PRIVACY AND PUBLIC HEALTH PRACTICE SERIES

Information Management for State Health Officials

Public Health, Law Enforcement, and Privacy Issues

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Public Health, Law Enforcement, and Privacy Issues

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The Association of State and Territorial Health Officials is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. territories, and the District of Columbia. ASTHO's members, the chief health officials in these jurisdictions, are dedicated to formulating and influencing sound public health policy, and assuring excellence in state-based public health practice.

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Executive Summary

This issue report examines the benefits derived from a "culture of cooperation" that has risen through recent partnerships between public health and law enforcement. Public health and law enforcement share similar goals. Together the agencies can accomplish their missions as well as protect the public's health and privacy.

Public health and law enforcement are both engaged in issues that are of critical importance to communities. The information one agency needs to accomplish its goal sometimes intersects with the other's information needs. For instance, in the event of an outbreak, public health needs to characterize when, where, and how exposures occurred to determine who is at-risk and who may need future care. If the outbreak is not naturally occurring, law enforcement needs to identify where the event occurred and how victims were exposed. They may need to interview victims to develop evidence that can lead to those responsible.

This issue report features three partnerships around privacy issues that have been key components of urgent or emergency situations:

- North Carolina's Public Health Regional Surveillance Team Six and the North Carolina State Bureau of Investigation.
- The North Carolina State Division of Public Health and the State Bureau of Investigation.
- The New York City Department of Health and Mental Hygiene, the New York City office of the Federal Bureau of Investigation, and the New York Police Department.

Events that may require quarantine or isolation orders are rare, and the decision to quarantine or isolate requires balancing what is best for the public's health versus the individual's civil liberties. This issue report also discusses the following efforts:

- Minnesota's experience with 11 potential Severe Acute Respiratory Syndrome (SARS) cases.
- Iowa's public health disaster legislation.

In addition to state and local efforts, the federal government is assisting the growth of partnerships between public health and law enforcement. Every year the CDC's Public Health Law Program and the American Society for Law, Medicine & Ethics co-sponsor a public health law conference: "The Public's Health & the Law in the 21st Century." This event creates networking opportunities between public health and law enforcement, further encouraging the development of partnerships.

About ASTHO

The Association of State and Territorial Health Officials (ASTHO) is the national nonprofit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO's members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to assuring excellence in state-based public health practice. Guided by its policy committees, ASTHO addresses a variety of key public health issues and publishes newsletters, survey results, resource lists, and policy papers that assist states in developing public policy and promoting public health programs at the state level.

About the HIPAA Task Team/Privacy & Public Health Practice Workgroup

Due to the complexity of the Health Insurance Portability and Accountability Act (HIPAA) rules coupled with the timeframe for implementation, ASTHO formed a group that could identify and share states' needs for HIPAA Privacy Rule implementation. The purpose of the HIPAA Task Team was to identify issues that impact primarily state health departments—recognizing many of these same issues will pertain to local health departments. Since its creation in 2003, the HIPAA Task Team has grown to address other privacy topics than the HIPAA Privacy Rule. For this reason, the group changed its name to the Privacy & Public Health Practice Workgroup in 2006 to accurately reflect its interests in all privacy and security issues affecting public health.

The Privacy & Public Health Practice Workgroup consists of senior leaders in state health departments as well as members of the National Association of County and City Health Officials (NACCHO), ASTHO affiliate organizations, and other interested organizations. ASTHO has provided leadership by developing forums for states and other interested parties to discuss privacy and security related issues as they pertain to public health practice.

ASTHO is working with the Centers for Disease Control and Prevention (CDC) Health Information Privacy Office's Acting Privacy Rule Coordinator, Gail Horlick, MSW, JD to continue the Privacy & Public Health Practice Workgroup forums and to write issue reports on the topics considered in each forum. During the development of this report, ASTHO also worked with the Privacy Rule Coordinator, Beverly Peeples, JD, and Acting Privacy Rule Support Officer, Antonia J. Spadaro, EdD, RN.

The topic for this sixth issue report in the "Information Management for State Health Officials" series is: Public Health, Law Enforcement, and Privacy Issues. The information in this report is largely based on a HIPAA Task Team conference call held on public health, law enforcement, and privacy issues in emergency situations. This report also addresses privacy issues during events that may require quarantine and isolation.

