

HEALTH LAW

Number 79 February 2003

NEW NORTH CAROLINA PUBLIC HEALTH BIOTERRORISM LAW

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In the aftermath of the anthrax letter attacks of 2001, the nation faced a grim new reality: the knowledge that there are terrorists with the will and the ability to use biological weapons against civilians in the United States. Twenty-three people contracted anthrax from the letter attacks; five of those died. The numbers may seem small when compared with the September 11 attacks, the Oklahoma City bombing, or other terrorist acts on U.S. soil, but the impact on local and state public health systems was huge. The experience exposed the strengths and weaknesses of the laws that support public health systems and showed how those laws can permit—or prevent—a rapid and appropriate response to a health threat caused by biological, chemical, or nuclear terrorism. (For brevity, the remainder of this bulletin will use the term *bioterrorism* to describe terrorism using nuclear, biological, or chemical agents. *NBC agents* will be the shorthand term for the three categories of agents.)

In the fall of 2002, the North Carolina General Assembly enacted a new law that more clearly defined the role of public health in responding to bioterrorism (S.L. 2002-179, hereinafter called the 2002 Bioterrorism Act). The new law supplements, but does not replace, older public health laws.

Background to the 2002 Bioterrorism Act

The anthrax letter attacks spurred a new national focus on public health laws, particularly the state laws that prescribe the role, duties, and powers of public health systems. Legislators and public health officials throughout the country evaluated their laws, seeking an answer to this question: Would those laws support an effective response to a health threat caused by bioterrorism?

In North Carolina, a review of state public health laws revealed that some of the fundamental legal tools for responding to bioterrorism were in place. State laws addressing the control of diseases and the abatement of some environmental hazards provided a good partial foundation.

The state's communicable disease laws, in particular, provided some means for detecting and containing a threat. Those laws require physicians and others to report known or

suspected communicable diseases and conditions,¹ require individuals to comply with communicable disease control measures,² and authorize public health officials to issue isolation or quarantine orders when necessary to contain the spread of disease.³ However, the communicable disease laws do not clearly authorize health care providers to release confidential information to public health officials about troublesome symptoms, syndromes, or trends that do not quite fit the reporting requirements but could nevertheless indicate a significant health threat. They do not provide for systematic syndromic surveillance—that is, the routine evaluation of health information in a population to identify suspicious symptoms or conditions that may indicate a threat. Also, since they address only diseases caused by biological agents, they do not provide for the reporting of health information that could indicate a bioterrorist attack using nuclear or chemical agents.

Two other laws predating the 2002 Bioterrorism Act provided some support for a public health response to acts that contaminate property with NBC agents. State and local public health officials have the authority to abate public health nuisances⁴ and imminent hazards.⁵ Using those powers, officials can order the decontamination of property once a public health threat is identified. But those laws are of no use in *detecting* a health threat caused by contamination of property, as they do not authorize public health officials to investigate to determine whether contamination by NBC agents exists.

The 2002 Bioterrorism Act attempts to address these gaps in the public health laws. Among other things, the new law

- Empowers the state health director to order tests and investigations to determine whether a public health threat exists due to bioterrorism.
- Gives public health officials new access to otherwise confidential information about symptoms, syndromes, and trends that could indicate a public health threat caused by bioterrorism.
- Creates new, explicit legal protections for individuals who are affected by certain public health orders.

1. G.S. 130A-135 through 130A-139.

2. G.S. 130A-144(f).

3. G.S. 130A-145.

4. G.S. 130A-19.

5. G.S. 130A-20.

Reorganization of Public Health Statutes

In addition to the substantive changes described in this bulletin, the 2002 Bioterrorism Act made two major organizational changes to the public health statutes (G.S. Chapter 130A).

First, it created a new Article 22, entitled “A Terrorist Incident Using Nuclear, Biological, or Chemical Agents.” Article 22 contains the following new public health law provisions specific to bioterrorism: (1) powers and duties of the state health director in a suspected bioterrorist incident and the rights of individuals affected by those orders (G.S. 130A-475); (2) access to health information for the purpose of detecting health threats caused by bioterrorism and the protection of that information (G.S. 130A-476); (3) abatement of public health threats caused by bioterrorism (G.S. 130A-477); and (4) tort liability of state employees and officers acting pursuant to Article 22 (G.S. 130A-478). In addition, the 2001 law that established the state’s biological agents registry (G.S. 130A-149) was moved into Article 22 and recodified as G.S. 130A-479.

