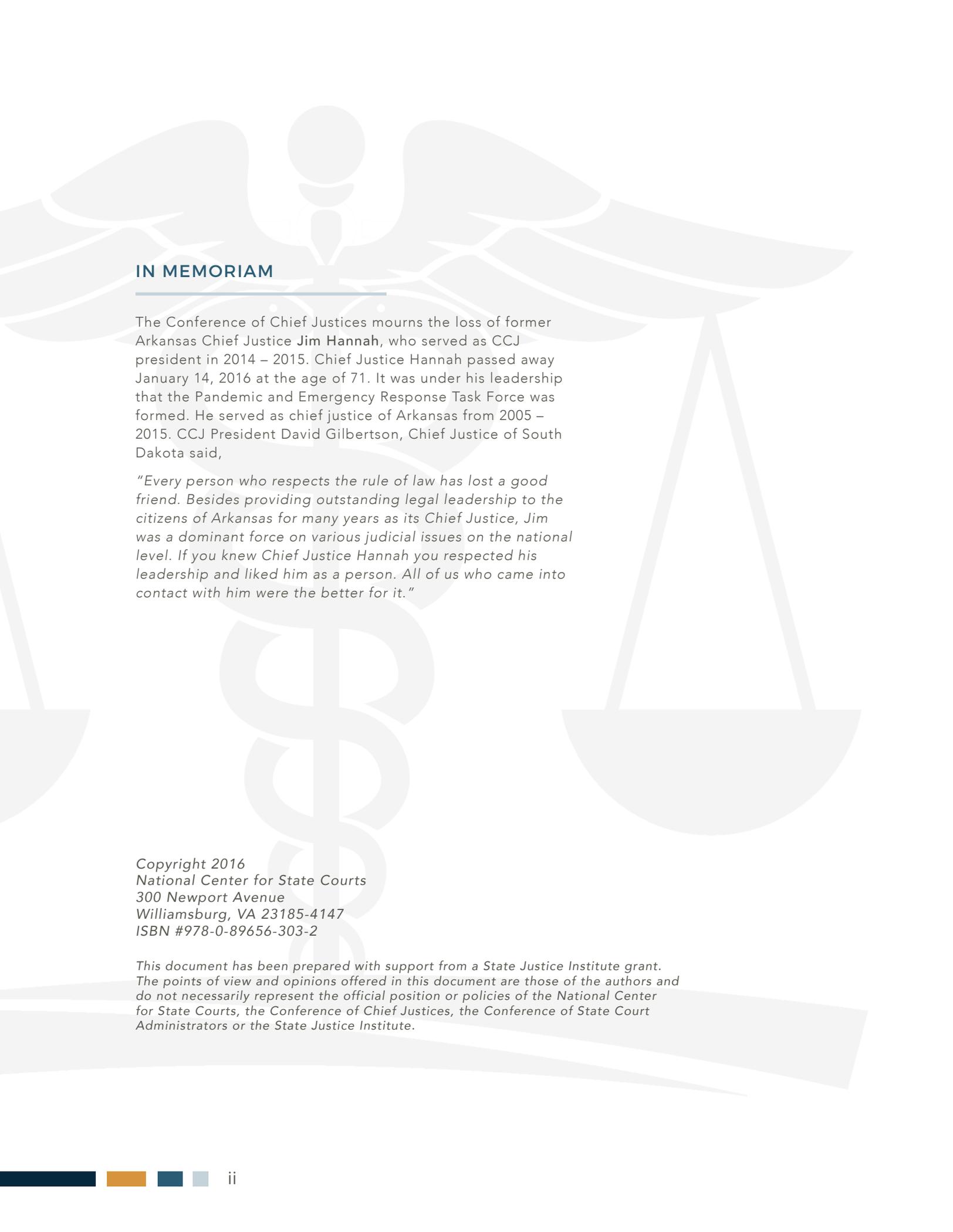


PREPARING FOR A

# PANDEMIC

An Emergency Response Benchbook  
and Operational Guidebook for State  
Court Judges and Administrators





## IN MEMORIAM

---

The Conference of Chief Justices mourns the loss of former Arkansas Chief Justice **Jim Hannah**, who served as CCJ president in 2014 – 2015. Chief Justice Hannah passed away January 14, 2016 at the age of 71. It was under his leadership that the Pandemic and Emergency Response Task Force was formed. He served as chief justice of Arkansas from 2005 – 2015. CCJ President David Gilbertson, Chief Justice of South Dakota said,

*“Every person who respects the rule of law has lost a good friend. Besides providing outstanding legal leadership to the citizens of Arkansas for many years as its Chief Justice, Jim was a dominant force on various judicial issues on the national level. If you knew Chief Justice Hannah you respected his leadership and liked him as a person. All of us who came into contact with him were the better for it.”*

Copyright 2016  
National Center for State Courts  
300 Newport Avenue  
Williamsburg, VA 23185-4147  
ISBN #978-0-89656-303-2

*This document has been prepared with support from a State Justice Institute grant. The points of view and opinions offered in this document are those of the authors and do not necessarily represent the official position or policies of the National Center for State Courts, the Conference of Chief Justices, the Conference of State Court Administrators or the State Justice Institute.*

# **Preparing for a Pandemic:**

## **An Emergency Response Benchbook and Operational Guidebook for State Court Judges and Administrators**

Conference of Chief Justices  
Conference of State Court Administrators  
Pandemic and Emergency Response Task Force



---

The Pandemic and Emergency Response Task Force would like to extend gratitude and appreciation to all those who contributed to the success of this work:

The Board of the State Justice Institute for its generous support;

The Conference of Chief Justices and Conference of State Court Administrators for their support and recognition of the importance of this project;

The National Conference of State Legislatures and the National Governors Association for their partnership;

Legal staff in the Administrative Office of the Pennsylvania Courts for their drafting assistance;

Dr. Jeffrey P. Gold and his staff at the University of Nebraska Medical Center and Nebraska Medicine's biocontainment unit, including Dr. Phil Smith, Dr. Chris Kratochvil and Ms. Shelly Schwedhelm, for hosting the Task Force on a tour of the Unit and for sharing their time and expertise in a discussion of the legal ramifications of biocontainment and highly-infectious disease transmission in the future; and

The NCSC staff who helped make this project a success, including Elizabeth Buner, Elizabeth Maddox, Lorri Montgomery and Lee Suskin.

CONFERENCE OF CHIEF JUSTICES  
**PANDEMIC AND EMERGENCY  
RESPONSE TASK FORCE**

---

**Task Force Chair**

**Hon. Jean Hoefer Toal**  
*Chief Justice*  
*Supreme Court of South Carolina*

**Mr. Joseph Baxter**  
*State Court Administrator*  
*Rhode Island*

**Hon. Jonathan Lippman**  
*Chief Judge*  
*New York State Unified Court System*

**Prof. Allison Winnike**  
*Director of Research, Research Professor*  
*University of Houston Law Center*  
*Health Law and Policy Institute*

**Hon. Michael G. Heavican**  
*Chief Justice*  
*Supreme Court of Nebraska*

**Hon. Charles C. LaVerdiere**  
*Chief Judge*  
*Maine District Court*

**Hon. Maureen O'Connor**  
*Chief Justice*  
*Supreme Court of Ohio*

**Mr. Frederick Isasi**  
*Director, Health Division*  
*National Governors Association*

**Hon. Paul L. Reiber**  
*Chief Justice*  
*Supreme Court of Vermont*

**Senator Richard T. Moore**  
*Past President, National Conference of*  
*State Legislatures, Massachusetts*

**Mr. Zygmunt Pines**  
*State Court Administrator*  
*Pennsylvania*

---

**National Center for State Courts Staff**

**Nora Sydow, JD**  
*Senior Court Management Consultant*

**Pamela Casey, PhD**  
*Principal Court Research Consultant*

---

# TABLE OF CONTENTS

- 1 PART I.**  
Introduction and Purpose
  
- 5 PART II.**  
Legal Issues Arising During a Pandemic: A Guide to Developing a  
Pandemic Benchbook
  
- 7 CHAPTER 1:**  
Jurisdiction of Public Health Issues
  - 1.10 Federal and State Roles
    - 1.11 The Limited Role of the Federal Government
      - a. The United States Constitution
      - b. Federal Constitution Generally Silent
      - c. Federal Law that Impacts a Pandemic Response
    - 1.12 The Broader Role of State Government
      - a. States have Historically Assumed the Primary Role in Public Health  
Issues
      - b. Sources of the State’s Public Health Authority
        - (1) Police power
        - (2) The doctrine of *parens patriae*
  - 1.20 State and Local Venue Determinations
  - 1.30 Administrative Process v. Trial Court
  - 1.40 Applicability of State Rules of Court to Public Health Cases
  
- 11 CHAPTER 2:**  
Executive Branch Authority in a Public Health Emergency
  - 2.10 Executive Branch Authority in a Public Health Emergency
  - 2.20 Local Health Departments
  - 2.30 Relationships between State and Local Health Departments
  - 2.40 Executive Branch Authority to Order a State of Emergency
    - 2.41 Immunity of Government Actors during a Declared State of Emergency
  
- 13 CHAPTER 3:**  
Searches, Seizures, and Other Government Actions to Ensure Public  
Health
  - 3.10 Searches and Seizures Generally
    - 3.11 The United States Constitution

- 3.12 The State Constitution
- 3.20 Searches and Inspections of Premises
- 3.30 Searches of Persons
  - 3.31 Procurement of and Testing of Physical Evidence from an Individual's Body
  - 3.32 Public Health Surveillance
  - 3.33 Disease Reporting and Notification
  - 3.34 Disease Investigation and Contact Tracing
  - 3.35 Sexual Partner Notification and the Duty to Warn

## **19 CHAPTER 4:** Proceedings Regarding Limitations on Individual Liberties and the Rights of Petitioners

- 4.10 Limitations on the Person
  - 4.11 Isolation and Quarantine
  - 4.12 Mandatory/Involuntary Testing and Treatment for Communicable Diseases
  - 4.13 Mandatory Vaccinations
  - 4.14 Social Distancing
- 4.20 Limitations on Property and Economic Interests
  - 4.21 Abatement of Public Nuisances
  - 4.22 Government Takings for Public Health Purposes
    - a. What is a taking?
    - b. When must the government compensate the property owner for a taking?
  - 4.23 Sanitary Regulations
  - 4.24 Regulation and Closure of Businesses
  - 4.25 Evacuations
  - 4.26 Animal Health
  - 4.27 Destruction of Personal Property
- 4.30 Limitations on Privacy
  - 4.31 Disclosure of Medical Information and the Health Insurance Portability and Accountability Act (HIPAA)
  - 4.32 Disclosure of Medical Information and State Privacy Law
  - 4.33 Access to Public Records
- 4.40 Rights of the Petitioners
  - 4.41 Writ of Habeas Corpus
  - 4.42 Right to Counsel
  - 4.43 Special Populations
    - a. Americans with Disabilities Act
    - b. Minors
    - c. Native Americans within Indian Country
    - d. Non-English Speaking Persons
- 4.50 Costs Incurred During Isolation and Quarantine
  - 4.51 Food, Medicine and Necessities
  - 4.52 Loss of Income and Other Expenses

## **29 CHAPTER 5:** Model Orders and Court Rules

- 5.10 Model Orders
  - a. Investigation, Testing and Treatment
  - b. Notice of Rights and Waiver of Counsel
  - c. Isolation and Quarantine
  - d. Condemnation and Destruction of Property
  - e. Continuity of Court Operations
- 5.20 Model Court Rules

---

## **31 APPENDICES**

- APPENDIX A – Public Health Primer
- APPENDIX B – Public Health Glossary
- APPENDIX C – State Health Districts or Local Health Units
- APPENDIX D – Selected Emergency Statutes
- APPENDIX E – Selected Provisions of the State Public Health Code
- APPENDIX F – Selected Case Law
- APPENDIX G – Selected Model Petitions, Affidavits, and Orders
- APPENDIX H – Selected Court Rules
- APPENDIX I – Judicial Checklists and Other Tools
- APPENDIX J – Contact Information

## **59 Part III.**

### Operating the Courts during a Pandemic

- A. Implications for the Courts
- B. Powers of the Chief Justice or State Court of Last Resort
- C. Appearance of Individuals Posing a Potential Threat to Public Health
- D. Juror Management Considerations
- E. Additional Judicial Personnel
- F. Consolidation of Cases
- G. Emergency Court Closure and Relocation of Court
- H. Limiting Public Access to the Courts
- I. Communication
- J. Technology Preparedness

## **65 Part IV.**

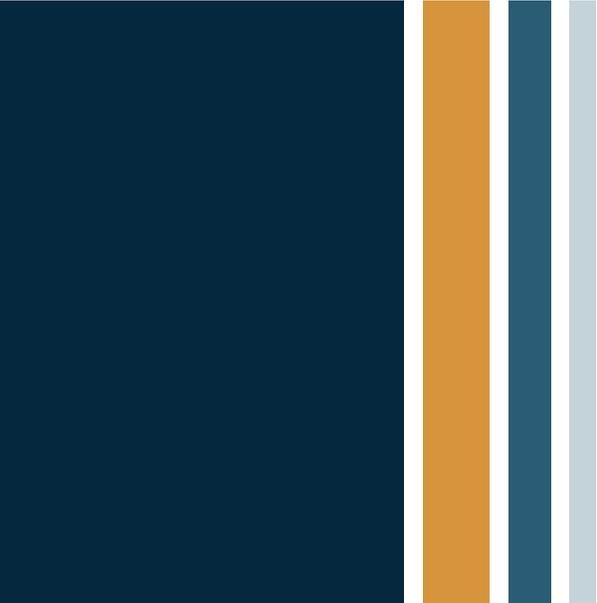
### Planning and Implementation: Putting it All Together

## **69 Part V.**

### Resources

- A. Pandemic and Public Health Benchbooks
- B. Other Resources





# PART I

Introduction and Purpose

---

**PART 1** Introduction and Purpose



---

# INTRODUCTION

## AND PURPOSE

Emergency preparedness in the judicial branch received significant attention and priority after the terrorist attacks of September 11, 2001 and Hurricane Katrina in 2005. These tragedies provided lessons learned about the need to prepare for emergencies, and guidance from court leadership organizations followed. In 2006, the Conference of State Court Administrators issued a position paper on emergency preparedness and the National Association for Court Management published a Business Continuity Mini Guide. The next year, the National Center for State Courts produced a Continuity of Operations (COOP) Planning Guide.<sup>1</sup> Since then, judicial branches across the country, at both the state and local levels, have significantly improved their disaster preparedness efforts. Courts have identified mission-essential functions, created preparedness plans and created continuity of operations plans.

In the fall of 2014, the United States experienced a public health scare concerning the Ebola virus. On September 30, 2014, the Centers for Disease Control and Prevention announced that Thomas Eric Duncan, a Liberian national visiting the United States from Liberia, had been diagnosed with Ebola in Dallas, Texas. Mr. Duncan, who had been visiting family in Dallas, was treated at Texas Health Presbyterian Hospital Dallas. Mr. Duncan died of Ebola on October 8th.<sup>2</sup> That same month, a petition was filed in a Maine court challenging the quarantine and direct active monitoring of a local nurse, Kaci Hickox, due to potential Ebola exposure. Courts across the nation took notice. Many court leaders questioned whether their courts were prepared to answer the complex legal questions that a full-blown Ebola epidemic would raise. Only approximately twenty states had developed public health benchbooks, and many of those were already somewhat dated.<sup>3</sup> In response, the Conference of Chief Justices called for the creation of a Pandemic and Emergency Response Task Force to help courts better prepare for the complex legal issues that public health crises present. The Task Force was formed in December 2014.

This Guide is a blueprint for developing a pandemic benchbook. The Task Force hopes the Guide will prompt state and local court leaders without an existing pandemic benchbook to create one and will prompt states with such a benchbook to keep it regularly updated and their judicial officers and court staff trained.

Part III of this Guide also offers strategies and resources to assist judges and

administrators to take steps to keep the courts open, and to be able to respond to the persons seeking emergency judicial relief, while protecting the health and safety of all participants.

The Task Force anticipates that this Guide will serve as an impetus for collaboration between the judicial, executive and legislative branches within states. As the Conference of State Court Administrators aptly recognized,

The need for comprehensive governmental coordination was never more evident than immediately following Hurricane Katrina, which demonstrated that cooperative efforts among different levels and branches of government drive an overall ability to respond to and recover effectively from a catastrophic event. Good emergency planning requires an enormous amount of advance coordination among different court levels and between the courts and a host of state and local agencies on a wide range of facility, security, law enforcement and emergency management issues. Unfortunately, many courts currently do not have a seat at the table when state and local emergency management agencies develop first response and COOPs.<sup>4</sup>

Pandemic benchbooks provide judges with legal authority as they strive to keep their courts open during a pandemic. They are also an excellent reference for the legal questions that may arise during public health threats, and they explain the role of the courts during such events. Many states that have developed a pandemic benchbook have learned that it serves not only as a resource for the bench, but also for the bar, public health officials and others. ❖

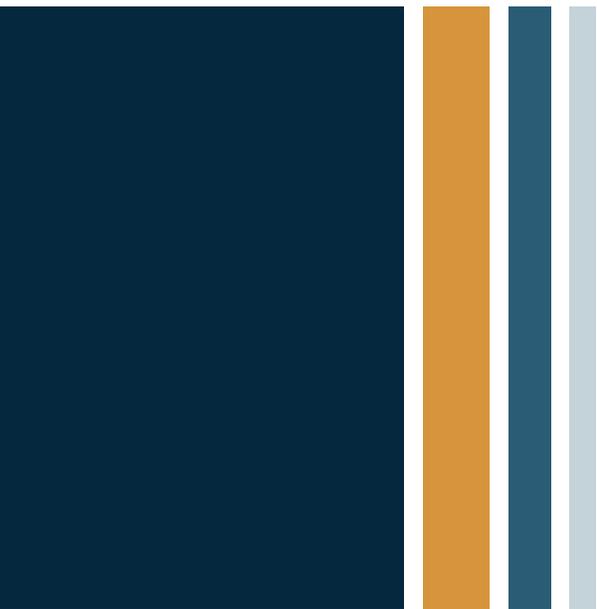
---

1. See Conference of State Court Administrators, *Position Paper on Emergency Preparedness in the State Courts*, National Center for State Courts (Dec. 2006); *Disaster Recovery Planning for Courts: A Guide to Business Continuity Planning*, National Association for Court Management (2006); *Continuity of Court Operations: Steps for COOP Planning*, National Center for State Courts (2007).