Other reports in this series include:

- *HIPAA Privacy Rule Implementation in State Public Health Agencies: Successes, Challenges, and Future Needs*
- *Integrating Child Health Information Systems While Protecting Privacy: A Review of Four State Approaches*
- *Meeting the Challenges Presented by the HIPAA Privacy Rule in Public Health Practice*
- *The Impact of the HIPAA Privacy Rule on Syndromic Surveillance*
- *Data Sharing with Covered Entities Under the HIPAA Privacy Rule: A Review of Three State Public Health Approaches*

These reports are available on the ASTHO website at www.astho.org.

Introduction

This issue report examines partnership efforts between public health and law enforcement with regard to privacy issues that can affect the agencies during emergency situations and events that may require quarantine and isolation.

Public health and law enforcement are both engaged in issues that have critical importance to communities. Each agency has similar goals when it comes to the public.

Public health's goals consist of:
- Protecting health and safety of the public.
- Stopping further cases of disease and outbreaks.
- Building science base for future prevention.

Law enforcement's goals consist of:
- Protecting health and safety of the public.
- Stopping further crimes from occurring.
- Apprehending and convicting criminals.[1]

The information an agency needs to accomplish its goal sometimes intersects with the information needs of another agency. In order to prevent future outbreaks, public health needs to characterize when, where, and how an exposure occurred, to determine who is at-risk and may need future care. Law enforcement needs to find where the event occurred, to uncover the criminal methods used to expose victims, and to interview victims to develop evidence that can lead to those responsible.

Public health and law enforcement have not always worked together harmoniously, but recent threats have brought about more coordination, cooperation, and collegiality supporting stronger relationships between the agencies. Cooperation and coordination occur most often when there are strong personal relationships. These strong personal relationships allow people to plan and look forward rather than react by looking back. This "culture of cooperation" occurs through joint seminars, conferences, and discussions, joint table top exercises, and fostering personal interaction.[2]

HIPAA and the Privacy Rule—An Overview

Issued under HIPAA, the federal Privacy Rule was intended to provide individuals with new protections regarding the confidentiality of their health information and to establish new protections for healthcare providers, health plans, and other entities to protect such information.[3] On April 14, 2003, most entities were required to be in compliance with the Privacy Rule.

The Privacy Rule addresses the use and disclosure of individuals' health information and establishes an individuals' right to obtain and control access to this information.[4] Specifically, the rule covers "protected health information," defined as individually identifiable health information that is held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.[5]

Privacy Rule protections are extended to all individuals, regardless of the state in which they live or work, but the rule does not pre-empt state privacy laws that are more stringent or more protective.[6] Therefore, each state may have different restrictions on the ability to use and disclose protected health information.

The Privacy Rule specifically allows for disclosures of an individual's protected health information to public health authorities without the individual's authorization. Covered entities may disclose protected health information to a public health authority authorized by law to collect or receive information for preventing or controlling disease, injury or disability or for the conduct of public health surveillance, investigations, and interventions.[7]

The Privacy Rule covers standards for uses and disclosures required by law[8], disclosures for law enforcement purposes[9], and uses and disclosures to avert a serious threat to health or safety.[10]

Public Health and Emergency Situations

While public health and law enforcement have important goals that are separate and distinct from each other, in emergency situations their shared interests are best addressed collaboratively. The public gains the benefit of health and safety when both agencies work together toward their specific goals. This is illustrated in the following summaries of partnership efforts in North Carolina and New York City.

North Carolina's Partnerships with Law Enforcement Agencies

> North Carolina is fortunate to have well-developed partnerships with law enforcement agencies at the state and local level. With both agencies at the table to discuss issues, we are prepared and the public-at-large is better protected. – *ASTHO President Leah M. Devlin, DDS, MPH, North Carolina State Health Director*[11]

The North Carolina Division of Public Health has participated in numerous collaborations with the Federal Bureau of Investigation (FBI) and the North Carolina State Bureau of Investigation. One of these partnerships at the state-level is the new "fusion center," an Information Sharing and Analysis Center, referred to as "ISAAC" and led by the State Bureau of Investigation.

