Medical Care Branch Director with establishment of hospital-based alternate care sites
    - Manage the registration and assignment of solicited and unsolicited volunteers

- Provide medical, nutritional and mental health services and support for hospital personnel responding to the incident

o Internal and External Key Contacts:

Internal

- Command and Section Chiefs for information on critical issues and resource needs on an ongoing basis
- Employee health department personnel
- Mental health personnel and/or clerical staff to provide mental health/emotional support for incident personnel

External

- Vendors, contractors, and suppliers of resources and services
- Local, regional and state-level personnel resources (i.e., Emergency System for the Advance Registration System of Volunteer Health Professionals, disaster registries, Medical Reserve Corps Community Emergency Response Teams, Volunteers in Police Service.

- **Service Branch Director**
  - o Position Mission:
    - Organize and manage the services to maintain hospital communications, information technology and systems
    - Provide for food and water for staff
    - Supervise Communications, Information Technology/Information Services, and Staff Food and Water Unit Leaders
  - o Role in a Surge Event:
    - Maintain communications and Information Technology services, as able
    - Inventory, procure, allocate and provide food and water for staff responding to the incident (Staff Food and Water Unit Leader), in collaboration with the Operations Section, Infrastructure Branch, Patient Food and Water Unit Leader. Note: for efficiency, the duties of the Staff and Patient Food and Water Unit Leaders may be consolidated and report to the Logistics Section, rather than staff two positions
  - o Internal and External Key Contacts:

    Internal
    - Command and Section Chiefs for information on critical issues and resource needs on an ongoing basis
    - Procurement Unit Leader for access to contracts, agreements and suppliers

    External

- Vendors, suppliers and contractors to provide goods and services

- **Support Branch Director**
  - Position Mission:
    - Organize and manage the services required to maintain the hospital's supplies, facilities, transportation and labor pool
    - Ensures the provision of logistical, psychological, and medical support of hospital staff responding to the incident
    - Provides support for the families of hospital personnel
    - Supervises the Employee Health and Well Being, Family Care, Supply, Facilities, Transportation and Labor Pool and Credentialing Unit Leaders
    - Manages donations from the public if presented to the hospital. Coordinates with local emergency management (Office of Emergency Services) on donations management programs
  - Role in a Surge Event:
    - The support for operations and hospital personnel is essential for efficient and effective response and recovery operations. During a surge event, support resources may be limited and require prioritization and allocation.
    - Maintain current inventories of supplies, equipment, food and water
    - Project the current and future need for supplies, equipment, pharmaceuticals and personnel and procure these resources as appropriate
  - Internal and External Key Contacts:

    Internal
    - Command Staff and Section Chiefs for ongoing resource needs and projections for future needs

    External
    - Vendors, suppliers and contractors to provide goods and services

- **Employee Health and Well Being Unit Leader**
  - Position Mission:
    - Provide medical care and surveillance for injured or ill staff responding to the incident
    - Provide psychosocial/behavioral health support and services to staff
    - Coordinate mass prophylaxis/vaccination/immunization of staff, if required
  - Role in a Surge Event:

- Establish site and procedures to provide medical care and follow up to ill or injured hospital personnel responding to the incident; communicate services and location to the Hospital Command Center and hospital personnel
- Project immediate and future capacities to provide services based on current information and situation
- Establish an area for hospital personnel rest and relaxation and nutritional services
- Assess for staff use of appropriate/recommended personal protective equipment, if applicable
- Anticipate increased need for employee services created by patient surge, extended work hours, exposure to infectious patients, concerns about the incident and family welfare and initiate actions to meet the needs

o Internal and External Key Contacts:

Internal

- Safety Officer notification of any health risks or other clinical issues related to staff
- Mental health, social services and clergy department personnel to augment services
- Labor Pool and Credentialing Unit Leader for additional staffing
- Staff Food and Water Unit Leader to ensure provision of nutrition to staff responding to the incident
- Public Information Officer to assist with development of situation updates for hospital personnel
- Command and General Staff for situation updates and projections of staff needs for medical and/or psychological care

External

- Local mental health providers and/or Local faith-based organizations (i.e., churches) to augment services to responding personnel

- **Labor Pool and Credentialing Unit Leader**
  - o Position Mission:
    - Collect and inventory available staff and volunteers at a central point (Labor Pool) for assignment
    - Maintain adequate numbers of medical and non-medical personnel
    - Implement hospital plan, policies and procedures to credential solicited and unsolicited volunteers
  - o Role in a Surge Event:

- Establish a Labor Pool in a designated location and communicate location and status to Section Chiefs and Hospital Command Center Staff
- Inventory the number and category (i.e., Registered Nurse, Medical Doctor, aides, technicians, etc.) of staff currently available in the facility for assignment or reassignment
- Assess personnel needs in the hospital departments through the Section Chiefs, Branch Directors or Unit Leaders
- Project staffing needs, in collaboration with Planning Section, and develop staffing plan for next operational period and 96 hours out
- Activate hospital call back procedures (i.e., call trees) according to staffing plan
- Activate hospital plans and community agreements for augmentation of staff with recognized teams (i.e., Medical Reserve Corp, Volunteers in Police Service, Community Emergency Response Team, Disaster Medical Assistance Team)
- Implement hospital plan for credentialing and use of medical and non-medical volunteers to augment staffing
- Assign Labor Pool personnel to designated work area as requests for additional staffing are received from Hospital Command Center staff

o Internal and External Key Contacts:

Internal

- Command Staff, Section Chief, and Branch Directors for personnel requests
- Liaison Officer to request staffing resources from the Medical and Health Operational Area Coordinator and/or local Emergency Operations Center.
- Staff Food and Water Unit Leader for nutritional support to Labor Pool personnel awaiting assignment
- Public Information Officer for informational messages and situation updates for Labor Pool personnel awaiting assignment
- Resources Unit Leader to report personnel available in and assigned from the Labor Pool

External

- Community volunteer organizations and teams to provide additional personnel (i.e., MRC, CERTS, etc.)
- Personnel registries under contract with the hospital

- **Finance/Administration Unit Leader**
  - o Position Mission:

- Monitor the utilization of financial assets and account for incident-related expenditures
- Provide periodic cost reports to the Command and General Staff
- Supervise Time, Procurement, Compensation/Claims, and Cost Unit Leaders

o Role in a Surge Event:

- Activate contracts and agreements to procure goods and services needed in the response and recovery activities
- Account for all incident-related personnel time and attendance

o Internal and External Key Contacts:

Internal

- All Hospital Command Center staff
- Accounting department personnel

External

- Vendors and suppliers of goods and services
- Financial institutions for extension of credit and access to funds

The key positions outlined may be activated during a catastrophic surge event. When hospital management personnel resources are limited, Incident Management Team positions may be combined **within the Sections** and Branch Directors and Section Chiefs may assume additional duties and responsibilities. The HICS Incident Management Team positions not described above may also be activated to improve the span of control and more effectively manage the hospital's response and recovery.

The principles and practices of Incident Command System can be applied to hospital emergency management through the Hospital Incident Command System, or HICS. HICS provides hospitals with a standardized management structure, a logical chain of command, role definition and accountability, and a common language to facilitate interagency communications. Using HICS in a catastrophic surge event will improve hospital response and recovery and facilitate a return to readiness.

Endnotes

[1] NIMS Integration Center, *NIMS Implementation Activities for Hospitals and Healthcare Systems, September 12, 2006, http://www.fema.gov/emergency/nims/alert/2006.shtm.*
[2] Federal Emergency Management Agency, Emergency Management Institute, Independent Study100 HC, Introduction to the Incident Command System for Healthcare/Hospitals, http://training.fema.gov/EMIWeb/IS/is100HC.asp
[3] The Joint Commission, EC.4.12, B1, January 1, 2008.
[4] The Joint Commission, EC.4.12, A3, January 1, 2008.
[5] *Emergency Management Principles and Practices for Healthcare Systems.* The Institute for Crisis, Disaster, and Risk Management at the George Washington University; for the Veterans Health Administration/US Department of Veterans Affairs. Washington, D.C., June 2006. Available at http://www1.va.gov/emshg.
[6] California Emergency Medical Services Authority, Hospital Incident Command System, Version IV, September 2006, www.emsa.ca.gov/hics/hics.asp.

5. All Facilities Letter 06-33: CDPH Licensing and Certification Temporary Permission for Increased Patient Accommodations

Hospital compliance requirements include 22 CCR 70809 which states that no hospital shall have more patients or beds set up for overnight use than its approved licensed capacity except in the case of a justified emergency when temporary permission may be granted by the Director of CDPH or his or her designee. Beds not used for overnight stay, such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in x-ray or laboratory departments, are not included in the approved licensed bed capacity.

Permission to temporarily exceed licensed bed capacity, however, may be granted upon the facility's submission and CDPH Licensing and Certification District Office approval of an application for increased patient accommodations. This application, the All Facilities Letter 06-33: CDPH Licensing and Certification Temporary Permission for Increased Patient Accommodations Request Review and Approval Sheet, is included below.

December 20, 2006 AFL 06-33

TO: GENERAL ACUTE CARE HOSPITALS

SUBJECT: REPLACEMENT OF AFL 04-28 - INCREASED PATIENT ACCOMMODATIONS

Authority:

California Code of Regulations, Title 22, §70809 (a), (b), and (c)

This AFL supersedes and replaces AFL 04-28 in its entirety and eliminates the use of Attachments A and B of AFL 04-28.

Background:

On January 18, 2005 the Department of Health Services Licensing and Certification (DHS L&C) Program issued AFL 04-28 - Increased Patient Accommodations Due to Seasonal or Unexpected High Patient Influx.

AFL 04-28 referred to situations of temporary hospital overcrowding due to a disease

outbreak or an unexpected event such as a mass casualty incident (generally related to a natural or human-caused disaster). These types of events may lead to a rapid influx or "surge" in patient volume requiring flexibility for increased patient accommodations. AFL 04-28 also indicated that approval for increased patient accommodations would be a temporary measure and would not be permitted as long-term solutions for chronic problems of hospital overcrowding.

Since AFL 04-28 was distributed, requests for temporary permission for increased patient accommodations have frequently been associated with situations unrelated to a disease outbreak or an unexpected event such as a disaster or mass casualty incident. DHS L&C recognizes that situations may occur that are important to report to L&C and constitute a valid medical emergency (such as Neonatal Intensive Care Unit flexibility needs). These situations fall within the challenges hospitals may experience in providing sufficient beds for ongoing, customary medical or business operations. They do not, however, fall under the intent of AFL 04-28, which addresses disease outbreak or unexpected events such as a disaster or mass casualty incident.

The frequency of requests L&C receives for increased patient accommodations that are non-disease or disaster related has caused L&C to further clarify the factors district offices will consider when reviewing requests for increased patient accommodations. Effective with this AFL, L&C will assess requests based on the worksheet included in AFL 06-33 Attachment A.

How to Submit a Request for Temporary Permission for Increased Patient Accommodations:

When a disease outbreak or an unexpected event such as a disaster or mass casualty incident occurs that requires increased patient accommodations, L&C should be contacted immediately with a request for advance approval for the increased accommodations. It is recognized that rapidly changing emergency conditions may affect requesting and receiving advance approval. However, hospitals should not make an assumption that the request will be approved until, at a minimum, it is verbally authorized by an L&C representative. L&C approval will be confirmed through a fax sent to the hospital, and a copy of the fax will be included in the hospital's file at the L&C district office.

During normal business hours (8:00 a.m. – 5:00 p.m.) contact the local DHS L&C district office you customarily work with for your geographic location.

For after-hour requests, or if the local DHS L&C district office is non-operational due to an emergency/disaster, follow the process below:

For facilities <u>outside Los Angeles County</u> notify the:

State Office of Emergency Services Warning Center at (916) 845-8911

Ask that they notify the DHS duty officer

For facilities in Los Angeles County notify the:
Los Angeles County Operator at (213) 974-1234
Ask that they notify the on-call Health Facilities Inspection Division Supervisor

If you have questions about this AFL or the enclosed attachment, please call your local district office to discuss them.

Sincerely,

Original Signed by Kathleen Billingsley, R.N.

Kathleen Billingsley, R.N.
Deputy Director

Attachment

cc: California Hospital Association
Emergency Medical Services Authority

AFL 06-33 Attachment A
DHS L&C
Temporary Permission for Increased Patient Accommodations
Request Review and Approval Sheet

District office name:	Date of request:
Facility name: Address:	Facility phone no: Facility fax no: Contact person name:

Brief description of conditions causing the increased patient accommodations:
Duration of request (give approximate number of days necessary):
Accommodations requested:

I. Request for Approval

A. Considerations for approving the increased patient accommodation request require one of the following (check appropriate box):

(1) ☐ A disease outbreak (verifiable through sources such as the LEMSA, local Public Health Officer, DHS Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: increased cases of seasonal influenza, onset of a SARS-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency).

(2) ☐ An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: a natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

B. Exhausting Available Alternatives:

The hospital must exhaust available alternatives before requesting an increased patient accommodation. Check boxes below that apply:

- ☐ Rescheduling non-emergent surgeries and diagnostic procedures.
- ☐ Transferring patients to other beds or discharge as appropriate.
- ☐ Setting up clinics for non-emergency cases (if possible).
- ☐ Requesting ambulance diversion from LEMSA, if appropriate.

C. Adequate Staff, Equipment and Space:

The hospital must make arrangements for adequate staffing, equipment and space for increased patient accommodation. Check boxes below that apply:

- ☐ A plan is in place for staff if the request is for use of alternate space.
- ☐ A plan is in place for equipment if the request is for use of alternate space.
- ☐ The proposed space for care of patients provides sufficient square footage to ensure access for safe care.

II. DHS L&C Action and Disposition:

- ☐ Permission granted from: _____ to _____
- ☐ Permission denied: briefly describe why request was denied in comments/conditions below:

Comments/conditions:

_____

_____

_____

L&C DO staff signature: _____

Instructions L&C DO**:** Permission to increase patient accommodations will be time limited and dependent on the facts presented that substantiate a disease outbreak or an unexpected emergency event exits. Initial approval for increased patient accommodations may be given verbally, but a signed written approval must be distributed (faxed) to the hospital and filed in the hospital's facility folder.

6. Fatality Management Resources: Additional Guidance for Setting up Temporary Morgues

The following references can be used as additional guidance for setting up temporary morgues:

- Mass Fatality Response Plan, Office of the Coroner, Parish of East Baton Rouge: http://ci.baton-rouge.la.us/Dept/OEP/plan/annexu/Appendix2.pdf.
- Capstone Document: Mass Fatality Management for Incidents Involving Weapons for Mass Destruction. Prepared by US Army Research Development and Engineering Command (formerly known as US Army Soldier and Biological Chemical Command), Military Improved Response Program and Department of Justice, Office of Justice Programs, Office for Domestic Preparedness, August 2005
- Mass Fatality Management – Concept of Operations, Initial Draft, Law Enforcement Branch, California Office of Emergency Services, October 26, 2006.
- Disposal of Dead Bodies – World Health Organization
- Occupational Safety and Health Administration Fact Sheet – Health and Safety for Workers for Handling Human Remains
- Management of Dead Bodies after Disasters – Field Guide for First Responders – World Health Organization
- Infectious Disease Risks from Dead Bodies – Pan American Public Health
- Disposing of Liquid Wastes from Tsunami-Affected Areas – Guidance from Centers for Disease Control and Prevention
- Management of Dead Bodies in Disaster Situations – World Health Organization
- Guidelines for Mass Fatality Management During Incidents Involving Chemical Agents – US Army Soldier and Biological Chemical Command (SBCCOM), 2001
- National Association of Medical Examiners Mass Fatality Plan, 2002
- Joint Tactics, Techniques and Procedures for Mortuary Affair in Joint Operations (Joint Pub 4-06), Joints Chiefs of Staff, August 1996
- The Minnesota Department of Health, Disaster Mortuary Emergency Response Team (D-MERT) Plan (http://www.health.state.mn.us/terrorism.html) provides detailed guidance on setting up temporary morgues.

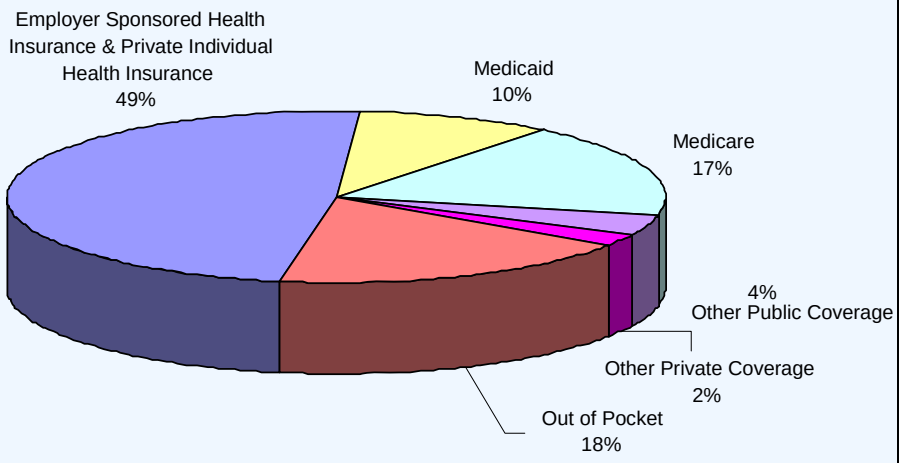
Note: Guidelines from other State and federal agencies do not necessarily comply with California laws, regulations and standards. These references have been provided for informational purposes only.

7. Current Funding Sources

This section provides an overview of the existing funding and reimbursement programs and their rules and processes. The series of process flows each summarize a current source for individual healthcare coverage. In order to put the California coverage environment into context and to understand the financial effect of an increased demand for healthcare services on various payer and provider organizations across the State, it is important to understand the distribution of coverage for Californians today. It is also important to have an understanding of those payers who are accountable for payment of medical services in the State and the potential effect of a surge in the demand for those services on these payers is important as the surge consequences may affect these organizations inordinately. The pie charts and process flows of various insurance coverage types are documented for these purposes.

7.1. National Payer Expenditure Distribution, Medical Expenditure Panel Survey

National Health Care Expenditure Distribution by Payer (2005)

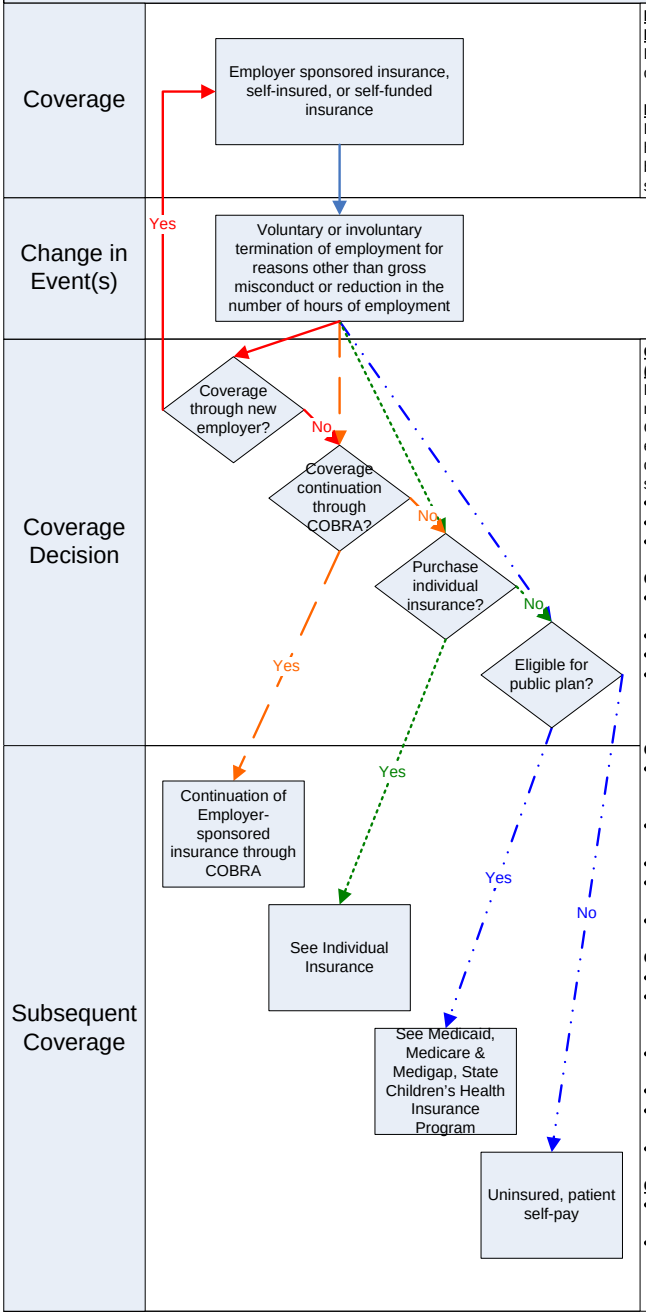


Payer	Percentage of Total Expenditures (2005)
Employer Sponsored Health Insurance & Private Individual Health Insurance	48.5%
Medicaid	9.6%
Medicare	17.4%
Other Public Coverage	4.0%
Other Private Coverage	2.2%
Out of Pocket	18.2%

Source: Medical Expenditures Survey Panel (2005)

7.2. Private Group Health Insurance

Private Group Health Insurance



Employer Sponsored/Self-Insured/Self-Funded Health Insurance Eligibility
Eligibility varies by employer and health insurance plan offerings.

Employer-Sponsored Plan Benefits
Each employer-sponsored, self-insured, or self-funded health plan subject to COBRA continuation have different benefits, catastrophic and other coverage limits, and cost-sharing policies.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 Eligibility
Health plan enrollment through COBRA is limited to 18 months with a possible 11-month extension for disability. Continuation of health care coverage is contingent upon employer participation and plan offerings, even in the event of Chapter 7 Liquidation or Chapter 11 Bankruptcy private-sector:

- Employers with 20 or more employees
- Employee organizations
- State or local governments

Qualifying Events for Employees

- Voluntary or involuntary termination of employment for reasons other than gross misconduct, or
- Reduction in the number of hours of employment, or
- Becomes Medicare eligible, or
- If student is employed by the University, the University defines employee status. Otherwise students do not qualify.