2. Only two people have contracted Ebola in the United States - they are both nurses who cared for Duncan - and they have both recovered. See 2014 Ebola Outbreak in West Africa - CASE COUNTS, CENTERS FOR DISEASE CONTROL AND PREVENTION (updated July 13, 2015) <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html>.

3. The Center for Public Health Law Partnerships, founded in October 2003 with funding from the CDC's Public Health Law Program, in collaboration with the University of Louisville, published a public health judicial reference guide. Several states have used this guide as a model in drafting their own public health benchbooks.

4. Conference of State Court Administrators, *Position Paper on Emergency Preparedness in the State Courts* (Dec. 2006), at [http://cosca.ncsc.dni.us/WhitePapers/EmergencyPreparednessStateCourts\\_Dec06.pdf](http://cosca.ncsc.dni.us/WhitePapers/EmergencyPreparednessStateCourts_Dec06.pdf).



# PART II

Legal Issues Arising During a  
Pandemic: A Guide to Developing  
a Pandemic Benchbook

- 
- CHAPTER 1** Jurisdiction of Public Health Issues
- CHAPTER 2** Executive Branch Authority in a Public Health Emergency
- CHAPTER 3** Searches, Seizures, and Other Government Actions to Ensure Public Health
- CHAPTER 4** Proceedings Regarding Limitations on Individual Liberties and the Rights of Petitioners
- CHAPTER 5** Model Orders and Court Rules

# CHAPTER 1.

## JURISDICTION OF PUBLIC HEALTH ISSUES

### 1.10 Federal and State Roles

#### 1.11 The Limited Role of the Federal Government

##### a. The United States Constitution

The preamble to the Constitution speaks generally to the federal government's interest in promoting the general welfare of its citizens. Article 1, § 8 contains two provisions that allow the federal government to regulate activities that directly impact public health: The *Commerce Clause* gives Congress the power to regulate commerce with foreign nations, between the states, and with Indian tribes,<sup>5</sup> and the *Taxing and Spending Clause* empowers Congress to levy and collect taxes for the general welfare of the United States.<sup>6</sup> Congress enacts laws affecting public health through these express Constitutional provisions.

##### b. Federal Constitution Generally Silent

No other Articles or Amendments provide a role for the federal government in matters of public health other than in discrete geographic areas directly under its control (e.g., military bases). This silence, viewed in conjunction with the Tenth Amendment's reservation of undelegated powers to the states, indicates that the federal government's public health powers extend only to the boundaries permitted by its defense, interstate commerce, and tax powers.

##### c. Federal Law that Impacts a Pandemic Response

(1) Pursuant to its itemized powers, the federal government may assume responsibility for public health emergencies precipitated by acts of war or terrorism.

(2) Some statutes and regulations give the federal government authority to act if a state response is insufficient. These include the *Public Health Service Act*, 42 U.S.C. § 264(a) (authorizing the Surgeon General to make and enforce regulations to prevent the spread of communicable diseases into the United States from a foreign country, or from state to state); the

*Stafford Act*, 42 U.S.C. § 5122 (authorizing federal assistance to supplement state and local public health efforts); and 42 C.F.R. § 70.2 (authorizing the Director of the CDC to implement disease control measures if it is determined that measures taken by state or local authorities are insufficient to prevent the spread of disease to another state).<sup>7</sup>

(3) Federal law provides broad immunity protections to individuals and governmental actors providing assistance during a public health emergency.<sup>8</sup> State laws also may provide immunities for government actors and Good Samaritans.

(4) The Americans with Disabilities Act may provide protections to a person with a communicable disease. See *infra* Section 4.43.

(5) The Health Insurance Portability and Accountability Act (HIPAA) and federal regulations place limitations on the disclosure of medical information during a pandemic. See *infra* Section 4.31.

(6) Federal law authorizes the federal government to place a Native American on Indian lands in isolation or quarantine. See *infra* Section 4.43.

## 1.12 The Broader Role of State Government

### a. States have Historically Assumed the Primary Role in Public Health Issues

States have historically borne much of the responsibility for preventing and responding to public health threats. *Jacobson v. Massachusetts* (1905) is thought to be the most important judicial decision in public health.<sup>9</sup> In *Jacobson*, the plaintiff objected to a smallpox vaccine mandated by the City of Cambridge as authorized by the State.<sup>10</sup> The U.S. Supreme Court not only upheld the constitutionality of the state's vaccine requirement, but emphasized that "The safety and health of the people. . . [are] for [the] Commonwealth to guard and protect. They are matters that do not ordinarily concern the National Government."<sup>11</sup> In another case, the U.S. Supreme Court recognized the well-established principle that states have the authority to enact public health laws, including those involving quarantine. "[U]ntil Congress has exercised its power on the subject, such state quarantine laws and state laws for the purpose of preventing, eradicating, or controlling the spread of contagious or infectious diseases, are not repugnant to the Constitution of the United States . . ." <sup>12</sup>

In the event of a public health crisis, state, county, and local agencies would most likely be required to work in conjunction with the federal government.

### b. Sources of the State's Public Health Authority

#### (1) Police power

Police power gives state government the right to protect the public's safety, health and morals by restraining and regulating liberty and the use of property.<sup>13</sup> To justify using police power, a state (a) must be acting in the interests of the public generally (as opposed to a particular class of people) and (b) must be using means that are reasonably necessary to accomplish its goal that are not *unduly* oppressive.<sup>14</sup>

#### (2) The doctrine of *parens patriae*

The phrase *parens patriae* literally means "parent of the country." The doctrine is derived from the English constitutional system wherein the King retained certain powers

in his capacity as the “father” of his country. “A state in the exercise of its police power may, within constitutional limitations, not only suppress what is offensive, disorderly or unsanitary, but enact regulations to promote the public health, morals or safety and the general well-being of the community.”<sup>15</sup> It is a broad power that has been used by states to protect the public health and abate public nuisances.<sup>16</sup>

## **1.20 State and Local Venue Determinations**

Jurisdiction refers to “a court’s power to decide a case or issue a decree.”<sup>17</sup> Venue refers to “the proper or possible place for a lawsuit to proceed.”<sup>18</sup> The benchbook should include state statutes and court rules that determine which court or courts have jurisdiction and venue in a public health emergency. This, in many instances, will likely be a trial court of general jurisdiction. The statute creating that court should dictate whether it is a court of record. States should also consider whether statutes and rules need amendment to enable the courts to promptly and appropriately respond in an emergency.

## **1.30 Administrative Process v. Trial Court**

Public health entities at the state, county, or local level may have authority to issue cease and desist, quarantine, or other orders, and they may have authority to administer and execute administrative search warrants to protect the public health. This authority may be conferred by statutes, regulations or ordinances. Court action may be sought if an individual refuses to obey an administrative order or comply with an administrative search warrant. The benchbook should include the authority of administrative agencies to act, the administrative review/appeal process, and the court’s authority to act if and when a public health authority’s orders have been ignored, violated or challenged in public health cases. A clear explanation of the administrative versus judicial process in public health cases can provide much needed assistance to the court and help expedite cases.

## **1.40 Applicability of State Rules of Court to Public Health Cases**

Adjudication of public health cases has been rare and is therefore unfamiliar to most trial court judges. There has been little litigation in public health cases since the 1940s and 1950s or before. In some instances, the latest case law on public health cases is from the early 1900s. Compounding this, both statutes and court rules may be antiquated or non-existent with regard to public health cases.<sup>19</sup> Statutes may be devoid of constitutional protections recognized long after they were drafted. In these cases, courts will have to ensure a petitioner’s legal rights are respected – notwithstanding the precise wording of a statute. The benchbook should provide guidance on due process and other constitutional protections.

Similarly, courts should examine their procedural rules to ensure they fully address how public health cases will be heard. For example, do court rules allow for the taking of testimony over the telephone or through video-conference equipment? If not, it may be difficult for an individual in quarantine to be meaningfully heard. Do court rules address how a large group of people can challenge the imposition of control measures, such as a large-scale quarantine or isolation order? Do court rules allow for a hearing *en masse*? States should consider the procedural challenges that could arise in a public health emergency and refer these challenges to the entity responsible for drafting amended court procedural rules. The benchbook should provide guidance to judges on the court’s existing rules and should be updated if new rules are adopted. ❖❖

---

5. U.S. CONST. art. I, § 8, cl. 3.

6. U.S. CONST. art. I, § 8, cl. 1.

7. For an explanation of federal and state quarantine and isolation authority, see JARED P. COLE, CONGRESSIONAL RESEARCH SERVICE, FEDERAL AND STATE QUARANTINE AND ISOLATION AUTHORITY (Oct. 9, 2014), *available at* <http://fas.org/spp/crs/homesecc/RL33201.pdf> (updating an earlier version by Kathleen S. Swendiman & Jennifer K. Elsea, *available at* <http://biotech.law.lsu.edu/cases/pp/RL33201.pdf>).

8. *See, e.g.*, Federal Public Readiness and Emergency Preparedness Act, 42 U.S.C. § 247d-6d; Federal Volunteer Protection Act, 42 U.S.C. § 14501, et seq.

9. LAWRENCE O. GOSTIN AND LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 121 (Berkeley, Cal.: University of California Press 3d ed. 2016) (citing JAMES A. TOBEY, PUBLIC HEALTH LAW 355 (New York: Commonwealth Fund 2d ed. 1939)).

10. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

11. *Id.* at 38.

12. *Compagnie Francaise de Navigation a Vapeur v. State Bd. of Health*, 186 U.S. 380, 387 (1902).

13. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996).

14. *Lawton v. Steele*, 152 U.S. 133, 137 (1894).

15. *Bacon v. Walker*, 204 U.S. 311 (1907).

16. *See, e.g.*, *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592 (1982).

17. BLACK'S LAW DICTIONARY 927 (9th ed. 2009).

18. *Id.* at 1695.

19. Lawrence O. Gostin, *Public Health Law Reform*, 91 AM. J. PUB. HEALTH 1365-68 (2001).

# CHAPTER 2.

## EXECUTIVE BRANCH AUTHORITY IN A PUBLIC HEALTH EMERGENCY

### 2.10 Executive Branch Authority in a Public Health Emergency

States developing a pandemic benchbook will need to consult state law that defines which governmental entity has what authority in the event of a public health emergency. Presumably, principal authority to order disease prevention and control measures, such as large-scale quarantines, evacuations, etc., lies with the Governor and state department of health. In some jurisdictions, this authority may be vested in county-level officials or local health departments. The benchbook should include who has the authority and responsibility to take what steps in a public health emergency. The declaration of a state of emergency may activate other statutory provisions or alter the chain of command. This should be recognized and understood in a public health emergency.

### 2.20 Local Health Departments

Drafters of pandemic benchbooks will need to take into account the state's public health legal and administrative structure. A state may have a unified structure, where all health department employees work under one individual or office. Conversely, a state may have a fragmented system where primary authority to act in an emergency lies with county or municipal-level officials. The benchbook should include the circumstances under which a particular state or local department has the authority to act and who has standing to seek court enforcement of an administrative order or the imposition of disease control measures.

### 2.30 Relationships between State and Local Health Departments

As noted in Section 2.20 above, each state has authority to create a public health structure most suitable to its needs. From an adjudicatory perspective, the public health and administrative structure may impact considerations such as jurisdiction, standing, and venue. The benchbook should include the authority of public health officials to order certain disease control measures and whether any of those measures, such as closing court facilities, could impact the continuity of court operations.

## 2.40 Executive Branch Authority to Order a State of Emergency

Most or all states authorize the Governor or Chief Executive to order a state of emergency. Each state's benchbook should include the legal authority to order a state of emergency and should include the trial judge's authority to take steps needed to maintain court operations and to adjudicate cases during a state of emergency. Some questions include, but are not limited to:

- Does the declaration of a state of emergency apply to court operations and the authority of judges to issue orders?
- Does the declaration of a state of emergency toll the statute of limitations or speedy trial requirements?
- What is the authority of trial courts to continue court operations in a state of emergency?
- Can cases be transferred to another part of the state unaffected by the emergency declaration?
- Who has the authority to order transfers?

The benchbook should include these legal and practical considerations if a state of emergency has been declared, or if a public health crisis occurs but no formal emergency declaration has been issued.

### 2.41 Immunity of Government Actors during a Declared State of Emergency

Individuals and governmental actors providing assistance during a public health emergency are afforded broad immunity protections by federal law.<sup>20</sup> The benchbook should include state laws that provide immunities for government actors and Good Samaritans. ❖

---

20. See, e.g., Federal Public Readiness and Emergency Preparedness Act, 42 U.S.C. § 247d-6d; Federal Volunteer Protection Act, 42 U.S.C. § 14501, et seq.

# CHAPTER 3.

## SEARCHES, SEIZURES, AND OTHER GOVERNMENT ACTIONS TO ENSURE PUBLIC HEALTH

### 3.10 Searches and Seizures Generally

#### 3.11 The United States Constitution

The Fourth Amendment to the U.S. Constitution provides: “The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.” The Fourth Amendment applies to the acts of all government officials, including both civil and criminal authorities.<sup>21</sup> The Fourth Amendment’s protections apply not only to criminal searches and seizures, but to non-criminal searches and seizures, such as health and safety inspections, as well.<sup>22</sup>

A search occurs when government action infringes upon an expectation of privacy that society recognizes as reasonable.<sup>23</sup> A seizure of an individual occurs when government action meaningfully interferes with an individual’s freedom of movement.<sup>24</sup> A seizure of property occurs when government action meaningfully interferes with an individual’s possessory interest in that property.<sup>25</sup>

Public health benchbooks from Kentucky, Indiana, Michigan and Ohio provide the most thorough analysis of Fourth Amendment jurisprudence applicable to public health-related searches and seizures. The following is a general outline of the Fourth Amendment constitutional analysis provided in these benchbooks:

1. No unreasonable searches and seizures
2. Definitions
  - a. Search
  - b. Seizure
    - i. Of individual
    - ii. Of property
  - c. Government Action

- i. State hospital employees are government actors
  - ii. Probable Cause
- 3. Applicability of Fourth Amendment outside criminal context
- 4. Applicability of Fourth Amendment to physical evidence obtained from individual
  - a. Detention to obtain evidence as seizure
  - b. Obtaining and examining evidence as search
  - c. Physical characteristics exposed to public not protected by Fourth Amendment
  - d. Obtaining physical evidence via significantly invasive or newly emerging medical procedures unreasonable in certain circumstances
    - i. Case-by-Case analysis
    - ii. Factors relevant to reasonableness inquiry
- 5. Applicability of Fourth Amendment to information obtained without physical intrusion of premises or persons
  - a. Character of premises highly relevant to analysis
  - b. Character and extent of information obtained relevant to analysis
  - c. Character of technology may be relevant to analysis
- 6. Reasonableness analyzed
  - a. Context-specific inquiry
  - b. No “least intrusive” requirement
  - c. Warrant generally required
    - i. Character of individual interests involved not dispositive
    - ii. Valid warrants
  - d. Exceptions to warrant requirement potentially applicable in the public health context
    - i. Consent
    - ii. Special needs

### 3.12 The State Constitution

The benchbook should include an analysis of search and seizure issues under the state constitution and related case law.

### 3.20 Searches and Inspections of Premises

The Fourth Amendment to the U.S. Constitution guarantees people “the right to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures” by the government. The Fourth Amendment requires that any search or seizure by a government actor must be reasonable.<sup>26</sup>

All state officials must meet the reasonableness requirement of the Fourth Amendment, even those officials conducting civil searches and seizures.<sup>27</sup> Public health officials authorized to conduct searches of private property must either obtain consent of the property owner or meet the reasonableness requirements of the Fourth Amendment.

In addition to the requirements of the U.S. Constitution regarding searches, the benchbook should include state constitutional and statutory provisions that address state authority over property and premises for public health purposes. Examples of such state laws include:

- (1) Inspections to prevent and contain infectious diseases;
- (2) Inspections to ensure compliance with sanitary standards;
- (3) Food, drugs, and cosmetics inspections;
- (4) Food establishment inspections; and
- (5) Inspection reports.<sup>28</sup>

### **3.30 Searches of Persons**

#### **3.31 Procurement of and Testing of Physical Evidence from an Individual's Body**

Under the Fourth Amendment, a warrant is generally required for the search and seizure of persons. Seizing bodily fluids is generally governed by the same Fourth Amendment standards, and the presumption when seizing bodily fluids is that a warrant is required. In order to procure bodily fluids from an individual's body for medical testing, three situations protected by the Fourth Amendment arise: (1) seizure of the person long enough to take a sample; (2) seizure of the physical sample itself (blood, urine or saliva); and (3) a search by analyzing the bodily fluid sample.

When courts have reviewed the constitutionality of bodily searches and extraction of bodily fluids in non-criminal contexts, they have applied the reasonable suspicion test or the "special needs" exception. Both tests are based on a balancing of public and private interests. The most likely exception applicable to the seizure of bodily fluids in a public health context is the "special needs" doctrine.<sup>29</sup> Under the "special needs" doctrine, when special needs beyond the normal need for law enforcement make the requirement of getting a warrant impracticable, that may justify departures from the normal warrant or probable cause requirements.<sup>30</sup> Special needs searches could potentially be employed in public health emergencies assuming that the circumstances render the warrant and probable cause requirements impracticable.

Different types of physical samples trigger different levels of Fourth Amendment protection. For example, characteristics clearly exposed to the public, such as voice samples and fingerprints, are not constitutionally protected under the Fourth Amendment.<sup>31</sup> Other characteristics somewhat exposed, such as fingernail samples, are still protected.<sup>32</sup> Some characteristics are clearly protected, such as urine samples and blood samples.<sup>33</sup>

#### **3.32 Public Health Surveillance**

There are two types of public health surveillance – passive and active. In passive surveillance, state or local health departments gather information about disease occurrence within a population primarily through disease reporting by hospitals, physicians, and other community sources. In active surveillance, state or local health departments take measures to identify all cases of disease, primarily by contacting and soliciting information from physicians, hospitals, clinics, laboratories, and other sources. Active surveillance is most commonly used to identify cases of infectious disease.