ISAAC will be fully functional in the summer of 2006, and is designed to accept information on suspicious activities or relevant data from all sources, including public health and other first responders, in communities across the state. First responders send information to ISAAC before that information is determined to be classified, or before the information becomes a known threat. Partners including the FBI, the North Carolina Attorney General's office, state and local sheriff's departments, public health, and others support ISAAC. The contributions from public health and law enforcement are interesting because both responders are in the community every day, but witness different activities. Public health's information on its own may not point to any actionable leads. But, when public health's view is coupled with law enforcement's view, the information has the potential to lead to an important breakthrough for both agencies.[12]

> A relationship based on trust and effective communication is important to any partnership. Public health and law enforcement have the opportunity to compile community information on an individual agency level and then add together to produce some amazing information that benefits the public at large. ISAAC is not unique. Other states have recognized the importance of this activity. We envision all states sharing information between fusion centers. In hindsight we look at the events surrounding the 9/11 terrorist attacks and realize we knew, we just didn't know we knew. – *Steve Cline, DDS, MPH, Epidemiology Section Chief, North Carolina Division of Public Health*[13]

Included in the list of partnerships is the state Steering Committee for Public Health Preparedness in which law enforcement is represented. Public health is a voting member along with law enforcement agencies called the State Emergency Response Commission. Each agency coordinates training efforts to educate the other agency on special topics where coordination is needed, including bioterrorism and the use of personal protective equipment.[14]

> As many other jurisdictions have seen, if we work together on a day-to-day basis, that means we are more in the loop. We have responded multiple times to suspicious substance calls with law enforcement and hazmat, and so now it's second nature for law enforcement to call public health to be involved in the process - *Martha Salyers, MD, MPH, Physician Epidemiologist, Public Health Regional Surveillance Team Six, North Carolina Division of Public Health*[15]

North Carolina's Public Health Regional Surveillance Team Six and the North Carolina State Bureau of Investigation share a relationship that has developed over the past few years around preparedness activities. This partnership involves preparing and responding to bioterrorism events, infectious disease

outbreaks, and other public health threats through collaborative planning, education, investigation, and surveillance.

Before the October 2001 anthrax events in the United States, the use of forensic epidemiology was limited to epidemiologic data and expert witnesses in class action suits and forensic investigations. After the anthrax events, the use of forensic epidemiology was broadened. The CDC Public Health Law Program developed a scenario-based training program to link law enforcement and public health through a series of trainings. In 2002, after the training, the Buncombe County Sheriff's Captain of Detectives expressed a desire to get more involved with forensic epidemiology. This interest led to North Carolina's first local Forensic Epidemiology Workgroup, including members of the following organizations:

- Local, state, and federal law enforcement
- Buncombe County Health Center (local public health agency)
- Local hospital
- District Attorney's office
- Fire department
- Regional hazmat
- Other partners, including visitors from health departments in the region.

Other counties in North Carolina have developed similar workgroups to address forensic epidemiology and the importance of collaboration between public health and law enforcement. In addition, the North Carolina Office of Public Health Preparedness and Response sponsors annual forensic epidemiology conferences to train law enforcement and public health staff through presentations and interactive scenarios.

The Forensic Epidemiology Workgroup members focused on four key issues.

Suspicious Substances Protocol for Street Officers. At the time, street officers had minimal training and no equipment to deal with a suspicious substance response. This protocol has led to the development of a statewide guideline, "Biological Agent Threats: Response Guideline," a response protocol that was vetted by law enforcement and public health.

Quarantine Isolation Protocol. This protocol addressed outdated quarantine and isolation tools. With the assistance of the District Attorney's office, law enforcement, and public health, templates were created for the magistrate's office to use in the event of a disease outbreak. The group created a Mass Quarantine Memorandum of Agreement, a Model Isolation Order, a Model Quarantine Order, and a Quarantine and Isolation Annex to the county Emergency Operations Plan.

Evidence Collection and Handling Protocol. Law enforcement collects evidence for forensic examination and criminal prosecution. Public health acquires samples for analysis. The individual collections must be completed without compromising the other's protocols and needs. Asheville's Regional Public Health Laboratory, the sheriff's department, hazmat, the public health regional surveillance teams, and industrial hygienist worked together to create a methodology to address needs for both law enforcement and public health for the collection of samples and evidence in an outbreak investigation.