Qualifying Events for Spouses

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct, or
- Reduction in the hours worked by the covered employee, or
- Covered employee becomes entitled to Medicare, or
- Divorce or legal separation of the covered employee, or
- Death of the covered employee

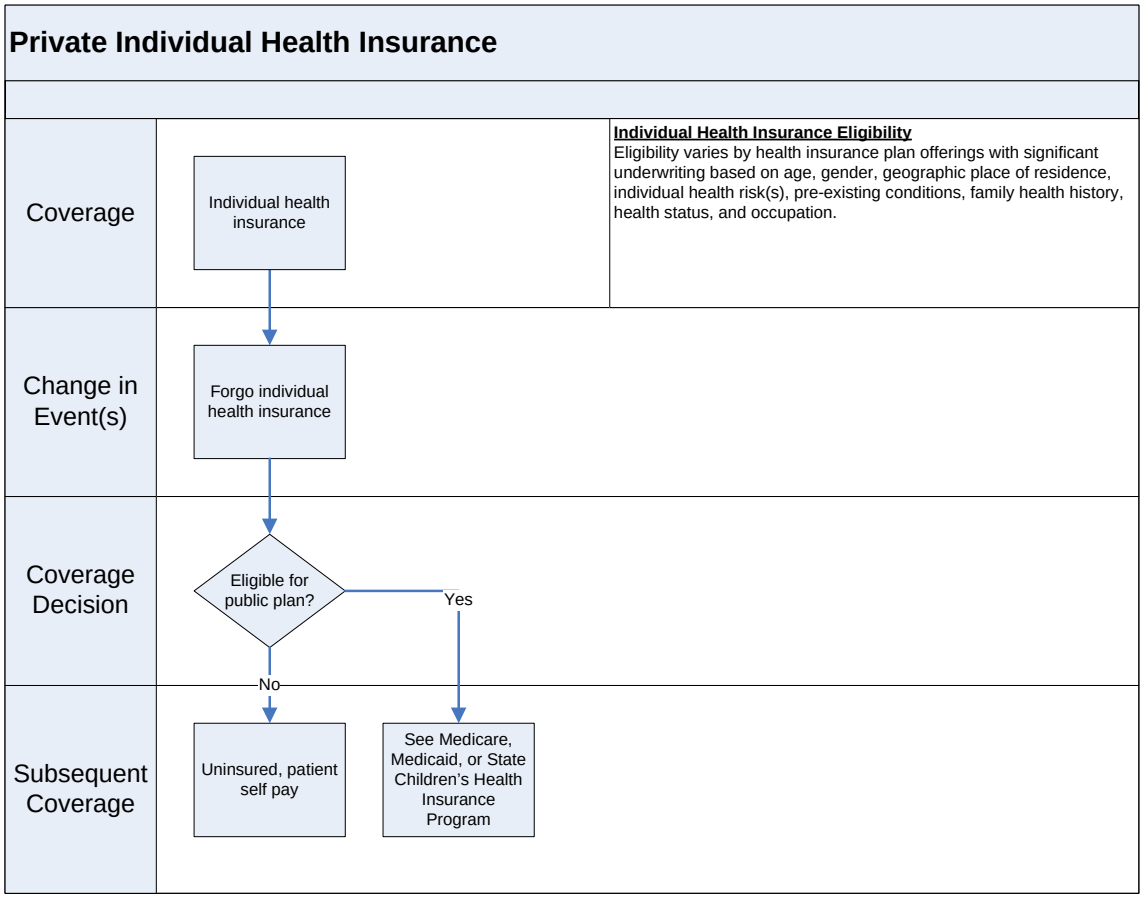
Qualifying Events for Dependent Children

- Loss of dependent child status under the plan rules, or
- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct, or
- Reduction in the hours worked by the covered employee, or
- Covered employee becomes entitled to Medicare, or
- Divorce or legal separation of the covered employee, or
- Death of the covered employee

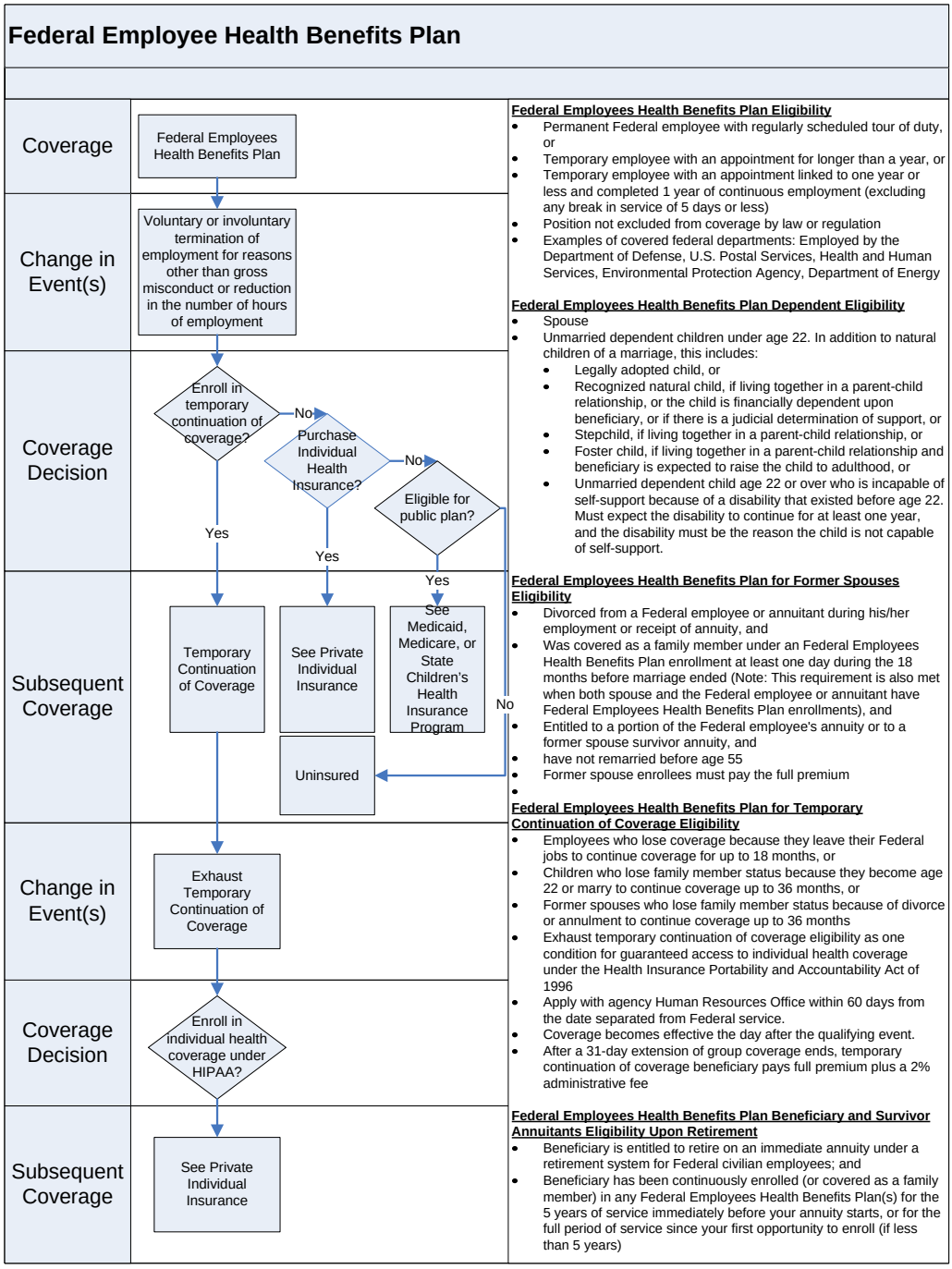
COBRA Premiums

- Premiums are calculated at 102% of current employer-sponsored health insurance.
- Premiums for disability beyond the initial 18-months of coverage and extended for another 11 months are calculated at 150% of the current group rate. Beneficiaries pay the entire premium.

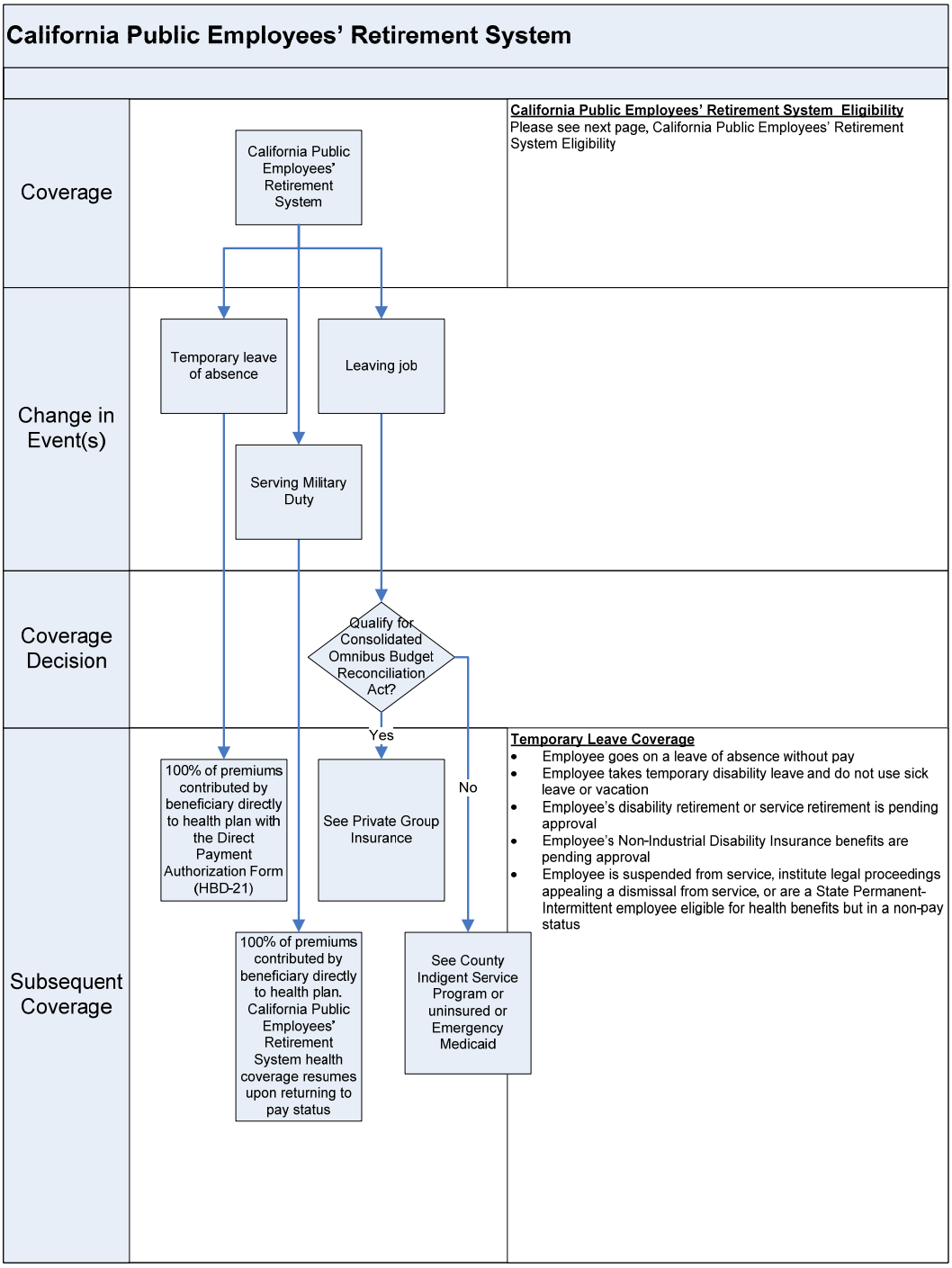
7.3. Private Individual Health Insurance



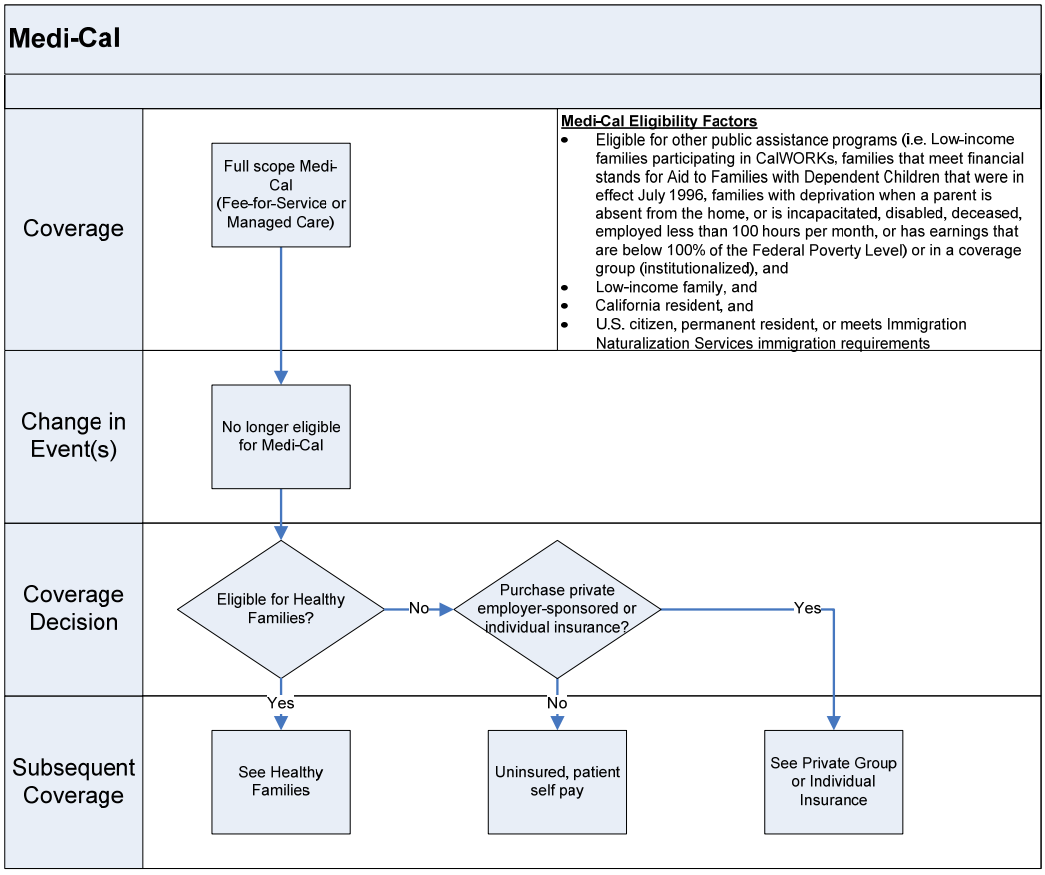
7.4. Federal Employee Health Benefits Plan



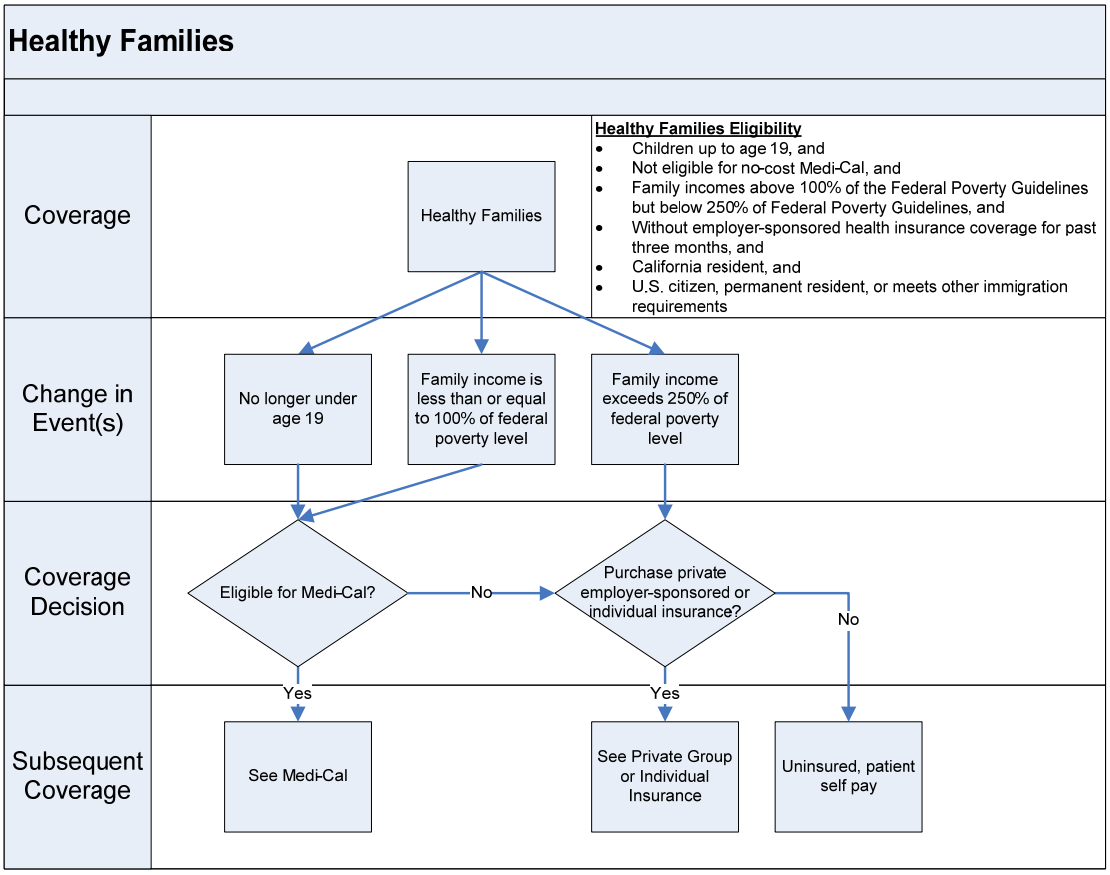
7.5. California Public Employees' Retirement System



7.6. Medi-Cal


Medi-Cal
Coverage
Full scope Medi-Cal (Fee-for-Service or Managed Care)
Medi-Cal Eligibility Factors
Eligible for other public assistance programs (i.e. Low-income families participating in CalWORKs, families that meet financial stands for Aid to Families with Dependent Children that were in effect July 1996, families with deprivation when a parent is absent from the home, or is incapacitated, disabled, deceased, employed less than 100 hours per month, or has earnings that are below 100% of the Federal Poverty Level) or in a coverage group (institutionalized), and
Low-income family, and
California resident, and
U.S. citizen, permanent resident, or meets Immigration Naturalization Services immigration requirements
Change in Event(s)
No longer eligible for Medi-Cal
Coverage Decision
Eligible for Healthy Families?
No
Purchase private employer-sponsored or individual insurance?
Yes
Yes
No
Subsequent Coverage
See Healthy Families
Uninsured, patient self pay
See Private Group or Individual Insurance

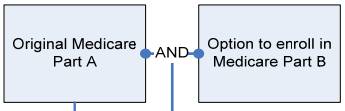
7.7. Healthy Families



7.8. Medicare & Medigap

Medicare & Medigap

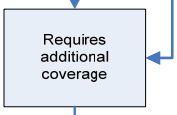
Coverage



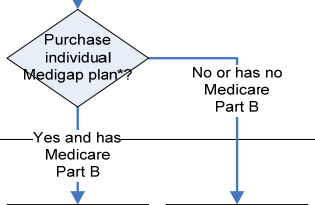
Basic Medicare Eligibility

- Citizens or permanent residents 65 years of age and older who worked for at least 10 years in Medicare-covered employment or has a spouse who worked in that capacity, or
- Persons receiving Social Security or Railroad Retirement Board disability benefits for 24 months and may be under 65 years of age, or
- Persons with disability and may be under 65 years of age, or
- End-Stage Renal Disease and may be under 65 years of age

Change in Event(s)



Coverage Decision



Medigap Availability

- Medigap plans are available to those enrolled in Original Medicare Part A and Part B.
- Medigap plans are not available to Medicare Advantage (MA) enrollees. However if the MA plan has failed to meet contractual obligations, the enrollee files grievance with the MA Plan, Medicare, or State Insurance Department, and the MA Plan is at fault, then Medicare beneficiary has the right to purchase Medigap plans A, B, C, or F (may have more choice depending state of residence) 63 calendar day after MA plan termination and Original Medicare commencement.

***Medigap Open Enrollment Period and Afterwards**

Medigap open enrollment period lasts 6 months starting on the first month in which the beneficiary is

- Age 65 or older, and
- Enrolled in Medicare Part B
- Medigap insurance companies may apply underwriting for pre-existing for enrollment after the Medigap open enrollment period. Plan offer is not guaranteed.

Supplemental Coverage

Basic Benefits for Medigap Plans A through J

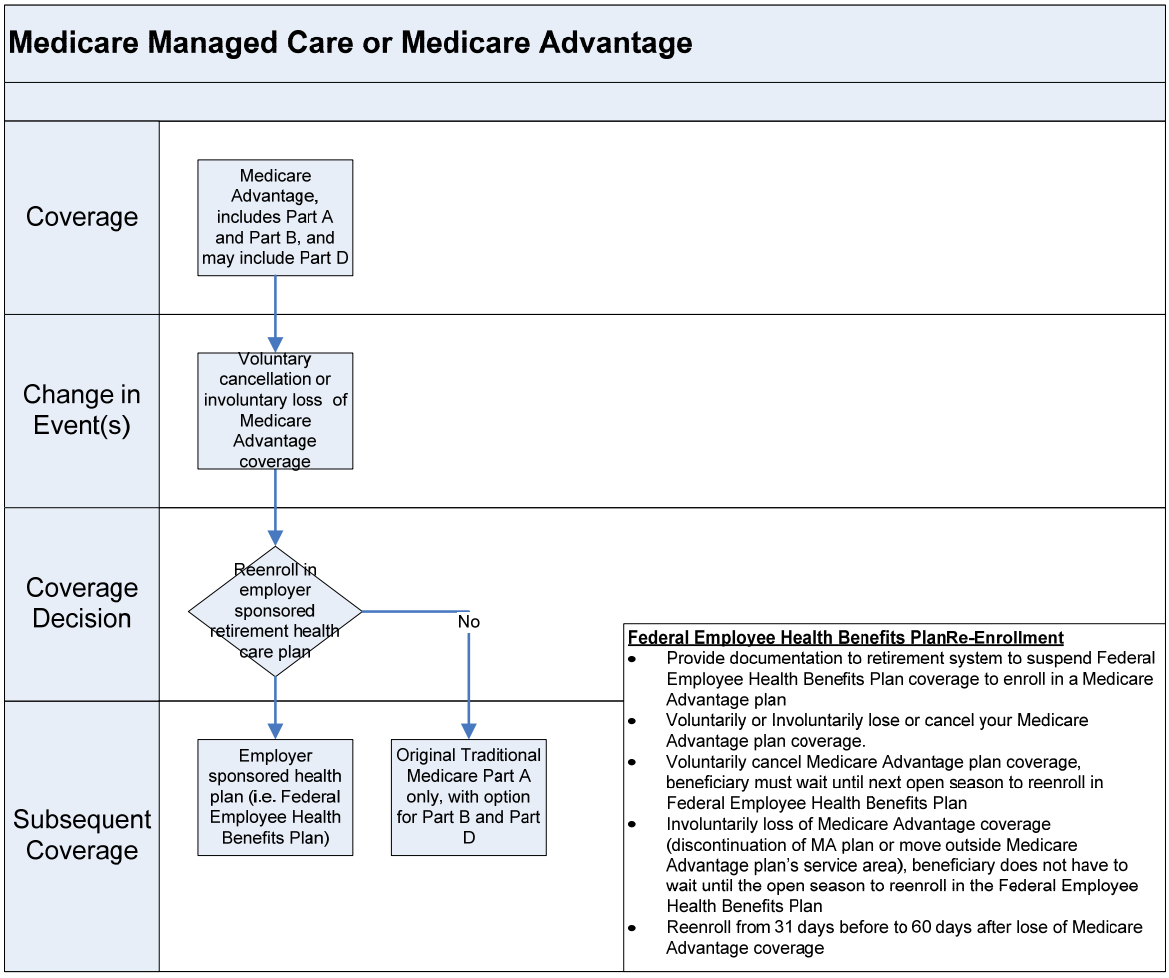
- Medicare Part A coinsurance: a set amount per day for days 61-90 of a hospital stay and a higher set amount for days 91-150 of a hospital stay (while using 60 lifetime Medicare-covered days)
- Hospital benefits
- Medicare Part B coinsurance or copayment after meeting the annual deductible
- First three pints of blood or equal amounts of packed red blood cells per calendar year, unless beneficiary or someone else donates blood to replace what the beneficiary uses

Basic Benefits for Medigap Plans K and L

- Medicare Part A coinsurance: a set amount per day for days 61-90 of a hospital stay and a higher set amount for days 91-150 of a hospital stay (while using 60 lifetime Medicare-covered days)
- Hospital benefits .
- Medigap Plan K/L pays 50%/75% of Medicare Part B coinsurance or copayment after meeting the annual deductible and 100% of coinsurance for Medicare Part B preventive services.
- Medigap Plan K/L pays 50%/75% of the first three pints of blood or equal amounts of packed red blood cells per calendar year, unless beneficiary or someone else donates blood to replace what the beneficiary uses.
- Medigap Plan K/L pays 50%/75% of the first hospice cost-sharing for all Medicare Part A Medicare-covered expenses and respite care.