The benchbook should include a summary of state law surrounding public health data collection in the following areas:

- A. State public health data collection;
  1. Purpose
  2. Health data to be collected
  3. Liability
  4. Confidentiality of individual medical information
- B. Surveillance of Carriers of Infectious Diseases;
- C. Surveillance of Newborns; and
- D. Reporting of Immunizations.<sup>34</sup>

### 3.33 Disease Reporting and Notification

State law may specify when and which health professionals and health facilities are to report confirmed and suspected cases of certain communicable diseases, including the manner in which the report is to be made.<sup>35</sup> The benchbook should include provisions on state and local reporting requirements for health professionals.

### 3.34 Disease Investigation and Contact Tracing

When a patient infected with a communicable disease is reported, a disease investigation begins. State or local health departments may be vested with the power to perform investigations of communicable disease infections to prevent transmission of the disease. Indiana's public health benchbook provides a good description of disease investigation and contact tracing:

A trained disease investigator, who is usually an employee of the local health department, interviews the patient, the patient's family members, physicians, nurses, and anyone else who may have knowledge of the patient's recent contacts and activities. The goal of this investigation is to identify persons who may have been exposed to the disease, as well as persons, animals, or places that may have been the source of the disease. Identified contacts are then screened for the disease and treated as necessary. The investigative process is repeated until the source of the disease (referred to as the "index case" if a person) is identified and all known contacts have been screened. The type of contacts screened depends upon the nature of the disease in question. Investigation of a sexually transmitted disease (e.g., HIV/AIDS) only requires screening of the sexual partners of infected individuals. In contrast, a disease spread by respiratory droplets, such as tuberculosis, may require extensive screening of all casual contacts and persons in proximity to infected individuals.<sup>36</sup>

The benchbook should include state or local authority to perform disease investigations.

### 3.35 Sexual Partner Notification and the Duty to Warn

Many states have laws that require that individuals infected with certain sexually transmitted diseases inform sexual partners of their disease status prior to engaging in activities scientifically proven to be associated with a high risk of disease transmission.<sup>37</sup>

Such laws may address what diseases are subject to notification; carrier's duty to warn; warnings by physicians; reports by other individuals; and penalties for violations of duty to warn. The benchbook should include state laws that require notification. ❖❖

- 
21. See *New Jersey v. T.L.O.*, 469 U.S. 325, 335 (1985). State hospital employees are government actors. See *Ferguson v. City of Charleston*, 532 U.S. 67, 76 (2001).
  22. See *Torres v. Puerto Rico*, 442 U.S. 465, 473 (1979); *Marshall v. Barlow's Inc.*, 436 U.S. 307, 312 (1978); *Camara v. Municipal Court of San Francisco*, 387 U.S. 523, 533-34 (1967).
  23. See *United States v. Jacobsen*, 466 U.S. 109, 113 (1984); *Katz v. United States*, 389 U.S. 347, 361 (1967) (Harlan, J., concurring).
  24. *Michigan v. Summers*, 452 U.S. 692, 696 (1981).
  25. See *Jacobsen*, 466 U.S. at 113.
  26. *Nat'l Treasury Emps. Union v. Von Raab*, 489 U.S. 656, 665 (1989) (citations omitted).
  27. *T.L.O.*, 469 U.S. at 335 (citations omitted).
  28. See pandemic benchbooks from Ohio, Indiana, Kentucky and Michigan for examples.
  29. See *Nat'l Treasury Emps. Union*, 489 U.S. at 668 (1989) (holding that probable cause is not required for combating threat that "rarely generate[s] articulable grounds for searching any particular place or person").
  30. *Id.*
  31. See *United States v. Dionisio*, 410 U.S. 1 (1973).
  32. See *Cupp v. Murphy*, 412 U.S. 291, 295 (1973). In *Cupp*, the police took fingernail scraping samples from a man, who voluntarily came to the police station after the strangulation death of his wife, against his wishes. Though the court stated that this "severe, though brief intrusion" required "constitutional scrutiny," it nevertheless held that under the circumstances the search was constitutionally permissible because it was incident to valid arrest and law enforcement had probable cause to believe the man had murdered his wife.
  33. *Nat'l Treasury Emps. Union*, 489 U.S. at 668.
  34. See Kentucky and Indiana's benchbooks.
  35. For example, Kentucky law requires licensed health professionals and licensed health facilities to report confirmed and suspected cases of certain communicable diseases. 902 K.A.R. 2:010. The time period in which reporting is required varies by disease and the pattern of cases, ranging from immediate reporting for dangerous, highly contagious diseases (e.g., smallpox) to up to five (5) business days for reporting diseases that pose less of an immediate threat (e.g., syphilis). *Id.*
  36. *Public Health Law Benchbook for Indiana Courts* (2005), <<http://www.in.gov/judiciary/admin/2901.htm>>.
  37. See Public Health Law Research, Temple University, *State Statutes Explicitly Related to Sexually Transmitted Diseases in the United States, 2013* (June 5, 2014), <http://www.cdc.gov/std/program/final-std-statutesall-states-5june-2014.pdf>.



# CHAPTER 4.

## PROCEEDINGS REGARDING LIMITATIONS ON INDIVIDUAL LIBERTIES AND THE RIGHTS OF PETITIONERS

### 4.10 Limitations on the Person

#### 4.11 Isolation and Quarantine

As discussed in Chapter 1, the power to quarantine individuals in order to protect the public from disease is a clearly established power of the state.<sup>38</sup> Pandemic benchbooks should include the following information and authority related to isolation and quarantine:

- a. Definition;
- b. State or Local Authority;
- c. Procedures, Conditions, and Enforcement (including the distinction between emergency and non-emergency isolation and quarantine procedures);
- d. Termination of Isolation/Quarantine;
- e. Special Populations;
- f. Federal Quarantine Authority; and
- g. Federal Court Review.

#### 4.12 Mandatory/Involuntary Testing and Treatment for Communicable Diseases

Citizens have a right to refuse medical treatment. However, as discussed in Chapter 1, this right can be outweighed by the government interest in protecting the public health and safety.<sup>39</sup> Benchbooks should include authority that addresses under what circumstances a court can order mandatory testing and treatment for communicable diseases.

#### 4.13 Mandatory Vaccinations

It is within the police power of the state to require mandatory vaccinations.<sup>40</sup> However, the state cannot force any individual to receive a vaccination if it would be unsafe for that individual.<sup>41</sup>

State law may or may not provide for an exemption based on religious or conscientious objections to mandatory vaccination, but in the event it does,

the statute must not discriminate between members of organized churches and religious groups and individuals that are not so organized.<sup>42</sup>

All 50 states have statutes requiring specified vaccines for students. Although exemptions vary from state to state, all school immunization laws grant exemptions to children for medical reasons. Almost all states grant religious exemptions for people who have religious beliefs against immunizations. Eighteen states allow philosophical exemptions for those who object to immunizations because of personal, moral or other beliefs.<sup>43</sup>

The benchbook should include state statutes that address the prevention of communicable diseases by vaccinations and any statutory provisions that address the authority to mandate vaccinations during a public health emergency.

#### **4.14 Social Distancing**

Social distancing is a community infection control measure that can be crucial to controlling the spread of communicable disease. Social distancing works by separating healthy persons from infected persons to control the spread of infection.

Examples of social distancing measures include closing schools, child daycare centers, churches, and theaters, and limiting social interaction at libraries, colleges and universities.<sup>44</sup> Social distancing may be voluntary or compulsory. Benchbooks should include any state authority related to social distancing during a public health threat and, in particular, any authority to close courthouses.

### **4.20 Limitations on Property and Economic Interests**

#### **4.21 Abatement of Public Nuisances**

A public nuisance is an unreasonable interference with a right common to the general public.<sup>45</sup> In the context of public health, public nuisances are those actions or uses of property that significantly interfere with the public's health or safety.<sup>46</sup> Pursuant to their police powers, state and local government entities may require remediation of public nuisances.<sup>47</sup>

Benchbooks should include authority that addresses (1) how a public nuisance is identified; (2) the jurisdiction and proceedings to enjoin a public nuisance; and (3) remedies when a public nuisance is found, including court, legislative, executive, health department, and criminal remedies.<sup>48</sup>

#### **4.22 Government Takings for Public Health Purposes**

The Fifth Amendment to the U.S. Constitution guarantees that no person "shall be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation."<sup>49</sup> Pursuant to its eminent domain power, the government must provide just compensation when it takes private property for public use. This constitutional guarantee of compensation is "designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole."<sup>50</sup> The government taking must substantially advance legitimate state interests to be constitutional.<sup>51</sup>

The pandemic benchbook should address authority that identifies when a taking has occurred and when compensation for a taking is required. The following is a summary of 5<sup>th</sup> Amendment jurisprudence found in several existing pandemic benchbooks. Note that this analysis should be supplemented with state constitutional and statutory provisions related to takings for public health and nuisance purposes.

**a. What is a taking?**

*1. Takings per se*

Takings per se entitle the property owner to compensation without a case-specific inquiry. There are two types of takings per se:

(1) Physical invasions occur when the government physically takes possession of an individual's private property for public purposes.<sup>52</sup>

(2) When a government's regulation results in a permanent denial of all economically beneficial or productive uses of the property.<sup>53</sup> This is known as a regulatory taking.

*2. Case-specific takings*

When government regulation denies some, but not all, economically beneficial or productive uses of private property, a taking may nonetheless exist if the impact of the regulation on the property is sufficiently severe.<sup>54</sup> Government action that is found to be a case-specific taking, rather than a per se taking, may be subject to the compensation rule.

Consideration of the following factors is necessary in making case-specific taking determinations:

- i. The economic impact of the regulation on the property owner;
- ii. The extent to which the regulation has interfered with reasonable investment-backed expectations;
- iii. The character of the governmental action;
- iv. What uses the regulation permits;
- v. Whether inclusion of the protected property was arbitrary or unreasonable; and
- vi. Whether judicial review of the agency decision was available.<sup>55</sup>

**b. When must the government compensate the property owner for a taking?**

1. The government is not obligated to compensate a property owner for abatement or destruction of property pursuant to police power in cases of emergency.<sup>56</sup>

2. The government must compensate a property owner for per se takings pursuant to police power unless the proscribed conduct or use was a restriction inherent in the owner's original title.<sup>57</sup>

3. The government is, as a general rule, not obligated to compensate a property owner for other publically beneficial regulations pursuant to police power that affect property value.<sup>58</sup>

4. State case law may determine that the government must compensate a property owner for the improper exercise of police power.<sup>59</sup>

### 4.23 Sanitary Regulations

State and local public health departments may inspect both public buildings and private dwellings to ensure compliance with sanitary laws and regulations. The benchbook should include state law that addresses the remedies available upon a finding that a building or dwelling is not in compliance with sanitary standards, along with the processes involved in pursuing those remedies.<sup>60</sup>

### 4.24 Regulation and Closure of Businesses

The benchbook should include the authority for state or local public health officials to close businesses to control the spread of an epidemic.

### 4.25 Evacuations

The benchbook should include any authority for officials to evacuate people from public and private property.

### 4.26 Animal Health

Because some animal diseases are directly capable of causing illness in humans and may acquire this capability by mutating in certain hosts, animal diseases are relevant to public health. The benchbook should include an overview of the state and local entities (for example, the State Department of Agriculture) empowered to monitor animal health. In addition, it should include a summary of their responsibility and authority for quarantine; mandatory vaccination; isolation and destruction; and mandatory reporting.

### 4.27 Destruction of Personal Property

The benchbook should include any state or local laws that address the authority of public health officials to disinfect, renovate, or destroy bedding, clothing, or other property when necessary or as a reasonable precaution against the spread of contagious or infectious diseases.

## 4.30 Limitations on Privacy

### 4.31 Disclosure of Medical Information and the Health Insurance Portability and Accountability Act (HIPAA)

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) proscribes “individually identified health information . . . created or received by a health care provider, health plan, employer or health care clearinghouse” from being disclosed to others without the written authorization of the individual, except for disclosures for certain specified purposes, such as treatment, payment and health care operations.<sup>61</sup>

#### Covered entities include:

- (1) **Health Plans.** HIPAA applies to individual or group plans that provide or pay the cost of medical care.
- (2) **Health Care Clearinghouses.** HIPAA applies to public or private entities that process or facilitate the processing of health information.

(3) **Health Care Providers.** HIPAA applies to providers of medical or health services or any person or organization that furnishes, bills, or is paid for health care in the normal course of business.<sup>62</sup>

State and local public health departments are covered entities under HIPAA because they offer health care services. However, public health departments may designate themselves as “hybrid entities” and designate those portions of their organizations which provide health care services. HIPAA applies to the designated portions of the organization, but the non-designated portions of the organization need not comply with HIPAA’s privacy requirements.<sup>63</sup>

Court records are not covered under HIPAA because a court is not a covered entity under HIPAA. While 45 C.F.R. § 164.512(e) contains special requirements for covered entities in the production of personal health information in response to a trial subpoena or discovery request, once the information becomes part of the court record it is no longer subject to HIPAA.

Covered entities may disclose protected health information without authorization to the following persons or officials for public health purposes:

(1) **Public Health Authority; Disease Prevention and Control.** Protected health information may be disclosed to a public health authority authorized by law to collect such information to prevent or control disease, injury, or disability.<sup>64</sup>

(2) **Certain Foreign Government Agency Officials.** Protected health information may be disclosed to officials of foreign government agencies acting in collaboration with a public health authority.<sup>65</sup>

(3) **Exposed Persons; If Otherwise Legally Authorized.** Protected health information may be disclosed to persons who may have been exposed to communicable diseases or who are at risk of contracting or spreading a disease, if the covered entity is otherwise authorized by law to notify such a person as necessary in the conduct of a public health intervention or investigation.<sup>66</sup>

(4) **Employers.** Protected health information may be disclosed to an employer if such information is related to workplace medical surveillance.<sup>67</sup>

(5) **Additional Uses of Protected Health Information.** Covered entities may disclose protected health information without an individual’s consent or authorization for additional purposes included in 45 C.F.R. § 164.512.

HIPAA preempts contrary state laws unless a specific exception applies, such as:

(1) **Compelling Need.** The state law serves a compelling need related to public health, safety or welfare.<sup>68</sup>

(2) **More Stringent State Law.** The state law provides more stringent privacy protections for health information than the applicable HIPAA provisions.<sup>69</sup>

(3) **Reporting.** The state law provides for the reporting of disease, injury, child abuse, birth, death, or other public health surveillance or investigation.<sup>70</sup>

(4) **Audits; Monitoring.** The state law requires health plans to report or provide access to health information for purposes of financial audits or other program monitoring.<sup>71</sup>

#### 4.32 Disclosure of Medical Information and State Privacy Law

Benchbooks should include state privacy laws that govern the privacy of medical information.

#### 4.33 Access to Public Records

As a general rule, the public is entitled to full and complete information regarding the actions of government agencies, officials and employees. State laws, as well as the federal Freedom of Information Act, govern this access. However, as noted in several pandemic benchbooks, “This general policy of public disclosure may prove problematic in the event of a public health emergency, such as an infectious disease outbreak: disclosing the identity of infected individuals subject to isolation and quarantine orders may subject them to discrimination or retaliatory activities, while disclosing the scope of government containment efforts may intensify public panic. In such situations, the government may seek to maintain the confidentiality of certain public records to protect individuals and the public at large.”<sup>72</sup> The benchbook should include any statutory exceptions to the general rule of public access to public records, including the process to respond to records requests and the remedies available upon denial of access to public records.

### 4.40 Rights of the Petitioners

#### 4.41 Writ of Habeas Corpus

Individuals subjected to quarantine or isolation may choose to petition for a writ of habeas corpus to challenge the state’s actions of quarantine or isolation. The benchbook should include authority that specifies the following:

- (1) Procedure for bringing a writ of habeas corpus in a public health case in state or local courts;
- (2) Jurisdiction and venue for hearing the petition;
- (3) Required contents of the petition; and
- (4) Remedies available to the court.

#### 4.42 Right to Counsel

In order to comply with due process requirements, individuals subjected to isolation or quarantine should be provided the right to counsel. Many states have statutes that expressly provide for a right to counsel in quarantine and isolation cases.<sup>73</sup> At least one state has statutory authority that provides a right to counsel in mandatory vaccination cases.<sup>74</sup>

The benchbook should include state or local provisions on the right to counsel for individuals subject to isolation or quarantine and whether counsel will be provided at state or local expense to indigent individuals.

## 4.43 Special Populations

### a. Americans with Disabilities Act

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The right of access to the courts falls under Title II Public Services, Section A of the ADA.<sup>75</sup> In 2004, the U.S. Supreme Court held that “Title II, as it applies to the class of cases implicating the fundamental right of access to the courts, constitutes a valid exercise of Congress’ § 5 authority to enforce the guarantees of the Fourteenth Amendment.”<sup>76</sup> The states are not immune from Title II lawsuits under the Eleventh Amendment. Title II of the ADA ensures that the earlier nondiscrimination requirements of section 504 of the Rehabilitation Act of 1973 that applied to public entities receiving federal financial assistance now apply to all state public entities including courts. States may also have disability rights legislation or court rules that are broader than Title II. States must comply with Title II, the Rehabilitation Act and their own state laws or court rules.<sup>77</sup>

The Americans with Disabilities Act Amendments Act of 2008 (ADAAA) maintains the ADA’s three-prong definition of a disability while ensuring that the definition of disability is construed as broadly as possible. The person must otherwise be a “qualified individual” or eligible for the services or program.

Disability is defined as:

- 1) A physical or mental impairment that substantially limits major life activities;
- 2) A record of impairment; or
- 3) Being regarded as having the impairment.