Ad Hoc Issues. A fourth group collaborated in May 2003 to solve a privacy issue under HIPAA's Privacy Rule. Collaboration may not have occurred without the development of their prior working relationship on the Forensic Epidemiology Workgroup. The issue arose as law enforcement attempted to get information from the local hospital about a patient who was part of a criminal investigation. Members of the workgroup from hospital training and risk management staff, city, county and sheriff's department, and the district attorney, came together to discuss their issues and come up with a mutually agreeable means of addressing HIPAA concerns that clarified public health access to protected health information and clarified law enforcement needs. This discussion was the basis for a consistent dialogue on future cases.

One example of how this collaboration has benefited both public health and law enforcement occurred in early 2005, when North Carolina law enforcement was called to the scene of what had been identified as a methamphetamine lab. Arriving at the scene, law enforcement determined that the apartment did not contain a methamphetamine lab. Instead, the apartment contained cases of different types of chemicals and solutions that were being stored.

Law enforcement called public health, which dispatched its regional surveillance team. Both organizations worked side-by-side to determine the steps required to clean up the scene. Although law enforcement officers are generally comfortable with chemical agents, when a biological threat or infectious disease is suspected, law enforcement benefits from public health's knowledge.

> We as law enforcement, specifically the North Carolina State Bureau of Investigation, have enjoyed the partnership with public health, and probably quite frankly should have been together at the table long before 9/11. – *Pam Tully, Special Agent in Charge (SAC), Intelligence and Technical Services, North Carolina State Bureau of Investigation*[16]

A simulated collection exercise called Heartbreaker was held on February 14, 2005. First responders made up of law enforcement and hazardous materials teams simulated the events that would unfold when public health was called to the scene of a variety of events, including an explosion in a building, a chemical spill on a train car, and a suspicious substance situation. All agencies participated in the effort.[17] The exercise showed the importance of communication between agencies when terms of art are used, such as specimen or evidence. Specimens are collected by public health to analyze at a different location. Evidence is collected by law enforcement officials to use in a prosecutorial situation.

The personal protective equipment needed, the risks involved in the suspected agent, and other pertinent information is shared with law enforcement through public health trainings. An important area addressed is the terminology and definitions used in true evidence collection.[18]

The dual use of a potential clue at a scene led to the importance of looking at an event with both objectives in mind: looking at a crime scene from a law enforcement perspective with the intent of having a successful prosecution and looking at an outbreak scene from a public health perspective with the intent of preventing further outbreaks. What may be classified as a "specimen" to a public health epidemiologist may also be considered "evidence" to a law enforcement officer. These issues are important in criminal trials where the chain of evidence and custodial issues are raised by the defense. The purpose of documenting the chain of custody is to allow an individual on the witness stand to be able to testify to the identity of the investigator who discovered the material, where the material was found, and the nature of its composition.

These collaborative efforts have also clarified points at which each organization should submit laboratory samples, allowing the sender to receive timely laboratory results and, if requested by law enforcement, a chain-of-custody form. In North Carolina, the State Bureau of Investigation can complete forensic processing and chemical analysis, but cannot do biological testing. This must be sent to the state health laboratory. Additionally, a state mobile laboratory is available for the FBI to use with regional surveillance teams.

The education and training initiatives established for both law enforcement and public health as to collection, documentation, and submission of samples has further defined this successful partnership. As a result, public health now has a more prominent place at the table during disaster planning in all venues from emergency management to law enforcement. On the other side of the partnership, law enforcement and first responders see the benefit of working with public health.

New York City's Partnership with the FBI

The partnerships that were developed in North Carolina have resulted in a better understanding among public health and law enforcement. According to leaders in public health and law enforcement, these enhanced working relationships will result in a more effective response, that includes the protection of privacy.

New York City has encountered numerous emergency situations, including the terrorist attacks and anthrax events of 2001. The partnership between New York City Department of Health and Mental Hygiene (DHMH), the New York Office of the Federal Bureau of Investigation (FBI/NYO), and the New York Police Department (NYPD) is an example of collaboration between public health and law enforcement.