Summary of Benefits	A	B	C	D	E	F**	G	H	I	J**	K	L
Basic Benefits	x	x	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Facility Coinsurance			x	x	x	x	x	x	x	x	x	x
Medicare Part A Deductible		x	x	x	x	x	x	x	x	x	x	x
Medicare Part B Deductible			x			x				x		
Medicare Part B Excess Charges						x	x		x	x		
Foreign Travel Emergency			x	x	x	x	x	x	x	x		
At-Home Recovery				x			x		x	x		
Preventive Care					x***					x***		
** Medigap Plans F and J also have a high-deductible option.												
*** Medigap policies cover some preventive care that isn't covered by Medicare.												

7.9. Medicare Managed Care or Medicare Advantage

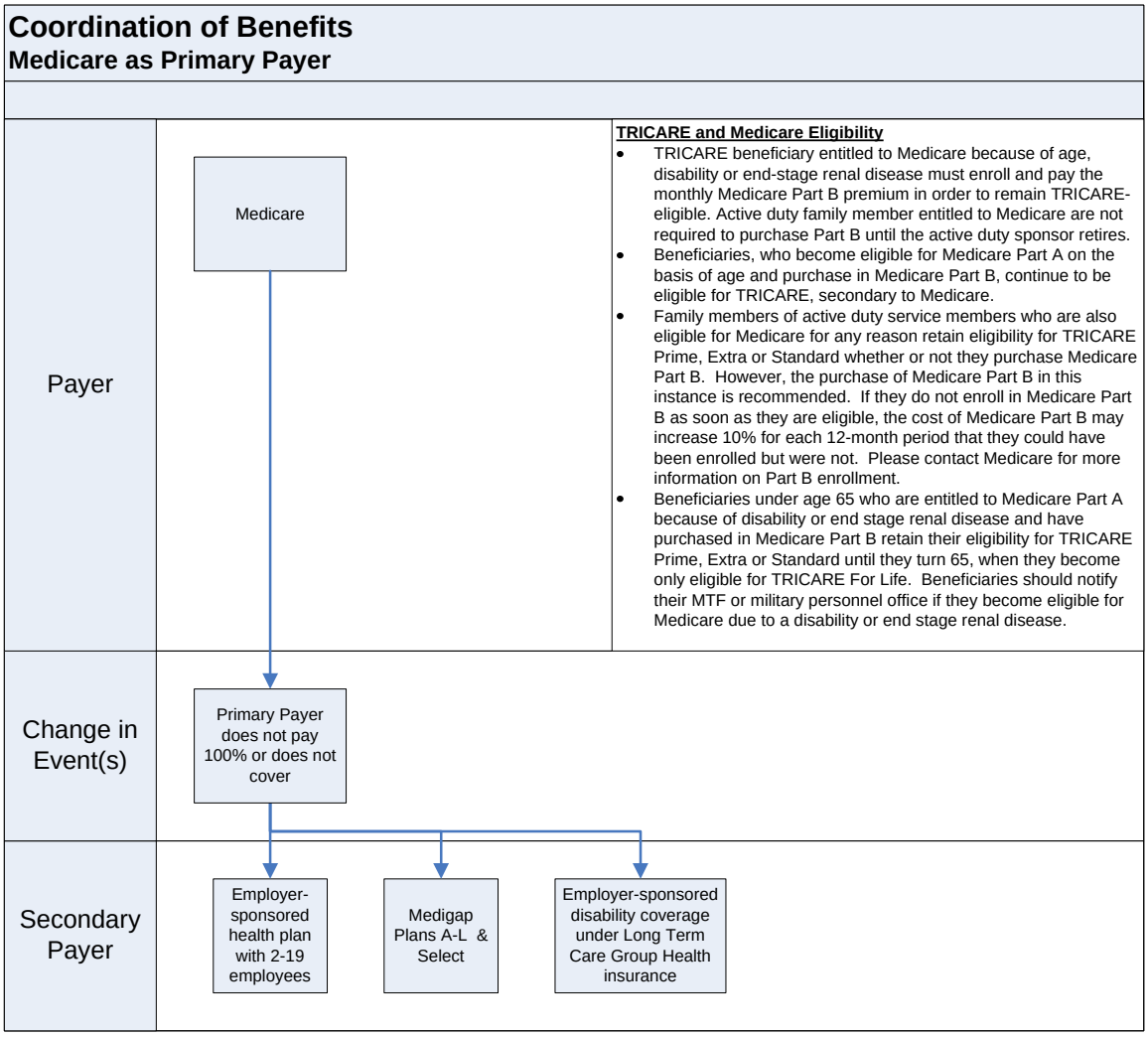


7.10. Coordination of Benefits: Dual Eligibility - Medicare & Medi-Cal

Coordination of Benefits
Dual Eligibility - Medicare & Medi-Cal

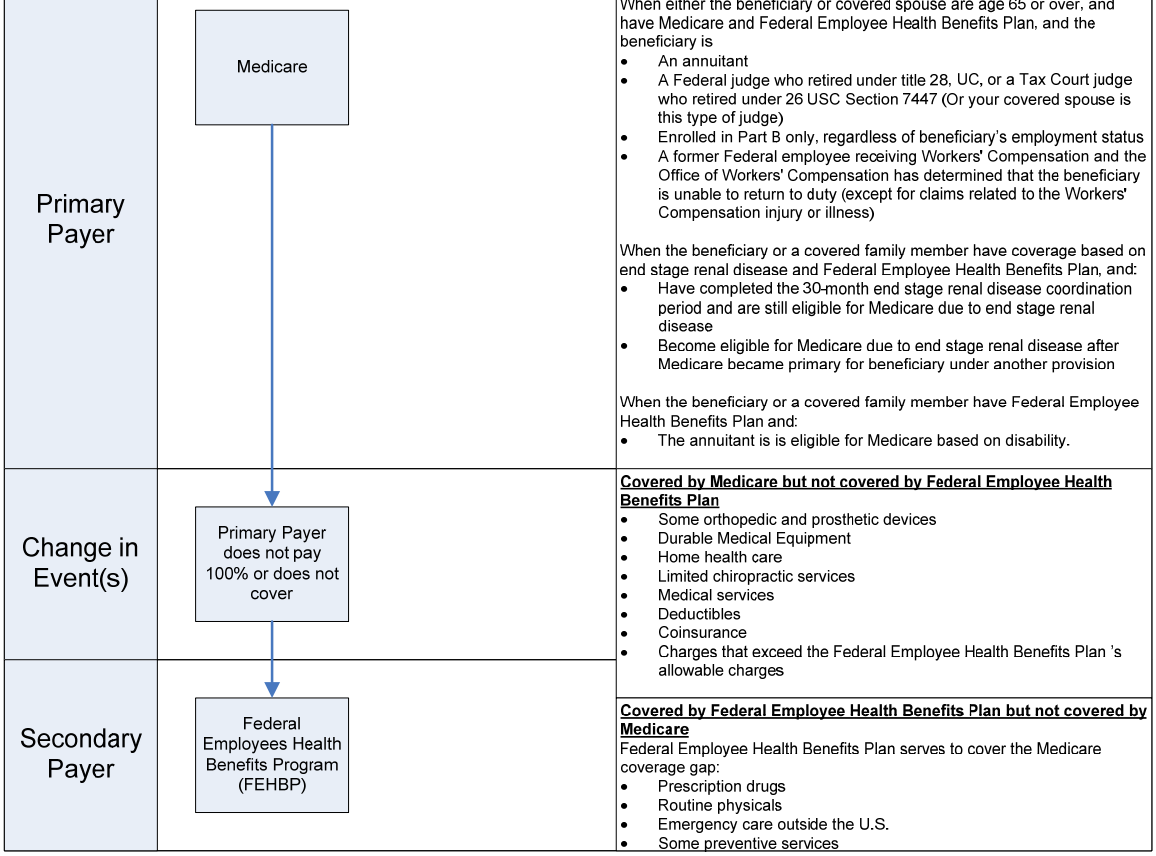
Primary Payer	Medicare Part A with option to enroll in Part B and Part D	**Basic Medicare Eligibility** • Citizens or permanent residents 65 years of age and older who worked for at least 10 years in Medicare-covered employment or has a spouse who worked in that capacity, or • Persons receiving Social Security or Railroad Retirement Board disability benefits for 24 months and maybe under 65 years of age, or • Persons with disability and maybe under 65 years of age, or • End-Stage Renal Disease and maybe under 65 years of age **Medicare Savings Eligibility in Addition to Basic Medicare Eligibility** **Qualified Medicare Beneficiaries** • Resources at or below twice the standard allowed under the Supplemental Security Income program ($4,000 for an individual, and $6,000 for a couple), and • income at or below 100% of the Federal poverty level, and • Medicaid pays for monthly Medicare premiums, deductibles, and coinsurance **Specified Low-Income Medicare Beneficiaries** • Resources at or below twice the standard allowed under the Supplemental Security Income program, and • income exceeds the Qualified Medicare Beneficiaries level but less than 120% of federal poverty level, and • Medicaid pays for monthly Medicare Part B premiums **Qualifying Individuals** • Resources below twice the standard allowed under the Supplemental Security Income program, and • income exceeds the Specified Low-Income Medicare Beneficiaries level but less than 135% of federal poverty level, and • Medicaid pays for monthly Medicare Part B premiums **Medicare Part A Buy-In** **Qualified Disabled and Working Individuals** • Persons with Medicare due to disability, and • Subsequently lose Medicare benefits because of re-employment
Change in Event(s)	Primary Payer does not pay 100% or does not cover Medicaid only, Qualified Medicare Beneficiaries plus, or Specified Low-Income Medicare Beneficiaries plus? NO → No – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals, or Qualified Disabled and Working Individuals Yes	**Examples of Services Not Covered by Medicare but Covered by Medicaid** • Nursing facility care beyond the 100 day limit covered by Medicare • Eyeglasses • Hearing aids • Medicare cost sharing for Qualified Medicare Beneficiaries
Secondary Payer	Full scope Medicaid Limited Medicaid	**Medicaid Eligibility for Dual Eligibility** • Categorically needy, or • Optional Medically Needy coverage groups, or • Special income levels for institutionalized or home and community-based waivers, but do not meet the income or resource criteria for Qualified Medicare Beneficiaries or Specified Low-Income Medicare Beneficiaries

7.11. Coordination of Benefits: Medicare as Primary Payer



7.12. Coordination of Benefits: Medicare as Primary Payer and Federal Employee Health Benefits Plan as Secondary Payer

Coordination of Benefits
Medicare as Primary Payer and Federal Employee Health Benefits Plan as Secondary Payer



Medicare is the primary payer when
When either the beneficiary or covered spouse are age 65 or over, and have Medicare and Federal Employee Health Benefits Plan, and the beneficiary is

- An annuitant
- A Federal judge who retired under title 28, UC, or a Tax Court judge who retired under 26 USC Section 7447 (Or your covered spouse is this type of judge)
- Enrolled in Part B only, regardless of beneficiary's employment status
- A former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation has determined that the beneficiary is unable to return to duty (except for claims related to the Workers' Compensation injury or illness)

When the beneficiary or a covered family member have coverage based on end stage renal disease and Federal Employee Health Benefits Plan, and:

- Have completed the 30-month end stage renal disease coordination period and are still eligible for Medicare due to end stage renal disease
- Become eligible for Medicare due to end stage renal disease after Medicare became primary for beneficiary under another provision

When the beneficiary or a covered family member have Federal Employee Health Benefits Plan and:

- The annuitant is is eligible for Medicare based on disability.

Covered by Medicare but not covered by Federal Employee Health Benefits Plan

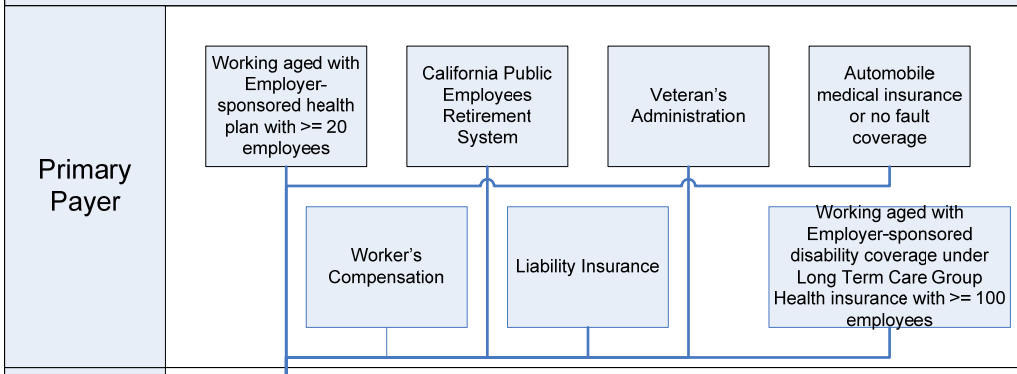
- Some orthopedic and prosthetic devices
- Durable Medical Equipment
- Home health care
- Limited chiropractic services
- Medical services
- Deductibles
- Coinsurance
- Charges that exceed the Federal Employee Health Benefits Plan 's allowable charges

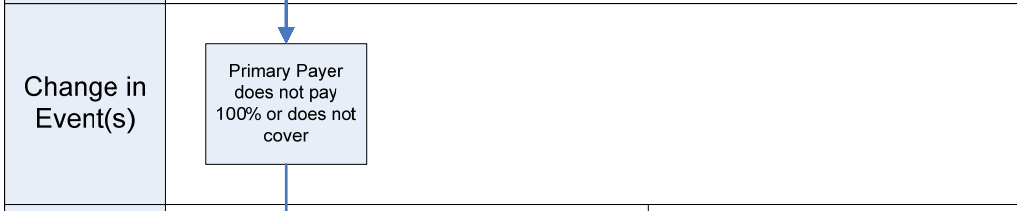
Covered by Federal Employee Health Benefits Plan but not covered by Medicare
Federal Employee Health Benefits Plan serves to cover the Medicare coverage gap:

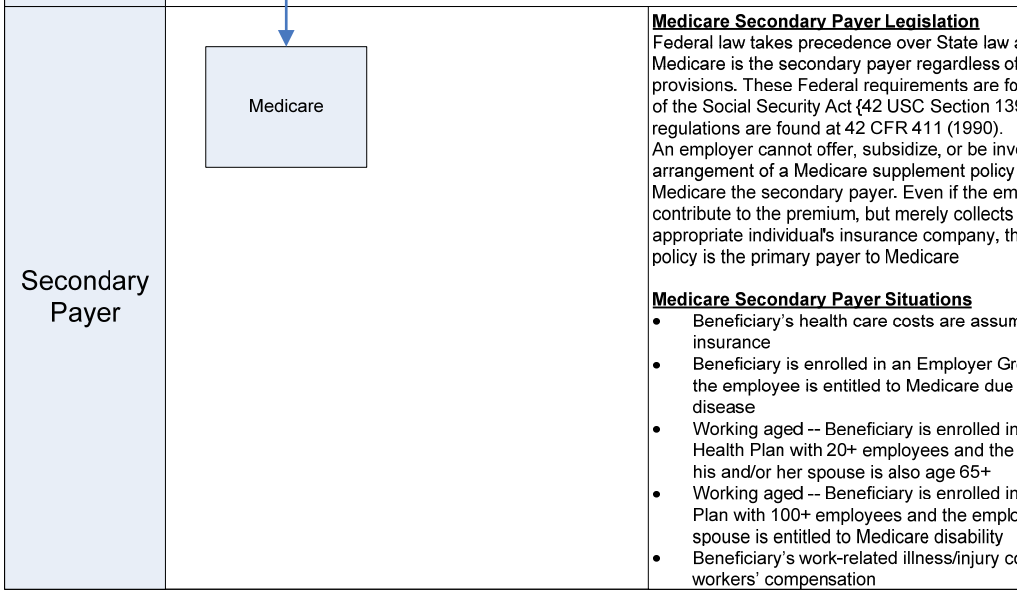
- Prescription drugs
- Routine physicals
- Emergency care outside the U.S.
- Some preventive services

7.13. Coordination of Benefits: Medicare as Secondary Payer

Coordination of Benefits
Medicare as Secondary Payer





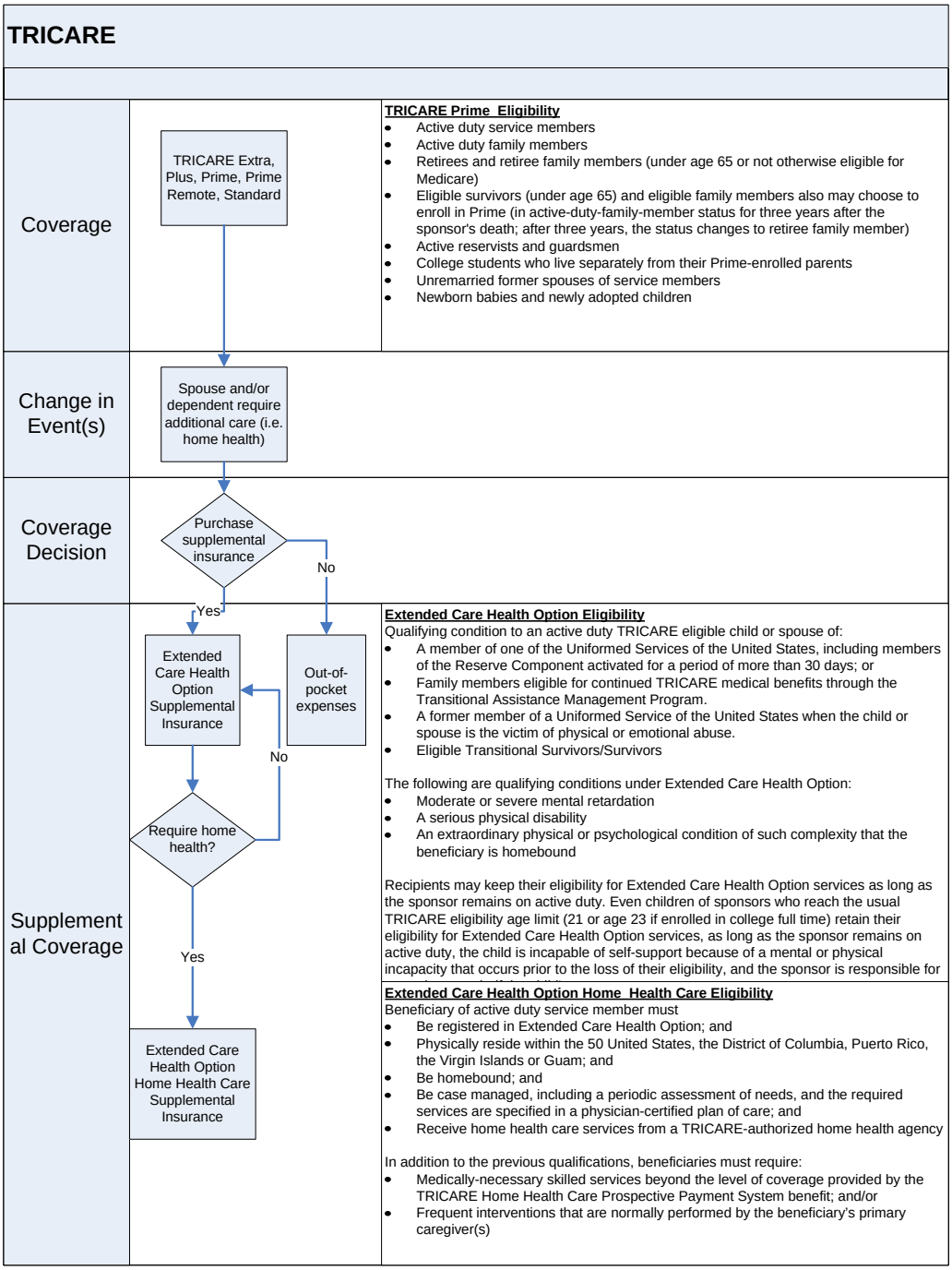


Medicare Secondary Payer Legislation
Federal law takes precedence over State law and private contracts. Medicare is the secondary payer regardless of state law or plan provisions. These Federal requirements are found in Section 1862(b) of the Social Security Act {42 USC Section 1395y(b)(5)}. Applicable regulations are found at 42 CFR 411 (1990).
An employer cannot offer, subsidize, or be involved in the arrangement of a Medicare supplement policy where the law makes Medicare the secondary payer. Even if the employer does not contribute to the premium, but merely collects it and forwards it to the appropriate individual's insurance company, the group health plan policy is the primary payer to Medicare

Medicare Secondary Payer Situations

- Beneficiary's health care costs are assumed by auto accident insurance
- Beneficiary is enrolled in an Employer Group Health Plan and the employee is entitled to Medicare due to end stage renal disease
- Working aged -- Beneficiary is enrolled in an Employer Group Health Plan with 20+ employees and the employee is age 65+ or his and/or her spouse is also age 65+
- Working aged -- Beneficiary is enrolled in a Large Group Health Plan with 100+ employees and the employee and/or his/ her spouse is entitled to Medicare disability
- Beneficiary's work-related illness/injury costs are assumed by workers' compensation