Having a communicable disease might be regarded as an impairment under the ADA. Major bodily functions are included in the definition of major life activities so the effects on internal organs and systems must be considered. The definition of major life activities includes learning, reading, concentrating, thinking, and communicating. An impairment “substantially limits” a major life activity if the person cannot perform a major life activity the way an average person in the general population can, or is significantly restricted in the condition, manner or duration of doing so.

The final ADA Title II regulations went into effect in March of 2011. These regulations specify the circumstances under which a public entity does not have to provide a specific action as a “reasonable accommodation.” These include an “undue financial or administrative burden” or a “fundamental alteration” of the service or program. The burden is still on the public entity to prove that compliance would pose this burden or alteration. In addition, the public entity has to provide an alternative to comply with the nondiscrimination requirement.

The benchbook should address these legal questions:

- (1) Does an individual’s infectious disease make them qualified under the ADA?;
- (2) According to disability law, what does the court need to do to provide reasonable accommodations to disabled persons subject to isolation and quarantine proceedings?; and
- (3) Are there state statutes or rules that establish disability rights for persons with communicable diseases?

## b. Minors

Drafters should address how the state and local isolation and quarantine laws apply to minors. Some questions regarding minors that have been addressed in existing benchbooks include: (1) where a minor is placed under isolation or quarantine, what contact should be provided for parents and other caregivers?, and (2) who has the authority to make medical and legal decisions on behalf of a minor who is under isolation or quarantine?<sup>78</sup>

## c. Native Americans within Indian Country

State laws may be enforced against Native Americans on Indian lands only if expressly provided by Congress. Congress has authorized the adoption of rules for state officials and employees to enter Indian country to enforce state health laws, including isolation and quarantine laws. However, no such rules have been adopted.<sup>79</sup> The Federal government may place a Native American who is afflicted with a contagious or infectious disease in isolation or quarantine to protect the health of the Native American or others.<sup>80</sup>

## c. Non-English Speaking Persons

Pandemic benchbooks should include any state statutes or case law that addresses the question of how the court should ensure that due process is provided when a person subject to isolation or quarantine proceedings is a non-English speaker or has a communication-related disability.

## 4.50 Costs Incurred During Isolation and Quarantine

### 4.51 Food, Medicine and Necessities

State court decisions have recognized the duty of the governmental unit ordering isolation or quarantine to furnish food and other necessities during the period of quarantine if the restricted individual cannot afford the items.<sup>81</sup> The benchbook should include any related state statutes or state court decisions.

### 4.52 Loss of Income and Other Expenses

In addition to expenses connected with food, medicine and other necessities, confined individuals could experience financial changes due to loss of income. The government could be responsible.<sup>82</sup> The benchbook should include any related state statutes or state court decisions. ❖❖

38. See *supra* 1.12(a).

39. See *supra* 1.12(a).

40. See *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905).

41. *Id.*

42. *E.g.*, *Dalli v. Bd. of Educ.*, 267 N.E.2d 219, 220 (1971) (addressing an exemption from vaccination for objectors who subscribed to beliefs of “a recognized church or religious denomination” and thus gave preferential treatment to recognized religions).

43. National Conference of State Legislatures, *States with Religious and Philosophical Exemptions from School Immunization Requirements* (Jan. 21, 2016), <http://www.ncsl.org/research/health/school-immunization-exemption-state-laws.aspx>.

44. See James G. Hodge, et al. *Legal Preparedness for School Closures in Response to Pandemic Influenza and Other Emergencies: A Review and Report Submitted to the Centers for Disease Control and Prevention* (April, 2008), <http://www2a.cdc.gov/phlp/docs/Legal%20Preparedness%20for%20School%20Closures%20in%20Response%20to%20Pandemic%20Influenza.pdf>. This report contains a summary of state laws regarding closing schools in emergency and non-emergency public health situations.
45. See Restatement (Second) of Torts § 821B(1) (1979).
46. See *generally* Restatement (Second) of Torts § 821(B)(2)(a) (1979).
47. See *Lawton v. Steele*, 152 U.S. 133, 136 (1894).
48. For example, see the Arkansas Public Health Benchbook 51-56 (2009), <http://www.healthy.arkansas.gov/aboutADH/RulesRegs/PublicHealthLawBenchBook2009.pdf>.
49. U.S. CONST. amend V.
50. *Penn. Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 123-24 (1978) (citing *Armstrong v. United States*, 364 U.S. 40, 49 (1960)).
51. See, e.g., *Lingle v. Chevron U.S.A., Inc.*, 544 U.S. 528, 531 (2005) (citations omitted).
52. *Tahoe-Sierra Pres. Council v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 322 (2002).
53. *Lucas v. S.C. Coastal Council*, 505 U.S. 1003, 1018 (1992).
54. See *Penn. Cent. Transp. Co.*, 438 U.S. at 136; *Penn. Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922) (“[W]hile property may be regulated to a certain extent, if regulation goes too far it will be recognized as a taking.”).
55. *Penn. Cent. Transp. Co.*, 438 U.S. at 136-37; see *Tahoe-Sierra Pres. Council*, 535 U.S. at 330-32.
56. See *Lucas*, 505 U.S. at 1029, n. 16; *Bowditch v. Boston*, 101 U.S. 16, 18 (1879) (holding that the destruction of a building to prevent the spread of fire does not entitle the building owner to compensation).
57. See *Lucas*, 505 U.S. at 1026-27.
58. See *id.*, at 1023-24.
59. See, e.g., *Ky. Airport Zoning Comm’n v. Ky. Power Co.*, 651 S.W.2d 121, 125 (Ky. Ct. App. 1983); *Helena v. Dwyer*, 42 S.W. 1071, 1071 (1897); *City of Frankfort v. Slipher*, 162 N.E. 241, 246 (Ind. Ct. App. 1928); *Bd. of Educ. v. Mich. Bell Tel. Co.*, 215 N.W.2d 704 (1974).
60. See Michigan, Kentucky, and Indiana benchbooks.
61. 42 U.S.C. § 1320d(6)(A); 45 C.F.R. §§ 164.502, 164.508, 164.510.
62. 45 C.F.R. §§ 160.102 and 160.103.
63. 45 C.F.R. § 164.504.
64. 45 C.F.R. § 164.512(b)(1)(i).
65. *Id.*
66. 45 C.F.R. § 164.512(b)(1)(iv).
67. 45 C.F.R. § 164.512(b)(1)(v).
68. 45 C.F.R. § 160.203(a)(1)(iv).
69. 45 C.F.R. § 160.203(b).
70. 45 C.F.R. § 160.203(c).
71. 45 C.F.R. § 160.203(d).
72. *Public Health Law Judicial Reference Guide for Kentucky Courts* 72 (August 2006), [https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at\\_download/file](https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at_download/file).
73. See, e.g., OR. REV. STAT. § 433.466.
74. See CONN. GEN. STAT. § 19a-131e(d).
75. Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq.
76. *Tennessee v. Lane*, 541 U.S. 509, 533-34 (2004).
77. See also Deborah Smith, *The ADA and the Courts*, NATIONAL CENTER FOR STATE COURTS, KNOWLEDGE AND INFORMATION SERVICES MEMO (forthcoming).
78. See *Minnesota Isolation and Quarantine Benchbook* (2008), [http://www.mncourts.gov/Documents/0/Public/Isolation\\_and\\_Quarantine/Isolation\\_and\\_Quarantine\\_Benchbook.pdf](http://www.mncourts.gov/Documents/0/Public/Isolation_and_Quarantine/Isolation_and_Quarantine_Benchbook.pdf).
79. 25 U.S.C.S. § 231(1) (2015).
80. 25 U.S.C.S. § 198 (2015).
81. See, e.g. *Commonwealth v. Irwin*, 1904 WL 2601 (CCP Venango, 1904) and *Zellinger v. Allentown*, 1896 WL 3663 (CCP Lehigh County, 1896). See also *Hutchinson v. Carthage*, 73 A. 825 (Me. 1909) (holding that a town was obligated to pay the expenses of a man who took care of a quarantined family); *Loudoun v. Merrimack County*, 53 A. 906 (N.H. 1902) (holding that a county was liable for reimbursing a town for the costs of medicine, medical assistance, and “necessaries” furnished to “paupers” who were quarantined with diphtheria); *Hudgins v. Carter County*, 72 S.W. 730 (Ky. 1903) (holding that a physician could recover from the county money for the services he rendered to individuals who were quarantined with

smallpox).

82. See *Phelps v. Sch. Dist.*, 221 Ill. App. 500 (Ill. App. Ct. 1921) (Teacher was awarded compensation for her salary when a school was closed for two months due to an influenza epidemic.).

# CHAPTER 5.

## MODEL ORDERS AND COURT RULES

### 5.10 Model Orders

Benchbooks should include examples of model orders covering such matters as investigation, testing and treatment, notice of rights and waiver of counsel, isolation and quarantine, condemnation and destruction of property, and continuity of court operations. The following are orders found in existing benchbooks.

#### A. Investigation, Testing and Treatment

- Subpoena for Investigations into Public Health Emergencies
- Order for Pre-Hearing Detention and Medical Examination
- Order to Procure Biological Evidence from an Individual's Person
- Order to Procure Biological Evidence from an Individual's Person by Necessary Force
- Order for Involuntary Treatment and Commitment
- Application for an Order of Disclosure of Public Health Information
- Order of Disclosure of Public Health Information

#### B. Notice of Rights and Waiver of Counsel

- Notice of Rights
- Waiver of Counsel

#### C. Isolation and Quarantine

- Model Summons for Individual to Appear at Hearing Regarding Court Enforcement of Isolation or Quarantine Order
- Consent Order for Home Quarantine
- Consent Order for Hospital Quarantine
- Consent Order for Working Quarantine
- Order Declaring an Area Quarantine
- Emergency Temporary Order for Hospital Isolation
- Emergency Term Order for Hospital Isolation

- Emergency Temporary Order for Hospital Quarantine
- Emergency Term Order for Hospital Quarantine
- Emergency Temporary Order for Home Quarantine
- Emergency Term Order for Home Quarantine
- Emergency Temporary Order for Home Isolation
- Emergency Term Order for Home Isolation
- Continuation of Isolation or Quarantine Order
- Affidavit of State Public Health Official (Affidavit of public health employee confirming respondent's quarantine or isolation and justification for such orders)
- Isolation or Quarantine (Steps required to apply for Rule to Show Cause why petitioner should not be released from isolation or quarantine)
- Verified Petition for Order to Show Cause (Respondent's Application for Order to Show Cause to be released from isolation or quarantine)
- Application for Review of Conditions of Isolation or Quarantine (Petitioner alleges statutory requirements for conditions of isolation or quarantine have not been complied with)
- Petitioner's Request for Hearing (Respondent requests hearing for isolation or quarantine conditions)

#### **D. Condemnation and Destruction of Property**

- Motion for Order of Destruction (Petition for court order authorizing destruction of property to eliminate source of infection)
- Affidavit to Accompany Motion for Order of Destruction
- Condemnation of Property

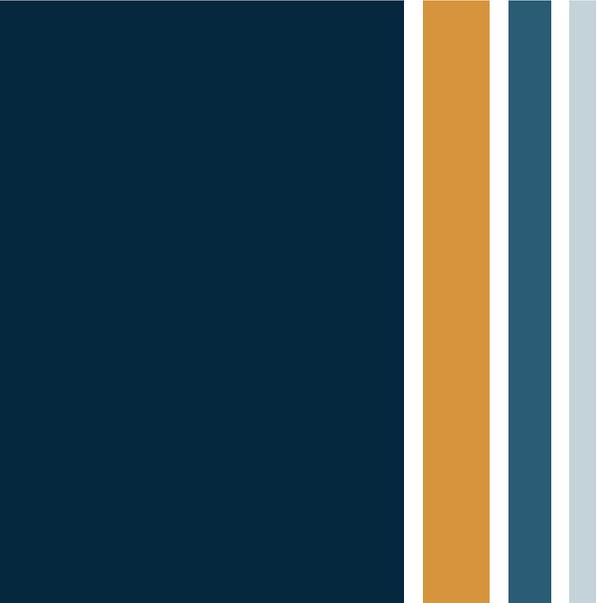
#### **E. Continuity of Court Operations**

- Motion for Change of Venue (Required if court where venue properly lies is unavailable)
- Declaration of Judicial Emergency and Designation of Alternate Facility for the Conduct of Judicial Business
- Declaration of Judicial Emergency and Designation of Alternate Facility for the Conduct of Judicial Business, and Emergency Order on Extension of Deadlines and Other Time Schedules
- Public Health Notice of Motion and Motion for Expedited Hearing (Public Health moves to conduct an expedited hearing for the Respondent due to the urgency of the Public Health Emergency)

### **5.20 Model Court Rules**

Some states have enacted measures to define the judiciary's responsibilities and authority to help ensure the continuity of court operations in the event of a public health emergency. Such measures may be enacted in statute by the legislature, as in California, see Gov't Code §§ 68115-18 (Judicial Emergency), or may be promulgated in a rule of the court, as in Pennsylvania, see Pennsylvania Rule of Judicial Administration Nos. 1950-53.





# APPENDICES

---

<b>APPENDIX A</b>	Public Health Primer
<b>APPENDIX B</b>	Public Health Glossary
<b>APPENDIX C</b>	[State] Health Districts or Local Health Units
<b>APPENDIX D</b>	Selected Emergency Statutes
<b>APPENDIX E</b>	Selected Provisions of the [State] Public Health Code
<b>APPENDIX F</b>	Selected Case Law
<b>APPENDIX G</b>	Selected Model Petitions, Affidavits, and Orders
<b>APPENDIX H</b>	Selected Court Rules
<b>APPENDIX I</b>	Judicial Checklists and Other Tools
<b>APPENDIX J</b>	Contact Information

# APPENDIX A

## PUBLIC HEALTH PRIMER

Public health primers are included in many pandemic benchbooks and address such topics as (1) defining public health; (2) identifying the essential public health activities; (3) providing a brief history of public health in the United States; and (4) discussing the role of government in public health.<sup>83</sup>

The Health Law and Policy Institute of the University of Houston Law Center has drafted summaries of several infectious diseases that provide an excellent primer for use in pandemic benchbooks, and they are reproduced with permission below.<sup>84</sup>

### I. Ebola

#### *Epidemiology*

The largest Ebola outbreak occurred in 2014 in West Africa, particularly in Guinea, Sierra Leone, and Liberia. There were approximately 20 cases confirmed in Nigeria, all stemming from a single traveler returning from Liberia, but prompt recognition and isolation measures prevented further spread of the disease in Nigeria.

#### *Disease process, diagnosis, and treatment*

There are five Ebola virus species, of which four can infect humans. Ebola viruses require special containment measures and barrier protection. The virus can survive in liquid or dried material for many days. The virus may be inactivated with gamma radiation, heating for an hour at 60° C, or boiling for 5 minutes. Freezing or refrigeration does not kill the virus. The virus is sensitive to bleach and other disinfectants.

The natural reservoir for Ebola virus is not known. It infects humans through close contact with infected animals, including chimpanzees, fruit bats, forest antelopes or other bushmeat as well as contact with the blood, bodily fluids or skin of humans infected with Ebola. It is not spread through water, or in most cases, food, unless it is infected animal tissue. Transmission via inanimate objects contaminated with infected bodily fluids is possible.

The incubation period is usually 4 to 10 days but can range from 2 to 21 days.

There is no evidence of communicability during the incubation period in nonfebrile, asymptomatic individuals. The main routes of infection are through mucous membranes (the nose, mouth, and rarely, the genital tract), the eyes, and small skin breaks. Airborne transmission of the virus alone has not been demonstrated but aerosolized droplets of contaminated body fluids are infectious.

There are four phases of the disease: an influenza-like syndrome; acute phase; false or pseudo remission; and aggravation. The influenza-like syndrome includes sudden fever, intense weakness, muscle aches, joint pain, nausea and vomiting, headache and a sore throat. In the acute phase (days 1 through 6), there is persistent fever, headache, intense fatigue, vomiting, diarrhea, and abdominal pain. In the false or pseudo remission phase (days 7 to 8), the patient may feel slightly better and ask for food. Some patients recover during this phase and survive the disease. In the aggravated phase (day 9) the patient gets worse. They may develop red or purple spots that represent bleeding into the skin, a diffuse skin rash, difficulty breathing, cough, hiccups, throat and chest pain, or cardiovascular distress and shock.

The virus spreads throughout the body and kills cells and tissues of the liver, spleen, kidneys, lymph nodes, testicles and ovaries. It damages the blood vessels and platelet cells in the blood stream, ultimately leading to bleeding and uncontrollable hemorrhage from the organs and throughout the body.

The virus also compromises and suppresses the patient's immune system overall, increasing the risk of secondary infections developing. Ebola virus has a high fatality rate.

At the onset of symptoms, Ebola may mimic malaria, typhoid fever, influenza, or other disease. This may delay recognition and the use of prompt isolation measures.

Diagnosis of the disease is based on specific isolation of the virus or detection of specific immune substances in the blood.

There is no proven virus-specific treatment and in most settings, care is supportive in nature. Providing fluids, maintaining good oxygen levels and blood pressure levels and treating other infections if they occur may significantly improve the chances of survival.<sup>85</sup> Efforts are underway to develop Ebola vaccines, and clinical trials to test vaccine candidates are ongoing.

Ebola is considered a potential biologic weapon. Development of effective drugs and vaccines is considered to be an urgent matter.

#### CDC protocol for Emergency Room and Hospital triage and care of suspected cases

The cornerstone of controlling an Ebola outbreak is interrupting the transmission chain. This requires several strict public health measures that must be instituted quickly and includes: isolation of patients, barrier precautions, and identification and tracking of all patient contacts.

The CDC recommends a 3-tiered system for managing and evaluating patients with suspected or confirmed cases of Ebola. Health care facilities chosen by state and local health officials, in cooperation with hospital leaders, will serve as frontline facilities providing emergency department screening services, assessment sites prepared to receive, isolate and treat patients until a confirmatory diagnosis is made, or treatment centers

which provide care through screening, assessment and post-confirmatory diagnostic testing.<sup>86</sup> Ebola treatment centers are approved by the CDC.