The DHMH and the FBI/NYO began working together closely in 2000. Medical epidemiologists, Dr. Marci Layton and Dr. Joel Ackelsberg, met with Special Agents Ian B. Vabnick and William A. Zinnikas, the Weapons of Mass Destruction Coordinator for FBI/NYO, along with legal counsel from both agencies. Their goal was to identify common interests and goals and determine how they could conduct joint investigations and share information to ultimately protect the public's health and safety. Initially, local law enforcement was not included in discussions. It is important to note that the FBI/NYO and the DHMH built a relationship of trust and confidence with the expectation that each side would perform its function effectively, while respecting their counterparts' institutional needs and priorities. These components were key to their successful partnership.

When the anthrax outbreak occurred in New York City in October 2001, the DHMH, the FBI/NYO and the NYPD (through the Joint Terrorism Task Force) coordinated their investigations, conducting joint interviews of persons in the affected media outlets and collaborating on an extensive environmental investigation. When an inhalational anthrax case occurred a couple of weeks later, all agencies shared information and worked together closely. Public health participated in daily investigation meetings at FBI/NYO headquarters.

Subsequent bioterrorist concerns (e.g., smallpox), and the desire to formalize an agreement that would outlive the trusting relationships developed by those in the DHMH and the FBI/NYO, catalyzed another look at the protocol. But this time, NYPD and NYC emergency management officials were asked to participate. The final product of this partnership was an agreement between the DHMH, NYPD, and the FBI/NYO to conduct joint public health and law enforcement investigations following suspected or confirmed bioterrorist attacks.

Key elements of the joint protocol

- During joint investigations conducted in health care settings, and while patients and their contacts are interviewed, DHMH is the lead agency.
- Any interviews will take place removed from the affected area thereby alleviating the concern that it may be a crime scene or a health hazard.
- When law enforcement and public health personnel are jointly interviewing patients, questions are limited to how the suspect may have been exposed or infected.
- Law enforcement will not be present when public health collects confidential medical information. Sharing of any confidential information with law enforcement will be in accordance with local, state and federal laws and regulations. The Health Commissioner has the authority to approve sharing of confidential information with law enforcement (and other third parties) in order to protect the public's health.
- During investigations, public health and law enforcement may assign liaisons to each other's parallel investigations.
- After the event is concluded, all shared information and documents will be maintained in a secure manner that is agreed upon by all parties.

While drafting the protocol and throughout the experience, all agencies realized that it was important to avoid the disruptive effect a joint investigation might have on healthcare facilities. For example, if the DHMH notified NYPD or

the FBI/NYO that it had identified a patient with symptoms and findings consistent with infection caused by a potential biological threat agent, a measured response would be needed by law enforcement. If a large number of law enforcement officers descended on a local hospital, patients and hospital staff could be intimidated, physicians might think twice before reporting suspected infections in the future, and hospital operations could be disrupted in ways that would not be beneficial to any of the agencies involved in the investigation. These types of considerations must be taken into account when a joint investigation is conducted.

> "In order to maintain the confidence and cooperation of the medical community, public health must in fact be, and be perceived as, the lead epidemiological investigator. If we lose the cooperation of the medical community, we will kill the goose that lays the golden egg of early warning. Public health has broad authority to conduct epidemiological investigations in order to ascertain the existence of disease outbreak, to discover the source of an infection, unreported cases and unknown contacts, and to take whatever action is necessary to mitigate morbidity and mortality. Law enforcement's investigation into criminal or actual bioterrorist events will need to focus on the same areas, creating a mutuality of interest."[19]
> *- Wilfredo Lopez, General Counsel for Health, New York City Department of Mental Health and Hygiene*

All agencies take their stewardship of confidential information very seriously. The protocol limits the information which is exchanged to that allowed by the New York City Health Code, the Federal Privacy Act, HIPAA, and all other applicable laws, rules, and regulations.

During a presentation to the HIPAA Task Team by Drs. Layton and Ackelsberg, the audience raised a concern as to the necessity of the protocol if HIPAA allows disclosure for law enforcement purposes. First, it should be noted that the primary reasons for the protocol were to clarify respective roles and ground rules for the conduct of a joint investigation and define the circumstances under which information could be shared, used, and maintained.