7.14. Coordination of Benefits: Federal Employee Health Benefits Plan as Primary Payer and Medicare as Secondary Payer

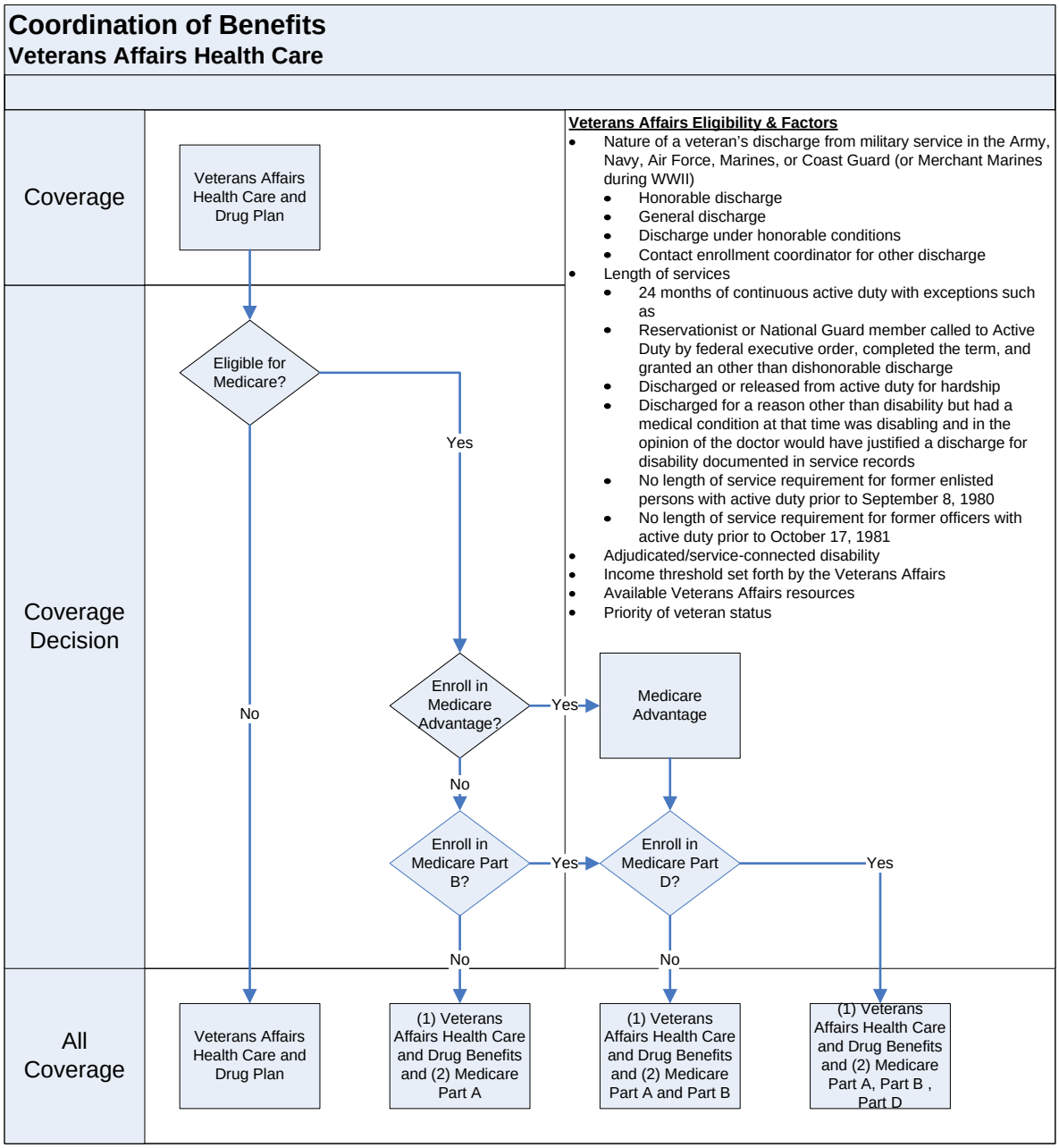


7.15. Tricare

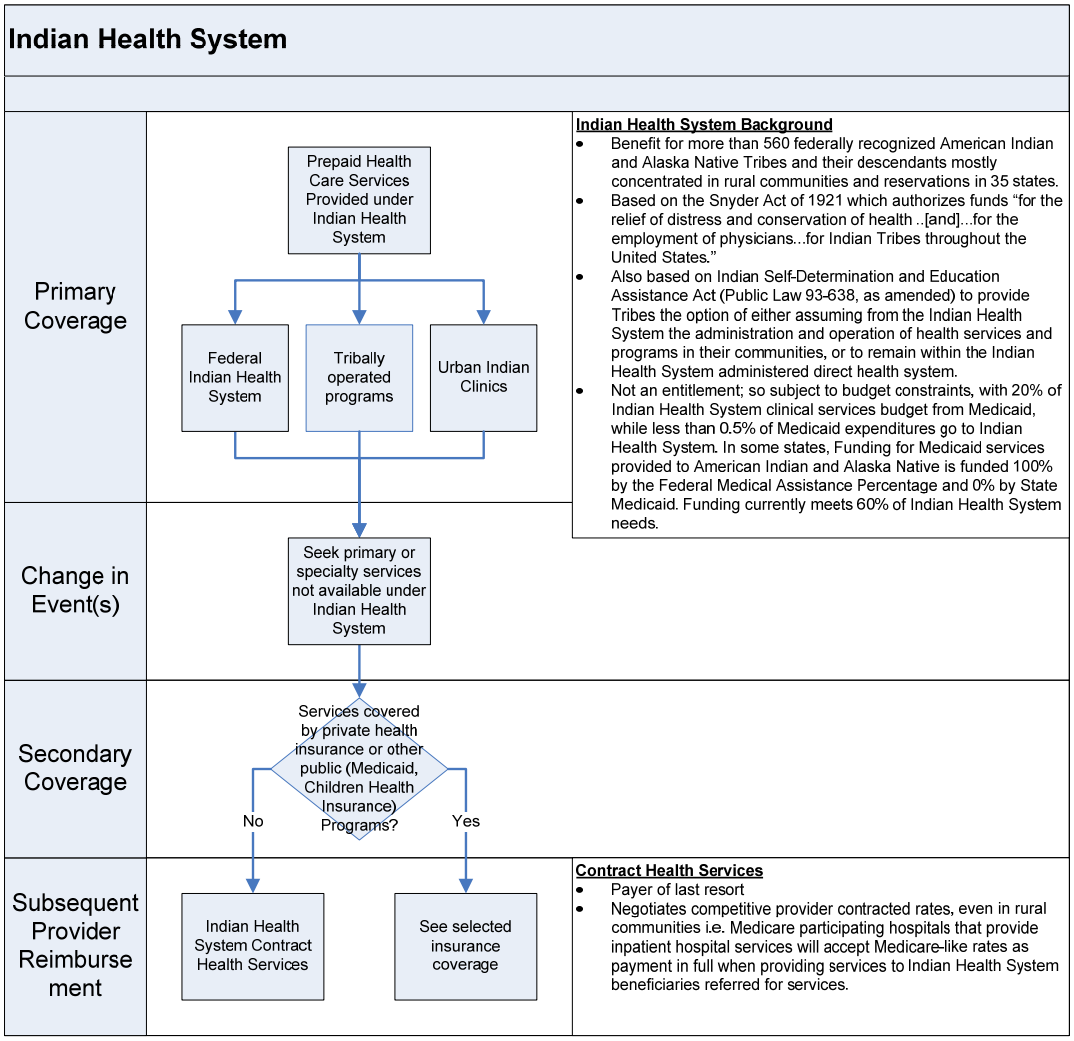
TRICARE

Coverage	TRICARE Extra, Plus, Prime, Prime Remote, Standard	**TRICARE Prime Eligibility** • Active duty service members • Active duty family members • Retirees and retiree family members (under age 65 or not otherwise eligible for Medicare) • Eligible survivors (under age 65) and eligible family members also may choose to enroll in Prime (in active-duty-family-member status for three years after the sponsor's death; after three years, the status changes to retiree family member) • Active reservists and guardsmen • College students who live separately from their Prime-enrolled parents • Unremarried former spouses of service members • Newborn babies and newly adopted children
Change in Event(s)	Spouse and/or dependent require additional care (i.e. home health)	
Coverage Decision	Purchase supplemental insurance No Yes	
Supplemental Coverage	Extended Care Health Option Supplemental Insurance Out-of-pocket expenses No Require home health? Yes Extended Care Health Option Home Health Care Supplemental Insurance	**Extended Care Health Option Eligibility** Qualifying condition to an active duty TRICARE eligible child or spouse of: • A member of one of the Uniformed Services of the United States, including members of the Reserve Component activated for a period of more than 30 days; or • Family members eligible for continued TRICARE medical benefits through the Transitional Assistance Management Program. • A former member of a Uniformed Service of the United States when the child or spouse is the victim of physical or emotional abuse. • Eligible Transitional Survivors/Survivors The following are qualifying conditions under Extended Care Health Option: • Moderate or severe mental retardation • A serious physical disability • An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound Recipients may keep their eligibility for Extended Care Health Option services as long as the sponsor remains on active duty. Even children of sponsors who reach the usual TRICARE eligibility age limit (21 or age 23 if enrolled in college full time) retain their eligibility for Extended Care Health Option services, as long as the sponsor remains on active duty, the child is incapable of self-support because of a mental or physical incapacity that occurs prior to the loss of their eligibility, and the sponsor is responsible for **Extended Care Health Option Home Health Care Eligibility** Beneficiary of active duty service member must • Be registered in Extended Care Health Option; and • Physically reside within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands or Guam; and • Be homebound; and • Be case managed, including a periodic assessment of needs, and the required services are specified in a physician-certified plan of care; and • Receive home health care services from a TRICARE-authorized home health agency In addition to the previous qualifications, beneficiaries must require: • Medically-necessary skilled services beyond the level of coverage provided by the TRICARE Home Health Care Prospective Payment System benefit; and/or • Frequent interventions that are normally performed by the beneficiary's primary caregiver(s)

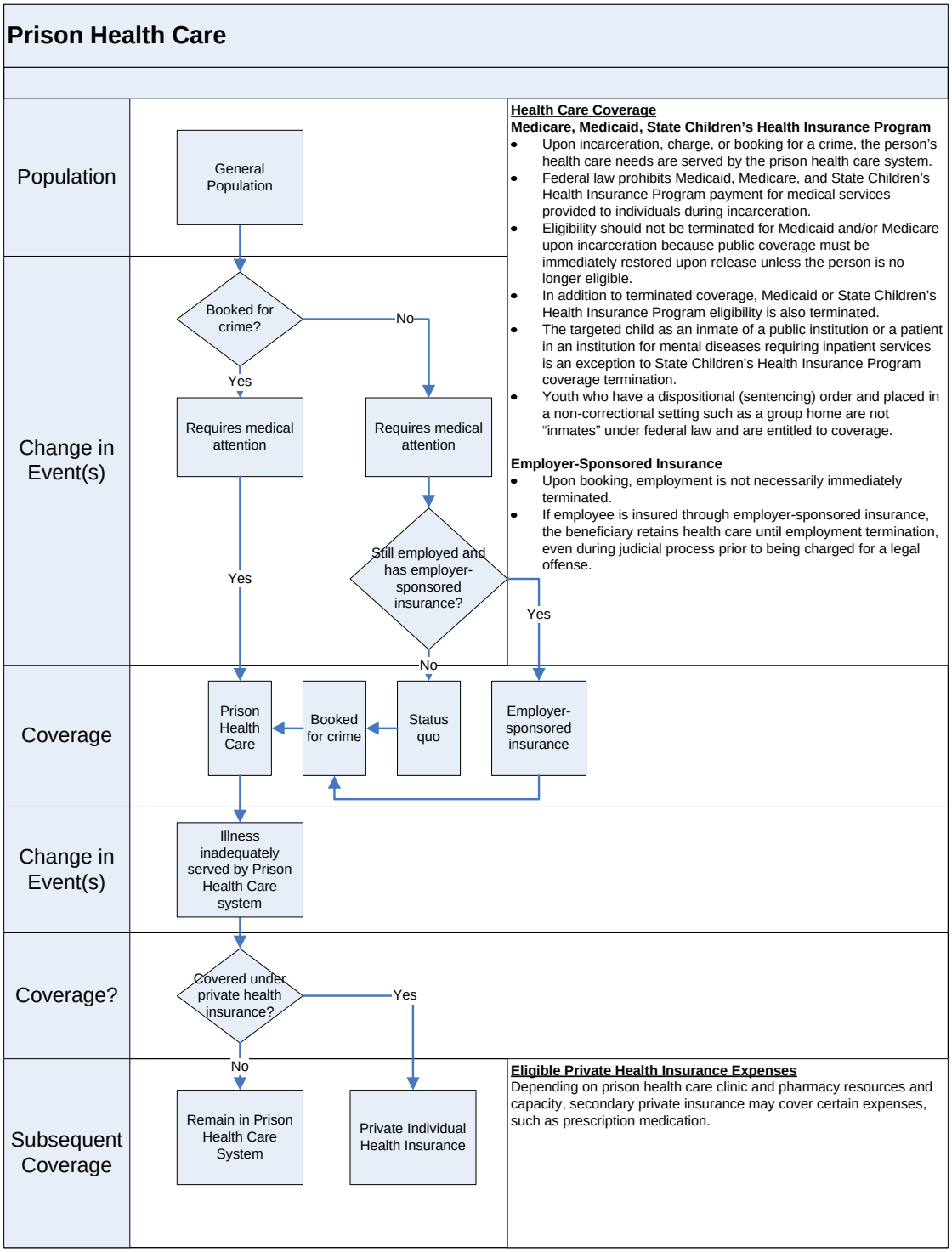
7.16. Coordination of Benefits: Veterans Affairs Healthcare



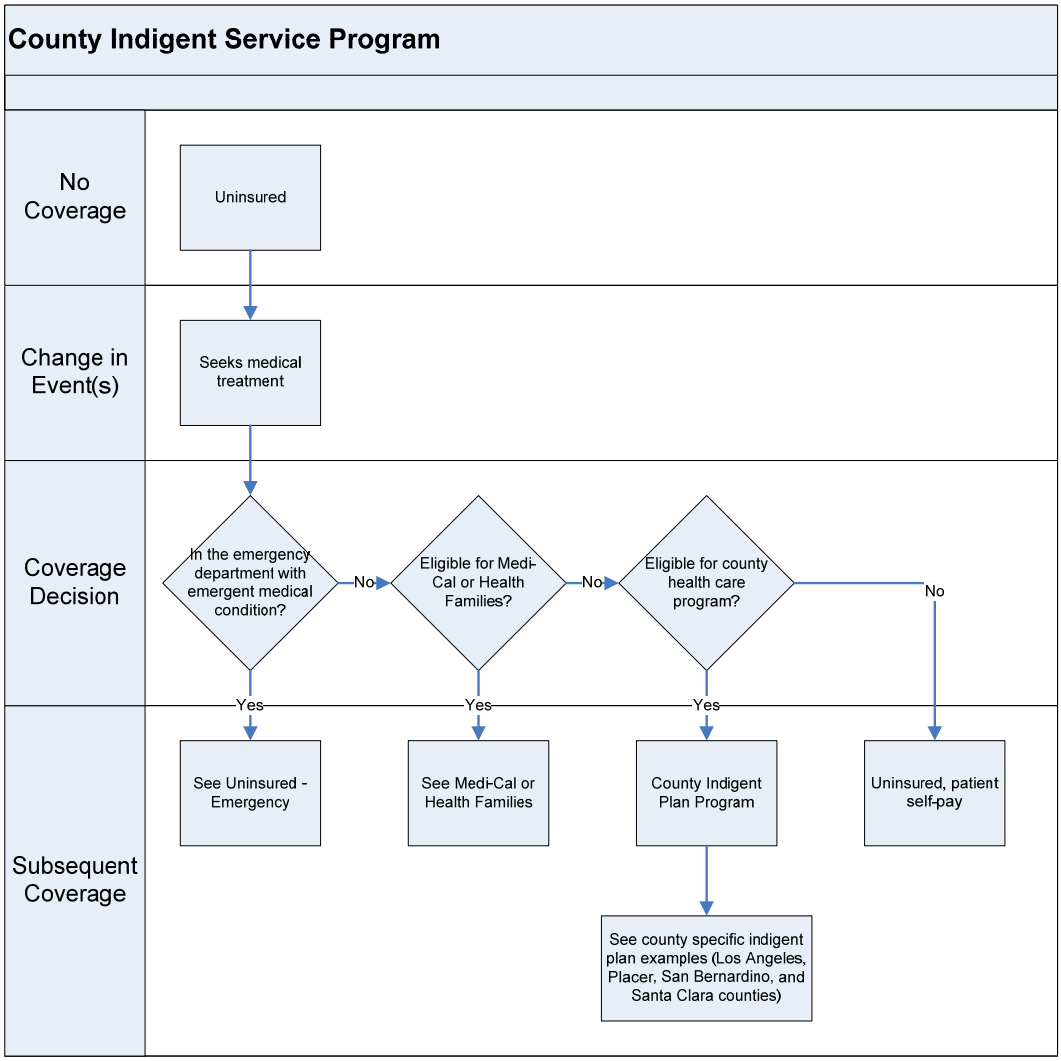
7.17. Indian Health System



7.18. Prison Healthcare



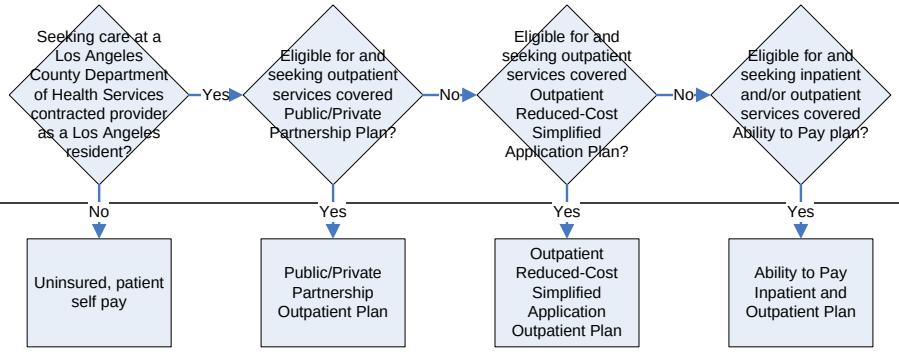
7.19. County Indigent Service Program



7.20. Los Angeles County Indigent Plans

Los Angeles County Indigent Plans

Coverage Decision



Subsequent Coverage

Eligibility & Benefits

Public/Private Partnership Eligibility

- Ineligible for Medi-Cal, Medicare, private insurance, or other medical coverage at a number of county facilities
- Family Income does not exceed 133.33% of federal poverty level
- No assets test
- Los Angeles county resident
- No immigration status restriction
- Medical necessity
- No age restriction

Public/Private Partnership Benefits

Outpatient services for 12 months such as:

- Limited blood and blood derivatives
- Limited chronic hemodialysis services
- Limited dental services
- Family planning services
- Hospital outpatient and outpatient clinic services
- Laboratory and radiology services
- Limited medical supplies, durable medical equipment, prosthetics, and/ or orthotics dispensed by physicians, licensed pharmacies, or durable medical quipment dealers and prosthetic or orthotic providers
- Limited optometry services
- Limited eye appliances
- Limited outpatient audiology services
- Prescription drugs
- Nonprescription drugs
- Physician Services
- Limited podiatry services
- All services provided at designated agencies and sites
- Does not cover cosmetic services.
- Does not cover inpatient care.

Outpatient Reduced-Cost Simplified Application Eligibility

- Ineligible for Medi-Cal, Medicare, private insurance, or other medical benefits at a number of county facilities
- Family income does not exceed 133.33% of federal poverty level
- Assets test
- Los Angeles county resident
- No immigration status restriction
- Medical necessity
- No age restriction

Outpatient Reduced-Cost Simplified Application Benefits

Outpatient services for 6 months:

- Limited blood and blood derivatives
- Chiropractic services
- Limited chronic hemodialysis services
- Limited dental services
- Emergency room care
- Family planning services
- Hospital outpatient and outpatient clinic services
- Laboratory and radiology services
- Limited medical supplies, durable medical equipment, prosthetics, and/ or orthotics dispensed by physicians, licensed pharmacies, or durable medical equipment dealers and prosthetic or orthotic providers
- Limited optometry services
- Limited eye appliances
- Limited outpatient audiology services
- Limited hearing aids
- Limited outpatient occupational therapy, physical therapy and/or speech pathology services
- Limited outpatient rehabilitation services in a rehabilitation facility
- Prescription drugs
- Nonprescription drugs
- Physician Services
- Limited podiatry services
- All participating provider services
- Does not cover cosmetic services

Ability to Pay Eligibility

- Uninsured or limited Medi-Cal, Medicare, private insurance, or other medical coverage at a number of county facilities
- Income sliding scaled based on Medi-Cal maintenance need
- Assets test
- Los Angeles county resident
- No immigration status restriction
- Medical necessity
- No age restriction

Ability to Pay Benefits

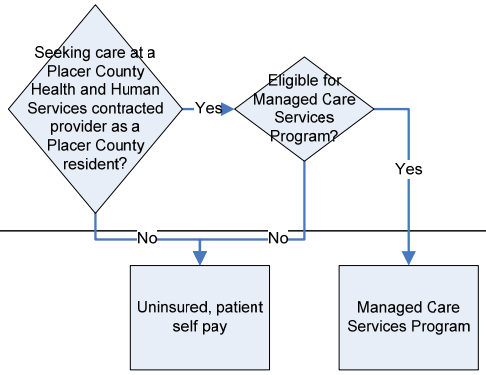
Outpatient services for 6 months and inpatient services for 30 days such as:

- Limited private insurance deductible
- Acute inpatient hospital care
- Blood and blood derivatives
- Chiropractic services
- Chronic hemodialysis services
- Limited dental services
- Emergency room care
- Family planning services
- Hospital outpatient and outpatient clinic services
- Laboratory and radiology services
- Limited medical supplies, durable medical equipment, prosthetics, and/or orthotics dispensed by physicians, licensed pharmacies, or durable medical equipment dealers and prosthetic or orthotic providers
- Limited optometry services
- Limited eye appliances
- Limited outpatient audiology services
- Limited hearing aids
- Limited outpatient occupational therapy, physical therapy and/or speech pathology services
- Limited outpatient rehabilitation services in a rehabilitation facility
- Prescription drugs
- Nonprescription drugs
- Physician Services
- Limited podiatry services
- All participating clinic services
- Does not cover cosmetic services

7.21. Placer County Community Clinic and Managed Care Services Program

Placer County Community Clinic and Managed Care Services Program

Coverage Decision



Subsequent Coverage

Eligibility & Benefits

Managed Care Services Program Eligibility

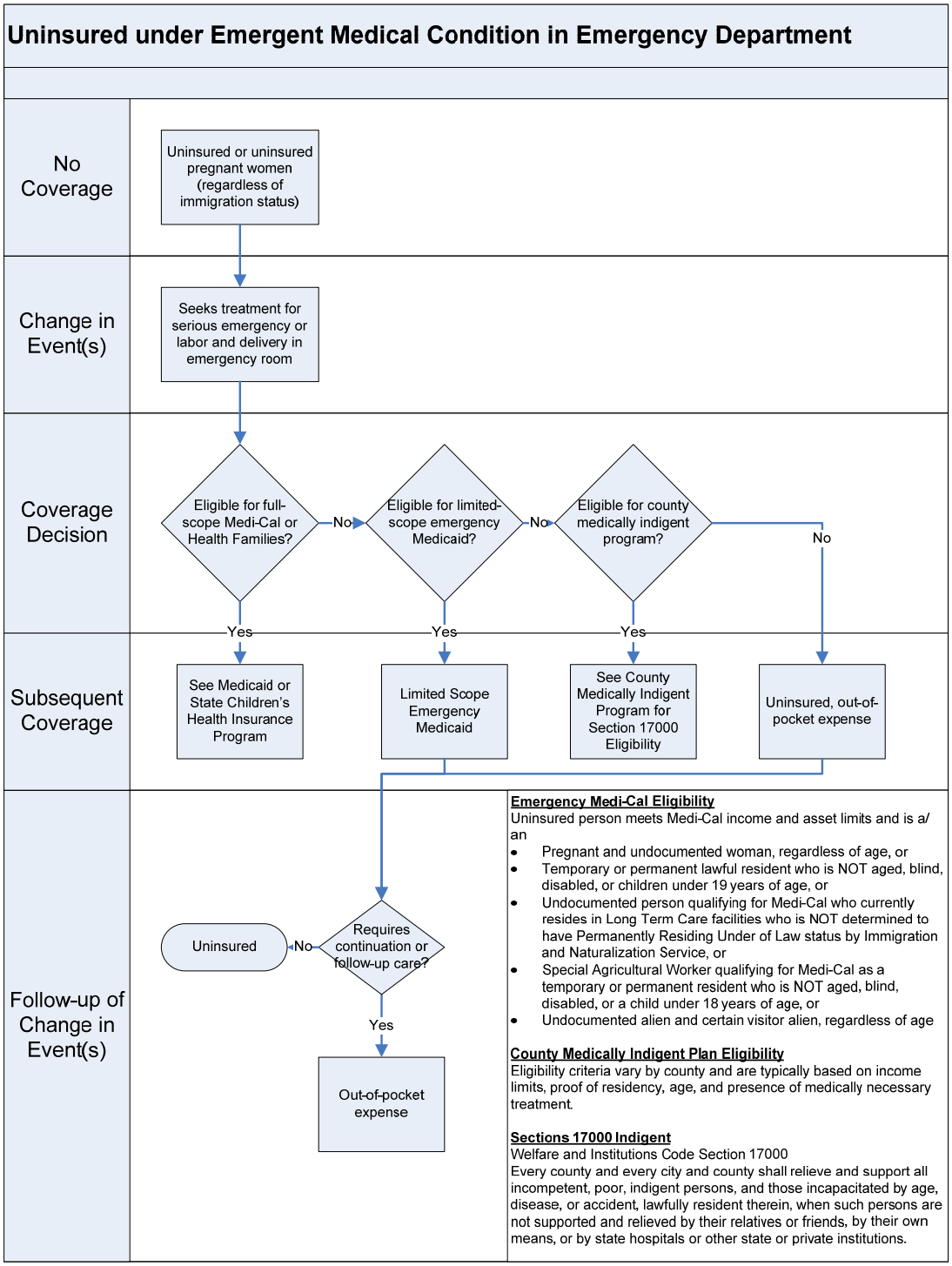
- Uninsured and denied of public insurance
- Family income does not exceed 100% of FPL or $99 + Medi-Cal family income level
- Assets test
- Placer county resident
- Legal immigration status
- Ages 21-64