A patient presenting to an emergency room with possible risk factors for Ebola undergoes a standardized sequential screening protocol and a positive result will trigger the use of personal protective equipment, avoidance of close patient contact, placement of masks and gloves for the patient, and removal to a designated isolation area within the emergency room. Patients with a risk factor, and signs or symptoms of Ebola within 21 days are considered to be under investigation. When a person is under investigation, has had signs or symptoms for fewer than 3 days, and has a negative preliminary diagnostic test, this poses a challenge for health care facilities because the patient must still be kept in isolation for an additional 72 hours pending a second negative diagnostic test. During these intervening 72 hours, if the patient develops other manifestations of the underlying disease, they will need evaluation to rule out other causes, as well as monitoring for the diagnosis of Ebola.

Patients who refuse to comply with recommended isolation and testing represent a significant safety risk to others in the health care facility and public at large. A meeting with local law enforcement, county and state health department officials, hospital leaders, security and risk management is required. It is important for all involved to agree to a specific plan of action because making legal decisions at the bedside of an evolving medical condition is almost impossible.

Patients who are competent but refuse to stay at the hospital are allowed to leave via a route that is isolated from emergency department staff and other patients. The county health director and county attorney are immediately contacted for an isolation hold order; once verbally received it is also sent via other means such as personal delivery, fax or other electronic media. Local law enforcement is then contacted to enforce the order, return the patient to the hospital and remain in isolation until all testing is negative or Ebola is confirmed and they are moved to a biocontainment unit. Law enforcement will need to wear full personal protective equipment prior to and during all contact with the patient under investigation.

If the patient is incompetent, the treating physician may order a temporary medical hold order and hospital security in full personal protective equipment must escort the patient to the designated isolation area.

## **II. Middle Eastern Respiratory Syndrome (MERS)**

### ***Epidemiology***

The first case of MERS occurred in 2012 in Saudi Arabia. MERS is caused by a virus and is associated with high mortality rates, particularly in patients with pre-existing diabetes or renal failure. The largest outbreak occurred in the Arabian Peninsula, although since May 2015 there has been an ongoing outbreak in the Republic of Korea.

A case of MERS is defined as one with fever and pneumonia or acute respiratory distress syndrome, recent travel to countries in or near the Arabian Peninsula within 14 days prior to symptoms or contact with a traveler from this region who developed a respiratory illness and fever.

MERS is caused by a coronavirus. This family of viruses causes illnesses ranging from the

common cold to Severe Acute Respiratory Syndrome (SARS). Coronaviruses have high rates of genetic mutation and change and a tendency to cross from one species to another, for example, from animals to humans. The coronavirus that causes MERS has not been found to cause disease in humans. The exact source and mode of transmission of MERS to humans is not known although in the current outbreak it is believed to have 'jumped' from camels to humans either through direct contact or through unpasteurized camel milk.<sup>87</sup>

MERS cases are reported throughout the year, although the disease is seasonal. Human to human transmission does occur, either through respiratory droplets or direct contact, although only to a limited extent. Close contact appears to be necessary for human to human transmission. The risk of infection from inanimate surfaces is not well understood although under controlled laboratory conditions, the virus has been recovered from surfaces after 48 hours.<sup>88</sup>

Prevention of MERS transmission relies primarily on droplet precautions (wearing a surgical mask) or contact precautions (wearing a gown and gloves when caring for a patient or in the room). Eye protection is advisable as well.

### ***Vaccinations***

There are no current vaccines for MERS.

### ***Disease process, diagnosis, and treatment***

MERS is transmitted through respiratory droplets. Infected patients may have no symptoms or have an acute illness with fever or an upper respiratory infection. In its worst form, MERS causes a highly lethal pneumonia and/or multi-organ failure.<sup>89</sup>

The incubation period is estimated as 5 to 14 days. Initially patients may develop symptoms of fever, cough, chills, sore throat, muscle and joint aches. They may develop shortness of breath and progress to pneumonia within the first week and may require respiratory support with a ventilator. About one-third of patients will also develop gastrointestinal symptoms such as vomiting or diarrhea.

Diagnosis is made either on blood work or detection of the virus in bodily fluid specimens. The highest concentrations of virus are in fluids in the lungs, sputum, or the deep throat (trachea) so it is best to obtain specimens from these areas.

There is no specific treatment for MERS; supportive therapy is the cornerstone of management.

## **III. Pandemic Influenza**

### ***Epidemiology***

Influenza epidemics typically occur in the fall and winter months in the United States, as well as in other areas with temperate climates. Worldwide, influenza epidemics result in approximately 3 to 5 million cases of severe illness and 250,000 to 500,000 deaths every year.

Influenza viruses are extremely diverse and are divided into three major groups: A, B, and C, with A being the most notorious for its ability to reassert its genes and produce

new variants of flu virus. Influenza A type is associated with more severe disease and pandemics in humans than the other types.<sup>90</sup>

Type A influenza infections emerge from animal reservoirs such as birds and bats, although the virus may acquire the ability to infect other mammals such as horses, pigs, seals, and humans.<sup>91</sup> Type A influenza viruses are further subtyped by two proteins, hemagglutinin (H) and neuraminidase (N). Occasionally, influenza viruses may be transmitted directly from animals to humans, such as the avian influenza H5N1 and H7N9 strains. Avian influenza strains are associated with high mortality rates in humans.

The most serious influenza pandemic in recorded history occurred in 1918 and 1919 and was called the “Spanish flu” which killed over 50 million people worldwide.<sup>92</sup> This pandemic was caused by the H1N1 strain. Other pandemics occurred in 1957 and in 1968; these involved different flu strains.

In 2009, type A influenza (H1N1) caused the first influenza pandemic of the 21<sup>st</sup> century. It affected over 24 countries, and an estimated 285,000 deaths, with most deaths occurring in young, previously healthy adults.<sup>93</sup> However, this death toll may be a falsely low estimate. An exhaustive review of the 2011 H1N1 pandemic showed the worldwide fatalities due to this virus were understated by a magnitude of ten-fold.<sup>94</sup> The 2009 pandemic also disproportionately affected pregnant women. Household transmission of pandemic flu had an attack rate of up to 45%.<sup>95</sup> Household attack rates are highest among children and adolescents.

In 2013, the H7N9 influenza virus emerged in China. Infections in poultry and wildlife are not obvious, but it causes severe respiratory disease in humans. Control of this strain has been achieved by closing live poultry markets.<sup>96</sup>

Current viral threats include re-emergence of H2N2 (not seen in humans for about 50 years), or mutation of the H5N1 or H7N9 strains to the point of being transmissible from humans to humans, in lieu of current animal to human transmission.

## **Vaccination**

Vaccination is done annually for influenza because the virus changes its genetic makeup and expression; these changes allow the virus to escape the immune response created by prior vaccinations or infections. Each year, a new influenza vaccine is released, which includes coverage for the dominant viral forms of the previous year and forms considered to be at high risk for occurring in the new flu season. The World Health Organization has been remarkably accurate in predicting which dominant circulating strains will emerge over the last 45 years. Only twice, in 1997 and 2003, has the recommended strain not matched the one that emerged.<sup>97</sup>

Efforts are underway to develop a ‘universal’ influenza vaccine but it is not clear how long such a vaccine would provide protection. A universal vaccine would help circumvent the problem that occurs whenever a pandemic is identified: the need to determine the specific genetic code of the pandemic strain quickly to allow for production of the necessary substances in a vaccine form for immunization against the (ongoing) pandemic strain.

In addition to preventing the pulmonary complications of influenza, the vaccine can prevent medical disasters that may be triggered by influenza such as heart attack and stroke.<sup>98</sup>

### ***Disease process, diagnosis, and treatment***

The pandemic influenza virus behaves similarly to other influenza viruses. A large number of influenza infections are asymptomatic or associated with mild disease that does not require medical attention. Risk factors for severe disease include the extremes of age, chronic underlying medical illness, pregnancy, and, in an unexpected finding during the H1N1 pandemic, obesity.

There are no features to help distinguish between pandemic flu and other causes of influenza-like illness. Symptoms usually occur within a week of exposure and people with the virus are infectious for about 8 days after the onset of symptoms. Common symptoms include the abrupt onset of fever, runny nose, fatigue, sore throat, cough, generalized muscle aches or headache. Some people may also have diarrhea and vomiting.

Cultures are best for diagnosis if they are obtained in the first 2 to 3 days after the onset of symptoms. Rapid detection tests have been developed but their accuracy is still not optimal.

The treatment of influenza continues to be antiviral medications although resistance to components of these drugs is known, and with the ability of the flu virus to modify its genes, resistance is inevitable. The need for continued development of effective antivirals remains urgent.

### ***Complications***

Most people infected with influenza recover, although severe cases, particularly severe viral pneumonia, may require hospitalization and significant supportive care. Rarely, influenza may cause inflammation of the heart, seizures triggered by fever, inflammation of the brain and spinal cord, damage to the brain and liver (Reye's syndrome), inflammation with damage of muscles, or cause the immune system to attack the nervous system resulting in progressive paralysis (Guillain-Barré syndrome). Secondary bacterial infections, such as bacterial pneumonia, may occur as well.

## **IV. Measles**

### ***Epidemiology***

Prior to the availability of a vaccine to prevent measles (rubeola), 90% of Americans had been infected by the time they were 15 years old.<sup>99</sup> Of the estimated 3 to 4 million people annually infected in the years immediately preceding the vaccine, 400 to 500 died; 150,000 had respiratory problems; and 4,000 developed swelling of the brain (encephalitis) from the disease. Infants and young children are the most susceptible to measles, with the highest attack rate occurring between the ages of 5 to 9 years of age.<sup>100</sup>

While thought of as a childhood disease, the demographics of measles have shifted. Since 2001, half of the reported cases in the U.S. occurred in people 20 years of age and older.<sup>101</sup>

### ***Vaccination effectiveness***

The measles vaccine is extremely effective at preventing the disease. One dose of the measles vaccine is 93% effective in preventing the disease if exposed and two doses is

97% effective in preventing the disease if exposed to the virus. Approximately 3 out of 100 people vaccinated against measles can still contract the virus; the reason for this is not known. If a person has received two doses of the vaccine, no booster shots are necessary. The vaccine is safe to give to egg-allergic children. Administration of the vaccine may prevent the disease if it is given within 72 hours of exposure.

When a critical portion of a community is vaccinated against a contagious disease, most members in that community are protected and there is little chance for an outbreak to occur. Even those who are ineligible for the vaccine(s) get some protection because they are surrounded by a large portion of the community that will neither contract nor spread the disease. This is known as community or herd immunity and is applicable to a variety of diseases for which there are vaccines, e.g., measles, influenza, mumps, pneumococcal disease. In a setting where large portions of the population are immune to a disease, chains of infection are likely to be disrupted, a process that slows or stops the spread of disease. The more people in a community who are immune, the smaller the chance that those who are not immune will come into contact with an infectious individual.<sup>102</sup>

In 2000, the CDC declared measles to be 'eliminated' in the United States.<sup>103</sup> Elimination is defined as the absence of continuous disease transmission for 12 months or more in a specific geographic area; the disease is no longer endemic or constantly present in the U.S. Measles does continue to occur, however, and the incidence has been increasing in the United States since 2000. It is believed to be brought into the U.S. by unvaccinated travelers (Americans or foreign visitors) who contract the virus abroad, and then transmit it to others who are not vaccinated.

### ***Disease process, diagnosis, and treatment***

Measles is a highly contagious virus and humans are its only reservoir. It is transmitted by respiratory droplets and the virus may survive on contaminated surfaces for an hour. The disease has four distinct stages: incubation, prodromal (catarrhal), rash (exanthematous), and recovery. The incubation period is 8 to 12 days and people are most infectious 1 to 2 days before they have any symptoms. The infectiousness peaks about 3 days before a rash develops. Patients remain contagious until about 4 days after the rash appears.

After the incubation period, the person enters the prodromal or catarrhal stage. The classic trio of symptoms includes cough, inflammation of the lining of the nasal cavities (similar to a cold), and reddened eyes (conjunctivitis). Sensitivity to light may be present. Fever, loss of appetite, and a general sense of not feeling well are common as well. The blue-white 'spots' of measles, known as Koplik spots, appear 1 to 2 days before a generalized rash and are found on the inside of the cheeks, often across from the molars.<sup>104</sup> They last for 1 to 3 days and, given their short duration and location, are often not seen.

The rash or exanthematous stage starts at the top of the body and spreads down over about a day; it does not involve the palms of the hands or soles of the feet. The rash lasts 3 to 7 days, may turn from reddish to brownish in color, and the skin on top of the rash may start to peel, in the same pattern as the rash appeared.<sup>105</sup> During the rash stage, the person may have enlarged lymph nodes, an enlarged spleen, enlarged lymph nodes deep in the abdomen, and abdominal pain. Ear infections, pneumonia, and diarrhea may also occur during the rash phase; they are more common in infants.

Recovery and clinical improvement may be seen 48 hours after the rash starts. The cough may last for several weeks. Even after the disease is resolved, the person has a weakened

immune system and increased susceptibility to other bacterial and viral infections, which lead to increased measles related morbidity and mortality.

Diagnosing measles requires either satisfying CDC clinical criteria or showing laboratory evidence of the virus.

There is no specific antiviral treatment for measles. Supportive therapy addresses fever, keeping the person well-hydrated, and promptly treating complications, such as pneumonia. Antibiotics are recommended only to treat secondary bacterial infections.

The World Health Organization recommends vitamin A therapy for children with measles as pre-existing vitamin A deficiency (uncommon in the United States) may worsen the prognosis. Because of the highly contagious nature of measles, persons suspected of having it or having been exposed to it (without prior immunization or naturally occurring infection) should be isolated. Confirmed cases should be reported to the local health department.

### ***Disease complications***

The most common complications of measles are diarrhea and ear infections; the most common cause of death is pneumonia. Other complications include croup, diarrhea and dehydration. Complications involving the brain and nervous system may result in febrile seizures or swelling of the brain (encephalitis). Encephalitis usually occurs 2 to 5 days after the rash has started and is more common in older adults and children. It is thought to result from direct viral infection of the brain tissue.<sup>106</sup>

A rarer complication involving the brain leads to progressive behavioral and cognitive deterioration and, ultimately, death occurs 8 to 10 years after the acute infection. Measles may also lead to eye complications including acquired blindness; this is more commonly seen in countries where vitamin A deficiency is common.<sup>107</sup>

Women who develop measles during pregnancy have a higher risk of pneumonia, preterm labor, miscarriage and lower birth weight babies.

## **V. Tuberculosis and Multi-Drug Resistant Tuberculosis**

### ***Epidemiology***

Tuberculosis (TB) is caused by a mycobacterium, and strains that are resistant to anti-TB drugs have been reported worldwide.<sup>108</sup> The emergence of these multi-drug resistant TB (MDR-TB) strains is one of the most dangerous threats to global TB control.

In 2012, there were 8.6 million cases of TB and 1.3 million deaths worldwide attributed to the disease.<sup>109</sup> The proportion of MDR-TB cases is steadily increasing and it is estimated that there are over 500,000 cases annually worldwide, and growing.<sup>110</sup>

Modelling shows that maintenance of current TB rates requires each TB case to infect 20 contacts.<sup>111</sup> Recent studies show that each TB index case usually infects 2.6 to 5.9 contacts so this model may overestimate the number of contacts needed to maintain current rates of TB infection in a population.<sup>112</sup>

TB occurs in a higher percentage of blacks in the US; the reasons for this are unclear.

There is also a higher incidence of TB among people who are incarcerated (4% to 5% of TB cases occur in this population), the homeless, residential care facilities, nursing homes, those infected with HIV, those with cancer or diabetes, and among travelers to or from high burden countries.

Multi-drug resistant TB (MDR-TB) refers to TB strains resistant to drugs commonly used to treat TB. Treatment outcomes for MDR-TB are worse than those for patients with non-resistant TB, with less than half of all cases successfully treated. Globally it is estimated that there are 350,000 to 610,000 cases of MDR-TB, with 9% of those cases being extensively drug resistant.<sup>113</sup> Most MDR-TB cases result from a large gap between diagnosis and treatment, incomplete treatment, and poor treatment outcomes. Once drug-resistance develops, the risk of transmission of the same drug-resistant strain is possible; half of MDR-TB cases occur through this way.

### ***Vaccines***

The only licensed vaccine for TB is BCG (bacille Calmette-Guerin). The vaccine was created over 75 years ago and it provides a variable degree of protection against pulmonary disease. It does, however, provide consistent and reliable protection against disseminated disease in childhood. Revaccination during adolescence does not provide improved protection. BCG vaccination in the U.S. is only for people who meet very specific criteria and with the recommendation for vaccination from a TB expert.

### ***Disease symptoms, diagnosis, treatment***

TB is primarily a disease of the lungs and it is transmitted by respiratory droplets through coughing, talking, breathing, and sneezing. Coughing seems to produce the most airborne particles. TB mycobacterium may survive from 1 day to 4 months on dry surfaces. Disinfection is done with special cleaning agents such as glutaraldehyde or a hypochlorite solution.

Exposure to TB often results in latent TB infection which has a 5% to 10% lifetime risk of progressing to active TB. Most active TB cases occur within the first 2 years after infection. Latent TB is considered a reservoir for new disease and ongoing TB transmission within a community.

Latent TB does not have any active disease signs or symptoms.<sup>114</sup> It is diagnosed either through tuberculin skin testing or other methodologies. The skin test is usually positive within 3 to 6 weeks of infection, although it may take up to 3 months in some patients. Once a skin test is positive, it remains so throughout one's life, even after treatment. Those who have received the BCG vaccine for TB will always have a positive skin test. A variety of factors may lead to a falsely positive, or falsely negative, skin test. A chest x-ray may also be used to confirm the diagnosis of TB.

Diagnosis of latent TB does not provide any information about the duration or activity of the latent infection, which is an infection localized to an area within the lungs. Latent infection may reflect a state where the infection is actively replicating organisms ('percolating') or it may reflect a state where the infection has been cleared and immunity to TB has developed in the person. People with suspected latent TB are treated to prevent further possible spread of the disease as well as to diminish the risk for progression from latent disease to active disease. Contacts of latent TB cases need to undergo history and physical examination, chest x-ray and provide a sample of sputum for testing for culture

tests.