Wilfredo Lopez, General Counsel for Health at the DHMH, has pointed out that HIPAA is not an obstacle to covered entities making disclosures to public health, and that HIPAA-permissible disclosures to public health are broad and include those required by law[20] and for authorized public health activities, including public health investigations.[21] HIPAA-authorized disclosures to law enforcement[22] are much more limited.[23] Additionally, individual state and local laws may present legal barriers to this kind of cooperation. This confusion is one reason the protocol agreement has been drafted into a legal document allowing for such disclosure and information sharing.

Sharing confidential medical information, which was developed as part of an epidemiologic investigation with law enforcement participation, is coupled with a requirement that the information be secured in a way that meets each agency's strict internal security and privacy standards. Each agency had its own concerns about how information would be maintained and who might have access to it.

Public health wanted to ensure that information would be shared with law enforcement in a way that would not compromise routine public health activities following an incident. For example, if public health shares confidential information with law enforcement, it should be done so that providers continue to report diseases to public health. If the information is shared with law enforcement, and subsequently placed in the wrong hands, an individual's privacy could be violated.

Law enforcement had its own set of concerns, especially involving the admissibility (e.g., chain-of-custody, etc) of any "evidence" that might have been collected by members of the medical community. It was also important for public health to make sure that when it collects data, it does not appear to be agents of law enforcement.

Five years after the initial partnership was created, the three agencies have continued to build on this work. After a formal joint investigation agreement was signed in the fall of

2004, more than 120 senior public health and law enforcement investigators participated in one-day training sessions in 2005 to become familiar with the agreement and work through a challenging case study based on a previous epidemiological investigation.

Periodically, joint investigation teams have been mobilized. In February 2006, a Manhattan resident was diagnosed in Pennsylvania with inhalation anthrax. Public health and law enforcement investigators collaborated closely as the event unfolded. This enabled the Mayor, Health commissioner, Police commissioner and FBI officials to stand together, less than a day after first learning about the incident, and explain confidently to New Yorkers that the illness had not been caused by bioterrorism but by a naturally occurring exposure to anthrax spores. Without the collaboration between these two public sectors, this conclusion would not have been reached as quickly or as efficiently.[24]

Coordination During Isolation and Quarantine

Events that require quarantine and isolation are rare and orders are implemented only in extreme situations. If an event occurs where an individual would be subject to isolation or quarantine, both public health and law enforcement agencies would follow their state laws and regulations, which may mandate coordination among many partners. Each state's statutes and regulations differ in this area. However, the legal basis and authority for instituting these procedures must be established and agreed upon by all involved agencies prior to a health emergency. Public health, law enforcement, and other local authorities such as the judicial system, should be familiar with these issues before an event happens to avoid confusion during an event.

The statutory authority to isolate and quarantine is held by the state or local public health officer, who has this authority whenever a contagious disease outbreak is confined within the state's borders. The power to quarantine is considered a police power reserved for the states. The Tenth Amendment provides an inherent authority for the state to protect the health and welfare of its citizens.[25]

Quarantine — the separation and restriction of movement of *well* persons presumed to have been exposed to a contagious disease. Quarantine usually occurs in the home, but could be in another facility. It can be voluntary or mandatory.

Isolation — the separation and restricted movement of *ill* persons with a contagious disease. Isolation occurs in a hospital setting or at home, depending upon the medical needs of the patient.

Isolation may also be applied to populations and, while it is often voluntary, it may be mandatory.[26]

MINNESOTA

During the 2003 SARS (Severe Acute Respiratory Syndrome) outbreak, 11 people in Minnesota were evaluated as potentially having SARS. Of the three probable and eight suspected cases, none were confirmed as SARS in the laboratory.[27] The Minnesota Department of Health recommended isolation for possible SARS cases. Additionally, health care workers who provided care for these patients were placed under close observation for any symptoms.[28]

The Minnesota Department of Health (DOH) learned from its experiences with the SARS outbreak, recognizing that isolation and quarantine were primary tools for the containment of SARS, which had no available vaccine or treatment. The DOH also realized that both an appropriate legal framework and adequate resources were needed if the state ever found itself in the position of treating another SARS case.[29] The SARS outbreak, combined with current reports of avian influenza and the continuing risk of bioterrorism, prompted Minnesota to reauthorize its isolation and quarantine procedures in 2005.[30]

In Minnesota's public health system, the state health agency will lead any isolation or quarantine response.[31] The decision to quarantine an individual requires a balancing of what is best for the public's health versus the civil liberties of the quarantined individual.

