

Chapter 18:

Prevention and Control

of Communicable

Diseases

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18.1 Chapter Summary

This chapter covers communicable/infectious diseases and related mandatory reporting, control and prevention strategies, and enforcement mechanisms. It provides a brief overview of the national, state and local public health agencies and systems, and their coordination with federal and tribal authorities. In addition to the general overview, two communicable diseases, HIV/AIDS and tuberculosis (TB), are specifically covered because these diseases have special reporting, control, prevention, and enforcement mechanisms.

18.2 Overview of Communicable/Infectious Diseases and Public Health

The public health system relies on health care providers and facilities to report certain contagious diseases to local or state authorities. There are two purposes for reporting these diseases. One purpose is to gather data, monitor the incidence of communicable diseases, and collect information necessary to guide prevention and control efforts. The second purpose is to ensure appropriate management of the individual's disease and thereby prevent the spread of the disease to others. Before the public health system can function, it must first be aware of the individual's disease status, hence reporting is critical.

The Washington State Board of Health requires nearly all health professionals to report communicable diseases. Reporting of specified communicable diseases and conditions to public health authorities is mandatory. The principal health care provider, defined as the attending physician or other provider primarily responsible for diagnosis and treatment, has the primary responsibility of reporting the disease or condition to the appropriate public health department. The health care facility providing the treatment is responsible for reporting if the attending physician fails to do so. Laboratories are also required to report evidence of certain communicable diseases specified by the Board of Health and to forward certain specified organisms/specimens to the state laboratory for confirmation. Other health care providers are also responsible for reporting if such a report has not already been made to the local health department. Submission of specimens to the public health department by the testing laboratory does not relieve the primary health care provider or facility from any mandatory reporting responsibilities.

If an individual is unwilling or unable to accept voluntary treatment, then a public health examination, treatment, or detention order may be obtained. Public health orders are the enforcement tool of last resort. Public health orders are supported by judicial order, and violation of a public health order is a misdemeanor. In addition to orders, other outreach and enforcement mechanisms are used. Often these "less-restrictive" measures may be more effective than imposing criminal sanctions. Many local health departments employ caseworkers who deliver public health services on the streets. These caseworkers may locate persons suspected of carrying an infectious disease, draw blood for testing, counsel them on the control of their disease, help notify their sexual partners, and/or deliver medications.

18.3 Competing Interests and Concerns

Tensions exist within the health care system related to the reporting of communicable/infectious diseases. Concerns arise around claims of burdensomeness, redundancy, and concerns for confidentiality. While health care providers recognize that reporting is necessary to protect the public health, as well as required by law, providers may consider such reporting burdensome. To promote reporting and ease the burden of compliance, public health agencies try to make reporting as easy as possible by allowing telephone reporting and/or supplying educational materials and reporting forms to providers and facilities.

Overlapping reporting obligations may also give rise to tensions within the system. Since both health care providers and testing laboratories must meet reporting requirements regarding the same individual, some providers feel the system is unnecessarily redundant or that they are checking on each other's activities. From a public health

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perspective however, such double reporting creates a safety net that is preferable to a system that risks no reporting at all. Overlapping reports also generally result in more complete information regarding each case.

Confidentiality of health care information also creates concerns about reporting. Health care providers need to respect and protect the patient's privacy and, at the same time, adhere to mandatory reporting requirements. Both state and federal healthcare privacy laws allow providers to disclose the information necessary to comply with the provider's mandatory reporting obligations.² If only used for statistical purposes, patient identifiers are removed from records. The confidentiality of more complete health records, for tracking the testing and treatment of individual patients, must be protected to prevent unauthorized disclosure.

18.4 State and Local Communicable Disease and Public Health Legal Authorities

18.4.1 State Authorities

At the state level, the Washington State Department of Health (DOH) is entrusted with administering public health programs and related management and support services to public health departments and health care facilities.³ These services include but are not limited to: immunizations, tuberculosis, sexually transmitted diseases, AIDS and communicable disease epidemiology, and emergency planning. The powers and duties of the Secretary of DOH include investigating outbreaks and epidemics of disease that may occur, and advising local health officers as to measures to be taken to prevent and control outbreaks and epidemics. The DOH Secretary has the same authority as local health officers but may only exercise such authority when the local health officer fails or is unable to do so, in an emergency where the safety of the public health demands it, or by agreement with the local health officer or board of health.⁴

The Washington State Board of Health provides a forum for public participation in health policy and advises the Secretary on health policy matters.⁵ The Board also has authority to adopt public health rules, and may delegate its rulemaking authority to the Secretary.⁶ Examples of communicable disease related rules reviewed and adopted by the Board include immunization requirements and procedures for isolation and quarantine.⁷

The state health officer is a physician designated by the Secretary of DOH to serve as statewide health officer. In the absence of such designation by the secretary, the state health officer has primary responsibility for public health matters in the state.⁸ The state health officer also distributes periodic epidemiologic summary reports and an annual review of public health issues to local health officers and local health departments. The state health officer may require reporting of cases and suspected cases of disease and conditions, in addition to those required under existing law, if the disease or condition is newly recognized or recently acknowledged as a public health concern, and an epidemiological investigation would contribute to understanding of the disease or condition.⁹

² See RCW 70.02.050(2)(a) and (b).

³ See generally RCW 43.70.020; chapter 246-101 WAC. The Department of Health website is also an excellent source of information on the structure, organization and relationships of the public health system. <http://www.doh.wa.gov>.

⁴ WAC 246-01-060.

⁵ RCW 43.20.050. The Board maintains a website with current information on its agendas and activities. <http://www.doh.wa.gov/SBOH/>.

⁶ WAC 246-01-050.

⁷ RCW 28A.210.080; RCW 28A.210.140.

⁸ WAC 246-100-011(30); WAC 246-101-010(40).

⁹ WAC 246-101-015.

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18.4.2 Local Authorities

At the local level, the local board of health has supervision over providing for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department.¹⁰ Local health departments are defined as the county or district which provides public health services to persons within that area.¹¹

The local health officer is an individual appointed by the local board of health as the health officer for the local health department, or as the director of public health of a combined city-county health department.¹² Duties of the local health officer include review and determination of appropriate action for each suspected case of a reportable disease or condition or any disease or condition considered a threat to public health and each reported outbreak or suspected outbreak of disease. The local health officer also institutes measures for disease prevention and infection control, including isolation, detention and quarantine measures necessary to prevent the spread of communicable disease.¹³ In carrying out these duties, the local health officer may invoke the power of the courts to enforce any measures when necessary.¹⁴

The local health officer at the local health department is also responsible for establishing reporting and record systems that maintain the confidentiality of written records and written and telephoned disease case reports.¹⁵ The local health officer notifies health care providers within the health district regarding reporting requirements. Local health officers are also responsible for distributing appropriate report forms and notifying the principal health care provider, if possible, prior to initiating a case investigation by the local health department.