Patients with latent TB and who are asymptomatic but have growth of TB on their sputum culture are reclassified from latent infection to asymptomatic or subclinical disease infection. This occurs often in children and in patients with compromised immune systems. Patients with positive cultures are more likely to have lung lesions or tumors (e.g., Ghon's complex) on chest x-ray. They are also more likely to have a cough that may be severe and, through coughing, are more capable of infecting others.

Factors that influence progression of TB from latent to active states include age, immune system status, and both the nature of the exposure and infectious level of the index case. Any condition that affects the immune system, such as HIV, old age, cancer, malnutrition, immunosuppressive drugs, may lead to reactivation of the TB bacterium or secondary disease.<sup>115</sup> It is not possible to distinguish between reactivation of disease and re-exposure and reinfection.

Infants and children have immature immune systems and are not able to control initial or latent TB infection well. They may shed TB organisms even though they have no symptoms and abnormalities on chest x-rays are common. The risk for developing TB infection outside of the lungs in children under one year of age is extremely high.

Active TB may be due to active infection of the lungs or infection in other areas of the body such as skin, joints and bones, the lining of the brain and spinal cord, the abdomen, the genitourinary tract, or lymph nodes. Some patients may have both active lung infection as well as active infection in other parts of the body. Active infection of the lungs is the most common type of active TB. Active TB may cause symptoms such as severe and frequent coughing, coughing up blood, pain in the lining of the lungs, fever, weight loss, night sweats, and muscle wasting. It is this wasting away of patients that led to TB's moniker, consumption.

Diagnosis of active TB may include culture or biopsy of either lung lesions or lesions in other parts of the body. Drug susceptibility testing should be done in all patients with TB although in low-resource countries, this is quite difficult.

Active disease is commonly treated for 6 to 9 months with the caveat that if the infected person does not take the drugs correctly, or stops them too soon, they may develop bacteria that are resistant to therapy and they will become sick with TB. Treatment of MDR-TB is difficult; it often requires the use of less effective drugs that are more costly, toxic, and must be taken for prolonged periods of time. Monitoring of treatment is cumbersome and treatment success ranges from 36% to 79%; for strains resistant to an extensive number of drugs (XDR-TB) treatment is even less successful.<sup>116</sup>

Failure to detect drug resistance leads to improper therapy, premature death, increased resistance among TB strains, and ongoing infection in a community. While strides are being made to develop cheap and accurate tests for easier diagnosis of MDR-TB, international availability and accessibility to newer tests remains a barrier to their use.

### ***Complications***

Although TB disease is often subacute, it may present as sudden shock due to widespread infection (sepsis) and respiratory failure. There is also a known paradoxical reaction where patients actually get worse during treatment of disease, and this is thought to be due to an

exaggerated immune response of the body.

Patients may have massive bleeding in the lungs which is believed to occur when a TB lung infection erodes into a blood vessel in the lungs.

Brain and spinal cord lesions may result in swelling of the brain, seizures, and death. Infection and inflammation of the lining around the heart may lead to heart attacks or heart failure. Other complications depend on which organ system is involved. ❖❖

---

83. See Indiana, Kentucky, Michigan and Oregon benchbooks.

84. These summaries were drafted by Research Professor Allison Winnike, J.D. and Dr. Michele Curtis, M.D., M.P.H, J.D. (candidate expected 2017).

85. WORLD HEALTH ORGANIZATION, CLINICAL MANAGEMENT OF PATIENTS WITH VIRAL HAEMORRHAGIC FEVER: A POCKET GUIDE FOR THE FRONT-LINE HEALTH WORKER (Apr. 2014), <http://www.who.int/csr/resources/publications/clinical-management-patients/en/>.

86. Centers for Disease Control and Prevention, *Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease (EVD): A Framework for a Tiered Approach* (Feb. 20, 2015), <http://www.cdc.gov/vhf/ebola/hcp/us-hospital-preparedness.html>.

87. See, e.g., Chantal Bernadette Reusken et al., *Middle East respiratory syndrome coronavirus neutralising serum antibodies in dromedary camels: a comparative serological study*, 13(10) LANCET INFECT. DIS. 859 (Oct. 2013), [http://dx.doi.org/10.1016/S1473-3099\(13\)70164-6](http://dx.doi.org/10.1016/S1473-3099(13)70164-6); Chantal Bernadette Reusken et al., *Middle East Respiratory Syndrome coronavirus (MERS-CoV) serology in major livestock species in an affected region in Jordan, June to September 2013*, 18(50) EURO SURVEILLANCE 20662 (Dec. 12, 2013), <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20662>; Chantal Bernadette Reusken et al., *Middle East respiratory syndrome coronavirus (MERS-CoV) RNA and neutralising antibodies in milk collected according to local customs from dromedary camels, Qatar, April 2014*, 19(23) EURO SURVEILLANCE 20829 (Jun. 12, 2014), <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20829>.

88. Neeltje van Doremalen, Trenton Bushmaker & Vincent J. Munster, *Stability of Middle East respiratory syndrome coronavirus (MERS-CoV) under different environmental conditions*, 18(38) EURO SURVEILLANCE pii/20590 (Sept. 19, 2013), <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20590>.

89. Alimuddin Zumla, David S. Hui & Stanley Perlman, *Middle East respiratory syndrome 386(9997)*, LANCET 995 (Sept. 5, 2015), [http://dx.doi.org/10.1016/S0140-6736\(15\)60454-8](http://dx.doi.org/10.1016/S0140-6736(15)60454-8).

90. Pia Hardelid, Nick Andrews & Richard Pebody, *Excess mortality monitoring in England and Wales during the influenza A(H1N1) 2009 pandemic*, 139(9) EPIDEMIOL. INFECT. 1431 (Sept. 2011), <http://dx.doi.org/10.1017/S0950268811000410>.

91. Mike Kidd, *Influenza viruses: update on epidemiology, clinical features, treatment and vaccination*, 20(3) CURR. OPIN. PULM. MED. (May 2014), <http://dx.doi.org/10.1097/MCP.0000000000000049>.

92. Christopher J. L. Murray et al., *Estimation of potential global pandemic influenza mortality on the basis of vital registry data from the 1918-20 pandemic: a quantitative analysis*, 368(9554) LANCET 2211 (Dec. 23, 2006), [http://dx.doi.org/10.1016/S0140-6736\(06\)69895-4](http://dx.doi.org/10.1016/S0140-6736(06)69895-4).

93. Fatimah S. Dawood et al., *Estimated global mortality associated with the first 12 months of 2009 pandemic influenza A H1N1 virus circulation: a modelling study*, 12(9) LANCET INFECT. DIS. 687 (Sept. 2012), [http://dx.doi.org/10.1016/S1473-3099\(12\)70121-4](http://dx.doi.org/10.1016/S1473-3099(12)70121-4).

94. Lone Simonsen et al., *Global Mortality Estimates for the 2009 Influenza Pandemic from the GLaMOR Project: A Modeling Study*, 10(11) PLOS MED. e1001558 (Nov. 26, 2013), <http://dx.doi.org/10.1371/journal.pmed.1001558>.

95. Benjamin J. Cowling et al., *Comparative Epidemiology of Pandemic and Seasonal Influenza A in Households*, 362 N. ENGL. J. MED. 2175 (June 10, 2010), <http://dx.doi.org/10.1056/NEJMoa0911530>.

96. Hongjie Yu et al., *Effect of closure of live poultry markets on poultry-to-person transmission of avian influenza A H7N9 virus: an ecological study*, 383(9916) LANCET 541 (Feb. 8, 2014), [http://dx.doi.org/10.1016/S0140-6736\(13\)61904-2](http://dx.doi.org/10.1016/S0140-6736(13)61904-2).

97. Centers for Disease Control and Prevention, *Surveillance for Influenza --- United States, 1997--98, 1998--99, and 1999--00 Seasons*, 51(SS7) MMWR SURVEILLANCE SUMMARIES 1, 5-6 (Oct. 25, 2002), <http://www.cdc.gov/mmwr/PDF/ss/ss5107.pdf>; Centers for Disease Control and Prevention, *Update: Influenza Activity -- United States, 2003-04 Season*, 52(49) MMWR 1197, 1200 (Dec. 12, 2003), <http://www.cdc.gov/mmwr/PDF/wk/mm5249.pdf>.

98. Ivan F. N. Hung et al., *Prevention of acute myocardial infarction and stroke among elderly persons by dual pneumococcal and influenza vaccination: a prospective cohort study*, 51(9) CLIN. INFECT. DIS. 1007 (Nov. 1, 2010), <http://dx.doi.org/10.1086/656587>.

99. Walter A. Orenstein, Mark J. Papania & Melinda E. Wharton, *Measles Elimination in the United States*, 189(Supp. 1) J. INFECT. DIS. S1 (2004), <http://dx.doi.org/10.1086/377693>.

100. Yvonne A. Maldonado, *Rubeola virus (measles and subacute sclerosing panencephalitis)*, in PRINCIPLES AND PRACTICE OF PEDIATRIC INFECTIOUS DISEASES 1137 (Sarah S. Long, Larry K. Pickering & Charles G. Prober eds., 4th ed. 2012).

101. Centers for Disease Control and Prevention, *EPIDEMIOLOGY AND PREVENTION OF VACCINE-PREVENTABLE DISEASES* 216

- (Jennifer Hamborsky, Andrew Kroger & Charles Wolfe eds. 13th ed. 2015), <http://www.cdc.gov/vaccines/pubs/pinkbook/downloads/meas.pdf>.
102. Paul Fine, Ken Eames & David L. Heymann, "Herd Immunity": A Rough Guide, 52(7) CLIN. INFECT. DIS. 911 (Apr. 1, 2011), <http://dx.doi.org/10.1093/cid/cir007>.
103. Centers for Disease Control and Prevention, *Frequently Asked Questions about Measles in the U.S.*, (Apr. 17, 2015), <http://www.cdc.gov/measles/about/faqs.html>.
104. Robert T. Perry & Neal A. Halsey, *The Clinical Significance of Measles: A Review*, 189(Supp. 1) J. INFECT. DIS. S4 (May 1, 2004), <http://dx.doi.org/10.1086/377712>.
105. *Id.*
106. Wilbert H. Mason, Measles, in NELSON TEXTBOOK OF PEDIATRICS 1069 (Robert M. Kliegman et al., eds., 19th ed. 2011).
107. Robert T. Perry & Neal A. Halsey, *The Clinical Significance of Measles: A Review*, 189(Supp. 1) J. Infect. Dis. S4 (May 1, 2004), <http://dx.doi.org/10.1086/377712>.
108. Alberto Matteelli et al., *Multidrug-resistant tuberculosis today*, 90(2) BULL. WORLD HEALTH ORG. 78 (Feb. 2012), <http://dx.doi.org/10.2471/BLT.11.097360>.
109. WORLD HEALTH ORG., GLOBAL TUBERCULOSIS CONTROL REPORT 2013 (Nov. 2013), [http://www.who.int/iris/bitstream/10665/91355/1/9789241564656\\_eng.pdf?ua=1](http://www.who.int/iris/bitstream/10665/91355/1/9789241564656_eng.pdf?ua=1).
110. WORLD HEALTH ORG., GLOBAL TUBERCULOSIS CONTROL REPORT 2012 (June 2012), [http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502_eng.pdf).
111. Karel Styblo, *The relationship between the risk of tuberculous infection and the risk of developing infectious tuberculosis*, 60 BULL. INT'L UNION TUBERC. LUNG DIS. 117 (1985).
112. Frank van Leth, Marieke J. van der Werf & Martien W. Borgdorff, *Prevalence of tuberculous infection and incidence of tuberculosis; a re-assessment of the Styblo rule*, 86(1) BULL. WORLD HEALTH ORG. 20 (Jan. 2008), <http://dx.doi.org/10.2471/BLT.06.037804>.
113. WORLD HEALTH ORG., GLOBAL TUBERCULOSIS CONTROL REPORT 2014 (Aug. 2014), [http://apps.who.int/iris/bitstream/10665/137094/1/9789241564809\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/137094/1/9789241564809_eng.pdf?ua=1).
114. Padmini Salgame et al., *Latent tuberculosis infection - Revisiting and revising concepts*, 95(4) TUBERCULOSIS 373 (July 2015), <http://dx.doi.org/10.1016/j.tube.2015.04.003>.
115. Suzanne Verver et al., *Rate of reinfection tuberculosis after successful treatment is higher than the rate of new tuberculosis*, 171(12) AM. J. RESPIR. CRIT. CARE MED. 1430 (July 2005), <http://dx.doi.org/10.1164/rccm.200409-1200OC>.
116. Mario Raviglione et al., *Scaling up interventions to achieve global tuberculosis control: progress and new developments*, 379(9829) LANCET 1902 (May 19, 2012), [http://dx.doi.org/10.1016/S0140-6736\(12\)60727-2](http://dx.doi.org/10.1016/S0140-6736(12)60727-2).



# APPENDIX B

## PUBLIC HEALTH GLOSSARY

Many existing benchbooks include a public health glossary, and drafters should consider including this resource in the benchbook appendices.<sup>117</sup>

---

<sup>117</sup>. See Pennsylvania, Indiana, Georgia, Michigan, Kentucky, and Florida benchbooks.

# APPENDIX C

## STATE HEALTH DISTRICTS OR LOCAL HEALTH UNITS

Benchbooks should include a description of how the local health departments are organized (e.g. districts, units, or by county) and contact information for the entities. For example, Indiana has ten public health preparedness districts.

**Figure 1. Indiana’s Public Health Preparedness Districts**



---

# APPENDIX D

## SELECTED EMERGENCY STATUTES

Many existing benchbooks include selected emergency statutes, and drafters should consider including this resource in the benchbook appendices.

# APPENDIX E

## SELECTED PROVISIONS OF THE STATE PUBLIC HEALTH CODE

Many existing benchbooks include selected provisions of the state's public health code as a ready reference, and drafters should consider including this resource in the benchbook appendices.

---

# APPENDIX F

## SELECTED CASE LAW

Many existing benchbooks include selected case law, and drafters should consider including this resource in the benchbook appendices.

# APPENDIX G

## SELECTED MODEL PETITIONS, AFFIDAVITS, AND ORDERS

Many existing benchbooks include selected model petitions, affidavits and orders related to public health cases, and drafters should consider including them in the benchbook appendices.

---

# APPENDIX H

## SELECTED COURT RULES

Many existing benchbooks include related court rules, and drafters should consider including them in the benchbook appendices.

# APPENDIX I

## JUDICIAL CHECKLISTS AND OTHER TOOLS

Many existing benchbooks include judicial tools such as checklists and quarantine process diagrams. Drafters should consider developing similar tools, and the following are some examples.

**Figure 2. Texas Property Quarantine Process** <sup>118</sup>

Implementation of Control Measures on Property  
(Texas Health & Safety Code §§ 81.063-065, 067-068, 084, 087-088)