Isolation and quarantine orders involve an individual's due process rights as well as privacy protections provided by state law.[32] Minnesota's state statutes have a "least restrictive means necessary to prevent disease transmission" standard.[33] The standard addresses the place where an individual may be quarantined or isolated, not the length of time. For example, an individual may be confined to his/her private home instead of a hospital if it is appropriate.

Minnesota's Isolation and Quarantine statutes were reauthorized in 2005. It provides a modern legal framework that gives the DOH authority to use quarantine as a public health measure. It spells out procedures for making use of this authority, while also providing safeguards for the rights of individuals who may be placed under quarantine.[34]

A quarantine or isolation response requires the planning and coordination of many partners, including public health and law enforcement. In Minnesota, this means integrating law enforcement and courts for compliance needs, including education and personal protective equipment.[35]

There are clear procedures for implementing the Isolation and Quarantine statutes. DOH attorneys have worked with the state attorney general and the courts to develop detailed quarantine procedures and draft model quarantine orders. The DOH also works with judges and law enforcement officials to ensure that they are prepared to handle quarantine orders if the need arises.[36]

The DOH is working with hospitals and local public health agencies to develop health systems for handling the much larger number of quarantine or isolation cases that may occur if transmission of quarantineable diseases begins to occur in the broader community, including systems for providing food, and meeting other social service needs of those quarantined or isolated.[37]

IOWA

Law enforcement's role in any isolation or quarantine event in Iowa is specifically outlined in state laws and regulations. "All peace officers of the state shall enforce and execute a lawful department order for isolation or quarantine within their respective jurisdictions."[38] The Iowa Department of Public Health (IDPH) is responsible for taking "all reasonable measures to minimize the risk of exposure to peace officers and others assisting with enforcement of an isolation or quarantine order."[39] A reasonable measure that the IDPH uses to minimize the risk is to review the vaccine records of the peace officer who serves a quarantine order to ensure immunity to a vaccine preventable disease. Additionally, the IDPH provides training for all state peace officers on how to use personal protective equipment such as masks, booties, suits, and gloves.[40]

The IDPH collaborated with the Iowa chapter of the American Civil Liberties Union (ACLU), and other partners from the business sector, prior to developing the Iowa Code legislation for public health disasters.[41] The ACLU provided guidance for sections they felt were important to protect the civil liberties of individuals who refuse to obtain vaccinations, submit to physical exams, or be placed in quarantine.[42] Pursuant to Iowa's Administrative Code, such persons must be given notice and an opportunity to appeal the order.[43]

Any isolation or quarantine in Iowa shall be by the "least restrictive means necessary to prevent the spread of a communicable disease."[44] A starting point to determine the least restrictive means is to inquire whether the individual is eligible for home quarantine. The second step is to determine the incubation of the disease, thereby limiting the duration of time an individual is under quarantine.[45]

The Iowa legislature reviewed the laws pertaining to information sharing, authority to control the spread of disease, confidentiality, and authority to subpoena records provisions during its most recent session. The amended sections below will be enacted on July 1, 2006.

Information Sharing.[46] Until recently, the state information sharing law was limited to a "reportable disease or health condition, unusual cluster, or a suspicious event that may be the cause of a public health disaster."[47] The state legislature passed an amendment, effective July 1, 2006, that will broaden the sharing of information beyond those diseases that are classified as "reportable" disease to a health condition or an event that may cause a public health disaster.[48] This amendment will "improve the department's ability to conduct surveillance and investigations to prevent the spread of disease."[49]

Authority to Control the Spread of Disease.[50] This amendment also broadens the scope of a quarantine order. The term "area quarantine" concerns the ability to quarantine more than a person or group of persons. The area can be quarantined by way of controlling the ingress and egress of a building, facility, or an environment. Subsequent to the passing of this amendment, the IDPH will adopt rules to determine how area quarantine would be imposed. At the time this report was drafted, the following sections were being considered:

- Conditions and principles for quarantine.
- Due process procedures including the right to appeal from an order, both to the agency and to the district court.
- Rights of building and business owners in a facility subject to quarantine.
- Implementation and enforcement issues.

This type of quarantine avoids the administrative volume requiring the department of health to produce individual quarantine orders for the affected population.