Other duties of the local health officer include providing information publicly and ensuring the availability of HIV testing, AIDS counseling, and pretest and post-test counseling for voluntary, mandatory and anonymous testing and counseling.¹⁶ The local health officer assists health care providers in the partner notification process using identifying information of HIV-infected individuals.¹⁷ It is the responsibility of the local health officer to destroy referral information containing identities and identifying information on HIV-infected individuals and their at-risk partners immediately after notification or within three months, whichever occurs first.¹⁸

Additionally, each local health officer has the authority to carry out any additional steps necessary to verify a diagnosis reported by a health care provider, require any person suspected of having a reportable disease or condition to submit to examinations required to determine the presence of the disease or condition, and to investigate any case or suspected case of a reportable disease or condition or other illness, communicable or otherwise, if deemed necessary.¹⁹

18.5 Notifiable Conditions

One method of protecting the public's health is the requirement that health care providers, including professionals, facilities, and laboratories, notify the state or local health department whenever they encounter a confirmed or suspected notifiable condition. Based on the information in these mandatory reports, public health authorities take

¹⁰ RCW 70.05.060.

¹¹ RCW 70.05.010.

¹² RCW 70.05.070.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ WAC 246-101-505.

¹⁶ WAC 246-100-036.

¹⁷ WAC 246-100-072.

¹⁸ WAC 246-100-072.

¹⁹ See WAC 246-100-040 *et seq.* containing procedures for isolation and quarantine.

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steps to protect the public, including investigating outbreaks, assessing trends and patterns, and treating persons who are ill.²⁰

18.5.1 What are Notifiable Conditions?

The diseases and conditions that are considered “notifiable” and which are required to be reported, vary slightly for “health care facilities,” “health care providers,” and laboratories. Each category has its own table of notifiable conditions, including the name of the disease or condition, where the report must be made, and within what time frame.²¹ The tables can be found in the Washington Administrative Code (on the Internet or at your local library), as well as on the Department of Health website mentioned below.²²

Determine Your Reporting Obligations

The Department of Health maintains a Notifiable Conditions website with information on who must report, what must be reported and when, and forms for use in making required reports to state or local authorities.

<http://www.doh.wa.gov/Notify/>

Notifiable conditions include any disease or condition that may be of public health significance. Infectious diseases such as HIV/AIDS and other STDs, hepatitis A, B, and C, mumps, and measles are included, as well as non-infectious diseases and conditions such as animal bites, pesticide or shellfish poisoning, and certain birth defects.²³ The list of specific notifiable conditions is monitored and updated on a regular basis.²⁴

Notifiable conditions also include any cluster or suspected outbreaks of a disease or condition, even if it is not listed as a notifiable condition on its own. For example influenza and chickenpox are not listed on the notifiable conditions list, but a health care provider or facility must still report any outbreak or suspected outbreak of these diseases. Other diseases in this category include viral meningitis and any nosocomial infection due to suspected contaminated food or devices, and environmentally caused diseases.²⁵

18.5.2 Providers Who Must Report Notifiable Conditions

All licensed “health care facilities” must report notifiable conditions. The definition of “health care facility” includes hospitals, nursing homes, adult family homes, boarding homes, and any clinic where one or more professional practices.²⁶ For notifiable conditions such as sexually transmitted diseases (including HIV/AIDS),

²⁰ WAC 246-101-005.

²¹ See, e.g., WAC 246-101-101 (Table HC-1), which contains Notifiable Conditions for health care providers, WAC 246-101-201 (Table Lab-1), which contains Notifiable Conditions for laboratories), and WAC 246-101-301 (Table HF-1), which contains Notifiable Conditions for health care facilities. The Department of Health also maintains a current list of Notifiable Conditions on its website, by provider type. <http://www.doh.wa.gov/Notify/>.

²² State laws and administrative rules can be found on the Legislature’s website at: <http://www1.leg.wa.gov/LawsAndAgencyRules/>.

²³ See, e.g., WAC 246-101-101, Table HC-1.

²⁴ WAC 246-101-015.

²⁵ WAC 246-101-305(1)(c) ; WAC 246-101-305(1)(d).

²⁶ “‘Health care facility’ means: (a) Any facility or institution licensed under chapter 18.20 RCW, Boarding homes; chapter 18.46 RCW, Birthing centers; chapter 18.51 RCW, Nursing homes; chapter 70.41 RCW, Hospitals; chapter 70.128 RCW, Adult family homes; or chapter 71.12 RCW, Private establishments; (b) Clinics, or other settings where one or more health care providers practice; and (c) In reference to a sexually transmitted disease, other settings as defined in chapter 70.24 RCW.” WAC 246-101-010(14).

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facility also includes locations such as foster homes, child care agencies, hospices, blood banks, and home health agencies.²⁷

All licensed “health care providers” must report notifiable conditions.²⁸ A health care provider is any person who has a license or certification under Title 18 RCW, including physicians, nurses (RN, LPN), psychologists, social workers, and counselors.²⁹ Military providers practicing within the state of Washington fall within this definition regardless of whether their license is from Washington or another state.

Laboratories must also report notifiable conditions. A laboratory includes any location licensed as a medical test site.³⁰ Laboratories that are within health care facilities have reporting duties independent of the facility’s duties, and laboratories are responsible for reporting any notifiable conditions associated with specimens that they may have referred to laboratories outside of Washington.³¹

18.5.3 Timing of Reports

Some notifiable conditions require immediate reports by telephone to the state or local health department, such as measles or E. coli.³² Other infectious notifiable conditions must be reported within three working days.³³ A small number of conditions and diseases can be reported on a monthly basis, such as birth defects.³⁴

18.5.4 Content of Reports

Reports of notifiable conditions must include the name of the patient, their address, telephone number, date of birth, sex, diagnosis (or suspected diagnosis), pertinent laboratory data, the principal health care provider’s name and contact information, and the contact information of the person completing the report.³⁵ The patient health care information contained in the reports is treated confidentially by the local and state health departments.³⁶ For designated notifiable conditions, laboratories are required to submit biological specimens or cultures to the Department of Health within the specific time frame.

18.5.5 Providing Information to the Patient

Health care providers must counsel patients who have been diagnosed with communicable disease on disease control measures. The information provided to the patient must include information for contacts who may have been exposed to the disease.³⁷

²⁷ “‘Health care facility’ means a hospital, nursing home, neuropsychiatric or mental health facility, home health agency, hospice, child care agency, group care facility, family foster home, clinic, blood bank, blood center, sperm bank, laboratory, or other social service or health care institution regulated or operated by the department of health.” RCW 70.24.017(5).

²⁸ WAC 246-101-101.

²⁹ “‘Health care provider’ means any person having direct or supervisory responsibility for the delivery of health care who is: (a) Licensed or certified in this state under title 18 RCW; or (b) Military personnel providing health care within the state regardless of licensure.” WAC 246-101-010(15).