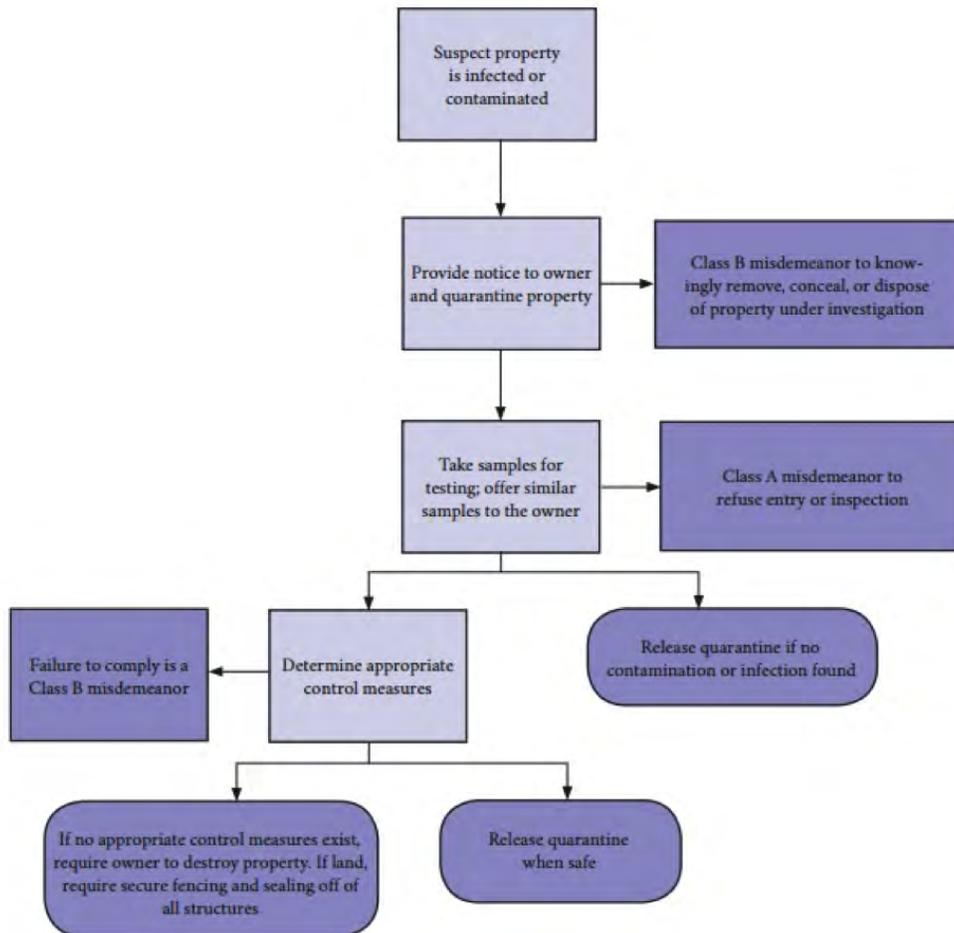


Figure 3. Oregon's Emergency Quarantine or Isolation Process <sup>119</sup>

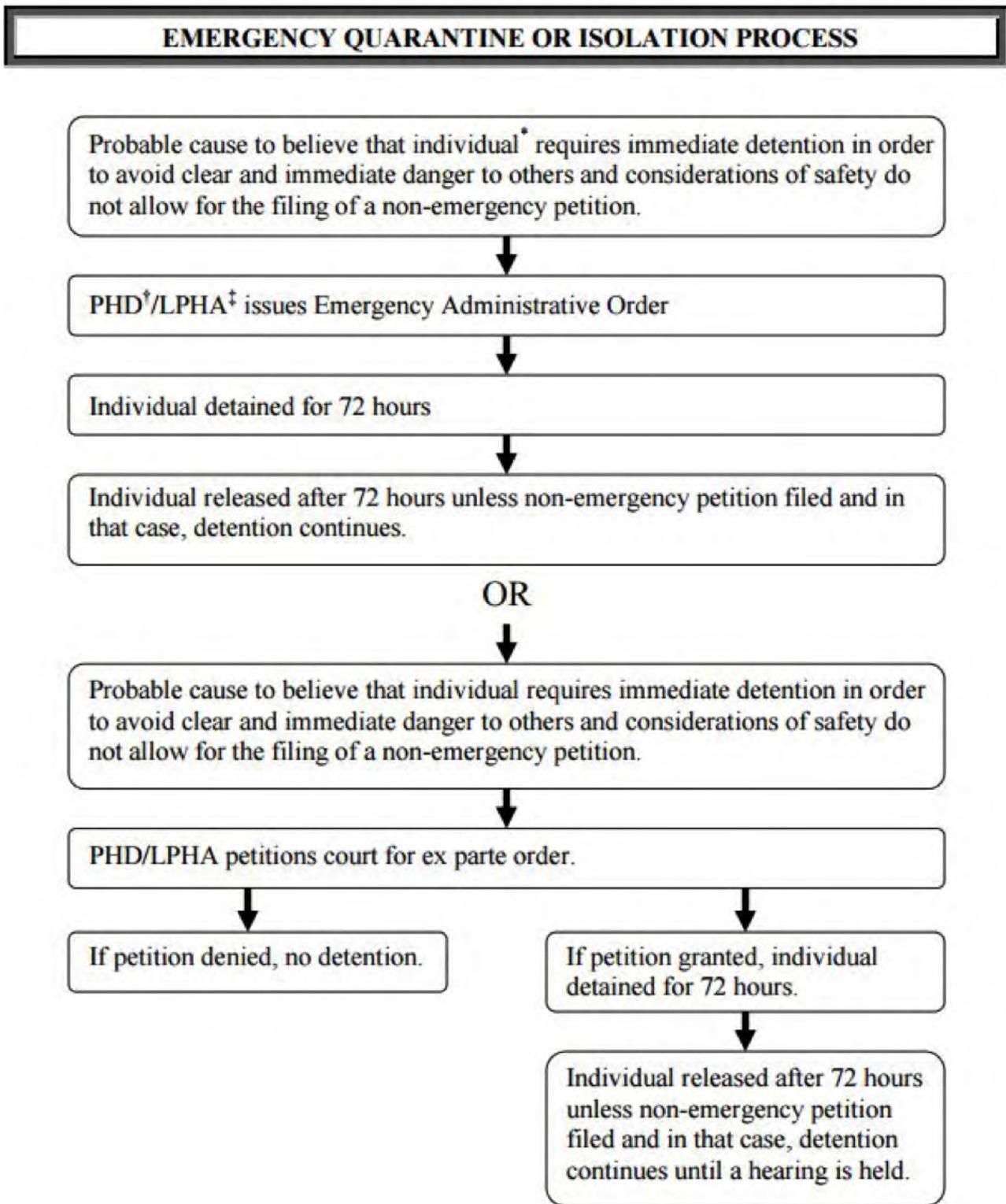
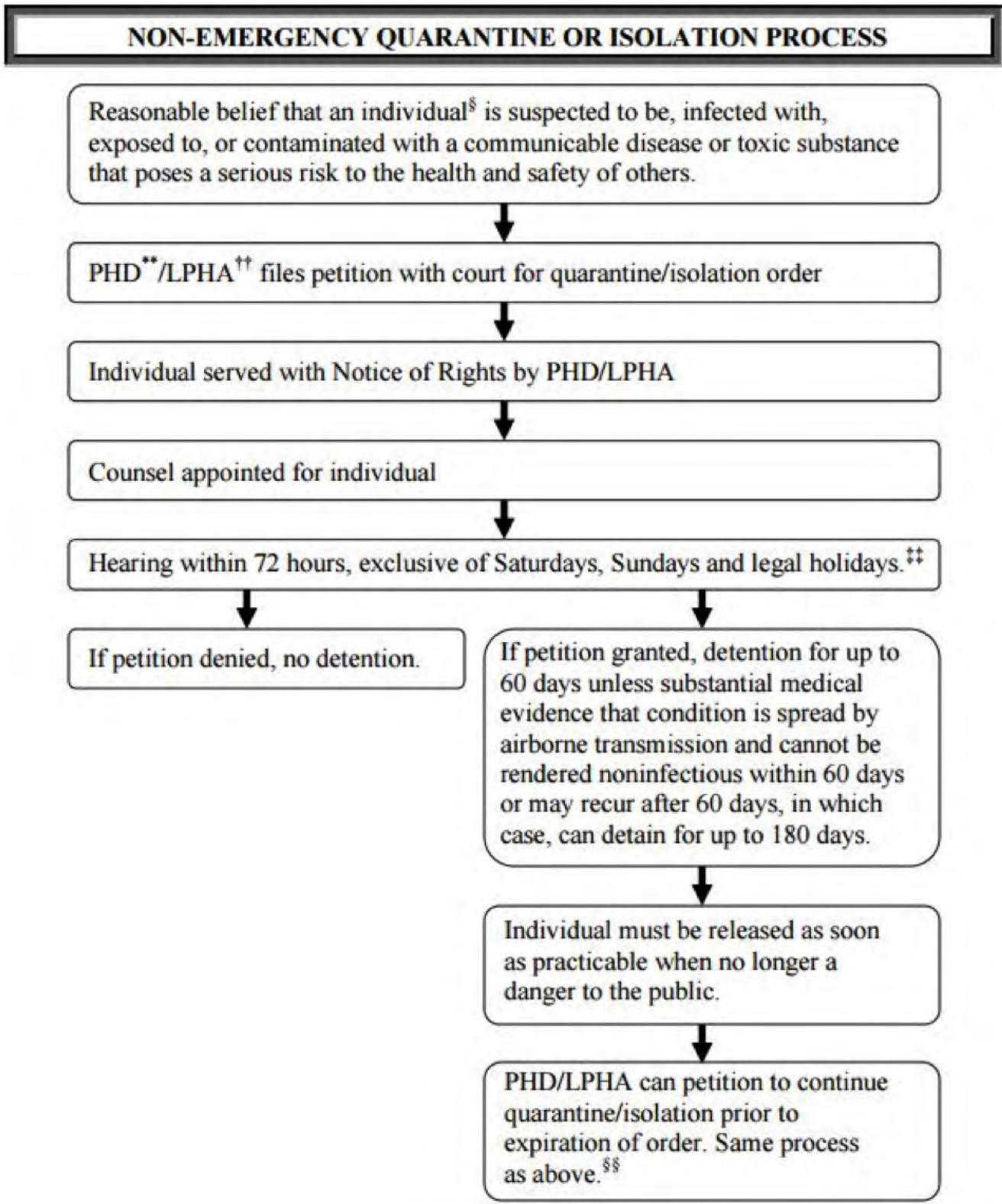


Figure 4. Oregon’s Non-Emergency Quarantine or Isolation Process <sup>120</sup>



## Figure 5. Florida Checklist for Habeas Corpus Hearing<sup>121</sup>

Purpose: to be used by judge for review of Quarantine (Exposed) / Isolation (Ill) Department of Health Orders.

### GENERAL REQUIREMENTS:

1. You are an acting circuit judge, a circuit judge, a district court of appeal judge, or a supreme court justice.
2. The petition is filed in the jurisdiction of the quarantined person/animal/property.
3. No filing fee is required.
4. No administrative agency review is required.
5. Speedy review is important (summary review).
6. Petition must be verified. Note: Can be sworn before a judge.
7. Petition may be filed by a family member, legal guardian, or friend.

### DEPARTMENT'S ORDER:

1. The order is signed by county health department director (medical doctor) or administrator (lay person).
2. The order concerns people or real property. Note: Goods/animals are handled by Department of Agriculture.
3. The person or property is sufficiently identified.
4. The medical need is articulated. The person or property poses "serious and present danger of harm to others."
5. The time period of the quarantine is defined.
6. Sufficient notice of time and place of this hearing was given.
7. Personal service was made.

### HEARING:

1. There is means for making a record (recording device). Note: No free copy unless indigent.
2. Court, personnel, parties, etc., are protected for health.
3. Who can be present?
  - \_\_\_\_\_ Department of Health Representative
  - \_\_\_\_\_ Petitioner
  - \_\_\_\_\_ Counsel for Department [Dept. Atty. / Atty. General / County Atty. / State Atty.]
  - \_\_\_\_\_ Counsel for Petitioner [Private / Legal Aid (civil) / Public Defender (criminal)]
  - \_\_\_\_\_ Public / Press

Note: There is a right to counsel. If petitioner is indigent, supply counsel. (Quarantine is a deprivation of a petitioner's liberty.)
4. The medical rights of the petitioner are protected.
5. The Department carried the burden of proof, "clear and convincing evidence."
6. The Department did not carry the burden of proof, "clear and convincing evidence."

**THINGS TO CONSIDER:**

- \_\_\_\_\_ 1. Was there exposure to contagious illness or is the petitioner ill (if reviewing isolation order)?
- \_\_\_\_\_ 2. Is non-compliance conduct evident?
- \_\_\_\_\_ 3. Will petitioner's "freedom" endanger the public?
- \_\_\_\_\_ 4. What is the severity of the "disease"?
- \_\_\_\_\_ 5. What is the treatment method?
- \_\_\_\_\_ 6. How is the infection spread?
- \_\_\_\_\_ 7. What is the time frame of the course of the illness?

Key: Match the restrictions to the threat.

Goal: Prevent the spread of a communicable disease.

Note: Check for bias in drawing a quarantine perimeter. Ask the petitioner why the quarantine order is unfair.

**COURT ORDER:**

- 1. The order must be written.
- 2. The order must state detailed facts.
- 3. The order must define closure / area of quarantine- "restrict or compel movement or action" to "protect society."

Note: Must be "least restrictive possible."

- 4. The order must give remedy. "Get medical test / obtain vaccine / finish treatment" by "any qualified person authorized by Department."
- 5. The order must make provision for "necessities" of food / safety / medical care to petitioner.

Note: But the provision of these necessities must not endanger others or degrade other services.

- 6. The order must state expiration date or return date to court.
- 7. The order must state the penalty for violation of order – second degree misdemeanor.
- 8. The order must state the means of appeal.

---

118. *Control Measures and Public Health Emergencies: A Texas Bench Book* (2014), <http://www.law.uh.edu/healthlaw/2014-HLPBenchBook-2.pdf>.

119. *Oregon Isolation and Quarantine Bench Book* (2011), [http://www.doj.state.or.us/pdf/oregon\\_isolation\\_and\\_quarantine\\_bench\\_book.pdf](http://www.doj.state.or.us/pdf/oregon_isolation_and_quarantine_bench_book.pdf).

120. *Id.*

121. *Pandemic Influenza Benchguide: Legal Issues Concerning Quarantine and Isolation* (2013), [http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic\\_benchguide.pdf](http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic_benchguide.pdf).

---

# APPENDIX J

## CONTACT INFORMATION

Benchbooks should include contact information for local, state and federal entities. Drafters should include, at minimum, the following contacts. This contact information should be updated regularly.

### **Federal Government**

- Centers for Disease Control and Prevention
- Federal Emergency Management Agency
- National Institutes of Health
- Office of the Surgeon General
- Public Health Service Commissioned Corps

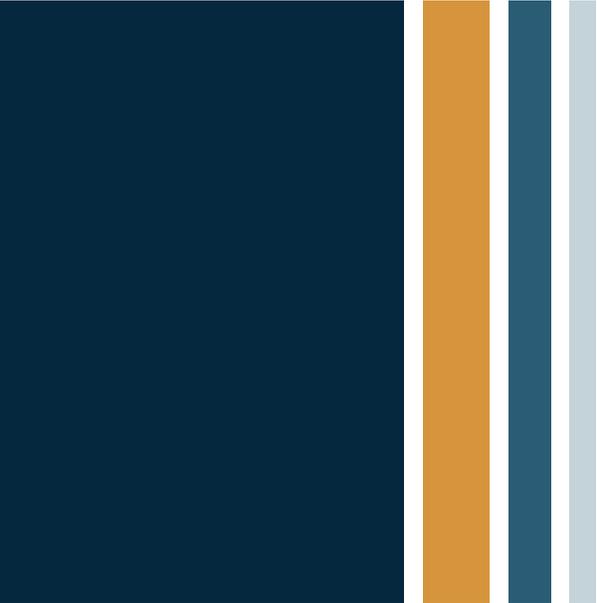
### **State and Local Government**

- State Department of Health
- Governor's Office
- Office of Attorney General
- State Judicial Branch
- Regional and Local Public Health Services

### **Other**

- Educational Institutions or Medical Facilities Institutions with Public Health Expertise





# PART III

Operating the Courts  
during a Pandemic

- 
- A** Implications for the Courts
  - B** Powers of the Chief Justice or State Court of Last Resort
  - C** Appearance of Individuals Posing a Potential Threat to Public Health
  - D** Juror Management Considerations
  - E** Additional Judicial Personnel
  - F** Consolidation of Cases
  - G** Emergency Court Closure and Relocation of Court
  - H** Limiting Public Access to the Courts
  - I** Communication
  - J** Technology Preparedness

# OPERATING

## THE COURTS DURING A PANDEMIC

### A. Implications for the Courts

Part II of this Guide provided a template for a benchbook that addresses the legal questions that could arise during a pandemic. Part III of this Guide provides guidance to administrators and judges on steps that need to be taken to ensure that the courts remain open and available to hear and resolve the legal questions that are filed with the court. Part III also reviews the specific implications for court administrators during a pandemic and offers strategies and resources to help them to prepare for the challenges that may arise.

Challenges facing the courts during a pandemic could include:

- (1) How to protect the health and safety of the litigants, judges, court staff, attorneys, jurors and all other persons in the court facilities despite their having face-to-face contact with each other;
- (2) How to perform the court's mission-critical functions when court staff, judges, jurors, attorneys, and court security officers are unavailable due to illness or death; and
- (3) How to respond to what could be a significant number of persons seeking emergency judicial relief from restrictions imposed by health authorities.

### B. Powers of the Chief Justice or State Court of Last Resort

Many states expressly give their Chief Justice or Supreme Court certain broad and individual powers during an emergency to facilitate the administration of justice. A pandemic benchbook should include any such authority.<sup>122</sup> It is anticipated that Emergency Rules would be issued by the Chief Justice or Supreme Court during a pandemic, and some anticipated topics include:

- Computation of time;
- Form of pleadings and motions;
- Service and filing of court documents;
- Continuances;
- Recording of proceedings;
- Confrontation rights;

- Open sessions of court;
- Form of the court record;
- Use of communication equipment;
- Oath (notary public or other person authorized to administer oaths must be present to witness);
- Expedited review procedures;
- Composition and transmittal of records of the lower tribunal; and
- Issuance of orders and opinions.<sup>123</sup>

Courts should review their rules in the topic areas above in the context of pandemic preparedness.

### C. Appearance of Individuals Posing a Potential Threat to Public Health

A court may be unwilling to permit an infected or potentially infected individual to appear in person because of the health threat such an individual poses. Litigants may be physically unable to attend a hearing in person due to illness. In the event an individual is not able or permitted to attend proceedings in person, the court should consider alternative appearance methods such as telephone appearances or videoconferencing. Benchbooks should include any authority that addresses when hearings can be held telephonically or via videoconference. Additional legislation or court rules may be needed to expand the discretion of judicial officers to use video and audio communications for appearances.

### D. Juror Management Considerations

The capacity to conduct jury trials during a public health threat will likely be impacted. However, the constitutional right to a speedy trial and an impartial jury requires courts to continue to perform this function. Two jury trial management issues that could arise during a pandemic include: 1) addressing a reduction in the jury pool, and 2) limiting juror exposure to contagions while serving. Drafters should consider including any rules or strategies that have been developed in the state for overcoming these jury management issues.<sup>124</sup> For example, Virginia identifies several strategies for addressing a reduction in jury pools including:

- (1) Reduce the number of jury trials scheduled by postponing civil and other jury trials where there is not a speedy trial issue;
- (2) Increase the number of jurors summoned to appear, noting that this increase must be balanced against the risk of calling more jurors than are realistically needed thereby unnecessarily exposing them to possible contagions; and
- (3) Clarify the policy for excusing jurors due to illness. Virginia notes that consideration should be given to implementing a more lenient excusal policy for illness during a pandemic, and the policy should address how to handle requests for excusal from populations most vulnerable to the flu (e.g., the elderly and pregnant women) and for those caring for sick family members, and the policy should identify who has authority for excusing jurors, the criteria for excusal, and whether any documentation will be required.<sup>125</sup>

Strategies for limiting juror exposure to contagions include:

- (1) Avoid having jurors report if the court anticipates a civil settlement or guilty plea, with consideration given to having the jurors report later than the scheduled trial time to allow

- the court to accept pleas or settlements or to continue cases in time to provide notice (posted outside courthouse and on phone recording) to jurors so they do not needlessly appear;
- (2) Have jurors report for service on a staggered schedule;
  - (3) Provide hand sanitizer and personal protective equipment (masks and gloves) to jurors if the locality is willing to provide these;
  - (4) Consider impaneling extra alternates to prevent having to adjourn or declare a mistrial should a juror fall ill;
  - (5) Require that jurors report directly to a courtroom as opposed to a jury assembly room; and
  - (6) To the extent possible, avoid passing exhibits between jurors.<sup>126</sup>

## **E. Additional Judicial Personnel**

States should have a mechanism that allows for an increase in the number of judicial officers available to hear matters in courts having original jurisdiction over public health.

