ORIGINAL RESEARCH

Examining New York City Hospitals' Nonuse of Medical Volunteers in Disasters

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ABSTRACT

Objective: To describe hospitals' perceptions of the New York City Medical Reserve Corps (NYC MRC); clarify administrative, legal, and clinical obstacles to the use of NYC MRC volunteers; and identify possible strategies to overcome these barriers.

Methods: We administered an informational questionnaire to 33 NYC hospitals and conducted 2 facilitated discussion groups comprising 62 hospital representatives.

Results: The most commonly reported hospital barriers to the use of MRC volunteers were concerns about the clinical competence of the volunteers, their lack of familiarity with medical technology used clinically in a hospital setting, and the potential for institutional liability.

Conclusions: Although the NYC MRC has the potential to assist the health care system in the event of a disaster, NYC hospitals will need clarification of the clinical and legal issues involved in the use of MRC volunteers for patient care. (*Disaster Med Public Health Preparedness*. 2015;9:391-395)

Key Words: voluntary workers, emergency preparedness, disasters, public health, emergency service, hospital

The use of medical volunteers has been an important aspect of federal programs designed to support emergency preparedness for the health care system. The federal government requires state and local health departments to build a robust volunteer management system to support health care response in an emergency.[1] In 2001, the federal government established the Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) to provide states with a standardized system for verifying volunteers' identities, licenses, status per the Professional Misconduct Board, hospital employment, and accreditations before a disaster occurs, enabling efficient deployment of volunteers during an emergency.[1] In response to the federal mandate, the New York City Department of Health and Mental Hygiene (DOHMH) created the NYC Medical Reserve Corps (NYC MRC) in 2004.[1] The NYC MRC is among the largest in the country, with 7710 preidentified, pretrained, skilled health care professionals who can be called on to serve during a large-scale catastrophic event. Facilities and emergency management leaders can request NYC MRC volunteers who have licenses and skills that closely match the needs of the emergency. Some volunteers are employed by a hospital and credentialed through that hospital for clinical privileges; others are not hospital employees and are not credentialed by a facility. NYC MRC volunteers are verified to confirm state licensing, employment, and good standing according to New York State misconduct boards. The NYC MRC conducts these verifications daily to make sure individuals still hold their state's license; however, attributes such as board certification or credentialing are not verified.

The NYC MRC has been successful in supporting DOHMH during numerous emergencies including response to hepatitis A exposures, influenza outbreaks, meningitis vaccination campaigns, point of dispensing sites, and providing medical assistance in general and special medical needs shelters during Hurricane Irene and Superstorm Sandy. However, NYC MRC resources have been largely untapped by NYC hospitals. Some hospitals have used MRC members to act as patients in emergency exercises, but most NYC hospitals would not consider using MRC volunteers as clinical staff in a disaster.

A review of the literature from 2006 to 2014 revealed limited research on the use of organized medical volunteers in clinical roles during disasters. Several articles focused on the many liability protections for individual medical volunteers and noted essentially no legal protections for institutions (ie, hospitals) that might use them. Therefore, hospitals (or any health

https://doi.org/10.1017/dmp.2015.78 Published online by Cambridge University Press

care facility) could be held liable for the actions of a medical volunteer, as well as for not providing adequate oversight of medical volunteers.[1–10] Additional review of the literature to determine if medical volunteers provided clinical care in hospital settings during Hurricanes Katrina and Rita did not yield information. However, one study described the deployment of registered volunteer health care professionals and legal barriers to their use in meeting surge capacity and providing public health support.[11]

This article discusses the Medical Volunteer Project, a joint effort of the DOHMH and the Greater New York Hospital Association (GNYHA). The GNYHA is a trade association consisting of nearly 250 hospitals and continuing care facilities, both voluntary and public, located in the NYC metropolitan area and upstate New York, as well as New Jersey, Connecticut, and Rhode Island. The project sought to investigate the barriers to NYC hospitals' use of organized medical volunteers in clinical roles at their institutions during a disaster and to identify actions that could be taken to overcome these barriers. This article does not address the use of spontaneous volunteers. Our primary focus is on organized medical volunteer systems with registered and credentialed health care professionals, defined here as trained health professionals who should be utilized by hospitals in clinical roles during disasters. Further research is needed in this area to explore why hospitals in large urban settings are reluctant to use organized medical volunteer systems during disasters.