³⁰ WAC 246-101-010(23). A medical “‘Test site’ means any facility or site, public or private, which analyzes materials derived from the human body for the purposes of health care, treatment, or screening. A test site does not mean a facility or site, including a residence, where a test approved for home use by the federal food and drug administration is used by an individual to test him or herself without direct supervision or guidance by another and where this test is not part of a commercial transaction.” RCW 70.42.010(8).

³¹ WAC 246-101-301; WAC 246-101-205(7).

³² WAC 246-101-101; WAC 246-101-110; WAC 246-101-301; WAC 246-101-310.

³³ WAC 246-101-101; WAC 246-101-110; WAC 246-101-301; WAC 246-101-310.

³⁴ WAC 246-101-101; WAC 246-101-110; WAC 246-101-301; WAC 246-101-310.

³⁵ WAC 246-101-115; WAC 246-101-315.

³⁶ WAC 246-101-120; WAC 246-101-230; WAC 246-101-320.

³⁷ WAC 246-101-105(7) ; WAC 246-101-305(7).

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18.5.6 Other Obligations

In addition to complying with the notifiable conditions reporting requirements, health care providers, facilities, and laboratories must cooperate with public health authorities during investigation of communicable diseases and outbreaks and notify officials of any potential barriers to isolation or quarantine.³⁸

18.6 Communicable Disease Prevention Mechanisms

State and local health officials are charged with protecting the public from numerous potential communicable diseases. To meet these obligations, they are given broad powers to prevent and control the spread of disease. This section provides just a few examples of the wide and varied range of prevention programs and mechanisms that protect the public from communicable diseases.

18.6.1 Immunizations

Immunizations are required before any child can attend childcare, preschool, or any public or private school in the state.³⁹ The immunization requirements, determined by the state Board of Health, are a primary tool in controlling the spread of communicable disease.⁴⁰ Exemptions from required vaccines are allowed only for limited reasons, such as the health of a particular child or religious accommodation.⁴¹ Courts recognize the validity of this exercise of public health powers and have upheld mandatory vaccination programs.⁴²

18.6.1.1 Influenza and Pneumococcal Disease

More than 200,000 people are hospitalized because of flu complications, and about 36,000 people die from flu in the U.S. each year. Most deaths occur in people sixty-five years of age and older.⁴³ The Center for Disease Control (CDC) has long recommended that all health care workers receive flu shots each year, yet under voluntary program immunization rates nationally for health care workers are less than 40%. State and local health departments and the federal Centers for Disease Control undertake public service announcements and vaccination campaigns, such as ‘Get Your Flu Vaccine,’ to increase public health care provider’s and the public’s awareness and utilization of prevention measures.⁴⁴

In 2005, the federal government began to require skilled nursing facilities (SNFs) to educate residents and/or the resident’s family about the advantages and possible disadvantages of receiving flu vaccines, and to ensure residents receive immunizations against influenza and pneumococcal disease. The new Medicare condition of participation requires SNFs to:

- Offer influenza immunization to each resident annually;
- Immunize each resident against influenza unless medically contraindicated or when the resident or the resident’s legal representative refuses immunization;
- Offer pneumococcal immunization once, if there is no history of immunization; and

³⁸ WAC 246-101-105(1), (6), (7); WAC 246-101-305(1), (6), (7).

³⁹ RCW 28A.210.080; WAC 246-100-166.

⁴⁰ RCW 28A.210.140; RCW 28A.210.060.

⁴¹ RCW 28A.210.090.

⁴² See e.g. *Lehman v. Partlow*, 119 Wash. 316, 205 P.420 (1922) (state board of health has authority to promulgate and enforce regulation requiring smallpox vaccination as requirement for school attendance). See also *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S. Ct. 358 (1905).

⁴³ Washington State Department of Health, <http://www.doh.wa.gov/FluNews/influenza.htm> (last visited Dec. 18, 2005).

⁴⁴ CDC Flu Gallery Patient Education Materials, December 2005. <http://www.cdc.gov/flu/professionals/flugallery/flyers.htm>.

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- Immunize residents against pneumococcal disease unless medically contraindicated or when the resident or the resident’s legal representative refuses immunization.⁴⁵

In January 2006, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released proposed new standards requiring all accredited organizations to reduce the risk of influenza transmission and infection throughout the organization.⁴⁶ The proposed standards require organizations to educate staff, provide access to no-cost influenza vaccine, and to monitor rates of vaccination.⁴⁷

In addition to regulatory mandates for vaccination of health care workers, health care providers may adopt mandatory influenza vaccination requirements for their workers as safety/infectious disease control measures to protect their patients and staff. Additionally, health care workers, under their professional ethical guidelines, may have an ethical duty to obtain vaccinations as doing so could prevent harm to their patients.

18.6.2 Infection Control Programs

As a condition of their license, all hospitals must have an infection control program.⁴⁸ The program must include components that cover the continuum of hospital staff and operations in order to prevent and control the spread of disease.⁴⁹ Antisepsis and hand washing, disposal of waste, laundry and linen procedures, and barrier use (e.g. gloves, masks, and gowns) are just some of the required elements of the required infection control program.⁵⁰ Staff members are trained in precautions against the transmission of HIV and other blood-borne pathogens.⁵¹ Hospital staff must be screened for tuberculosis and provided access to vaccination for hepatitis B.⁵²

18.6.3 Needle Exchange Programs

Intravenous drug use is a frequent method of transmitting communicable diseases, including HIV and hepatitis. Needle exchange programs are intended to slow the spread of AIDS and other infectious diseases among IV drug users, and those with whom they come into contact.⁵³

18.7 Control of Specific Diseases – Tuberculosis and HIV/AIDS

Washington has specific reporting, control and prevention, and enforcement mechanisms for tuberculosis (TB) and HIV/AIDS.

⁴⁵ 42 CFR 483.25(n).

⁴⁶ Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, Standard IC.4.15.

⁴⁷ *Id.*

⁴⁸ WAC 246-320-265.

⁴⁹ WAC 246-101-305(8). Program requirements can be found in WAC 246-320-265.

⁵⁰ *Id.* The hospital is also required to “Adopt and implement written policies and procedures consistent with the published guidelines of the centers for disease control and prevention (CDC) regarding infection control in hospitals, to guide the staff.” *Id.* State regulations regarding blood borne pathogens are contained in chapter 296-823 WAC. The state Department of Labor and Industries website provides additional helpful tools and links. www.lni.wa.gov/wisha/Rules/bbpathogens/default.htm.

⁵¹ WAC 246-320-165.

⁵² WAC 246-320-165; WAC 296-823-130. Safety/infectious disease policies that require mandatory vaccination, such as hepatitis, influenza or others, should provide for reasonable accommodation for workers for whom vaccination is medically contraindicated or who object to receiving vaccination based on religious beliefs or practices.

⁵³ See, e.g., *Spokane County Health District v. Brockett*, 120 Wash.2d 140, 144, 839 P.2d 324, 325 (1992).