Confidentiality. Iowa law currently states that a report or other information provided to the IDPH or local health agency, "which identifies a person infected with or exposed to a reportable or other disease or health condition" is confidential. This type of information cannot be accessed by the public.[51]

Authority to Subpoena Records. An additional amendment to the Iowa Code pertains to a new subsection allowing specific authorization to IDPH or local health agencies to subpoena records from anyone to conduct an investigation.[52]

This authorization may have assisted Iowa two years ago. In a 2004 measles outbreak, the department of health worked with law enforcement to enforce quarantine orders when individuals were unwilling to cooperate with the order.[53] During this event, one family being served with an involuntary quarantine order refused to open their door. The public health nurse contacted law enforcement, who arrived and assisted in serving the order.

Also during this situation, a national commercial airline refused to provide a passenger list to the department of health until their lawyers were contacted and approved, a process that would have taken several days. The passenger list was important because of the time available to provide vaccine to those who had been exposed. This list was the best method to contact individuals on the airplane who may have been in contact with the infected individual. The local health agency collaborated with the local police department, who in turn contacted a judge for a subpoena. In less than a day, a local ticket agent was subpoenaed and this person immediately turned over the passenger list.[54]

Although recent interactions between public health and law enforcement have been primarily due to bioterrorism preparedness, the measles outbreak solution shows how important it is for each agency is to achieve its respective goals while protecting the public's health.

Convening Public Health and Law Enforcement

The federal government is assisting the growth of partnerships between public health and law enforcement. Every year the CDC's Public Health Law Program and the American Society for Law, Medicine & Ethics co-sponsor a public health law conference: "The Public's Health & the Law in the 21st Century." The conference focuses on innovative legal tools and strategies for public health and explores cutting-edge

issues at the crossroads of public health and the law. The annual conference is for everyone who shapes and applies law as a public health tool including public health practitioners, health attorneys, judges, physicians and nurses, elected officials, attorneys general and other law enforcement professionals, researchers, and many others.[55] This event creates networking opportunities between public health and law enforcement, further encouraging the development of partnerships.

Conclusion

This issue report examined partnership efforts between public health and law enforcement with regard to privacy issues. During an emergency situation, especially when an individual may be subject to a quarantine or isolation order, privacy interests must be taken into account. Each state effort featured in this report has made it a priority to protect the privacy interests of individuals while balancing the interests of the public at large.

New York City and North Carolina partnered with the FBI or their respective state bureau of investigation. Both public health and law enforcement have benefited from the partnerships. The backbone of these partnerships is trust. By engaging in partnership activities at a base level, e.g., for preparedness drills, future instances of collaboration on new issues come along much easier.

As avian influenza and some vaccine preventable diseases threaten the United States, some states are taking the initiative to ensure their laws and regulations are updated. Minnesota's experience with SARS led them to reauthorize their quarantine and isolation statutes. Iowa's 2004 measles outbreak tested their state statutes and encouraged an updating of the laws by the Iowa legislature.

As each state develops partnerships with law enforcement, our partners at the federal level are also convening organizations to discuss public health law issues. The CDC's Public Health Law Program and the American Society for Law, Medicine & Ethics' annual public health law conference consistently brings current and potential partnering organizations to the table.

Public health and law enforcement have similar goals. Together the agencies can accomplish their missions as well as protect the public's health and privacy.

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Online Resources

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry Privacy Rule Homepage www.cdc.gov/privacyrule

Department of Health and Human Services Office of Civil Rights—HIPAA Guidelines www.hhs.gov/ocr/hipaa

National Institutes of Health http://privacyruleandresearch.nih.gov

Buncombe County Health Center www.buncombecounty.org/governing/depts/health/

Iowa Department of Public Health http://idph.state.ia.us/

Minnesota Department of Health
www.health.state.mn.us/

New York City Department of Health and Mental Hygiene
www.nyc.gov/html/doh/html/home/home.shtml

North Carolina Division of Public Health
www.ncpublichealth.com/index.htm

Georgetown University Health Privacy Project
http://healthprivacy.org

Public Health Grounds HIPAA Privacy Rule: Enhancing or Harming Public Health?
www.publichealthgrandrounds.unc.edu/privacy/index.htm

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