METHODS

Since 2002, with federal funding and support, the DOHMH has contracted with NYC hospitals to improve health care facility emergency preparedness and response capability. Every year, each hospital must complete contract deliverables, as well as elective deliverables that hospitals choose to participate in to enhance facility preparedness. In July 2012, a total of 56 hospitals contracted with DOHMH to receive federal funding from the Assistant Secretary for Preparedness and Response Healthcare Preparedness Program (ASPR HPP). Of those, 33 hospitals self-selected the Medical Volunteer Project as an elective contract deliverable. From November 1 through November 30, 2012, the emergency preparedness coordinators at these 33 hospitals were asked to complete an 11-question online questionnaire eliciting information on how hospitals access, utilize, and oversee medical volunteers during disasters; potential barriers to integrating medical volunteers into disaster response; and suggestions for reducing these barriers.

DOHMH and GNYHA also conducted 2 facilitated discussion groups; 62 individuals from the 33 hospitals participated. One session included clinical and administrative hospital personnel and the other included legal representatives. A conference call was also held to capture information from hospitals unable to send a representative to a group discussion session. Additionally, our project design did not attempt to determine differences in perspectives based on clinical roles (ie, nurses, physicians) on this issue, but instead sought to learn from a variety of disciplines and to obtain consensus on the issues of registered and credentialed medical volunteers being utilized in clinical roles in a hospital setting during disasters. On the basis of the contract with DOHMH, all individuals were recruited by the hospitals' emergency preparedness coordinators, were not randomly selected, and were bound to conform to the requirements for participation outlined in the contract (ie, completion of questionnaire and attendance at the discussion groups), thereby eliminating the need for individual signed consent forms.

The clinical discussion group consisted of 27 hospital staff members from environmental health and safety, emergency medicine, critical care, administration, medical affairs, prehospital care, staff workforce and development, and community outreach. An emergency medicine physician moderated the discussion. The legal discussion group consisted of 35 hospital personnel from auditing, compliance, human resources, risk management, general counsel, quality assurance, and regulatory affairs. An attorney moderated the discussion.

For both groups, the agenda included an overview of the NYC MRC with an emphasis on the MRC's response during Superstorm Sandy in 2012 and a presentation of the results of the online questionnaire. Participants were asked a series of questions, and brainstorming techniques were used to elicit feedback on why NYC hospitals are reluctant to use NYC MRC volunteers in clinical roles during a disaster. As the legal group discussed the Joint Commission requirements at length, the clinical group was provided with additional information pertaining to existing Joint Commission standards and state and federal requirements for the use of medical volunteers during disasters. The same format was used for the conference call with participants who were not able to attend one or both of the 2 discussion groups; we wanted input from all hospitals that chose this core elective. Two notetakers from DOHMH and GNYHA recorded the responses. The qualitative responses from each session were summarized and major themes were recorded. The DOHMH's institutional review board (IRB) determined that this project was exempt from IRB approval.

RESULTS

Twenty of 33 hospitals (60%) responded to the questionnaire: 5 hospitals (25%) were public, 15 (75%) were private, 18 (90%) were network-affiliated, and 2 (10%) were freestanding. Responding hospitals were distributed across all 5 NYC boroughs: Manhattan (5), Bronx (5), Queens (5), Brooklyn (4), and Staten Island (1).

Among questionnaire respondents, 100% had prior awareness of the NYC MRC and the opportunity to use its volunteers in their hospitals during an emergency. However, none

https://doi.org/10.1017/dmp.2015.78 Published online by Cambridge University Press

indicated the use during disasters of medical staff employed by other hospitals and not affiliated with their institution. Two facilities (10%) indicated having used staff from other hospitals within their network or health care systems, in both clinical and nonclinical roles, but did not use any medical staff from outside of their hospital's network or health care system.

Based on the most frequent responses on the questionnaires, the following were cited as the hospitals' most common concerns about the use of NYC MRC volunteers during disasters: lack of familiarity with hospital electronic health record systems, lack of hospital-specific training, lack of direct knowledge of the clinical competence or skills of the volunteers, hospital liability, and the lack of defined roles for MRC volunteers during disasters. Respondents willing to consider the use of MRC volunteers indicated most frequently that the hospital's potential use of medical volunteers would be primarily in nonacute care settings and nonclinical roles.