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18.7.1 Tuberculosis⁵⁴

Approximately 15 million individuals in the United States, and as many as 30% of the world's population, are infected with tuberculosis.⁵⁵ In 2002, Washington State reported 4.4 cases per 100,000 persons.⁵⁶ The five highest counties with the highest incidence rates were King, Yakima, Clark, Kitsap, and Snohomish.⁵⁷ Washington's comprehensive strategy for effective control and prevention of TB and multi-drug resistant TB includes the development of screening and detection procedures, public health tracking and reporting systems, education programs for the public and health care providers, improving availability and location of treatment facilities, infectious disease policies and procedures in treatment and confinement facilities, involuntary testing and detainment, removal of cultural and language barriers, and the provision of ancillary social services. The Department of Health TB Program coordinates prevention and control within the state, and counties maintain primary responsibility for prevention and control within their jurisdictions.⁵⁸

18.7.1.1 Reporting

Health care providers diagnosing or caring for a person with tuberculosis are required to report the case to the local health officer or local health department as a notifiable condition.⁵⁹ Within one day, all practicing physicians must report to the local boards of health in writing, the name, age, sex, occupation, and residence of every person having tuberculosis who the physician has attended or has come under their observation.⁶⁰ In addition, health care providers are to report the patient's status to the local health officer every three months or as requested.⁶¹

18.7.1.2 Control

The local health officer is invested with full powers of inspection, examination, treatment, and isolation or quarantine of all persons known to be infected with tuberculosis in an infectious stage or persons who have been previously diagnosed as having tuberculosis and who are under medical orders for treatment or periodic follow-up examinations.⁶² Reasonable efforts are made to educate individuals and obtain voluntary compliance; however, public health officials may order examination of persons suspected of having infectious tuberculosis who refuse to be examined as required by state law.⁶³ Orders for examination are to be in writing, setting forth the name of the person to be examined, the time and place of the examination, and such other terms and conditions as may be deemed necessary.⁶⁴

⁵⁴ For an overview of the history and changes in Washington's TB laws and a comparison with other public health delivery models for persons with HIV/AIDS or mental health conditions, see Vincler and Gordon, *Legislative Reform of Washington's Tuberculosis Law: The Tension Between Due Process and Protecting Public Health*, 71 WASH. L. REV. 989 (1996).

⁵⁵ *Tuberculoses*, JAMA Patient Page, JAMA. 2005; 293:2820.

⁵⁶ DOH TB Fact Sheet, <http://www.doh.wa.gov/cfh/TB/tbfact.htm> (last visited Dec. 28, 2005).

⁵⁷ *Id.*

⁵⁸ WAC 246-100-211(2)(a). DOH maintains a comprehensive TB Program website with information for clinicians and the general public. <http://www.doh.wa.gov/cfh/TB/default.htm>.

⁵⁹ WAC 246-100-211(1); WAC 246-101-101.

⁶⁰ RCW 70.28.010. Pursuant to WAC 246-101-101 health care providers must report tuberculosis "immediately."

⁶¹ *Id.*

⁶² RCW 70.28.031.

⁶³ RCW 70.28.031; WAC 246-170-051.

⁶⁴ RCW 70.28.031(d). If the local health officer has reason to believe that the individual will refuse to obey the order, the health officer may obtain an order from superior court requiring compliance. RCW 70.28.035.

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If treatment, isolation, or quarantine is determined to be necessary in a particular case, the health officer is to make an order in writing, setting forth the name of the person, the period of time during which the order is to remain effective, the place of treatment, isolation, or quarantine, and any other terms and conditions that are necessary to protect the public health.⁶⁵ Any person known to have acted in violation of an examination, treatment, isolation, or quarantine order is to be reported to the health officer who is required to contact the prosecuting attorney of the county where the violation occurred.⁶⁶ Any person found to be in violation of such order is guilty of a misdemeanor.⁶⁷ In addition, local health officers may commence proceedings for involuntary testing, treatment, and detention.⁶⁸

Inpatient services for persons with infectious or suspected cases of tuberculosis are provided in hospitals, or hospital units of correctional facilities, that comply with hospital infection control requirements and the current CDC Guidelines for Preventing the Transmission of Tuberculosis in Health Care Facilities.⁶⁹ In addition, hospitals are required to provide patients who are infectious or suspected of having tuberculosis with medical, nursing, laboratory, radiology, pharmacy, patient education, social services, and discharge conferences involving at least the current primary provider, a local health department representative, and transferring and receiving facility representatives.⁷⁰ Persons with suspected or infectious tuberculosis may also be housed and treated in other settings approved by the local health officer.⁷¹ The hospital maintains responsibility for determining when discharge is medically appropriate, but must notify the local health officer of the discharge in order to assure appropriate outpatient arrangements for the patient.⁷²

Local health departments are charged with the responsibility for assuring the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis. Services that must be provided include: prevention and screening, with emphasis on screening high risk populations; diagnosis and monitoring, including laboratory and radiology; and individualized treatment planning, based on the least restrictive measures necessary to assure appropriate treatment and case management.⁷³ The program must also include surveillance, case finding, contact tracing, and other aspects of epidemiologic investigation.⁷⁴

The local health departments are also responsible for: assuring the provision of inpatient or outpatient care (such as costs of care in the absence of third-party reimbursement); maintaining a register of all diagnosed

⁶⁵ RCW 70.28.031(e).

⁶⁶ RCW 70.28.031(g).

⁶⁷ RCW 70.28.033.

⁶⁸ WAC 246-170-051. Individuals facing involuntary treatment are provided with due process including notice, an opportunity for an evidentiary hearing, representation by counsel, and the right to cross-examine witnesses. WAC 246-170-051; 246-170-055. The court will order the least-restrictive measures effective to protect the public health. *Id.*

⁶⁹ WAC 246-170-041. Hospital infection control requirements can be found at WAC 246-320-265. The infection control program requirements include the hospital providing: designated patient rooms for patients with suspected or known infectious tuberculosis, including ventilation to maintain a negative pressure condition in each patient room as specified; appropriate use of respirators; and tuberculin skin testing of employees. Copies of the current CDC Guidelines can be obtained from the DOH TB Control Program.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² WAC 246-100-211(3); WAC 246-101-105(8)-(9).

⁷³ WAC 246-170-031.

⁷⁴ WAC 246-100-211(2)(b).