Managed Care Services Program Benefits

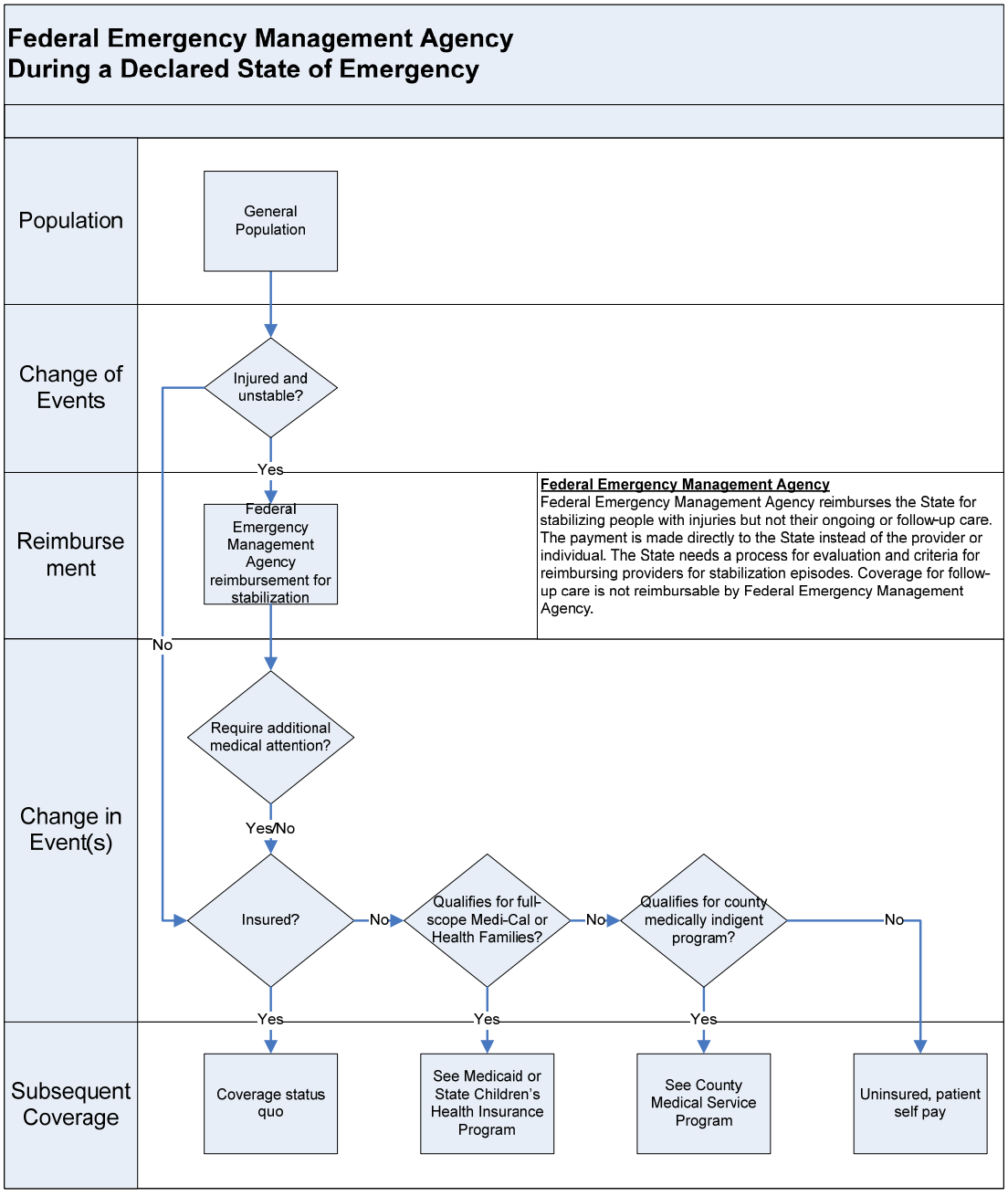
Outpatient services for 6 months and inpatient services for 30 days such as:

- Limited retroactive coverage for emergency care
- Limited acute inpatient hospital care
- Limited blood and blood derivatives
- Limited dental services
- Limited emergency room care
- Limited emergency ambulance services and medically necessary transportation from the acute hospital to other facilities for medically necessary, specialized, or tertiary care
- Limited home health agency services
- Limited hospital outpatient and outpatient clinic services
- Limited laboratory and radiology services
- Limited medical supplies, durable medical equipment, prosthetics, and/or orthotics dispensed by physicians, licensed pharmacies, or durable medical equipment dealers and prosthetic or orthotic providers
- Limited optometry services
- Limited outpatient occupational therapy, physical therapy and/or speech pathology services
- Limited outpatient rehabilitation services in a rehabilitation facility
- Limited prescription drugs
- Limited physician Services
- Limited podiatry services
- Limited skilled nursing services
- Physical exam for Social Security Disability, State Disability Insurance, or general assistance
- Does not cover
  - Pregnancy and infertility
  - Routine physicals
  - Any services provided by County Public Health
  - Organ transplant
  - Experimental procedures
  - Services not covered by Medi-Cal

7.22. Uninsured under Emergent Medical Condition in Emergency Department



7.23. Federal Emergency Management Agency Public Assistance



7.24. Federal Emergency Management Agency's Emergency Assistance for Human Influenza Pandemic[1]

Recognizing that a pandemic influenza scenario may require a different kind of local, state and federal response, the Department of Homeland Security recently outlined a policy document on Federal Emergency Management Agency’s Emergency Assistance for Human Influenza Pandemic. Given the rapidly infectious and deadly nature of human influenza, federal resource response for an outbreak is different from other disaster relief undertakings, and, as such, a separate policy was developed to address this potential situation. One of the differences between a pandemic and most other emergencies is that a pandemic may last much longer than most public emergencies and may include “waves” of influenza activity separated by months, affecting the ability of interstate mutual aid to respond and reducing the number of healthcare workers and first responders available to work. Additionally, resources in many locations could be limited, depending on the severity and spread of an influenza pandemic.

The full text of the Federal Emergency Management Agency's Disaster Assistance Policy on Emergency Assistance for Human Influenza Pandemic begins on the following page.

DAP9523.17

FEMA
DISASTER ASSISTANCE POLICY

I. TITLE: Emergency Assistance for Human Influenza Pandemic

II. DATE: March 31, 2007

III. PURPOSE:

Establish the types of emergency protective measures that are eligible under the Public Assistance Program during a Federal response to an outbreak of human influenza pandemic in the U.S. and its territories.

IV. SCOPE AND AUDIENCE:

The policy is applicable to all major disasters and emergencies declared on or after the date of publication of this policy. It is intended for personnel involved in the administration of the Public Assistance Program.

V. AUTHORITY:

Sections 403 (42 U.S.C. 5121-5206) and 502 (42 U.S.C. 5192) respectively, of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act), and 44 Code of Federal Regulations (CFR) §206.225(a)(3)(i).

VI. BACKGROUND:

A. The severity of the next human influenza pandemic cannot be predicted, but modeling studies suggest that the impact of a pandemic on the United States could be substantial. In the absence of any control measures (vaccination or drugs), it has been estimated that in the United States a "medium–level" pandemic could cause 89,000 to 207,000 deaths, 314,000 to 734,000 hospitalizations, 18 to 42 million outpatient visits, and another 20 to 47 million people being sick. Over an expected period of two years, between 15% and 35% of the U.S. population could be affected by an influenza pandemic, and the economic impact could range between $71.3 and $166.5 billion. This effect does not include members of the general population that may have to miss work to care for ill family members, potentially raising the population affected by an influenza pandemic to 55% during the peak weeks of community outbreak (Department of Health and Human Services, Centers for Disease Control and Prevention, Pandemic Flu: Key Facts, January 17, 2006).

DAP9523.17

FEMA
DISASTER ASSISTANCE POLICY

B. An influenza pandemic differs from other public health threats, in that:

- A pandemic will last much longer than most public health emergencies, and may include "waves" of influenza activity separated by months (in 20th century pandemics, a second wave of influenza activity occurred 3 to 12 months after the first wave).

- The numbers of health-care workers and first responders available to work is expected to be reduced. This population will be at high risk of illness through exposure in the community and in health-care settings.

- Resources in many locations could be limited, depending on the severity and spread of an influenza pandemic.

C. Assumptions:

1. Three conditions must be met for a pandemic to begin:

a. A new influenza virus subtype must emerge, for which there is little or no human immunity. (For example, the H5N1 virus, also known as bird flu, is a new virus for humans. It has never circulated widely among people, but has killed over half of those infected.)

b. It must infect humans and cause illness; and:

c. It must spread easily and sustainably (continue without interruption) among humans.

2. There will be large surges in the number of people requiring or seeking medical or hospital treatment, which could overwhelm health services.

3. High rates of worker absenteeism will interrupt other essential services, such as emergency response, communications, fire and law enforcement, and transportation, even with Continuity of Operations Plans in place.

4. Rates of illness are expected to peak fairly rapidly within a given community, because all populations will be fully susceptible to an H5N1-like virus.

5. Local social and economic disruptions may be temporary, yet have amplified effects due to today's closely interrelated and interdependent systems of trade and commerce.

FEMA
DISASTER ASSISTANCE POLICY

6. A second wave of global spread should be anticipated within a year, based on past experience.

7. All countries are likely to experience emergency conditions during a pandemic, leaving few opportunities for international assistance, as seen during natural disasters or localized disease outbreaks. Once international spread has begun, governments will likely focus on protecting domestic populations.

VII. POLICY:

A. The following Emergency Protective Measures (Category B) may be eligible for reimbursement to State and local governments and certain private non-profit organizations:

1. Activation of State or local emergency operations center to coordinate and direct the response to the event.

2. Purchase and distribution of food, water, ice, medicine, and other consumable supplies.

3. Management, control, and reduction of immediate threats to public health and safety.

4. Movement of supplies and persons.

5. Security forces, barricades and fencing, and warning devices.

6. Emergency medical care (non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostic tests for a period determined by the Federal Coordinating Officer).

7. Temporary medical facilities (for treatment of disaster victims when existing facilities are overloaded and cannot accommodate the patient load).

8. Congregate sheltering (for disaster victims when existing facilities are overloaded and cannot accommodate the patient load).

9. Communicating health and safety information to the public.

10. Technical assistance to State and local governments on disaster management and control.

11. Search and rescue to locate and recover members of the population requiring assistance and to locate and recover human remains.

12. Storage and internment of unidentified human remains.

13. Mass mortuary services.

14. Recovery and disposal of animal carcasses (except if another federal authority funds the activity – e.g., U.S. Department of Agriculture, Animal, Plant and Health Inspection Service provides for removal and disposal of livestock).

B. Eligible Costs. Overtime pay for an applicant's regular employees may be eligible for reimbursement. The straight-time salaries of an applicant's regular employees who perform eligible work are not eligible for reimbursement. Regular and overtime pay for extra-hires may be eligible for reimbursement. Eligible work accomplished through contracts, including mutual aid agreements, may be eligible for reimbursement. Equipment, materials, and supplies made use of in the accomplishment of emergency protective measures may be eligible.

C. Ineligible Costs. Ineligible costs include the following:

1. Definitive care (defined as medical treatment or services beyond emergency medical care, initiated upon inpatient admissions to a hospital).

2. Cost of follow-on treatment of disaster victims is not eligible, in accordance with FEMA Recovery Policy 9525.4 – Medical Care and Evacuation.

3. Costs associated with loss of revenue.

4. Increased administrative and operational costs to the hospital due to increased patient load.

5. Rest time for medical staff. Rest time includes the time a staff member is unavailable to provide assistance with emergency medical care.

6. Because the law does not allow disaster assistance to duplicate insurance benefits, disaster assistance will not be provided for damages covered by insurance. The PA applicant

FEMA
DISASTER ASSISTANCE POLICY

should not seek reimbursement for these costs if underwritten by private insurance, Medicare, Medicaid or a pre-existing private payment agreement.

Note: Ineligible costs remain ineligible even if covered under contract, mutual aid, or other assistance agreements.

D. Coordination with Emergency Support Function (ESF). Coordination among ESFs 3, 5, 6, 8, 9, 11, and 14 will be required.

VIII. ORIGINATING OFFICE: Recovery Division (Public Assistance Branch).

IX. SUPERSESSION: This policy supersedes all previous guidance on this subject.

X. REVIEW DATE: Three years from date of publication.

David Garratt
Acting Assistant Administrator
Disaster Assistance Directorate

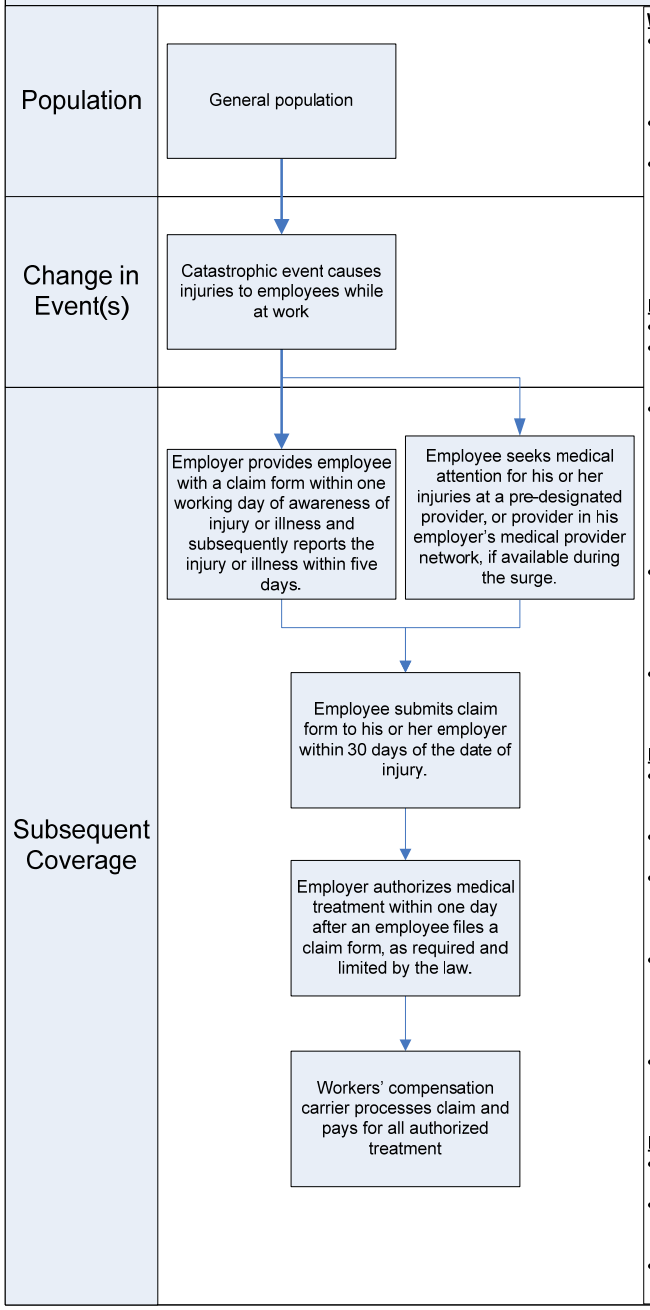
7.25. Funding Sources for Personnel during A Disaster

Although social and job responsibilities require personnel to work through disaster-relief medical surges during a disaster or pandemic, many organizations may have high personnel absenteeism rates and may be strained for personnel resources. They may recruit additional providers and staff to accommodate the medical surge. Organizations may consider the resources of these available programs that compensate for additional personnel salaries and overtime.

- Federal Emergency Management Agency Disaster Assistance for State Units on Aging and Tribal Organizations in National Disasters Declared by the President
- Federal Emergency Management Agency Emergency Assistance for Human Influenza Pandemic
- Veterans Health Administration Disaster Relief Program

7.26. Worker's Compensation During Declared Disaster

Workers' Compensation During Declared Disaster – General Population



Worker's Compensation Eligibility

- Workers' compensation covers injuries or illnesses that occur due to employment, including single events or injuries caused by repeated exposure (Labor Code Section 3208 and Section 3208.1)
- Workers' Compensation does not cover first aid (Labor Code Section 5401)
- Employees covered under Workers' Compensation are "every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes (a) aliens and minors (Labor Code Section 3351)

Employee Responsibility

- Report any injury or illness to employer as soon as possible.
- Complete the Workers' Compensation Claim Form and submit to employer within 30 days of the date of injury (Labor Code Section 5400)
- Should the employee disagree with any of the actions of the workers' compensation policy, submit an Application for Adjudication of Claims with the Workers' Compensation Appeals Board within one year of the date of the injury, or one year from the "last furnishing of indemnity or medical treatment benefits" by the employer or workers' compensation insurance carrier (State Compensation Insurance Fund).
- Pre-designate a physician, if interested, following certain rules and requirements. Each employee who chooses to pre-designate a physician must provide the name and address of the physician to his or her employer prior to becoming injured.
- The law states that employees are not responsible for co-payments or balance-due after the workers' compensation insurance carrier has paid the provider.

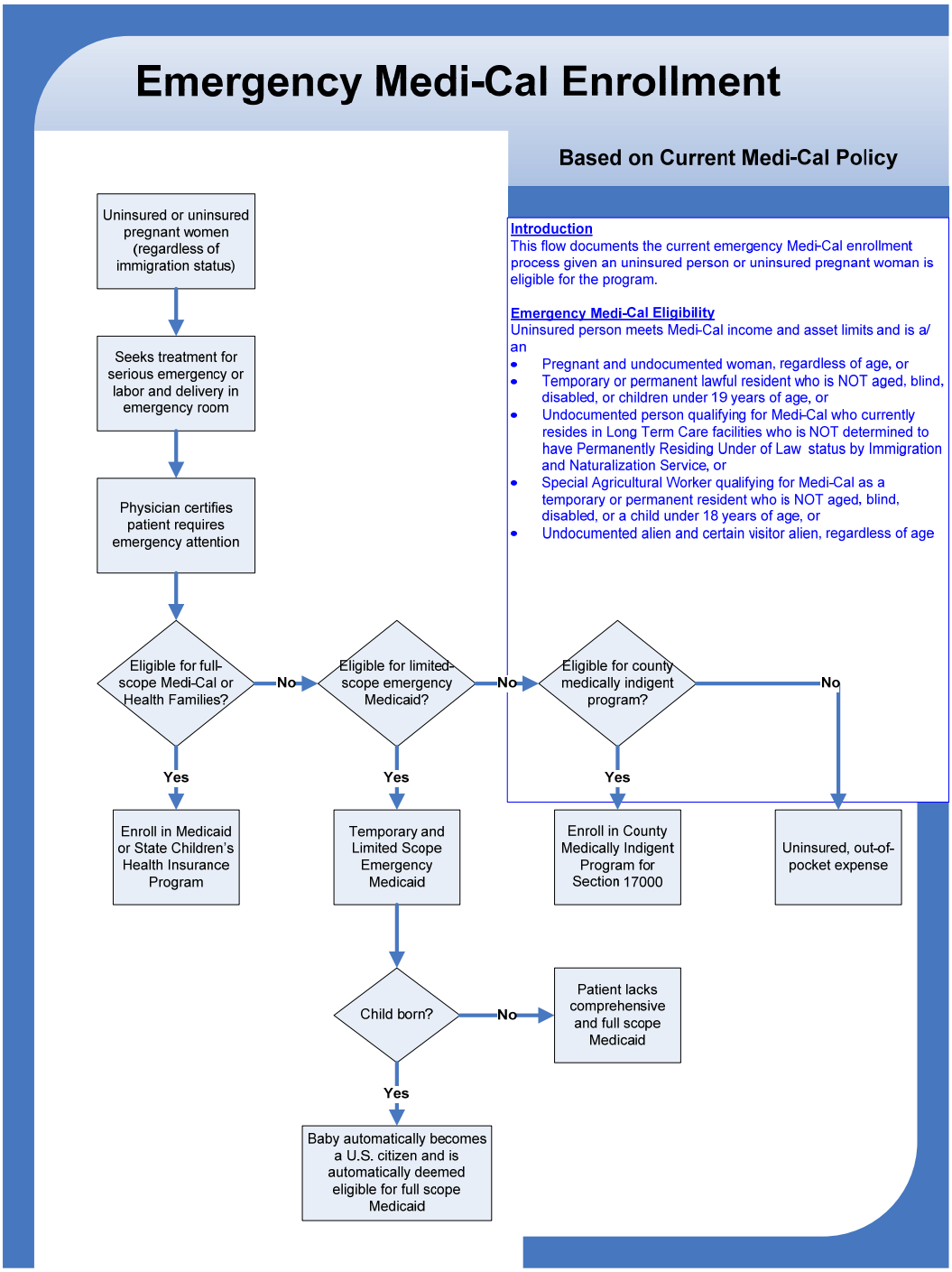
Employer Responsibility

- Provide the employee with a Workers' Compensation Claim Form within one working day after the injury or illness has been identified. (Labor Code Section 5401(a))
- Submit the completed claim form to the appropriate workers' compensation insurance carrier.
- Authorize medical treatment as required and limited by the law within one day after an employee files a claim. This authorization pertains until the claim is accepted or rejected, up to $10,000 in total.
- Report "within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond first-aid" within one day after an employee files a claim (State Compensation Insurance Fund).
- Employer must pay for workers' compensation and must have insurance or be self-insured. (Labor Code Section 3600 and Section 3700)

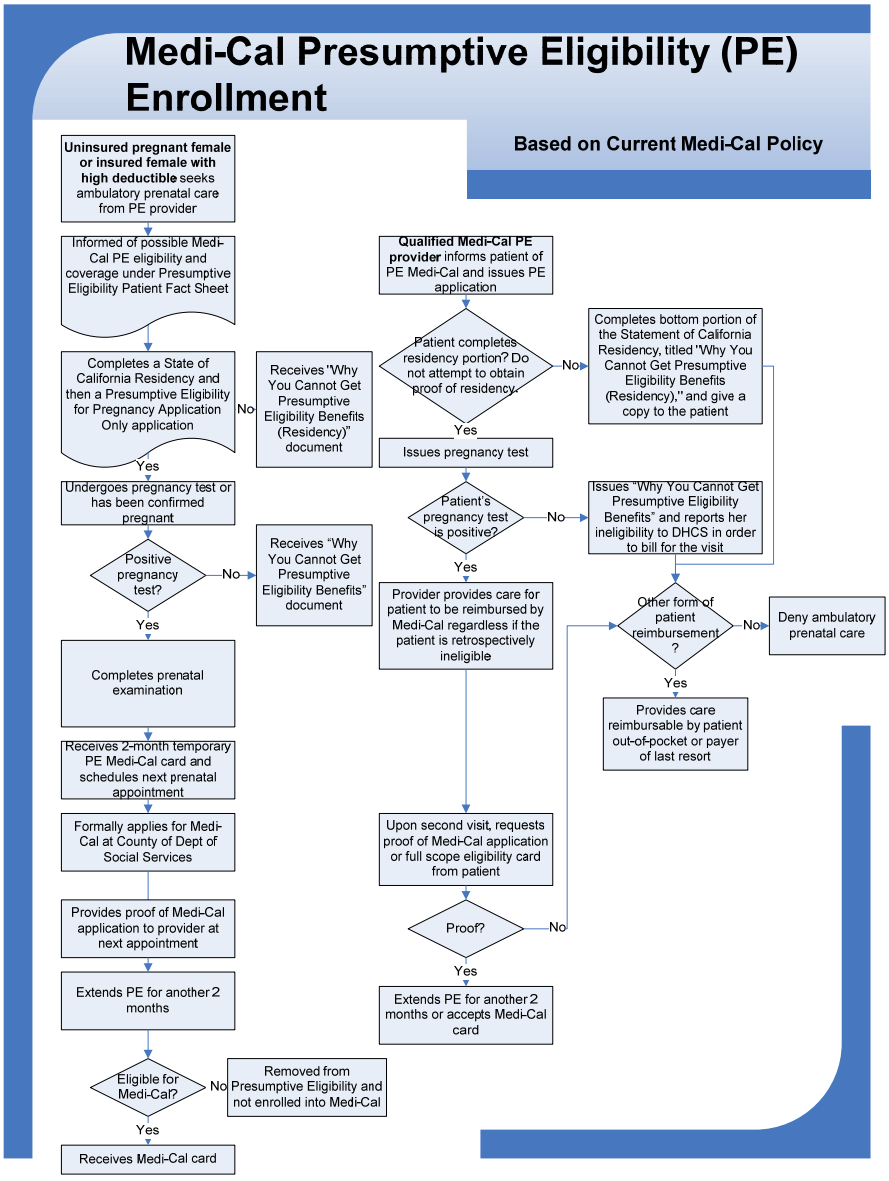
Payer Responsibility

- Accept or deny new claim within a reasonable time (Labor Code Sections 5814 and 5814.6; 8 CCR Section 10109)
- New claim presumed to be covered by workers' compensation if not denied within 90 days (Labor Code Section 5402(b))
- The workers' compensation insurance carrier pays for all authorized treatment.