All participants of the facilitated discussion group felt that unfamiliar medical volunteers were unlikely to be used in clinical roles in a disaster within hospitals. The legal discussion group reported concerns about volunteers' competence, inadequate information about volunteers' specific skills and clinical background (eg, date of last clinical practice, currently practicing or retired), lack of background checks, inadequate hospital resources during a disaster to oversee medical volunteers unfamiliar with the hospital, and volunteers' lack of familiarity with the institution's electronic health record system. Discussion group participants also had concerns about the lack of routine health assessments to screen for communicable disease in the volunteers and lack of verified fit-testing.

The legal discussion group echoed the clinical and administrative group concerns that medical volunteers' clinical skills and background experience are unknown, emphasizing that hospitals normally rigorously vet their new clinical staff and that new staff are thoroughly oriented to hospital operations, which includes electronic health records, hospital policies and procedures, and clinical protocols. This orientation would be very difficult to conduct in the midst of a disaster.

Discussion group participants suggested many possible uses of medical volunteers during a disaster. These included staffing nursing homes and primary care clinics, staffing point of dispensing sites, educating individuals who are not seriously injured but waiting to be seen, discharging patients with instructions, serving as interpreters, supervising unaccompanied minors and children, and supporting chaplain services. Most of these roles do not require clinical skills, and many do not take place in hospitals. Some of these roles, such as interpreter, child care worker, and chaplain support, require specialized training and qualifications. Another suggestion was to use MRC volunteers in citywide general shelters and special medical needs shelters, a role that the NYC MRC performed during Superstorm Sandy.

Participants also suggested changes that the NYC MRC could make to increase acceptance of medical volunteers at hospitals. These included conducting criminal background checks (especially to function as a child care worker), requiring specialty and background information on the MRC identification card, hospitals' conducting Just In Time trainings (eg, critical care areas protocols and procedures) prior to and specific to deployment of MRC volunteers, and creating preassigned teams in the MRC to train at local hospitals, which would encourage and nurture professional relationships and familiarize volunteers with hospital protocols and procedures.

DISCUSSION

Resistance to the use of volunteers in clinical roles seems widespread in NYC hospitals and may occur in other jurisdictions; however, this project is only a starting point and additional research is needed in this area. An informal survey conducted through the MRC Leader listserv on January 20, 2015, asked the question, "has anyone deployed MRC members to hospitals for disasters or non-disaster events and were they ever used in clinical role?" The 10 respondents included 3 MRC units whose medical volunteers were used in hospitals in nonclinical roles, 2 MRC units who helped with seasonal influenza vaccinations, and 2 MRC units who worked with hospital staff outside of the hospital setting. Only one MRC unit reported that one physician was given temporary hospital privileges, but that physician worked in a mobile emergency department and not in the hospital itself. In a large urban setting, it is difficult for a volunteer organization such as the NYC MRC to forge ongoing and strong relationships with the facilities in which its volunteers might serve. It is important to underscore the value of both the relationship between the NYC MRC and the hospitals and the relationship between the individual volunteers and the hospitals. Medical volunteers are often unknown entities to a facility; the competencies, skills, and clinical knowledge of a volunteer cannot be adequately assessed or overseen in the midst of a disaster. Many urban hospitals will therefore preferentially utilize clinical staff from their network hospitals, which have cross-credentialing.[3,12] Hospitals may need to become "facility-centric" for surge capacity, because external sources of staff are often delayed in responding. However, the NYC MRC should be considered as a resource to supplement clinical staffing resources during disasters.[13] During Superstorm Sandy, Staten Island hospitals utilized non-MRC community physician volunteers in clinical roles. They might have used these physicians because these hospitals are geographically isolated from those in the rest of the city. These were also physicians with whom the hospitals had ongoing relationships, thus confirming the importance of an established relationship between a hospital and medical volunteers.

https://doi.org/10.1017/dmp.2015.78 Published online by Cambridge University Press

A hospital's core institutional mission is to render high-quality clinical care to its patients in a way that adheres to its standards of care and ensures the safety of patients and staff. The challenges of adhering to standards of care[2] are significant in a disaster, with possible loss of resources, limited clinical and support staff, potential loss of essential services, and an increase in patient volume and acuity. Therefore, concerns about clinical competency can be magnified in a disaster.[4] Joint Commission standards for hospital operations and use of medical volunteers under normal conditions include appropriate orientation and oversight of volunteer performance; this would be even more difficult in the setting of a disaster. Acute-care settings in hospitals are strongly dependent on staff being familiar with the physical setting, hospital rules, clinical protocols, and existing "teams" that know each other's skills and competencies because they have worked together frequently. Incorporating new professional staff into hospital structure requires careful planning, orientation, and supervision, even under routine conditions; in the context of an emergency, this becomes very challenging. These challenges are particularly pertinent when the setting is an emergency department or intensive care unit, with acutely and critically ill patients requiring quick clinical intervention. There is also the need for familiarity with the hospital's medical technology and electronic health records systems, as these often differ from hospital to hospital.