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or suspected cases of tuberculosis; maintaining a register of individuals to whom the health department is providing preventative therapy; and furnishing DOH with quarterly status reports.⁷⁵ Each local health department is obligated to have available a physician knowledgeable in the diagnoses and treatment of tuberculosis (approved by DOH) for review of diagnoses, plans of management, and if appropriate, discharge from inpatient facilities. Sufficient nursing, clerical, and other appropriate personnel must also be provided to furnish supervision of preventative and outpatient treatment, surveillance, suspect evaluation, epidemiologic investigation, and contact workup.⁷⁶

18.7.2 Sexually Transmitted Diseases (Including HIV/AIDS)

18.7.2.1 Testing and Counseling

For each case of sexually transmitted disease (STD), including HIV and AIDS, a health care provider is required to educate the patient regarding the communicability of the disease and the need to refrain from acts that may transmit the disease to another.⁷⁷ If, after being diagnosed with an STD, there are reasonable grounds to believe that the individual is engaging in conduct that endangers the public health, state and local public health officers have the authority to examine and counsel, or cause to be examined and counseled, a person reasonably believed to be infected with or exposed to an STD.⁷⁸ Detention orders or restrictive measures may only be used as a last resort when other measures to protect the public health have failed, including documented reasonable efforts to obtain the voluntary cooperation of the person believed to be infected with or to have been exposed to a STD.⁷⁹ The burden of proof is on the state or local public health officer to show that reasonable grounds exist for the issuance of the orders or restrictive measures and that the terms and conditions imposed are no more restrictive than necessary to protect the public health.⁸⁰

⁷⁵ WAC 246-170-031.

⁷⁶ *Id.*

⁷⁷ WAC 246-100-202(1).

⁷⁸ RCW 70.24.024(3).

⁷⁹ RCW 70.24.024(2).

⁸⁰ *Id.*

Testing Patients Who Expose Providers to Potential HIV Infection

Health care providers who experience substantial occupational exposure to bodily fluids of another person may ask a state or local health officer to order counseling and testing of the person who was the source of the bodily fluids.⁸¹

Substantial exposure means: a physical assault upon the exposed person involving blood or semen; intentional, unauthorized, nonconsensual use of needles or sharp implements to inject or mutilate the exposed person; or an accidental parenteral or mucous membrane or non-intact skin exposure to blood, semen, or vaginal fluids.⁸²

In absence of a valid order, providers may not test patients for HIV without the patient's consent.⁸³

18.7.2.2 Control

Detention orders or restrictive measures are to be issued in the following sequence, starting with the least intrusive measure: 1) an order to submit to a medical examination, testing, or seek counseling; 2) an order to obtain medical treatment for curable diseases; and 3) an order to immediately cease and desist from specified conduct which endangers the health of others.⁸⁴

A person is reasonably believed to be infected or to have been exposed to a STD when there are laboratory test results which confirm or suggest a STD, when there has been direct observation of clinical signs by a health care provider that confirm or suggests a STD, or when information is obtained directly from an individual infected with a STD about the identity of his or her sexual or needle-sharing contacts.⁸⁵ If the information is received from an infected individual, the potential exposure to the STD must have occurred during a period when the disease may have been infectious, the contact must have been sufficient to transmit the disease, and in addition, the infected individual, in the health officer's judgment, must be credible and believable.⁸⁶

Written orders for medical examination, testing, treatment, and counseling are issued only after efforts to obtain voluntary cooperation have failed. Additionally, there must be sufficient evidence to "reasonably believe" that the person has an STD and is engaging in conduct endangering public health.⁸⁷ Written orders to cease and desist from specified activities may be entered only if it is determined that the infected

⁸¹ WAC 246-100-205; RCW 70.24.340. If the state or local public health officer refuses to order counseling and testing under this subsection, the health care provider may petition the superior court for an order. *Id.*

⁸² WAC 246-100-205(1).

⁸³ RCW 70.24.330. Minors may consent to testing and treatment once they reach the age of fourteen. RCW 70.24.110.

⁸⁴ RCW 70.24.024; WAC 246-100-203.

⁸⁵ WAC 246-100-203(1)(a).

⁸⁶ *Id.*

⁸⁷ WAC 246-100-203(1). "Conduct endangering public health" is defined, for all STDs, as anal, oral or vaginal intercourse; activities introducing blood, semen, or vaginal fluids into a body orifice, a mucous membrane, the eye, or an open cut, wound, lesion, or other interruption of the epidermis; or a needle puncture or penetrating wound resulting in exposure to blood, semen, or vaginal fluids. For HIV and Hepatitis B, "conduct endangering the public health" also includes the sharing of injection equipment and donating or selling blood, blood products, body tissues, or semen. WAC 246-100-203(1)(b).

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individual is engaging in conduct endangering public health, there is evidence supporting a reasonable belief that the person is infected or has been exposed to a STD, and procedures for a medical examination, testing, treatment, and/or counseling were followed and exhausted.⁸⁸

Court orders for detainment are only for persons infected with HIV who are engaging in behavior presenting imminent danger to public health.⁸⁹ Behavior presenting imminent danger to public health means anal, oral, or vaginal intercourse without a latex condom; sharing use of blood-contaminated injection equipment; or donating or selling HIV-infected blood, blood products, or semen.⁹⁰

18.8 Isolation and Quarantine – During Public Health Emergencies

18.8.1 Renewed Importance of Isolation and Quarantine as a Public Health Strategy

Large-scale isolation and quarantine of persons was a public health measure once consigned to history books. The potential for a mass-scale bioterrorism event led emergency planners to reconsider large-scale isolation and quarantine as a strategy for containing such a catastrophic event. Likewise, naturally occurring communicable diseases recently focused attention on isolation and quarantine, especially those diseases having the potential for rapid spread.⁹¹ Isolation and quarantine can be voluntary or compelled by public health officials. A recent study examining attitudes toward the use of quarantine in a public health emergency found a sizable proportion of the public opposed compulsory quarantine.⁹² The primary concerns expressed by persons surveyed for the study were overcrowding, infection, and the inability to communicate with family members. Nevertheless, public health emergency preparedness planners must plan for the likelihood that quarantine or isolation, perhaps on a mass-scale, may become necessary.

For an increasingly mobile society, worldwide travel takes hours, not weeks or months. Emerging infectious diseases, once far removed from us by time and distance, can arrive in any major city, at any time, and with little or no warning. In the U.S., large-scale, involuntary detention to reduce the spread of communicable disease is virtually unknown.⁹³

At the turn of the twentieth century the situation was much different. Isolation and quarantine could be imposed on communities with little or no public opposition. Often, it was the only public health strategy available to contain the spread of an infectious disease. In the intervening years, scientific progress changed the public health response to common communicable disease threats through readily available medical care—laboratory testing, antibiotics, antiviral medications, and effective immunizations.

Likewise from the turn of the century to now, the law has evolved to emphasize constitutional civil rights protections. Due process rights, individual autonomy, privacy, and liberty interests temper the government's police power to protect the public's health, safety, and welfare. If isolation or quarantine becomes necessary, public health officials must effectively balance competing interests—public health protection with civil rights.

⁸⁸ WAC 246-100-203(1)(e).

⁸⁹ WAC 246-100-203(2).

⁹⁰ WAC 246-100-203(2)(a).

⁹¹ Isolation and quarantine are frequently used to protect the food supply and other agricultural commodities. Legal issues around isolation and quarantine of agricultural commodities as public health measures exceed the scope of this chapter.