7.27. Emergency Medi-Cal Enrollment



7.28. Medi-Cal Presumptive Eligibility (PE) Enrollment



Medi-Cal Presumptive Eligibility (PE) Enrollment Notes

Based on Current Medi-Cal Policy

Introduction
The Presumptive Eligibility (PE) program allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for immediate, temporary ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application. The PE program is designed for California residents who believe they are pregnant and who do not have health insurance or Medi-Cal coverage for prenatal care.

This flow documents the current Presumptive Eligibility enrollment process in Medi-Cal given an uninsured pregnant woman or pregnant woman with a high plan deductible is eligible for the program.

Eligibility
Any woman who thinks she is pregnant and whose family income is under a certain amount is eligible for Presumptive Eligibility (PE) for Pregnant Women. However, she must seek this care through a participating provider and they will determine if you are eligible for this program. Ask the provider if he/she offers this coverage and how to apply.

Enrollment
To find a PE qualified provider that will enroll eligible persons in the PE program, ask the provider or the perinatal coordinator at the county health department for a list of PE providers in your area. Then contact the PE provider for an appointment to be enrolled in PE.

First Perinatal Appointment
The PE provider will ask the patient to complete a Statement of California Residency and then a "Presumptive Eligibility for Pregnancy Only" application. If the patient is determined eligible for PE, the provider will then complete the patient's pregnancy test. If your pregnancy test is negative, the patient will not be eligible for PE. If your test is positive, the patient will be issued a temporary Medi-Cal card (paper) for PE only (up to 2 months). This card IS NOT A MEDI-CAL CARD. It is only for specific PE services. The provider will complete the patient's examination and then schedule the patient for the next appointment.

After the First Appointment
PE patient must formally apply for Medi-Cal at the County Department of Social Services and provide proof of application to the PE provider before the expiration date on the temporary Medi-Cal card (paper). The PE provider will then extend the temporary Medi-Cal card for up to 2 months. The county will determine if the patient is eligible to receive Medi-Cal. If the patient is determined to be eligible for Medi-Cal the patient will be mailed a Medi-Cal Beneficiary Identification Card.

Receipt of Medi-Cal Card
Patient should notify her PE provider/Medi-Cal provider that the patient now has Medi-Cal. Stop using the temporary Medi-Cal Card (paper) and begin using the new Medi-Cal card.

Legislation
Social Security Administration. Title XIX SEC. 1920. [42 USC. Section 1396r-1] (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

Assembly Bill 2307 was passed on September 10, 2004 which, effective July 1, 2005, allows Primary Care Clinics to simultaneously apply to be a Qualified PE provider while applying to become a Medi-Cal provider.

Coverage
- Ambulatory (walk-in) prenatal care
- Limited family planning services
- Prescription drugs for conditions related to pregnancy.
- Does not cover emergency care
- Does not cover labor and delivery
- Does not cover inpatient care

Sources
(1) Medi-Cal Presumptive Eligibility Program
http://www.dhs.ca.gov/mcs/mcpd/meb/PresumptiveEligibility/
(2) Medi-Cal Presumptive Eligibility Program - Document and Sample Application
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/presum_m00o03p00.doc
(3) Medi-Cal Presumptive Eligibility Program - Information for Providers
http://www.dhs.ca.gov/mcs/mcpd/meb/PresumptiveEligibility/PE_Info/Info_Qual_provider.htm
(4) Medi-Cal Presumptive Eligibility Program - Information for Women Interested in Presumptive Eligibility (PE) for Pregnant Women
http://www.dhs.ca.gov/mcs/mcpd/meb/PresumptiveEligibility/PE_Info/Info_women.htm
(5) Medi-Cal Presumptive Eligibility Program - Qualified Provider Application
http://files.medi-cal.ca.gov/pubsdoco/Docframe.asp?wURL=/pubsdoco/publications/masters-MTP/part2/presumhqprvapp_m00o03p00.doc

7.29. Presumptive Eligibility Sample Application Form

State of California – Health and Human Services Agency — Department of Health Services

APPLICATION FOR PRESUMPTIVE ELIGIBILITY ONLY

Before completing this application, read the directions. If you need help completing this form, please ask your provider for assistance.

SECTION A. APPLICANT INFORMATION

Please list your Social Security number here, if you have one: _____ _____ _____

Home Address:	Number	Street	City	ZIP Code
Mailing Address (if different):	Number	Street	City	ZIP Code
Telephone Number(s):	Home	Work	Message	

If no permanent address, tell us where you can be reached:

SECTION B. HOUSEHOLD/INCOME INFORMATION

1. Please list in COLUMN I all family members (spouse, children, parents, siblings) living in your household, their relationship to you and their date of birth.
2. Has anyone ever asked for or gotten aid anywhere? ☐ YES ☐ NO
   If YES, explain: under what name, where, when and type(s) of aid.
3. If you or any family member in your household receive earned or unearned income, (include income from employment), self-employment, tips, commissions, pensions, Social Security, child/spousal support, gifts, disability, VA or unemployment benefits, etc.), list the total amount in COLUMN II under Gross Monthly Income, and where you got the money from under Source.

Column I			Column II	
Name: Last, First, Middle Initial	**Relationship**	**Date of Birth**	**Gross Monthly Income**	**Source**
	SELF			
	UNBORN			

If you need more space to answer, please write on the back of this sheet of paper and check this box. ☐

I CERTIFY I HAVE READ AND UNDERSTAND THIS FORM. I DECLARE THAT THE INFORMATION I HAVE PROVIDED IS TRUE, CORRECT, AND COMPLETE.

Signature or Mark of Applicant (or legal guardian)	Date
Signature of Witness to Mark of Applicant (or legal guardian)	Date

STOP!! *THIS COMPLETES YOUR APPLICATION FOR PRESUMPTIVE ELIGIBILITY* ***STOP !!***

FOR PROVIDER USE ONLY

Total Family Income: _____ *Number in Family:* _____ *Income Eligible:* ☐ Yes ☐ No

Annie Nomous, CNM
10 Somother Place
Anytown, CA 99999

MEDI-CAL ID: 59-7G-ZA00000-8-23
FIRST GOOD THRU:
PATIENT NAME:
DOB (MM/DD/YYYY):

PE Provider Signature: _____ Pregnancy Test Results? ☐ Positive ☐ Negative
PE Provider Title: _____ Date: _____ E.D.C.:_____

MC 263 PREMED 1 (4/96) (REQUIRED FORM - NO SUBSTITUTIONS PERMITTED) TOLL FREE NUMBER: 1 (800) 824-0088, FAX NUMBER: 1 (800) 409-1498

7.30. Qualified Provider for Presumptive Eligibility Participation Sample Application Form

This is an application to become a Qualified Provider for Presumptive Eligibility participation for the purposes of offering Presumptive Eligibility (temporary Medi-Cal) to your pregnant patients. ***You must provide prenatal services to qualify for Presumptive Eligibility participation.*** Please complete, sign, and return this application to the Presumptive Eligibility Support Unit.

If you have questions about this application or the Presumptive Eligibility (PE) for pregnant women program, contact the PE Support Unit at: 1-800-824-0088. For general information about Presumptive Eligibility (PE) for pregnant women, visit the web site at www.medi-cal.ca.gov.

FOR OFFICIAL USE ONLY

Date Received: _____

PE Number: _____

Authorization Code:

PART I

***Check only one*:**

☐ **PRIMARY CARE CLINIC THAT IS NOT YET A MEDI-CAL PROVIDER:** AB 2307 (Chapter 1, Statutes of 2004 [effective July 1, 2005]) allows Primary Care Clinics to apply for Presumptive Eligibility participation while waiting to be determined as a Medi-Cal provider. No Medi-Cal provider number is needed at the time of this application, or

☐ **MEDI-CAL PROVIDER:** When applying you must include your Medi-Cal provider number here:

_____

***NOTE*:** This number must match the site applying for PE participation. The provider at this site must be a provider in good standing. If you do not have a Medi-Cal provider number, contact the California Department of Health Services Provider Enrollment Unit at 1-916-323-1945.

PART II

1. Name of provider

Other name (if any used for provider services) | 2. County

Telephone number ( ) | FAX number ( )

3. Mailing address (no P.O. Box) for Site | City | ZIP Code

4. Contact person

Telephone number ( ) | FAX number ( )

5. Please estimate the number of pregnant patients your practice sees each month that are not covered by health insurance or Medi-Cal at the time of their initial pregnancy visit. | Of this number, how many do you expect will need Spanish language forms?

PART III

1. Do you participate in the Comprehensive Perinatal Services Program (CPSP)? ☐ Yes ☐ No

   NOTE: If you are not currently a CPSP provider, you may get information on how to enroll by contacting the California Department of Health Services, Maternal and Child Health Branch at (916) 650-0401.

2. Do you participate in the Family PACT (Planning, Access, Care, and Treatment) Program? ☐ Yes ☐ No

   NOTE: If you are not currently a Family P.A.C.T. provider, you may get information on how to enroll by contacting the California Department of Health Services at (800) 541-5555.

PART IV

CERTIFICATION

I hereby certify that all the above information is true and accurate to the best of my knowledge.

Signature | Title of Authorized Agent | Date

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government Code, Section 6250, et seq.

If you have questions about becoming a qualified provider for the PE pregnant women program, please contact the (PE) Support Unit at 1-800-824-0088.

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PRESUMPTIVE ELIGIBILITY
QUALIFIED PROVIDER RESPONSIBILITIES AND AGREEMENT

I understand that my responsibilities as a Qualified Provider include:

- Offering the Presumptive Eligibility (PE) program to my pregnant patients without health coverage or Medi-Cal;
- Screening interested patients for income eligibility via the prescribed PE forms and guidelines;
- Issuing eligible applicants a PE card and the one-page Medi-Cal application form, issuing replacement cards to recipients upon request;
- Renewing the PE card when the woman presents a copy of her timely application for Medi-Cal or California Work Opportunity and Responsibility to Kids (CalWORKs);
- Informing the pregnant patient at the time of the PE determination that she must file her Medi-Cal (or CalWORKs) application at her local county welfare office within a specified period of time in order for her PE to continue;
- Assisting the pregnant patient in completing her one-page Medi-Cal application if needed;
- Providing a written statement to the applicant if she is ineligible for PE, and informing her that she may still file for Medi-Cal (or CalWORKs) at the county welfare department;
- Notifying the California Department of Health Services within five working days with the required information on those patients eligible for Presumptive Eligibility and those not eligible due to a negative pregnancy test;
- Maintaining organized records of PE applications for three years from the last date of billing, making these records available to the California Department of Health Services upon request, and permitting periodic Department review of the records with adequate notice from the Department;
- Attending PE training and keeping current with changes affecting PE through provider bulletins, notices and/or further training.

I, (print name) _____, agree to cooperate with the California Department of Health Services in complying with the above Qualified Provider responsibilities. I am aware that if I do not comply with these responsibilities and the PE guidelines as outlined in the Medi-Cal Provider Manual, I may lose my status as a Qualified Provider. I agree to notify the California Department of Health Services in writing of any changes in my application information at least 10 days prior to the effective date of the change.

_____	_____	_____
Signature	Title of Authorized Agent	Date

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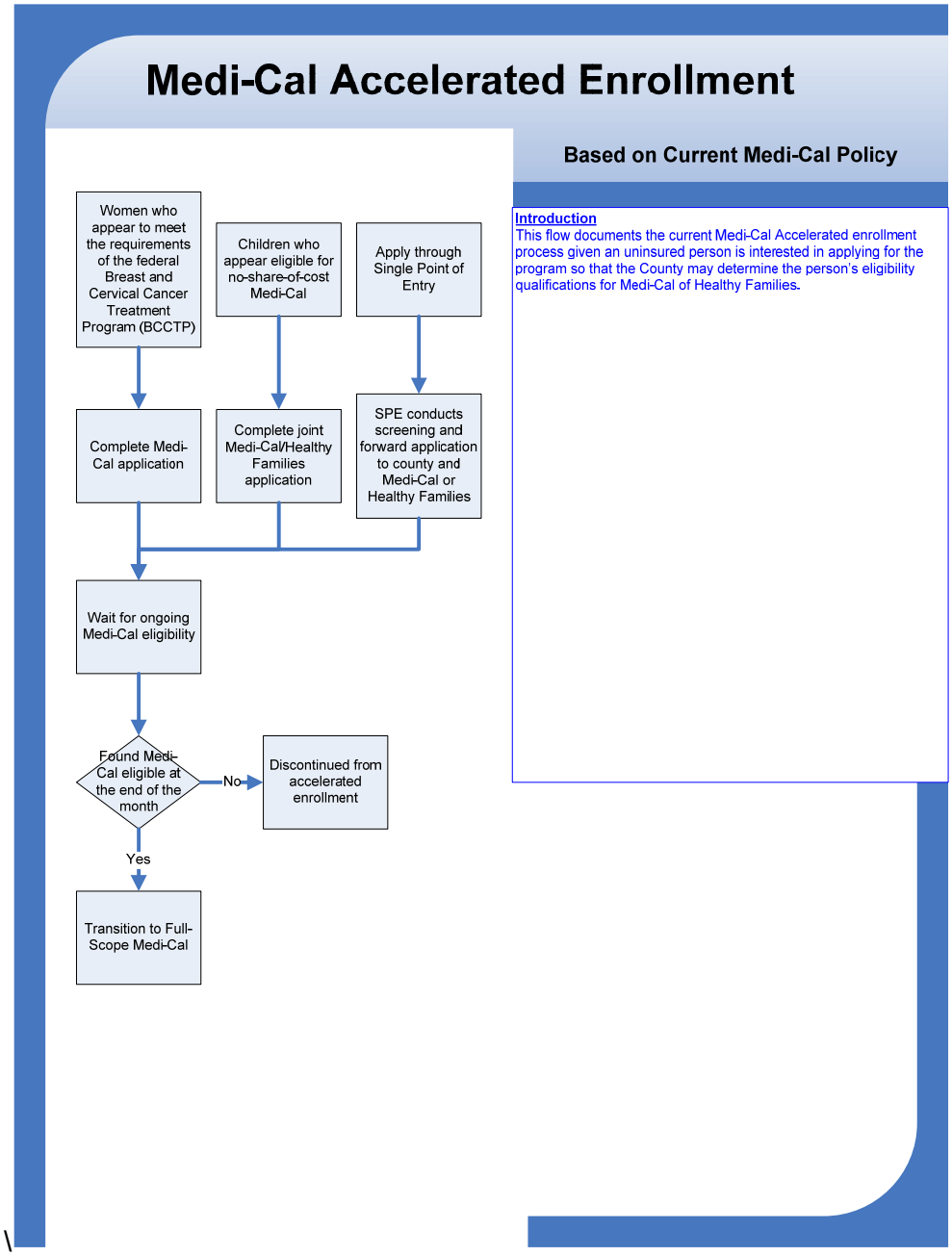
7.31. Medi-Cal Accelerated Enrollment



7.32. Additional Reimbursement Mechanisms

The following funding programs reimburse providers and facilities for emergency medical training, trauma related supplies and equipment, or for medical costs that would otherwise go uncompensated. The former two purposes may serve to prepare personnel for medical surges or to cope with the effects of a surge in demand for medical services. The latter supports the safety net program.

These funds are streamlined in normal day-to-day provider operations. Identified program grants are renewed annually and have a set amount designated to certain providers. The funding amount may not change under a disaster medical surge, however, the services will be available and the same eligibility and benefit rules for these programs will also apply during a medical surge. This information is current as of April 2007.

California Healthcare for Indigents Program (CHIP)

The California Healthcare for Indigents Program is sponsored by the California Department of Public Health and operated through the Office of County Health Services, with 26 participating large counties. California counties receive State allocated funds from Proposition 99 Tobacco Tax. Local counties disburse the annual funds to local hospitals and providers for uncompensated care rendered on the indigent and uninsured.[2]

California Rural Health Services

The Rural Health Services program is sponsored by the California Department of Public Health and operated through the Office of County Health Services, with 32 participating rural counties. California counties receive State allocated funds from Proposition 99 Tobacco Tax. Local counties disburse annual funds to local hospitals and providers for uncompensated care rendered for the indigent and uninsured.[3]

Emergency Medical Services Appropriation Contract Back Program

The Emergency Medical Services Appropriation Contract Back program is sponsored by the California Department of Public Health and operated through the Office of County Health Services, with 23 participating rural counties. California counties receive State allocated funds from Proposition 99 Tobacco Tax. Under the Emergency Medical Services Appropriation's Contract Back relationships, California's Office of County Health Services directly reimburses the counties' "Medi-Cal physicians for uncompensated emergency services provided to medically indigent persons".[4] Professional "claims may be initially reimbursed for up to 50% of the claimed amount and at the end of the year, may be reimbursed up to 100% of the claimed amount".[5] The latter reimbursement that makes up for the entire claim is contingent on available funds at the end of the fiscal year.[6] Reimbursement rates follow Medi-Cal's fee schedule.[7]

California Medical Services Program (County Medical Services Program)

County Medical Services Program is sponsored by the California Department of Public Health and serves over 40,000 indigent adults residing in 34 participating small and rural counties. Counties with less than 300,000 residents participate in County Medical Services Program. Otherwise counties participate in Medically Indigent Services Program. County Medical Services Program's mission is "to assist participating counties in meeting their

indigent healthcare responsibilities by partnering with these counties to deliver cost-effective, high quality healthcare services to County Medical Services Program members."[8] This program provides temporary medical, dental, vision, and/or prescription drug coverage as a provider of last resort for health services to low-income uninsured people with no other source of care."[9] Every county imposes different eligibility rules, but all local programs have at least the following eligibility requirements[10]:

- Family income is below 200% of the Federal poverty level
- During months of service, person's liquid assets are limited to $2,000 for a single person, $3,000 for two, and $3,150 for three (1 car, 1 home, and personal effects are exempt)
- Person is a county resident
- Person is 21-64 years of age
- Person seeks services that do not require medical necessity

Maddy Emergency Medical Services Appropriation for Physician Reimbursement

The Maddy funds are raised from California traffic funds and are used to reimburse physicians, surgeons and hospitals for emergency medical services provided to patients who are unable to pay for those services. Payments are distributed based on the following allocations:[11,12]

- 58% of the funds are reserved for reimbursements to (trauma) physicians "that render services to patients who do not make payment for emergency medical services". "This is provided to all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized".
- 22% of the funds are reserved for hospitals "providing disproportionate trauma and emergency medical care services".
- 17% of the funds are reserved to reimburse "other emergency medical services, as determined by each county, including, but not limited to, the funding of regional poison control centers". "Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services".
- 15% of the funds are reserved for reimbursement to "physicians and surgeons for all pediatric trauma centers, hospitals for pediatric trauma patients who do not make payment for emergency care services up to the point of stabilization, or, hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment throughout the county". "Local emergency medical services agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures". "Counties that do not maintain a pediatric trauma center will invest the money to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children".
- Up to 10% can be set aside for administrative costs.

Los Angeles County uses the Maddy funds for its Physician Services for Indigents Program and Trauma Physician Services for Indigents Program.[13]

Medically Indigent Services Program

As the provider of last resort for health services to low-income uninsured people with no other source of care," the Medically Indigent Services Program helps cover healthcare expenses for the 24 participating counties' indigent population.[14] Similar to County Medical Services Program, eligibility, enrollment, and coverage are unique to each county. Counties with more than 300,000 residents participate in Medically Indigent Services Program. Smaller counties participate in County Medical Services Program.