## **F. Consolidation of Cases**

In some circumstances, health departments may choose to bring a judicial action to enforce isolation or quarantine orders against numerous individuals as a class action.<sup>127</sup> However, as Kentucky notes in its benchbook, “Given the extensive intrusions upon individual liberties that isolation and quarantine may entail and the limited opportunity that class certification affords affected individuals to present their case to the court, class certification should be implemented only when no other feasible procedure exists for efficiently adjudicating all matters pending before the court.”<sup>128</sup> In the context of pandemic planning, states should examine existing rules that address the authority to hear cases as a class action or for the court to consolidate cases on its own motion.

## **G. Emergency Court Closure and Relocation of Court**

Court administrators should review authority related to emergency court closure or relocation of court during a public health crisis, including who can authorize a court closure and under what circumstances.<sup>129</sup>

## **H. Limiting Public Access to the Courts**

In the event of a pandemic or public health threat, the court may find it necessary to limit public access to the courthouse to protect the health of court staff, judicial officers and litigants. Administrators should review any rules that allow for limited access to courthouses and hearings, including any authority to limit access by the media or the public to court proceedings, and then determine whether any amendments are needed.

## **I. Communication**

During pandemic circumstances, it is essential that courts provide up-to-date, consistent and understandable information to judges, court staff, the community, the media, other courts, and other key court partners.

Courts should prepare a communications plan to ensure that they are ready to successfully communicate during a pandemic. The communications plan should include:

- The individual at the affected court (*i.e.* the clerk) responsible for notifying the individual at the state or county level (*i.e.* the Chief Justice or State or County Court Administrator) as soon as a pandemic emergency is identified or a court case is filed;
- The designation of a single point-of-contact (POC) at the state level and, where appropriate, a second POC at the local level. The POC(s) must work together to provide consistent, timely, accurate information; and
- Details about what is to be communicated to whom and how communication will take place.

The plan should also provide instructions for communication at the point when a pandemic plan is activated and for the duration of the emergency.<sup>130</sup> The plan should include the designation of a person at the AOC who will be trained and prepared to implement the plan if and when a pandemic occurs and a person at the AOC who will serve as the state POC if and when a pandemic occurs.

The POC(s) should provide frequent reports to the public and the media on the impact of the pandemic on court operations and the steps that the court is taking to address the challenges. The POC(s) should also provide frequent updates to judges, court personnel, attorneys, and litigants on any special court processes and procedures that have been implemented, along with any changes to the court schedule. The POC(s) should provide a consistent, confident message to the public that the courts will continue to function despite the public health crisis and that critical matters will be heard and resolved.

## J. Technology Preparedness

Unlike other natural disasters, a pandemic will not compromise a court's IT infrastructure. However, during a pandemic, courts would likely be faced with (1) a decrease in the availability of IT staff, both in-house and vendor or third-party supported technology, and (2) a significant increase in the need for technology that reduces face-to-face interaction. Efforts should be made to cross-train staff to assume the IT tasks and responsibilities of mission-critical functions. Pandemic preparedness planning should include supporting the IT and telecommunications infrastructure necessary to support telecommuting, remote appearances, videoconferencing, etc. 🍌

---

122. For example, through Supreme Court Rule 14(A) Ohio gives its Chief Justice the powers to do and direct to be done "all things necessary to ensure the orderly and efficient administration of justice for the duration of the emergency." Rule 14(A) also gives the Chief Justice the power during an emergency to suspend local court rules, promulgate temporary rules, transfer powers to judges in the state, and accelerate the appointment of judges.

123. See *Pandemic Influenza Benchguide: Legal Issues Concerning Quarantine and Isolation* 85 (2013), [http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic\\_benchguide.pdf](http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic_benchguide.pdf).

124. See, e.g., *Pandemic Influenza Bench Book for Virginia's Court System 7-2* (2013), <http://www.courts.state.va.us/programs/pfp/benchbook.pdf>.

125. *Id.*

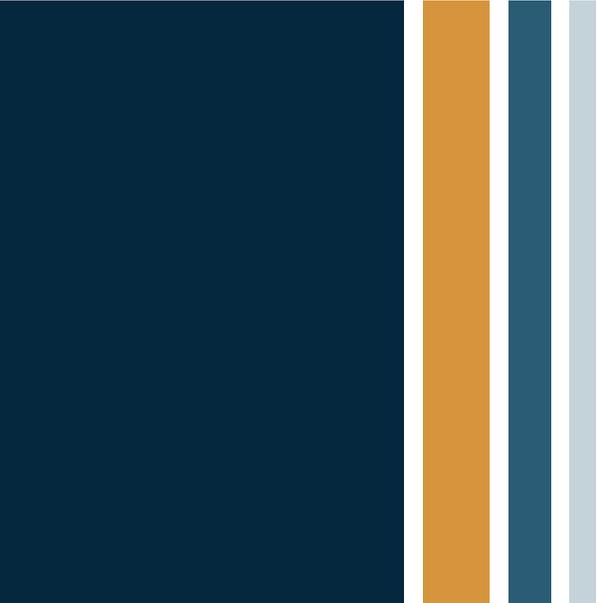
126. *Id.*

127. *Public Health Law Judicial Reference Guide for Kentucky Courts* 122 (Aug. 2006), [https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at\\_download/file](https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at_download/file).

128. *Id.*

129. For example, see New York's Judiciary Law § 8.

130. See *Virginia's Pandemic Influenza Bench Book for Virginia's Court System* for an excellent Information Dissemination Plan development worksheet. <http://www.courts.state.va.us/programs/pfp/benchbook.pdf>.



# **PART IV**

Planning and Implementation:  
Putting it All Together

---

**PART IV** Planning and Implementation: Putting it All Together



# PLANNING AND IMPLEMENTATION: PUTTING IT ALL TOGETHER

This Guide was intended to serve two purposes: (1) to help the judicial branch prepare judges to adjudicate legal issues that may arise during a public health emergency, and (2) to assist the courts to prepare for the operational challenges facing court administrators as they attempt to keep the courts open while protecting the health and safety of litigants, attorneys and court personnel, and while communicating the impact of the pandemic on court operations to litigants and the public.

How can states use this Guide to best prepare for a pandemic emergency?

The steps below provide a good blueprint to maximize preparedness by ensuring that judges have access to relevant statutes and case law when needed, and by making sure that administrators take the necessary steps to get cases heard promptly, protect the health and safety of all concerned, and minimize the concerns of the public and the court community.

- Establish a planning team.** Form a planning team with judicial branch personnel as well as other stakeholders. It might be helpful to create subcommittees focusing on areas such as logistics, human resources issues and legal issues.<sup>131</sup> Consider coordinating with stakeholder groups, such as public health, members of the bar, corrections, law enforcement and other court partners to ensure they have input into the court's planning efforts, but also to ensure that the courts are aware of and involved in current state and local planning and preparedness efforts.
- Review existing emergency preparedness and Continuity of Operations Plan (COOP) plans.** The planning team should learn if there are any existing emergency preparedness or COOP plans, or if there are any planning guidelines for pandemic planning that would inform and facilitate the court's efforts.
- Develop assumptions surrounding the nature of a potential event to guide the planning process.** The planning team should have something measurable upon which to base their planning, and something tangible from which to extrapolate specific impacts and implications. Gather data needed to assess the situation and to determine matters that need to be

addressed. These assumptions form a hypothetical context within which planners can work most effectively.<sup>132</sup>

- Draft Benchbook and Guide for Administrators.** Review this Guide along with state legal authority relating to public health matters and prepare a state pandemic benchbook and guide for administrators.
- Review current statutes and court rules.** Determine whether any amendments are needed to statutes and court rules to enable the court to perform critical functions during a pandemic. If and when new legislation is enacted or emergency or permanent rules are promulgated, amend the benchbook as needed.
- Develop a pandemic component to the court's Continuity of Operations Plan (COOP).**<sup>133</sup>
- Education and training.** Once the resources and plans are finalized, update them regularly and provide regular training to court staff and judicial officers.<sup>134</sup>

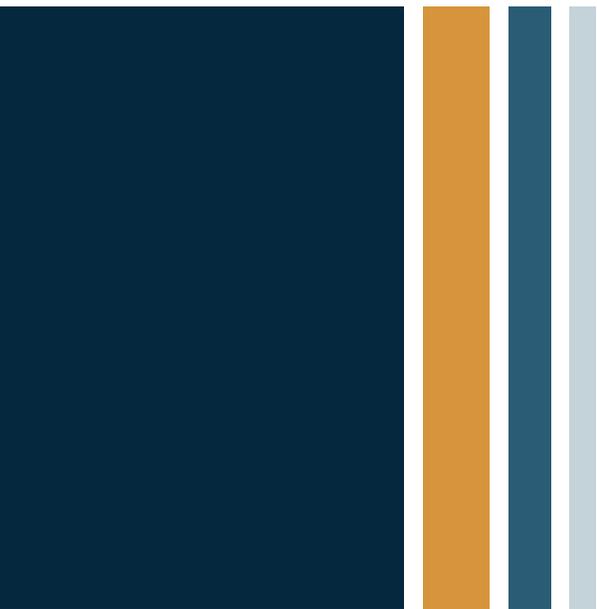
---

131. The New Jersey Judiciary employed such an approach and had three working groups: logistics, human resources and judicial and legal. Each working group was directed to draft plans for continued court operations in the event of a pandemic. The draft plans were then submitted to an Advisory Group of Assignment Judges for the development of a comprehensive report and recommendations for the Administrative Director.

132. The National Association for Court Management offers some assumptions specifically targeted to courts in its Business Continuity Management Mini Guide (2006).

133. See National Center for State Courts, Continuity of Operations: Steps for COOP Planning (2007), <http://www.ncsc.org/~media/Files/PDF/Services%20and%20Experts/Areas%20of%20expertise/Emergency%20Preparedness/toolkit.ashx>. Included in this guide is a section specifically addressing modified procedures for pandemic COOP planning.

134. For example, Pennsylvania held a three-day public health seminar for its judges in 2009. The training topics included (1) the history of threats to the public's health; (2) the nature of infectious disease; (3) Pennsylvania law and authorization to take action to control infectious disease; (4) jurisdiction in public health matters; and (5) the court's role in the administration of public health law. <http://www.pacourts.us/assets/files/newsrelease-1/file-1358.pdf?cb=abd265> The training coordinator's guide is available at <http://www.cphp.pitt.edu/cdc/manual/>.



# **PART V**

Resources

- 
- A** Pandemic and Public Health Benchbooks
  - B** Other Resources



---

# RESOURCES

## A. Pandemic and Public Health Benchbooks

### ARKANSAS

*Public Health Benchbook (2009)*

<http://www.healthy.arkansas.gov/aboutADH/RulesRegs/PublicHealthLawBenchBook2009.pdf>

### FLORIDA

*Pandemic Influenza Benchguide: Legal Issues Concerning Quarantine and Isolation (2013)*

[http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic\\_benchguide.pdf](http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic_benchguide.pdf)

### GEORGIA

*Pandemic Influenza Benchguide (2009)*

<http://w2.georgiacourts.gov/journal/index.php/october-2014/299-pandemic-guide-may-provide-help-for-ebola-crisis>

### INDIANA

*Public Health Law Benchbook for Indiana Courts (2005)*

<http://www.in.gov/judiciary/admin/2901.htm>

### KENTUCKY

*Public Health Law Judicial Reference Guide for Kentucky Courts (August 2006)*

[https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at\\_download/file](https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at_download/file)

### MICHIGAN

*Public Health Law Bench Book for Michigan Courts (October 2007)*

[http://www.michigan.gov/documents/ag/Michigan\\_Public\\_Health\\_Bench\\_Book\\_221936\\_7.pdf](http://www.michigan.gov/documents/ag/Michigan_Public_Health_Bench_Book_221936_7.pdf)

### MINNESOTA

*Isolation and Quarantine Benchbook (November 2008)*

[http://www.mncourts.gov/Documents/0/Public/Isolation\\_and\\_Quarantine/Isolation\\_and\\_Quarantine\\_Benchbook.pdf](http://www.mncourts.gov/Documents/0/Public/Isolation_and_Quarantine/Isolation_and_Quarantine_Benchbook.pdf)

**NEVADA**

*Involuntary Confinement Bench Book (Updated October, 2014)*

**NEW YORK**

*New York State Public Health Legal Manual: A Guide for Judges, Attorneys and Public Health Professionals (2011)*

<https://www.nycourts.gov/whatsnew/pdf/PublicHealthLegalManual.pdf>

**NORTH CAROLINA**

*Pandemic Emergency Bench Book for Trial Judges (August 2009)*

[http://www.sog.unc.edu/sites/www.sog.unc.edu/files/PandemicEmergencyBenchBook\\_Dec2009.pdf](http://www.sog.unc.edu/sites/www.sog.unc.edu/files/PandemicEmergencyBenchBook_Dec2009.pdf)

**OHIO**

*Public Health Preparedness Bench Book: A Guide for the Ohio Judiciary & Bar on Legal Preparedness for Public Health Emergencies & Routine Health Cases*

<http://www.supremecourt.ohio.gov/Boards/courtSecurity/PandemicPrepareGuide.pdf>

**OKLAHOMA**

*District Court, 20th Judicial District Pandemic Influenza Bench Book*

<http://www.ok.gov/health2/documents/EPRS-Pandemic%20Dist%20Ct%20Benchbook.pdf>

**OREGON**

*Oregon Isolation and Quarantine Bench Book (2011)*

[http://www.doj.state.or.us/pdf/oregon\\_isolation\\_and\\_quarantine\\_bench\\_book.pdf](http://www.doj.state.or.us/pdf/oregon_isolation_and_quarantine_bench_book.pdf)

**PENNSYLVANIA**

*Pennsylvania Public Health Law Bench Book (February 2007)*

<http://www.cphp.pitt.edu/upcphp/benchbook.pdf>

**SOUTH CAROLINA**

*Public Health Emergencies: A Resource for Bench and Bar (2012)*

<http://www.scdhec.gov/library/CR-010455.pdf>

**TEXAS**

*Control Measures and Public Health Emergencies: A Texas Bench Book, Allison N. Winnike ed. (2016)*

<http://www.law.uh.edu/healthlaw/2014-HLPIBenchBook-2.pdf>

**UTAH**

*Judicial Review of Orders of Restriction (2008)*

[http://health.utah.gov/epi/diseases/TB/guidelines/judicial\\_review.pdf](http://health.utah.gov/epi/diseases/TB/guidelines/judicial_review.pdf)

**VIRGINIA**

*Pandemic Influenza Bench Book for Virginia's Court System*

<http://www.courts.state.va.us/programs/pfp/benchbook.pdf>

**WASHINGTON**

*Public Health Emergency Bench Book*

<http://www.courts.wa.gov/manuals/?fa=manuals.showManualsPage&manualid=publicHealth&file=publicHealth-29>

## B. Other Resources

- A Framework for Improving Cross-Sector Coordination for Emergency Preparedness and Response: Action Steps for Public Health, Law Enforcement, the Judiciary and Corrections. Centers for Disease Control and Prevention (U.S.) (2008).  
[http://www.cdc.gov/phlp/docs/CDC\\_BJA\\_Framework.pdf](http://www.cdc.gov/phlp/docs/CDC_BJA_Framework.pdf)
- About Ebola. Centers for Disease Control.  
<http://www.cdc.gov/vhf/ebola/index.html>
- Conference of State Court Administrators, Position Paper on Emergency Preparedness in the State Courts (Dec. 2006).  
[http://cosca.ncsc.org/~media/Microsites/Files/COSCA/Policy%20Papers/EmergencyPreparednessStateCourts\\_Dec06.ashx](http://cosca.ncsc.org/~media/Microsites/Files/COSCA/Policy%20Papers/EmergencyPreparednessStateCourts_Dec06.ashx)
- Continuity of Court Operations: Steps for COOP Planning, National Center for State Courts (2007).  
<http://www.ncsc.org/~media/Files/PDF/Services%20and%20Experts/Areas%20of%20expertise/Emergency%20Preparedness/toolkit.ashx>
- Courthouse Preparedness for Public Health Emergencies: Critical Issues for Bioterror/Biohazard Preparedness Planning. University of Pittsburgh Center for Public Health Preparedness (Jan. 2006).  
<http://www.prepare.pitt.edu/pdf/CourthousePrepBooklet.pdf>
- Epidemics and the California Courts. Administrative Office of the California Courts (Oct. 2006).  
<https://www.cdph.ca.gov/programs/cclho/Documents/EpidemicsInTheCourts.pdf>
- JARED P. COLE, CONGRESSIONAL RESEARCH SERVICE, FEDERAL AND STATE QUARANTINE AND ISOLATION AUTHORITY (Oct. 9, 2014), available at <http://fas.org/sgp/crs/homsec/RL33201.pdf> (updating an earlier version by Kathleen S. Swendiman & Jennifer K. Elsea, available at <http://biotech.law.lsu.edu/cases/pp/RL33201.pdf>).
- Guidelines for Pandemic Emergency Preparedness Planning: A Road Map for Courts (March 2007).  
<https://www.american.edu/spa/jpo/upload/2091-2.pdf>
- LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (Berkeley, Cal.: University of California Press 3d ed. 2016).
- Daniel D. Stier, *The Courts, Public Health, and Legal Preparedness*, 97 AM. J. PUB. HEALTH S69–S73 (2007).
- Florida State Courts Strategy for Pandemic Influenza: Keeping the Courts Open in a Pandemic. Office of the State Courts Administrator (May 2007).  
<http://www.flcourts.org/core/fileparse.php/260/urlt/Best-Practices-Pandemic-Planning.pdf>
- State Public Health Counsel Directory. Centers for Disease Control.  
[http://www.cdc.gov/phlp/contacts/counsels\\_map.html](http://www.cdc.gov/phlp/contacts/counsels_map.html)





**State Justice Institute**

11951 Freedom Drive, Suite 1020  
Reston, VA 20190



**National Center for State Courts**

300 Newport Avenue  
Williamsburg, VA 23185