⁹² The study was jointly performed by the Harvard School of Public Health and the CDC and included surveys of persons in Hong Kong, Singapore, Taiwan and the U.S. See Robert J. Blendon, Et al., *Attitudes Toward the Use of Quarantine in a Public Health Emergency in Four Countries*, 25 HEALTH AFFAIRS 2 (2006):w15-w25 (published online Jan. 24, 2006; 10.1377/hlthaff.25.215).

⁹³ Individual isolation or quarantine is a commonly used method to reduce the spread of diseases such as TB.

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Washington State’s isolation and quarantine rules were adopted in 2003 in response to current events. The regulations, discussed below, incorporate the competing interests of police power and individual rights and define specific due process protections. If public health officials are called upon to use large-scale isolation and quarantine to respond to a rapidly-spreading communicable disease event or pandemic, government officials, judges, physicians, and lawyers must be ready to take swift and concerted action to protect both public health and civil rights.

18.8.2 The Public Health Basis for Isolation and Quarantine

Isolation and quarantine are discrete terms. Isolation means separating persons who are infected with a communicable disease from those who are still healthy. Isolation reduces the spread of communicable diseases by restricting the movements of those who are contagious.

Quarantine means separating persons who have been exposed to a communicable disease, but do not show signs or symptoms of illness, from persons who have not been exposed. Persons who have been exposed may become infectious as a result of their exposure and spread the infection to others. The incubation period of the disease determines the length of the quarantine. Quarantine of exposed persons, like isolation of infected persons, is intended to slow or stop the spread of an infectious disease.

Isolation and quarantine are very effective public health measures. Effective quarantine can be difficult to accomplish when individuals, who are not yet ill, are fearful and do not understand the importance of maintaining quarantine restrictions. If a lengthy quarantine evolves, and persons lack access to current information and to the necessities of daily living, public trust may erode and anger and panic may ensue, creating a high potential for social unrest.⁹⁴

If isolation or quarantine restrictions become necessary, voluntary compliance is optimal. But, if the public health danger warrants such measures, large-scale compulsory isolation or quarantine can be imposed and enforced as a matter of law.

18.8.3 Legal Basis for Isolation and Quarantine

18.8.3.1 Quarantine Authorized Under Federal Law

The Department of Health and Human Services (HHS) is authorized by federal law to act to prevent communicable diseases from entering the United States at United States borders and international ports of entry. In addition, the HHS Secretary has jurisdiction to take action to stop the spread of communicable diseases from state to state within U.S. borders.

Within HHS, the Centers for Disease Control (CDC) and more specifically, the National Center for Infectious Diseases, Division of Global Migration and Quarantine maintains Quarantine Stations at important international ports of entry, including SeaTac Airport. The CDC assigns public health officers at each station. Their role is to conduct public health and communicable disease surveillance and to respond to specific communicable disease threats or events entering the U.S. from abroad. U.S. Customs and Border Services⁹⁵ (CBS) and the U.S. Coast Guard are required to aid in the enforcement of quarantine rules and regulations.⁹⁶

⁹⁴ Any sudden and widespread disaster has the potential to evoke a similar response—witness the aftermath of Hurricane Katrina—and underscores the importance of emergency planning and preparedness.

⁹⁵ CBS is a component of the Office of Homeland Security.

⁹⁶ Applicable federal statutes are 42 U.S.C. 264-272 (Control of Communicable Diseases); 42 U.S.C. 252 (Medical Examination of Aliens); 8 U.S.C. 1182 (Aliens with Diseases of Public Health Significance); 8 U.S.C. 1222 (Detention of Aliens for Physical and Mental Examination). Applicable federal regulations are: 42 CFR 70 (Interstate Quarantine); 42 CFR 71 (Foreign Quarantine); and 42 CFR 34 (Medical Examination of Aliens).

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A Presidential Executive Order EO 13295 authorizes isolation and quarantine for specific communicable diseases. These diseases are cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, severe acute respiratory syndrome (SARS), and pandemic flu.⁹⁷

18.8.3.2 Quarantine Authorized Under State Law

The State Board of Health is authorized to adopt administrative rules for isolation and quarantine.⁹⁸ The Board adopted isolation and quarantine rules in 2003 taking into account the potential for detention of individuals or of groups in the event of a pandemic or other public health emergency.

The State Board included a preemption clause in its rules. Under WAC 246-100-040(7), these rules are superseded by state laws, rules, state or federal emergency declarations governing procedures for detention, examination, counseling, testing, treatment, vaccination, isolation, or quarantine for specified health emergencies or specified communicable diseases including, but not limited to, tuberculosis and HIV.⁹⁹

Subject to this limitation, the regulations address procedures for isolation and quarantine;¹⁰⁰ principles and conditions of isolation and quarantine;¹⁰¹ access to the quarantine or isolation premises;¹⁰² relief from an isolation or quarantine order;¹⁰³ right to counsel;¹⁰⁴ hearing consolidation;¹⁰⁵ and enforcement of local health officer orders.¹⁰⁶ The Attorney General's office developed model pleadings for the isolation and quarantine process.¹⁰⁷

18.9 Isolation and Quarantine Procedure

18.9.1 Initiation of Isolation or Quarantine

The isolation or quarantine process is initiated by a local health officer (LHO). The LHO must determine whether an individual or group has symptoms of or exposure to a communicable disease, and assess the degree of risk that the disease presents to others if immediate action is not taken.¹⁰⁸ To address the health risk, the

⁹⁷ This EO was updated in 2003 to add SARS and in 2005 to add pandemic flu. HHS has proposed federal isolation and quarantine rules which were published in the Federal Register at 70 Federal Register 71892-71948, November 30, 2005. As of February 21, 2007, the regulations have not been adopted in final form. The text of the proposed rule and public comments are available on the CDC's website for the Division of Global Migration and Quarantine: www.cdc.gov/ncidod/dq/nprm/docs/42CFR70_71.pdf.

⁹⁸ RCW 43.20.035.

⁹⁹ Under the Tenth Amendment the major source of authority to protect public health is the states' police power. The Emergency Management Act, ch. 38.52 RCW allows the Governor to act in the event of disaster beyond local control. This Act authorizes an integrated response at all levels of state and local government. The federal government also exercises authority derived from its exclusive power to regulate interstate and foreign commerce under the Commerce Clause and from Congress' authority to tax and spend. Article I § 8 of the U.S. Constitution.

¹⁰⁰ WAC 246-100-040.

¹⁰¹ WAC 246-100-045.

¹⁰² WAC 246-100-050.

¹⁰³ WAC 246-100-055.

¹⁰⁴ WAC 246-100-060.

¹⁰⁵ WAC 246-100-065.

¹⁰⁶ WAC 246-100-070.

¹⁰⁷ The model pleadings are found in [Appendix].

¹⁰⁸ Isolation and quarantine may also be necessary in cases of chemical, biological, or radiological agents that could spread if remedial action isn't taken and the risk to health is serious and imminent.