Transfer of Federal Trust Fund to the Emergency Medical Services Authority

The transfer of Federal Trust Funds to Emergency Medical Services Authority in the form of grants allows eligible states and local agencies to defray the cost of providing "paramedic training for fire services personnel, including, but not limited to, instructional supplies and trainee compensation expenses".[15] In order to be eligible for a grant, a state or local agency shall demonstrate a need for additional paramedics and all appropriated moneys is allocated to the California Fire Fighter Joint Apprenticeship Program to:

- "Offset the cost of paramedic training course development
- Enter into reimbursement contracts with eligible state and local agencies that in turn may contract with educational institutions for the delivery of paramedic training
- Allocate funds, in the form of grants, to eligible state and local agencies to defray the cost of providing paramedic training for fire services personnel, including, but not limited to, instructional supplies and trainee compensation expenses
- The extent permitted by federal law, the authority shall recover its transfer costs for administration."[16]

Trauma Care Fund

The California State Treasury allocates $20 million in Trauma Care Funds to local Emergency Medical Services agencies, for distribution to local Emergency Medical Services agency-designated trauma centers. Grant proposals should demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. These funds serve to:

- "Preserve or restore specialty physicians and surgeons on call that are demonstrated to be essential for trauma services within a specified hospital
- Acquire equipment that is demonstrated to be essential for trauma services within a specified hospital
- Plan and train for overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster
- Coordinate payment of emergency, non emergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay."[17]

Health Facilities Financing Authority Act

The California Health Facilities Financing Authority "issues revenue bonds to assist qualified private nonprofit corporations or associations, counties, and hospital districts in

financing or refinancing the construction, equipping or acquiring of health facilities".[18] "Qualified health facilities must demonstrate the financial feasibility of their projects".[19]

Social Services Block Grant

The Social Services Block Grant is used towards funding social services, behavioral health programs, and healthcare needs of the population. During Hurricane Katrina and Rita, Social Services Block Grant assisted those lacking health insurance or other adequate access to care to seek care and healthcare "safety net" providers to restore and resume their operations. Post-disaster relief projects include:[20,21,22,23]

- "Restoration and expansion of mental health services, substance abuse treatment and prevention services, and developmental disability services"
- "Restoration and development of comprehensive and integrated primary, preventive, and behavioral healthcare services, with an emphasis on restoring safety net services for the uninsured and underinsured"
- "Restoration of the healthcare work force"

"Diagnostic and detection equipment, lab equipment, and other medical supplies or devices purchase that may reduce high emergency room costs and improve health outcomes"

Endnotes

[1] United States Department of Homeland Security Federal Emergency Management Authority Disaster Assistance Policy DAP9523.17. Emergency Assistance for Human Influenza Pandemic. 2007 Mar 31.
[2] California Department of Health Services. California Office of County Health Services. California Healthcare for Indigents Program and Rural Health Services Program. http://www.dhs.ca.gov/hisp/ochs/chsu/CHIP/default.htm. Accessed 15 May 2007.
[3] Ibid.
[4] California Department of Health Services. California Office of County Health Services. Contract Back Program. http://www.dhs.ca.gov/hisp/ochs/CB/default.htm. Accessed 15 May 2007.
[5] Ibid.
[6] Ibid.
[7] California Department of Health Services. California Office of County Health Services. Contract Back Program. Letter to Providers Participating in EMSA Contract Back Program in re: EMSA Single Fee Schedule Revised Payment Periods. http://www.dhs.ca.gov/hisp/ochs/CB/letters/EMSACBLetter.doc. Accessed 15 May 2007.
[8] County Medical Services Program. Mission Statement. http://www.County Medical Services Programcounties.org/about/participating_counties.html. Accessed 15 May 2007.
[9] Ibid.
[10] California HealthCare Foundation. County Programs for the Medically Indigent Overview. http://www.chcf.org/documents/policy/CountyPrgrmsMedicallyIndigentCounty Medical Services Program.pdf. Accessed 15 May 2007.
[11] California Health and Safety Code Section 1797.115. http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=61406111203+3+0+0&WAISaction=retrieve Accessed 15 May 2007.
[12] Maddy Emergency Services Fund Physician Reimbursement Guidelines. http://www.acphd.org/AXBYCZ/Admin/Forms/sb%2012%20physician%20guidelines%2012-31-05.pdf Accessed 15 May 2007.
[13] Los Angeles Emergency Medical Services Reimbursement Programs Homepage. http://ladhs.org/ems/REIMBURSEMENT/PhysicianServices.htm. Accessed 15 May 2007.
[14] California HealthCare Foundation County Programs for the Medically Indigent in California Homepage. http://www.chcf.org/topics/view.cfm?itemID=123106. Accessed 10 May 2007.
[15] Health and Safety Code Section 1797.115. http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=61271929660+1+0+0&WAISaction=retrieve. Accessed 10 May 2007.
[16] Ibid.
[17] Assembly Bill 430 & Assembly Bill 425 as adopted in Health and Safety Code Section 1797.198-1797.199. http://www.emsa.ca.gov/emsdivision/ab430_text.asp. Accessed 10 May 2007.
[18] Government Code Section 15438.5. http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=6179837630+0+0+0&WAISaction=retrieve. Accessed 15 May 2007.
[19] Ibid.
[20] Social Services Block Grant White House Homepage. http://www.whitehouse.gov/omb/expectmore/summary/10003503.2005.html. Accessed 15 May 2007.
[21] Louisiana Recovery Association Social Services Block Grant Recommendation (June 15, 2006). http://www.lra.louisiana.gov/assets/junemeeting/SSBGreallocationresolution61506.pdf. Accessed 15 May 2007.
[22] Louisiana Recovery Association Social Services Block Grant Recommendation Resolution (February 15, 2006). http://www.lra.louisiana.gov/assets/SSBG%20resolution%20&%20supporting%20docs.doc. Accessed 15 May 2007.
[23] Social Services Block Grant Administration for Children and Families Appropriation Language. http://www.acf.dhhs.gov/programs/olab/budget/2006/2006_dod_appro_lang_109_148.pdf. Accessed 15 May 2007.

8. Funding Sources Eligibility, Benefits and Application Procedures

The funding sources matrix that begins on the next page is designed to be a reference guide for the healthcare community to identify sources of funding that may be used to meet the financial needs of planning and responding to a healthcare surge. It is included as a tool to highlight available funds and their prescribed uses. This list of funding sources provides available grants that facilities or individuals may apply for to plan and prepare for a disaster, to cope with a disaster or to deal with the disaster of an aftermath. The majority of these funds are federal government appropriations enabled by specific congressional legislation. Information on this matrix includes specific rules and guidelines on how agencies or individuals may qualify, apply and receive funds to cover defined benefits. These programs and grants are not a form of temporary or permanent source of healthcare coverage. Most funds cover eligible services such as property casualty and some cover medical services that is outside the direct provision of care. The amount and existence of funds is subject to federal fiscal year budget appropriation.

Program	Sponsor	Funding Timeline			Funding For						Application Resource Allocation	
		Pre-Disaster	Disaster	After-math	Facility/ Property	Medical Services	Planning	Staffing	Training	Supply & Equipment		
Bioterrorism Training and Curriculum Development Program (BTCDP)	Health and Human Services, Assistant Secretary for Preparedness and Response	X							X		**Complex**	Eligibility limited to previous fiscal year's awardees; long application
Hospital Preparedness Program (HPP)	Health and Human Services, Assistant Secretary for Preparedness and Response	X					X	X	X	X	**Moderate**	Requires narrative responses
Disaster Assistance for State Units on Aging (SUAs) and Tribal Organizations in National Disasters Declared by the President	U.S. Department of Health and Human Services (HHS) Administration on Aging (AoA)		X			X		X		X	**Moderate**	Lengthy application, involvement with grant staff
Commercial Equipment Direct Assistance Program (CEDAP)	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X								X	**Moderate**	
Competitive Training Grant Program (CTGP)	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X							X			
Emergency Assistance for Human Influenza Pandemic	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)		X		X, ACF	X		X		X	**Moderate**	Requires pandemic occurrence
Flood Mitigation Assistance (FMA) program	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)											
Hazard Mitigation Grant Program (HMGP)	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)		X		X						**Complex**	Requires state to collect and prioritize applicant projects

Program	Sponsor	Funding Timeline			Funding For						Application Resource Allocation	
		Pre-Disaster	Disaster	After-math	Facility/ Property	Medical Services	Planning	Staffing	Training	Supply & Equipment		
Pre-Disaster Mitigation (PDM) Program	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X			X		X				**Complex**	Collect sub-applicants under a single applicant, requires benefit-cost analysis
Public Assistance Grant Program	Department of Homeland Security Federal Emergency Management Agency (FEMA)											
State Homeland Security Program (SHSP)	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X					X		X	X	**Moderate**	
Superfund Amendments and Reauthorization Act (SARA), Title III	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X							X		**Simple**	
Urban Areas Security Initiative (UASI) Program	U.S. Department of Homeland Security Federal Emergency Management Agency (FEMA)	X	X	X			X		X	X	**Moderate**	
Emergency Management Performance Grants (EMPG)	U.S. Department of Homeland Security Office of Grants & Training	X						X	X	X	**Complex**	Extensive follow-up and evaluation
Economic Injury Disaster Loans for Small Businesses	U.S. Small Business Association (SBA)		X		X						**Simple**	

Program	Sponsor	Funding Timeline			Funding For						Application Resource Allocation	
		Pre-Disaster	Disaster	After-math	Facility/ Property	Medical Services	Planning	Staffing	Training	Supply & Equipment		
Pre-Disaster Mitigation Loan Program	United States Small Business Association (SBA)	X			X						**Moderate**	Requires project narrative, must conform to mitigation plans defined by FEMA
VHA Disaster Relief Program	VHA Health Foundation		X					X			**Simple**	
VHA Innovations in Hospital Emergency Preparedness	VHA Health Foundation	X					X				**Moderate**	Need to submit letter of inquiry then be invited to apply

9. Full Text of Social Security Act, Section 1135 Waiver

Under 42 U.S.C. Section 1320b-5 (section 1135 of the Social Security Act), the Secretary of Health and Human Services has the authority to waive certain requirements of Centers for Medicare and Medicaid Services programs in an emergency area during an emergency period.[1] These waivers are known as Section 1135 waivers. The Section 1135 waiver is designed to address the existing rules and requirements that may limit access to healthcare and impose financial barriers for providers during a healthcare surge. Context for how these waivers might be used during a healthcare surge can be found in Volume I: Hospitals, Section 12.1.3: Hospitals and Public Payers. The complete text of the Section 1135 waiver from 42 U.S.C. Section 1320b-5 is provided below.

AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES[2]

SEC. 1135. *[42 U.S.C. 1320b-5]* (a) PURPOSE.—The purpose of this section is to enable the Secretary to ensure to the maximum extent feasible, in any emergency area and during an emergency period (as defined in subsection (g)(1))—

(1) that sufficient healthcare items and services are available to meet the needs of individuals in such area enrolled in the programs under titles XVIII, XIX, and XXI; and

(2) that healthcare providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.

(b) SECRETARIAL AUTHORITY.—To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to healthcare items and services furnished by a healthcare provider (or classes of healthcare providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—

(1)(A) conditions of participation or other certification requirements for an individual healthcare provider or types of providers,

(B) program participation and similar requirements for an individual healthcare provider or types of providers, and

(C) pre-approval requirements;

(2) requirements that physicians and other healthcare professionals be licensed in the

State in which they provide such services, if they have equivalent licensing in another State and are not affirmatively excluded from practice in that State or in any State a part of which is included in the emergency area;

(3) actions under section 1867 (relating to examination and treatment for emergency medical conditions and women in labor) for—

(A) a transfer of an individual who has not been stabilized in violation of subsection (c) of such section if the transfer arises out of the circumstances of the emergency;

(B) [74] the direction or relocation of an individual to receive medical screening in an alternative location—

(i) pursuant to an appropriate State emergency preparedness plan; or

(ii) in the case of a public health emergency described in subsection (g)(1)(B) that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan or a plan referred to in clause (i), whichever is applicable in the State;

(4) sanctions under section 1877(g) (relating to limitations on physician referral);

(5) deadlines and timetables for performance of required activities, except that such deadlines and timetables may only be modified, not waived; [75]

(6) limitations on payments under section 1851(i) for healthcare items and services furnished to individuals enrolled in a Medicare+Choice plan by healthcare professionals or facilities not included under such plan; and[76]

(7) [77]sanctions and penalties that arise from the noncompliance with the following requirements (as promulgated under the authority of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d-2 note)—

(A) section 164.510 of title 45, Code of Federal Regulations, relating to—

(i) requirements to obtain a patient's agreement to speak with family members or friends; and

(ii) the requirement to honor a request to opt out of the facility directory;

(B) section 164.520 of such title, relating to the requirement to distribute a notice; or

(C) section 164.522 of such title, relating to—

(i) the patient's right to request privacy restrictions; and

(ii) the patient's right to request confidential communications.

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a Medicare+Choice plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of title XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to[78] a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider.[79] If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.[80]

(c) AUTHORITY FOR RETROACTIVE WAIVER.—A waiver or modification of requirements pursuant to this section may, at the Secretary's discretion, be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary.

(d) CERTIFICATION TO CONGRESS.—The Secretary shall provide a certification and advance written notice to the Congress at least two days before exercising the authority under this section with respect to an emergency area. Such a certification and notice shall include—

(1) a description of—

(A) the specific provisions that will be waived or modified;

(B) the healthcare providers to whom the waiver or modification will apply;

(C) the geographic area in which the waiver or modification will apply; and

(D) the period of time for which the waiver or modification will be in effect; and

(2) a certification that the waiver or modification is necessary to carry out the purpose specified in subsection (a).

(e) DURATION OF WAIVER.—

(1) IN GENERAL.—A waiver or modification of requirements pursuant to this section

terminates upon—

(A) the termination of the applicable declaration of emergency or disaster described in subsection (g)(1)(A);

(B) the termination of the applicable declaration of public health emergency described in subsection (g)(1)(B); or

(C) subject to paragraph (2), the termination of a period of 60 days from the date the waiver or modification is first published (or, if applicable, the date of extension of the waiver or modification under paragraph (2)).

(2) EXTENSION OF 60-DAY PERIODS.—The Secretary may, by notice, provide for an extension of a 60-day period described in paragraph (1)(C) (or an additional period provided under this paragraph) for additional period or periods (not to exceed, except as subsequently provided under this paragraph, 60 days each), but any such extension shall not affect or prevent the termination of a waiver or modification under subparagraph (A) or (B) of paragraph (1).

(f) REPORT TO CONGRESS.—Within one year after the end of the emergency period in an emergency area in which the Secretary exercised the authority provided under this section, the Secretary shall report to the Congress regarding the approaches used to accomplish the purposes described in subsection (a), including an evaluation of such approaches and recommendations for improved approaches should the need for such emergency authority arise in the future.

(g) DEFINITIONS.—For purposes of this section:

(1) EMERGENCY AREA; EMERGENCY PERIOD.—An “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exists—

(A) an emergency or disaster declared by the President pursuant to the National Emergencies Act[81] or the Robert T. Stafford Disaster Relief and Emergency Assistance Act[82]; and

(B) a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.

(2) HEALTHCARE PROVIDER.—The term “healthcare provider” means any entity that furnishes healthcare items or services, and includes a hospital or other provider of services, a physician or other healthcare practitioner or professional, a healthcare facility, or a supplier of healthcare items or services.

[74] P.L. 109-417, §302(b)(1)(A), amended subparagraph (B) in its entirety, effective December 12, 2006, and applicable to public health emergencies declared pursuant to section 319 of the Public Health Service Act (42 U.S.C. 247d) on or after such date.

For subparagraph (B) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 109-417.

[75] P.L. 108-276, §9(2), struck out "and".

[76] P.L. 108-276, §9(3), struck out the period and substituted a semicolon and "and".

[77] P.L. 108-276, §9(4), added paragraph (7), effective July 21, 2004.

[78] P.L. 109-417, §302(b)(1)(B), struck out "and shall be limited to" and substituted "and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to", effective December 19, 2006, and applicable to public health emergencies declared pursuant to section 319 of the Public Health Service Act (42 U.S.C. 247d) on or after such date.

[79] P.L. 108-276, §9(5), added this sentence, effective July 21, 2004.

[80] P.L. 109-417, §302(b)(1)(C), added this sentence, effective December 19, 2006, and applicable to public health emergencies declared pursuant to section 319 of the Public Health Service Act (42 U.S.C. 247d) on or after such date.

[81] P.L. 94-412.

[82] P.L. 93-288.

[1] MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
[2] 42 USC Section 1320b-5

10. Funding Sources – Lessons Learned from Louisiana

While every emergency is unique and situational, there are lessons that can be learned from past emergencies. The funding responses to Hurricane Katrina demonstrate what new federal appropriations were deployed and how the public and private payers responded to the emergency. Medicare, Medicaid and private payers all reduced or eliminated administrative barriers that could have precluded the efficient flow of money through the system, recognizing that certain rules, requirements and processes could not be feasibly addressed following the hurricane. These lessons highlight for California the kinds of response that may be possible. Understanding what occurred before allows for healthcare leaders, healthcare professionals and policy makers to develop additional ideas for how a similar emergency might be responded to in California. This section presents a historical overview of the kinds of funding resources that were deployed following the devastation of Hurricane Katrina, as well as the ways in which the public and private sectors utilized the opportunities for waivers and declarations to address the needs of the healthcare system following significant emergencies.

10.1. Examples of Funding Available during Katrina

The events in the Gulf Coast in 2005 following Hurricane Katrina and Hurricane Rita prompted a significant financial response from around the country. Special federal funding outside of normal program appropriations and channels was made available for the first time. This section highlights those funds, where they came from and what they were used for. For any future disaster, there is no obligation or guarantee that these funds would be made available for the same or similar purpose.

More than $2.8 billion was made available by the U.S. Department of Health and Human Services for Katrina-related healthcare needs. This included:

- $2 billion in federal payments from the Deficit Reduction Act to eligible States for healthcare assistance
- $70 million from a Federal Emergency Management Agency interagency agreement funding National Disaster Medical System treatment and uncompensated care pools
- $550 million in supplemental funds from a Social Services block grant to aid in relief efforts
- $90 million from a hurricane-related Head Start appropriation for replacing and repairing damaged or destroyed facilities and serving evacuee children
- $104 million from emergency Temporary Assistance for Needy Families to hurricane-damaged states and to provide “short-term, non-recurrent cash benefits for families traveled to another State”[1]

Congress’ hindsight and lessons learned from Katrina may contribute to future changes in Federal Emergency Management Agency’s policies and approach in providing medical aid and funding which may result in different funding outcomes for future disasters that require a surge in the demand for medical services. Likewise, although certain Federal Emergency Management Agency funds were included for Louisiana’s recovery, they are not

guaranteed for any emergency that might present in California. Experiences from Katrina should not preclude California from considering other sources of medical aid and funding.

10.2. Uncompensated Care Fund

An uncompensated care pool was developed by Centers for Medicare and Medicaid Services to provide States with a mechanism to reimburse providers that incurred costs that were not otherwise compensated. Eligible costs were incurred for providing medically necessary services and supplies for Katrina evacuees.[2] Beyond the basic disaster relief assistance legislated by the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Federal Emergency Management Agency entered a non-obligatory agreement with the Louisiana State government to fund a $70 million interagency uncompensated care pool. Funds were disbursed to the State Center of Medicaid and Medicare programs contingent upon the expansion of Medicaid eligibility through the 1115 waiver. Eligibility for Medicaid and Medicare was relaxed through increased income limits and self-attestation during a limited and temporary coverage period. Certification for providers involved expedited certification as long as the provider could prove a valid U.S. medical license in good standing. Funds covered medical care rendered by certified Medicaid and Medicare physicians. For more information on the uncompensated care pools during and following Hurricane Katrina see Section 11.5: Summary of Previously Issued Waivers and Declarations, specifically the Section 1115 Demonstration Waiver.

“On February 8, 2006, the President signed the Deficit Reduction Act of 2005 in which $2 billion in Federal funds was appropriated for Hurricane Katrina relief efforts, including the Hurricane Katrina demonstrations. Section 6201 provided authority for the provision of additional Federal payments to States under hurricane-related multi-State section 1115 demonstration projects as follows:

Section 6201(a)(1)(A) and (C). Provides funding for the non-Federal share of expenditures for healthcare provided to affected individuals (those who reside in a major disaster area declared as a result of Katrina and continue to reside in the same State) and evacuees (affected individuals who have been displaced to another State) under approved multi-state section 1115 demonstration projects (includes Medicaid, State Children's Health Insurance Program, and premium assistance)

- Section 6201(a)(1)(B) and (D). Provides funding for the total expenditures for uncompensated care pool costs for uninsured evacuees and uninsured affected individuals
- Section 6201(a)(2). Provides funding for the reasonable administrative costs related to such projects
- Section 6201(a)(3). Provides funding for the non-Federal share of expenditures for medical care provided to individuals under existing Medicaid and State Children's Heath Insurance Program plans
- Section 6201(a)(4). Provides funding for other purposes, if approved by the Secretary, to restore access to healthcare in impacted communities”[3]

10.3. Louisiana State Department of Corrections

Instead of assessing eligible costs at every corrections facility, the Department of Corrections healthcare system agreed to accept a flat rate per inmate serviced for emergency care and stabilization. This expedited Federal Emergency Management Agency funding to cover eligible services performed on inmates by utilizing existing prison healthcare providers.

10.4. Lessons Learned from Louisiana Medicaid

In response to the devastation from Hurricane Katrina, the Louisiana Medicaid system quickly made revisions to its policies and procedures to accommodate the needs of its patients in and around the Gulf Coast. This included developing overrides for their billing system to process claims without the prerequisite authorization and enrolling providers on an emergency basis. The following tool was used in providing this flexibility.

Claims Processing Disaster Planning Checklist[4]

To address some of the overrides necessary for the billing system, the Louisiana Medicaid Department developed the following checklist.

❑ Exempt new eligibles from:

❑ Dental Prior Authorization:

Combo edits ❑ Yes ❑ No
From:_____ To:_____

PA edits ❑ Yes ❑ No
From:_____ To:_____

❑ NEMT (Non-Emergency Medical Transport) Prior Authorization:

❑ Yes ❑ No
From:_____ To:_____

❑ Durable Medical Equipment Prior Authorization: ❑ Yes ❑ No
From:_____ To:_____

❑ Manually Priced ❑ Yes ❑ No
From:_____ To:_____

❑ Home Health Prior Authorization: ❑ Yes ❑ No
From:_____ To:_____

❑ PCS (Persons Care Services) Prior Authorization:

❑ Yes ❑ No
From:_____ To:_____

❑ HCBS (Home and Community Based Services) Prior Authorization:

❑ Yes ❑ No
From:_____ To:_____

❑ Case Mgmt Prior Authorization: ❑ Yes ❑ No
From:_____ To:_____

❑ Hospital Precert Prior Authorization: ❑ Yes ❑ No
From:_____ To:_____

❑ RX Prior Authorization: ❑ Yes ❑ No
From:_____ To:_____

Pharmacy
❑ Script Limit ❑ Yes ❑ No
From:_____ To:_____

❑ Bypass RX lock in
Edits for Medicaid Rec. ❑ Yes ❑ No
From:_____ To:_____

❑ Bypass Physician lock in
Edits for Medicaid Rec. ❑ Yes ❑ No
From:_____ To:_____

❑ Bypass RX lock in
Edits for evacuees ❑ Yes ❑ No
From:_____ To:_____

❑ Bypass Physician lock in
Edits for evacuees. ❑ Yes ❑ No
From:_____ To:_____

❑ Bypass 106 Edit for CC ❑ Yes ❑ No
From:_____ To:_____

❑ Suspend auto-assignments ❑ Yes ❑ No
From:_____ To:_____

❑ Suspend generation of identification
Cards for evacuees. ❑ Yes ❑ No
From:_____ To:_____

❑ Suspend generation of identification
Cards for Medicaid rec. in
Affected parishes ❑ Yes ❑ No
From:_____ To:_____

❑ Need New Explanation of Benefits? ❑ Yes ❑ No If yes, what are they for:_____

Emergency Provider Enrollment

The Louisiana Medicaid program developed an expedited process to enroll providers on an emergency basis and made modifications to its billing system to allow for overrides and issue payments to providers not previously enrolled in Louisiana Medicaid. This process was developed quickly in response to the devastation of Hurricane Katrina and included a shortened version of its normal process. This emergency provider enrollment process required a license number or Medicaid number from the provider's home state. Initially, providers were allowed to apply irrespective of whether they had seen displaced Louisiana Medicaid patients. As a result, Louisiana Medicaid received duplicate applications and submissions from providers just in case. In response, Louisiana Medicaid began requiring a copy of a claim form with all applications. Retrospective enrollments were allowed, and, in all, Louisiana Medicaid enrolled approximately 19,000 out-of-state providers. One recommendation that came out of Louisiana's emergency provider enrollment was to require a copy of the provider's license, not simply the license number.[5]

To facilitate the emergency provider enrollment, Louisiana Medicaid developed an enrollment packet.