Hospitals also have concerns about their potential liability for the actions of volunteers deployed to their institutions during a disaster. Current NYC and New York State regulations offer volunteers individual civil liability, limited immunity, or indemnification through statutory or regulatory provisions as long as the volunteer was acting in the scope of his or her responsibilities and the harm was not willful or grossly negligent.[9,10,14] The various legal provisions created to address the underlying immunity and liability protection of volunteers during disasters at both the federal and local levels have limitations. For example, the federal "governmental (or sovereign) immunity" provision "only protects government entities and not-for-profit entities."[9,10,14] However, there has been no provision established to protect hospitals from liability for the actions of medical volunteers. Other local laws such as the Good Samaritan law, which protects volunteers who render spontaneous care from civil liability, do not apply to volunteers rendering clinical care in a hospital. Additionally, the emergency statutes and mutual aid compacts (known as EMAC) offer some immunity protection to volunteers, if the individuals are working only with the requesting state and during a declared disaster.[9,10,14] Again, these approaches do not address the hospitals' liability if the medical volunteer should cause harm or injury to patients. In the hurricanes of the Gulf Coast, registered volunteer health care professionals who were deployed to the region faced challenges including lack of a license to work in that state, liability concerns, and concerns about compensation if they came to harm.[11] There is no uniform set of standards on hospitals' liability that outlines what the hospitals' legal protections are if they use medical volunteers during a disaster. A need exists for standards of liability protection for hospitals and their use of medical volunteers during disasters that are feasible and applicable to local jurisdictions.

As a result of this project, the MRC is making a number of changes, including increasing MRC contact with hospitals, in the hope that familiarity will make the NYC MRC more attractive to hospitals. The MRC will pilot the development of a pretrained hospital team for a specific hospital, in the hope that the model can be replicated in other hospitals. The NYC MRC will continue to partner with community organizations and the primary care sector to create more visibility in the health care community. The NYC MRC has recently mandated the inclusion of specialty information when their members register. These measures do not fully assess or ensure the clinical competence of a volunteer to work with or treat patients. At this time, it is not possible for the NYC MRC to take on the task of verifying competence, which would also require regular updating.

CONCLUSION

NYC's robust MRC program consists of diverse, skilled medical volunteers; the NYC MRC has been utilized in various public health roles, such as at shelters and point of dispensing sites, and has been shown to be an invaluable asset. NYC hospitals are resistant to the use of medical volunteers in clinical roles as part of a disaster response, however. Our findings are not applicable to all hospitals in large urban settings; the findings represent only a sample of hospitals in NYC. However, the findings are noteworthy and should be shared. Concerns regarding institutional liability have been a major impediment to hospitals using medical volunteers during disasters. Concerns about the clinical competency of medical volunteers remain a significant issue to be addressed, if the potential for medical volunteers to ameliorate patient surge and provide clinical expertise in a disaster is to be realized. Staffing is often a challenge for health care facilities during a disaster, and it is crucial that the wealth of resources of the NYC MRC be available to and used by NYC hospitals.

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https://doi.org/10.1017/dmp.2015.78 Published online by Cambridge University Press

Acknowledgments

The authors thank the Greater New York Hospital Association and New York City Hospitals for their participation in this project. It is important to note that the perceived barriers and suggestions generated during these brainstorming discussions and included here are not formal recommendations from the Greater New York Hospital Association.

Funding

This document was supported by grant number 1U90TP000546 from the Department of Health and Human Services (HHS).

Disclaimer

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Department of Health and Human Services, Office of Assistant Secretary of Preparedness and Response, or the Greater New York Hospital Association. This article is not intended to provide clinical or legal interpretation or opinion about federal or individual state laws nor does it constitute legal advice. Readers who seek legal interpretation or advice on federal, state, or local laws should consult a qualified attorney in the relevant jurisdiction.

Published online: June 22, 2015.

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https://doi.org/10.1017/dmp.2015.78 Published online by Cambridge University Press