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LHO may recommend quarantine, isolation, or other health measures such as examination, testing, vaccination, or treatment. The LHO must first ask the affected person or group to comply voluntarily with the recommended measures unless seeking voluntary compliance would itself create an imminent and serious risk of public harm. WAC 246-100-040(1). The person's home is likely the best location for voluntary quarantine. By contrast, isolation presumes that the person is already ill. During voluntary isolation, the likely location is a temporary or permanent facility where medical services and supportive care are available.

Employers—especially health care providers and facilities—should incorporate a staffing plan into contingency planning in the event of a pandemic, or mass outbreak of a communicable disease. The employment terms and conditions, protective equipment, access to vaccinations, and other occupational health concerns should be incorporated into planning.¹⁰⁹ In developing an emergency response plan, collective bargaining agreements, if applicable, should be taken into consideration.

If voluntary compliance is refused or the risk is unacceptable, the LHO has discretion to mandate compliance by issuing an immediate ten-day emergency detention order under WAC 246-100-040(3).¹¹⁰ As an alternative, or perhaps concurrently, the LHO may file an *ex parte* petition in superior court for an order authorizing involuntary detention under WAC 246-100-040(4).¹¹¹ The location for involuntary detention is up to the discretion of the LHO. Local law enforcement is responsible for enforcing the LHO's or superior courts involuntary isolation or quarantine orders. The statute and rules for isolation and quarantine do not specify the procedure used to enforce an involuntary isolation and quarantine order, but the mental health civil commitment statute, RCW 71.05.150 may be a reasonable comparator.¹¹² The law and rules are silent on the level of force allowed to detain a person or group.

A person or group who has been detained in isolation or quarantine may file a motion in superior court for an order to show cause why the person or group should not be released.¹¹³ The court has 48 hours to rule on the motion and, if granted, must schedule a hearing on the order to show cause as soon as practicable. The detention order remains in effect, pending the show cause hearing.

The circumstances may warrant extending the isolation or quarantine order beyond the 10-day maximum. If so, only the superior court can extend the involuntary quarantine or isolation period. The superior court can extend the isolation period of an LHO or superior court involuntary detention order.¹¹⁴ Practically, if the original quarantine or isolation was established by an LHO order, a lawsuit must be initiated using a summons and petition for order to authorize continued enforcement. If the superior court issued the original quarantine or isolation order, a request to extend the isolation or quarantine is made by motion under the existing superior court cause number.

¹⁰⁹ The International Labour Office published its 2004 working paper: *SARS: practical and administrative responses to an infectious disease in the workplace*. The full text is available on the ILO website at <http://www.ilo.org/public/english/protection/safework/accidis/sars.pdf>.

¹¹⁰ The LHO Order is most likely to be used if voluntary compliance is in doubt, or the LHO's formal order may better ensure compliance, or a Court Order cannot be readily obtained.

¹¹¹ The Court Order for involuntary isolation or quarantine is most likely to be used when the LHO is concerned that the affected person or group will fail to comply with an LHO Order or a Court Order and it may be necessary to seek enforcement using the Court's contempt power. Chapter 7.21 RCW. If the person or group is found to be in contempt, the penalty is incarceration and/or fine up to \$2000 per day.

¹¹² RCW 71.05.150(d), the mental health civil commitment statute, specifies the procedure law enforcement must use to take a person into custody to be placed in a facility for evaluation and treatment.

¹¹³ WAC 246-100-055

¹¹⁴ An LHO is not precluded from seeking voluntary continuation of quarantine or isolation by consent. However, such voluntary consent does not modify the limited term of the LHO or superior court order.

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18.9.2 Due Process and Individual Rights in Isolation and Quarantine

In 1905, the U.S. Supreme Court decided *Jacobson v. Massachusetts*, a landmark case upholding the state's right to exercise its police power to require smallpox vaccinations during a 1902 smallpox outbreak.¹¹⁵ Many current public health laws rely on the inherent police power for the authority to implement population-based public health measures. Simply stated, the police power allows states (and local governments) to limit private rights and interests through enactment of laws and regulations in order to protect the public's health, safety, and welfare.

Washington's public health laws and regulations are derived from the same police power source as the vaccination requirement in *Jacobson*. Public health protection was a vital concern to Washington's citizens when the state constitution was adopted. Almost unique among states, Washington's citizens included public health provisions in the state constitution. The State Board of Health was established in Article XX § 1. Article XX § 2 directed the legislature to enact laws to regulate the practice of medicine and surgery, and the sale of drugs and medicine.

In a 1918 Washington case, *State ex rel. McBride v. King County*, the state supreme court determined that a public health officer's determination of a need for isolation was final and conclusive and not subject to judicial review.¹¹⁶ Although *McBride* had a right to seek a writ of habeas corpus, the writ was suspended once the court determined that the detention was based on an exercise of police power by the local health authority.

Over time and through the evolution of due process protections, the state's broad public protection functions are now balanced with constitutionally protected rights. Through cases interpreting mental health civil commitment, involuntary detention is no longer a plenary police power except during the extreme circumstances of the Governor's declaration of an emergency.¹¹⁷ In civil mental health commitments, because liberty interests are at stake, Washington's laws provide a right to notice of the basis for detention, a right to counsel, and a right to a timely, fair, and impartial hearing.

Washington's courts have adopted the long-standing constitutional analysis that balances the government's powers with the individual rights at stake by examining three factors: 1) the private interest affected; 2) the risk of an erroneous deprivation of such interest and the probable value, if any, of additional or substitute procedural safeguards; and 3) the Government's interest, including the function involved, and the fiscal and administrative burdens that additional or substitute procedural requirements would entail.¹¹⁸

Until 2003, Washington's State Board of Health had not promulgated isolation and quarantine regulations despite having legislative authority to do so. But, in the aftermath of the September 11, 2001 terrorist attacks, and the national efforts to prepare for bioterrorism events, the State Board of Health proceeded with rule-making. The rules were drafted with two purposes.

First, the rules incorporated currently-recognized procedural due process protections, which had not been previously defined in statutes, regulations, or existing common law. In addition to the notice and hearing rights previously discussed, the isolation and quarantine rules provide for minimum principles and conditions for isolation and quarantine (WAC 246-100-045); restricted entry into isolation and quarantine premises (WAC 246-100-050); a right to counsel (WAC 246-100-060); and a provision allowing for consolidated hearings in the case of large-scale isolation and quarantine situations (WAC 246-100-065).

¹¹⁵ 197 U.S. 11 (1905).

¹¹⁶ 103 Wash. 409, 174 P. 973 (1918). In *McBride*, the detainee was alleged to have syphilis.

¹¹⁷ In extreme cases of civil unrest, catastrophic natural disasters, or attack, martial law could be imposed by the Governor by declaring a state of emergency under RCW 43.06.220. During a declaration of emergency, civil liberties may be suspended and the normal administration of civil laws may be placed under the control of military authorities.