10.5. Summary of Previously Issued Waivers and Declarations

Although each waiver and declaration is specific to a time and place, and previous issuance cannot be construed as a guarantee that the same waivers and declarations will be applied to a healthcare surge in California, understanding the historical practices can assist in planning efforts by serving as an example for the types of actions that can be taken to respond to a catastrophic emergency. This section summarizes in a table the waivers, declarations and emergency rules that have been used in previous emergencies, namely following Hurricane Katrina and the events of September 11, 2001, in New York. This section also includes a more detailed overview of these waivers, declarations and emergency rules and what specific administrative rule or requirement they addressed.

Waiver / Declaration	Issued By Whom / When	Rules / Requirements Addressed
Centers for Medicare or Medicaid Services: Medicare, Medicaid and State Children's Health Insurance Program		
Waiver under Section 1135 of the Social Security Act	Secretary of Health and Human Services, September 4, 2005 Following an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the Secretary of Health and Human Services.[6]	• Conditions of Participation • Pre-Approval Requirements • State Licensure Requirements • Out-of-Network Providers
Private Payers: Products Regulated by the Louisiana Department of Insurance		
Emergency Rules 15, 17, 19 and 20	Louisiana Commissioner of Insurance, September 20, 2005 Following the Governor's Declared State of Emergency and Executive Order granting a limited transfer of authority to the Commissioner.	• Medical Certifications • Referrals • Medical Necessity Reviews • Notification of Hospital Admissions • Right to Conduct Medical Necessity Reviews (for non-elective services) • Pharmaceutical Management • Claims Management • Co-payments, deductibles and coinsurance requirements • Non-payment of premiums and coverage continuity

Waiver / Declaration	Issued By Whom / When	Rules / Requirements Addressed
Medicaid		
Disaster Relief Emergency Medicaid Waiver Section 1115 Model Waiver	Secretary of Health and Human Services, September 16, 2005 Following the President's declared State of Emergency in Alabama, Louisiana, and Mississippi and the Secretary of the Department of Health and Human Services declared Public Health Emergency. [7]	• Simplified Eligibility Chart • 5 Months Temporary Eligibility • Simplified Application and Self-Attestation • Uncompensated Care Pool[8]
Disaster Relief Emergency Medicaid Waiver Section 1115 Model Waiver	Secretary of Health and Human Services, New York, September 2001[9]	• Simplified, expedited patient enrollment • Expanded eligibility guidelines

Section 1135 Waiver

In response to the devastation of Hurricane Katrina in and around the Gulf Coast in 2005, the Secretary of Health and Human Services utilized his authority under Section 1135(b) of the Social Security Act (42 USC Section 1320b-5) and waived the following regulations for Medicare, Medicaid and State Children's Health Insurance Program:

1. Certain conditions of participation, certification requirements, program participation or similar requirements, or pre-approval requirements for individual healthcare providers or types of healthcare providers, including as applicable, a hospital or other provider of services, a physician or other healthcare professional, a healthcare facility, or a supplier of healthcare items or services
2. The requirement that physicians and other healthcare professionals hold licenses in the State in which they provide services, if they have a license from another State (and are not affirmatively barred from practice in that State or any State in the emergency area)
3. Limitations on payments under Section 1851(i) of the Social Security Act to permit Medicare Advantage enrollees to use out-of-network providers in an emergency situation[10]

These waivers and modifications became effective September 6, 2005, but had retroactive effect to specific dates in Florida, Alabama, Louisiana, Mississippi and Texas. The waivers and modifications applied to the "geographic area covered by the President's declarations, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, on August 24, 2005 of a major disaster in Florida, on August 29, 2005 of major disasters in Alabama, Louisiana and Mississippi, and on September 2, 2005 of an emergency in Texas, all due to Hurricane Katrina."[11]

Centers for Medicare and Medicaid Services released a press release on September 6, 2005, explaining the ways in which it had responded to the needs of the healthcare system

affected by Hurricane Katrina. As documented in this press release, Centers for Medicare and Medicaid Services indicated that:

- “The normal burden of documentation will be waived and that the presumption of eligibility should be made.
- Healthcare providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricane Katrina, will be paid for services provided and will be exempt from sanctions for noncompliance, unless it is discovered that fraud or abuse occurred.
- Crisis services provided to Medicare and Medicaid patients who have been transferred to facilities not certified to participate in the programs will be paid.
- Programs will reimburse facilities for providing dialysis to patients with kidney failure in alternative settings.
- Medicare contractors may pay the costs of ambulance transfers of patients being evacuated from one healthcare facility to another.
- Normal prior authorization and out-of-network requirements will also be waived for enrollees of Medicare, Medicaid or State Children's Health Insurance Program managed care plans.
- Normal licensing requirements for doctors, nurses and other healthcare professionals who cross state lines to provide emergency care in stricken areas will be waived as long as the provider is licensed in their home state.
- Certain HIPAA privacy requirements will be waived so that healthcare providers can talk to family members about a patient’s condition even if that patient is unable to grant that permission to the provider.
- Hospitals and other facilities can be flexible in billing for beds that have been dedicated to other uses, for example, if a psychiatric unit bed is used for an acute care patient admitted during the crisis.
- Hospital emergency rooms will not be held liable under the Emergency Medical Treatment and Labor Act for transferring patients to other facilities for assessment, if the original facility is in the area where a public health emergency has been declared.”[12]

Section 1115 Demonstration Waiver: Disaster Relief Under Medicaid

Hurricane Katrina

“As a result of the Hurricane, the President of the United States declared a state of emergency in Alabama, Louisiana and Mississippi and the Secretary of the Department of Health and Human Services declared a Public Health Emergency. Secretary Michael Leavitt granted waivers of program requirements including waivers of title XIX and title XXI to the extent necessary to ensure that sufficient healthcare items and services were available to meet the needs of individuals enrolled in Medicaid and State Children's Health

Insurance Program. Centers for Medicare and Medicaid Services developed an expedited 1115 waiver process which became known as the 'Katrina Demonstrations.' Under these demonstrations, States were granted waivers of Federal requirements to allow for flexibility, administrative efficiency, and additional coverage needed to ensure that directly affected citizens received the healthcare services they required. Over the course of several weeks, Centers for Medicare and Medicaid Services approved 32 State demonstration programs, including 8 uncompensated care pools. These pools were to be used to reimburse providers that incurred uncompensated costs for medically necessary services and supplies for evacuees who did not have other coverage or relief options. The pool could also be used to provide reimbursement for benefits not covered under titles XIX and XXI in the State."

The waiver was issued as a section 1115 model waiver template to provide expedited healthcare coverage to meet the needs of low-income beneficiaries who needed healthcare and eliminated barriers in an effort to support evacuees. On average, Centers for Medicare or Medicaid Services-approved demonstration requests within 38 days of application. The demonstration states in which Hurricane Katrina victims were residing (host states) provided temporary eligibility for 5 months of Medicaid or State Children's Health Insurance Program coverage to evacuees who were parents, pregnant women, children under age 19, individuals with disabilities, low-income Medicare recipients and low-income individuals in need of long-term care, up to specified income levels. Evacuee status was established by self-attestation of displacement, income and immigration status, but evacuees were required to cooperate in demonstrating evacuee and eligibility status. Evacuees eligible under a disability category were required to provide a physician's statement verifying disability.

Evacuees were eligible to register for Medicaid or State Children's Health Insurance Program without many of the traditional administrative requirements for verification and enrollment. Centers for Medicare and Medicaid Services recognized that many of the evacuees' incomes and resources had changed significantly because of Hurricane Katrina, and that they did not have the usual documentation."[13] Evacuee eligibility was based on the home state eligibility rules.

Section 1115: Demonstration Waiver Funding

States were not required to meet budget neutrality tests under these demonstration programs, as individuals participating in the waiver were presumed to be otherwise eligible for Medicaid in their respective home state and costs to the federal government would have otherwise been incurred or allowable. Additionally, host states had the option to waive cost sharing for evacuees. If cost sharing was not waived, it had to be imposed consistent with title XIX and title XXI federal Medicaid and State Children's Health Insurance Program requirements.

In addressing costs to states, Centers for Medicare and Medicaid Services required that host states submit the full cost of providing care to evacuees, including the non-federal (state) share, when submitting their estimated expenditures to Centers for Medicare and Medicaid Services as a component of their usual cost reporting for determining federal

payments. States were required to submit claims directly to Centers for Medicare and Medicaid Services rather than submitting claims to home states, as would occur under regular procedures for out-of-State evacuees.

Uncompensated Care Pool

Uncompensated care pools were not offered as part of the model waiver template but were considered on an individual State-by-State basis. Centers for Medicare and Medicaid Services required that in order to receive approval for the use of an uncompensated care pool a State had to have a high number of evacuees and had to be co-located or closely located to one of the affected home states.

Eight States were approved to utilize an uncompensated care pool: Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, Tennessee, and Texas. Uncompensated care pools were approved to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for evacuees who did not have other coverage for such services and supplies through insurance, or other relief options available, including title XIX and title XXI, for a five month period, effective August 24, 2005, through January 31, 2006. The pool could also be used to provide reimbursement for benefits not covered under titles XIX and XXI in the State.

In submitting claims for reimbursement from the uncompensated care pool, providers were required to attest:

- That evacuees had no other healthcare coverage on the date of service
- The provider had received no reimbursement from any other source for the claim and/or expected to receive no reimbursement from any other source
- The recipient was a Katrina evacuee from one of the designated counties/parishes
- The services and/or supplies were medically necessary and within the scope of the Hurricane Relief effort

Preventing Fraud and Abuse

States were required to (1) verify circumstances of eligibility, (2) verify residency and citizenship of the evacuees, and (3) prevent fraud and abuse. States reported that circumstances of eligibility were verified to the greatest extent possible in order to prevent fraud and abuse. Compliance with these terms and conditions of the waivers is subject to audit."[14]

September 11, 2001

"Following the September 11, 2001, terrorist attacks, New York requested and received approval for a Section 1115 waiver known as "Disaster Relief Medicaid." The Disaster Relief Medicaid program allowed Medicaid applicants who were residents of New York City to receive four months of coverage if they met the eligibility requirements of the Medicaid or Family Health Plus program, and they applied for Disaster Relief Medicaid between September 11, 2001, and January 31, 2002."[15]

"Disaster Relief Medicaid was a temporary program that used a vastly simplified, expedited application process. Higher income eligibility guidelines and new immigrant eligibility rules were implemented as part of Disaster Relief Medicaid, making many more New Yorkers eligible for coverage. The income eligibility levels for Disaster Relief Medicaid were higher than under traditional Medicaid because the Family Health Plus guidelines were used. Family Health Plus is a Medicaid expansion for adults that was scheduled to be implemented in the fall of 2001, but was delayed in New York City as a result of the World Trade Center disaster. Income eligibility levels were increased from 87 percent of the federal poverty level for parents and 50 percent for single adults/childless couples to 133 percent and 100 percent, respectively. FHP also has no asset test."[16]

Louisiana State Emergency Rules 15 and 17

In response to Hurricane Katrina in Louisiana, the Governor of Louisiana declared a state of emergency which conferred emergency powers upon the Governor to deal with the disaster.[17] Additionally, under the guidelines of R.S. 29:724, the Governor was permitted to "suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency, if strict compliance with the provisions of any statute, order, rule, regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency."[18] With this authority, the Governor of Louisiana issued Executive Order KBB 2005 - 40 granting a limited transfer of authority to the Commissioner of Insurance.[19]

Under the authority of the Executive Order KBB 2005 - 40, the Commissioner of Insurance issued Emergency Rules 15 and 17, suspending certain statutes and regulations regarding health insurance.[20] These rules were extended through the aftermath of Hurricane Rita.

These emergency rules:

- Suspended certain statutes and regulations regarding health insurance in Louisiana[21]
- Applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods[22,23]
- Applied only to products regulated by the Louisiana Department of Insurance[24]
- Waived all restrictions relative to out-of-network access[25]
- Suspended:
  - Medical certifications
  - Referrals
  - Medical necessity reviews
  - Notification of hospital admissions
  - Right to conduct medical necessity reviews (for non-elective services)[26]
- Stipulated that claims for an initial 30-day supply prescription medication could not be rejected or pended regardless of date of last refill.[27]
- Stipulated that:

  - Individual and group policies could not be cancelled or terminated during the state of emergency even if premiums had not been received.
  - No renewals were allowed until January 1, 2006.[28]
- Stipulated that when a claim is submitted but the premium has not been received:
  - The insured was responsible for co-payments, deductibles and coinsurance
  - The insurer paid 50 percent of either the contracted rate or the nonparticipating rate
  - The provider accepted 50 percent as payment in full and could not bill the patient
  - If the entire premium was subsequently received, the claim was readjusted and paid according to the contract.[29]

Endnotes

[1] Norwalk, Leslie V. Testimony on Post Katrina Health Care: Continuing Concerns and Immediate Needs in the New Orleans Region, March 13, 2007
[2] Health and Human Services, "Summary of Federal Payments Available for Providing Health Care Services to Hurricane Evacuees and Rebuilding Health Care Infrastructure" January 25, 2006. http://www.hhs.gov/katrina/fedpayment.html
[3] Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, "Summary of State Reports for Medicaid and the State Children's Health Insurance Program Hurricane Katrina Section 1115 Demonstrations," March 2007, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hurricane%20Katrina%20Final%20Summary%20Report.pdf
[4] Checklist developed by Louisiana Medicaid.
[5] Interview with LA Medicaid Provider Enrollment Department, May 2007.
[6] 42 USC Section 1320b-5(g)(1).
[7] Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, "Summary of State Reports for Medicaid and the State Children's Health Insurance Program Hurricane Katrina Section 1115 Demonstrations," March 2007
[8] Centers for Medicare and Medicaid Services, Medicaid Fact Sheet, "Disaster Relief Emergency Medicaid Waiver Program, " http://www.astho.org/pubs/MedicaidWaiverTemplateFactSheet.pdf
[9] Kaiser Family Foundation, "New York's Disaster Relief Medicaid," August 2002. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14137
[10] U.S. Department of Health and Human Services, Section 1135 Waiver, Hurricane Katrina, September 4, 2005
[11] U.S. Department of Health and Human Services, Section 1135 Waiver, Hurricane Katrina, September 4, 2005
[12] U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, "Centers for Medicare or Medicaid Services Actions To Help Beneficiaries, Providers In Katrina Stricken Areas", September 6, 2005, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1546
[13] Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, "Summary of State Reports for Medicaid and the State Children's Health Insurance Program Hurricane Katrina Section 1115 Demonstrations," March 2007, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hurricane%20Katrina%20Final%20Summary%20Report.pdf
[14] Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations, "Summary of State Reports for Medicaid and the State Children's Health Insurance Program Hurricane Katrina Section 1115 Demonstrations," March 2007, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Hurricane%20Katrina%20Final%20Summary%20Report.pdf
[15] Baumrucker, Evelyne , April Grady, Jean Hearne, Elicia Herz, Richard Rimkunas, Julie Stone, and Karen Tritz. "Hurricane Katrina: Medicaid Issues", *Congressional Research Service Report RL33083 for Congress*, September 15, 2005
[16] Kaiser Family Foundation, "New York's Disaster Relief Medicaid," August 2002. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14137
[17] State of Louisiana Executive Order No. KBB 2005 - 40, September 19, 2005
[18] State of Louisiana Executive Order No. KBB 2005 - 40, September 19, 2005
[19] State of Louisiana Executive Order No. KBB 2005 - 40, September 19, 2005
[20] Louisiana Title 37, Insurance, Part XI Chapter 27: Emergency Rule 15 and 17
[21] Louisiana State Medical Society, "Louisiana Department of Insurance's Final Emergency Rules and Directives relative to Suspension of Certain Health Insurance Laws and Regulations Governing Louisiana Licensed Health Insurers Post Hurricane Katrina and Rita" http://www.lsms.org/Hurricanes/2005%20Emergency%20Rules%20%20Directives.pdf
[22] Louisiana State Medical Society, "Louisiana Department of Insurance's Final Emergency Rules and Directives relative to Suspension of Certain Health Insurance Laws and Regulations Governing Louisiana Licensed Health Insurers Post Hurricane Katrina and Rita" http://www.lsms.org/Hurricanes/2005%20Emergency%20Rules%20%20Directives.pdf
[23] Louisiana Title 37, Insurance, Part XI Chapter 27: Emergency Rule 15 and 17
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11. Current Patient Rights Resource Guide

Below is a listing of resources that can be accessed for information related to current patient rights.

Topic	Resource
Introduction to Patient Rights	http://www.law.berkeley.edu/clinics/ihrlc/pdf/IASCOperationalGuidelines final.pdf
Patient rights in a nursing home	http://www.dhs.ca.gov/lnc/nhrights/YourRightsAsAResidentInANursing Home-English.pdf
Access for Americans with Disabilities	Access for Americans with Disabilities Law 29 CFR 1630, 2 CCR 7285-8504
Patients' rights to emergency care	http://www.calpatientguide.org/iv.html
Patients' Rights to Coverage of Pre-Existing Conditions	http://www.calpatientguide.org/v.html
Patients' Right to File Timely Grievances with Health Plan	http://www.calpatientguide.org/vi.html
Patients' Right to have Health Maintenance Organization Decisions Independently Reviewed	http://www.calpatientguide.org/vii.html
Patients' Right to Appeal under Employee Retirement Income Security Act	http://www.calpatientguide.org/viii.html
Patients' Right to Medical Records/Confidentiality	http://www.calpatientguide.org/iii.html
Patients' Right to Informed Consent	http://www.calpatientguide.org/ii.html
Patients Rights to Continuous Care, Second Opinions, Referrals, and Information	http://www.calpatientguide.org/i.html
Patients' rights (or lack thereof) when involuntarily quarantined for the good of the public	1. http://academic.udayton.edu/health/syllabi/Bioterrorism/6Quarantine/PHLaw03.htm 2. http://www.cphan.org/libr/law101.ppt#294,34 3. http://www.phlaw.org/docs/TB_Due_Process-Rev_2005.pdf

12. California State Privacy Laws Pertaining to Government-Authorized Alternate Care Sites

Although an Alternate Care Site would not be subject to HIPAA regulations as it would not be a licensed healthcare facility, it would be covered by other state and local privacy laws. California State laws pertaining to the privacy of information are expected to remain effective during a healthcare surge. Alternate Care Sites should take reasonable steps to ensure the privacy of health information as required by the following statutes.

- **Confidentiality of Medical Information Act, California Civil Code 56 et seq.**

  Providers under the Confidentiality of Medical Information Act are defined as licensed or certified professionals or licensed clinics or healthcare facilities. Since an Alternate Care Site would not be licensed, it is reasonable to conclude that the Confidentiality of Medical Information Act would not specifically apply.

  In addition, there is an exception within the Confidentiality of Medical Information Act that gives licensed healthcare professionals and healthcare facilities authority to use or disclose medical information to a public or private entity authorized by law to assist in disaster relief efforts, so long as that information sharing is to notify or coordinate information in order to notify about the care of a patient or the patient's location and condition or death.

  Although the Alternate Care Site facility does not appear to fall within the scope of the Confidentiality of Medical Information Act, licensed healthcare professionals within the Alternate Care Site would most likely need to comply since they meet the definition of a provider under the Act. In situations where it may be necessary for healthcare professionals to disclose medical information but disclosure is not authorized or required by the statute, healthcare professionals would most likely be covered under the exception for disaster relief purposes. This exception authorizes the use of information to coordinate disaster relief and notification of next of kin.

- **Information Practices Act at Civil Code 1798 et seq.**

  The Information Practices Act in Civil Code Sections 1798 *et seq*, applies to all state agencies, including a state office, department, commission board and the University of California. An agency does NOT include "a local agency," including a county, city, district, or other local public agency. Therefore, it seems the scope and requirements of the Information Practices Act would not apply to an Alternate Care Site operated by a local government. The Alternate Care Site would, however, fall within the scope if it was state operated, or operated by a contractor to the State. Regardless, an Alternate Care Site should set appropriate safeguards to ensure the security and confidentiality of records containing any personal information.

  Disclosure of medical information is permitted if the disclosure is required as part of an individual's ordinary course of his or her official duties, or is necessary to perform an

individual's constitutional or statutory duties. Disclosure of medical information is also permitted to process healthcare claims.

Consequently, a government-authorized Alternate Care Site could collect and disclose information required to provide disaster relief services including provide or arrange to provide healthcare services. It could also make required reports and fulfill reporting obligations required by other laws (e.g., required reporting of communicable diseases). Under Section 1798.57, disclosure otherwise required or permitted by law, including for treatment and payment purposes, would be appropriate, and would not be subject to penalties under the Information Practices Act.

The Information Practices Act specifically states that it does not limit constitutional right of privacy. It also expressly provides that the Information Practices Act does not supersede the Emergency Services Act commencing with Section 6250. (Civil Code Section 1798.75) Therefore, if an Alternate Care Site is not able to comply with the requirements of the Information Practices Act due to circumstances created by the disaster, and the Alternate Care Site was operating under the authority of the Emergency Services Act including a Governor's order, it could take whatever reasonable measures necessary to operate during a disaster, and mitigate the effects of the disaster without being subject to penalties under the Information Practices Act.

The Local Health Officer is not authorized to suspend the statutory requirements of the Information Practices Act. Still, it seems the Alternate Care Site would not fall within the scope of the Information Practices Act so long as personal information was used only as required to respond to the disaster. Again, the Alternate Care Site would want to prepare in anticipation of a disaster to have security measures in place to safeguard personal information. Absent a Governor's order suspending the requirements of the Information Practices Act, should the Alternate Care Site be operated by the state (or its contractor), the requirements of the Information Practices Act would apply, except to the extent the state-operated Alternate Care Site was complying with any specific law or resulting order under the Emergency Services Act.

- **California Civil Code 1798.29**

  This statute indicates that any agency that owns or licenses computerized data that includes personal information shall disclose any breach of security should a non-authorized person or entity access (or be suspected of accessing) an unencrypted computer database containing last names and certain corresponding identifiers (such as Social Security Number). Therefore, should an Alternate Care Site maintain computerized information and an unauthorized person or entity access the computerized data, the Alternate Care Site would be required to report the breach of security. This statute does not contain an exception for disaster-related information sharing.

- **California Civil Code 1798.81.5**

  This law falls within a section of laws addressing privacy and security of customer records that are applicable to businesses (i.e., it is the private sector equivalent of

1798.29). A business is a defined term, and includes a range of business entities regardless of how organized. It does not include the state or local government. Customers are defined as individuals who provide personal information to a business in order to purchase or lease a product or obtain a service from the business. The security and contract requirements in Section 1798.81.5 do not apply to providers regulated by the Confidentiality of Medical Information Act. Thus, healthcare providers would fall within the requirements of the Confidentiality of Medical Information Act and not this title of the law. Nonetheless, to the extent any business would obtain private information to provide services to mitigate the effect of the disaster, such as a supply organization, they would need to keep individual information secure and comply with the breach notification law, if applicable in the situation.

- **California Civil Code 1798.84**

  A business that secures a customer's waiver of its rights under this title would be unenforceable as it is against public policy. It does not mean that the Governor could not waive or suspend these requirements.

- **California Civil Code 1798.85**

  Use and disclosure of Social Security Numbers is extremely protected and limited. A person's social security number cannot be displayed public ally, required to transmit or access certain information, or printed on items sent by mail unless authorized by law. With regard to healthcare, printing a person's Social Security Number on the triage cards, for example, may implicate the Alternate Care Site, but only if required to access care. In other words, it appears appropriate to request the patient's Social Security Number for entry on the card, so long as there are measures to prevent that card from "public display" and so long as care is not denied should the patient refuse or be unable to provide it for whatever reason. Systems should be designed to track and maintain those cards. A suggestion would be to use only the last four digits of a person's Social Security Number to prevent violating the requirements under this title.