¹¹⁸ See *Mathews v. Eldridge*, 424 U.S. 319 (1976); *In re Det of LaBelle*, 107 Wash.2d 196, 728 P.2d 138 (1986); *Born v. Thompson*, 154 Wash. 2d 749, 117 P.3d 1098 (2005).

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The second purpose was to consolidate the obligations of the public to comply, and law enforcement agencies' enforcement of orders by local public health officers and the rules of the State Board of Health. Through the State Board rule-making process, a full range of stakeholders and advocacy groups reviewed and commented on the proposed rules.¹¹⁹ The isolation and quarantine rules have never been tested in a real-life event or faced judicial review. However, the State Board made every effort to ensure that the isolation and quarantine rules meet minimum procedural due process standards and strike an appropriate balance between individual rights and the public's need for protection from a serious threat of communicable disease—whether naturally-occurring or of terrorist origin.

18.10 Collaboration of Federal, State and Tribal Authorities

18.10.1 National Incident Management System and Washington's Comprehensive Emergency Management Plan (CEMP)

Since 9-11, government agencies at all levels have been engaged in a massive effort to plan a coordinated response to potential public health emergencies—whether naturally-occurring or resulting from terrorism. Under Homeland Security Presidential Directive 5 (February 2003),¹²⁰ all levels of government must adopt the National Incident Management System (NIMS). Federal funding for emergency preparedness is contingent on NIMS compliance by states, local jurisdictions, and tribal entities. NIMS aligns emergency preparedness and emergency response from the federal to state to local government by defining a single Incident Command System (ICS) and standardizing procedures and processes. Washington's Emergency Management Division within the Military Department is responsible for implementing NIMS.

Under Washington's emergency management laws, chapter 38.52 RCW, the local government makes the first response to an emergency. Each affected local jurisdiction responds through its emergency managers and local emergency operations centers. The local emergency managers coordinate with the state's Emergency Management Division.¹²¹ If a disaster is beyond local control, the Governor will direct the Military Department's Emergency Management Division to take necessary action as authorized by the Emergency Management Act, chapter 38.52. RCW, including activating the state's Comprehensive Emergency Management Plan (CEMP). An all-hazards plan, the CEMP covers the full range of potential disasters—natural (fire, flood, earthquake, pandemic, volcano), terrorist actions (chemical, biological, nuclear), and technological hazards (telecommunications, vital computer systems).¹²²

This coordinated response relies, in part, on mutual aid agreements between key entities. Washington is part of the Emergency Management Assistance Compact (EMAC), a mutual aid agreement between forty-seven states through which emergency management officials at the state and local levels participate in training, planning, and exercises. The goal is to create the capacity for swift response when a disaster calls for resources from one or more states to be deployed and efficiently used to assist affected states.

18.10.2 Washington's Public Health Emergency Planning and Response Program

Public health response is a key component of the CEMP. Local Boards of Health and Health Officers have frontline responsibility for maintaining public health and sanitation in their jurisdiction.¹²³ If an emergency exists and the local health authorities fail to act, request assistance from the state, or are unable to act, the

¹¹⁹ Reviewers included the ACLU, judges' association, public health professionals, the private bar, and many other interested parties.

¹²⁰ George W. Bush, *Homeland Security Presidential Directive (HSPD)-5, Management of Domestic Incidents* (February 2003).

¹²¹ RCW 38.52.070(1).

¹²² The Governor has the power to declare a disaster, triggering the full range of emergency powers (e.g. activating the National Guard, proclaiming martial law). RCW 43.06.010 and RCW 43.06.220. The Governor is also empowered to seek federal assistance. However, the state's CEMP does not contemplate immediate federal assistance. Federal resources such as the Strategic National Stockpile (SNS) of medical supplies are pre-positioned in each region of the country to supplement state and local resources. The SNS can be deployed in response to an imminent or actual public health event upon the Governor's request.

¹²³ RCW 70.05.060; RCW 70.05.070. The power to order isolation and quarantine is in RCW 43.20.050(2)(d).

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Secretary of the Department of Health steps in under RCW 43.70.130(4). Washington's Department of Health has a Public Health Emergency Preparedness and Response Program (PHEPR) that works with all the local health jurisdictions in each region of the state to plan, train, and respond to public health disasters.¹²⁴

The PHEPR program takes an active role in coordinating the first line response to a public health emergency through training and outreach in local communities. The PHEPR program links local public health officials, tribal officials, community health care providers, and facilities, such as EMS services and physicians, through exercises and other joint activities. PHEPR also engaged public health officials in British Columbia, Alberta, Idaho, and Oregon to develop partner relationships to better coordinate a response to health threats across state or international borders.¹²⁵

18.10.3 The Centers for Disease Control and the Agency for Healthcare Research and Quality

The Centers for Disease Control (CDC) is the primary federal resource within the federal government for public health emergency response.¹²⁶ The CDC actively supports public health emergency planning efforts extending beyond state and local government to community health care providers, border states, tribal governments, and neighboring countries. The CDC has published a Public Health Emergency Response Guide for state, local, and tribal public health directors. The guide walks through each of the recommended response functions and tasks during the acute phase of a public health emergency.¹²⁷

The Agency for Healthcare Research and Quality (AHRQ), another agency of HHS, coordinates research on health care quality, cost, patient safety, and access to services. AHRQ serves private and public health care decision makers. AHRQ produced a number of resources including issue briefs, educational webcasts, and model response plans to integrate public health emergency response with community providers and facilities. AHRQ's research found that community providers are "critical sentinels" in detecting the first signs of a public health threat, and that better communication links between community providers and the public health infrastructure (i.e., local health departments, state laboratories, EMS, and emergency departments) are needed.¹²⁸ The public health community has made progress in achieving the goal of an integrated response to public health emergencies, and the work is on-going, but much work remains to be done.

¹²⁴ Local health jurisdictions are actively engaged in coordinating community efforts. For example, the Tacoma-Pierce County Health Department has entered into a government-to-government agreement with the Puyallup tribe to define roles and responsibilities for public health emergencies affecting tribal and local jurisdictions.

¹²⁵ Another example of cross-jurisdictional efforts is the CDC's Early Warning Infectious Disease Surveillance (EWIDS) program. EWIDS is developing and implementing a program to collaborate with states or provinces across international borders to provide rapid and effective laboratory confirmation of urgent infectious disease case reports in a border region by linking laboratory resources.

¹²⁶ The CDC is the division within the federal Department of Health and Human Services (HHS). The CDC must coordinate with the federal Department of Homeland Security and FEMA when the incident involves naturally-occurring public health threats or suspected bioterrorism.

¹²⁷ The guide is available online at: <http://www.cdc.org>.

¹²⁸ AHRQ Bioterrorism Issue Brief No. 6: *Bioterrorism and Other Public Health Emergencies: Linkages with Community providers*. (2005). <http://www.ahrq.gov/browse/bioterbr.htm>.