Second, several important public health laws were relocated within G.S. Chapter 130A. Definitions of communicable disease law terms such as *quarantine* and *isolation* were moved to G.S. 130A-2. The section that previously contained the definitions, G.S. 130A-133, was repealed. Readers should understand that those definitions have not disappeared from state law but have simply been relocated.

- Fosters planning and communication among state agencies that are likely to have a role in responding to a bioterrorist attack.

This bulletin summarizes the key provisions of the new law, focusing primarily on the impact of the 2002 Bioterrorism Act on the state’s public health laws and public health system.

New Powers for State Health Director

The 2002 Bioterrorism Act grants the state health director powers that can be divided into two categories: powers over property, and powers over persons and animals. Before exercising the new powers, the state health director must reasonably suspect two things: (1) that a public health threat may exist, and (2) that the threat may have been caused by a

terrorist incident⁶ using NBC agents.⁷ Further, the powers may be exercised only when and for as long as a public health threat may exist, all other reasonable means for correcting the problem have been exhausted, and no less-restrictive alternative exists.⁸ A *public health threat* is “a situation that is likely to cause an immediate risk to human life, an immediate risk of serious physical injury or illness, or an immediate risk of serious adverse health effects.”⁹

These new powers do not limit other legal authority granted to local or state public health officials in G.S. Chapter 130A.¹⁰ For example, the law that grants isolation and quarantine authority to both the state health director and local health directors is not limited or replaced by the new powers; nor are the laws that authorize state and local officials to abate public health nuisances and imminent hazards.

Powers over Property

When the state health director reasonably suspects that there may be a public health threat caused by bioterrorism, he or she may exercise the following powers over property.

Power to test for contamination

The state health director may test any real or personal property to determine the presence of NBC agents.¹¹

Power to close or evacuate property for the purpose of investigation

The state health director may evacuate or close any real property suspected of being contaminated by NBC agents in order to investigate. The director may not order a closure that exceeds ten calendar days. If a longer period of time is required to complete the

6. *Terrorist incident* is defined as “activities that occur within the territorial jurisdiction of the United States, involve acts dangerous to human life that are a violation of the criminal laws of the United States or of any state, and are intended to do one of the following: a. Intimidate or coerce a civilian population. b. Influence the policy of a government by intimidation or coercion. c. Affect the conduct of a government by mass destruction, assassination, or kidnapping.” G.S. 166A-21 (as amended by S.L. 2002-179).

7. G.S. 130A-475(a).

8. G.S. 130A-475(b).

9. G.S. 130A-475(d).

10. G.S. 130A-475(e).

11. G.S. 130A-475(a)(2).

investigation, the director may ask a superior court to order that the property remain closed until the investigation is completed.¹²

Power to order abatement of a public health threat

If the state health director determines that a public health threat may exist because of contamination of property resulting from bioterrorism, he or she may order any action to abate the public health threat.¹³

The secretary of Health and Human Services and local health directors already had the legal authority to abate or order abatement of public health nuisances and imminent hazards.¹⁴ The state health director’s new power to abate public health threats does not replace or limit those authorities. It is likely that the secretary or a local health director could use either the public health nuisance or the imminent hazard abatement authority to ensure that property contaminated with a NBC agent is cleaned up. What, then, distinguishes this new power from the pre-existing abatement powers?

First, the new power may be exercised only by a state official—the state health director—whereas public health nuisance and imminent hazard abatement powers may be exercised by either the secretary or a local health director. Second, the context in which public health threat abatement power may be exercised is narrower. The state health director may exercise the public health threat abatement authority only when it is reasonable to suspect a public health threat caused by bioterrorism. In contrast, the public health nuisance and imminent hazard authorities are not limited to the bioterrorism context. Third, the standard for ordering abatement of a public health threat appears to be somewhat lower than the standard for ordering abatement of a public health nuisance or imminent hazard. The state health director may order abatement of a public health threat that merely *may* exist because of contamination of property by a NBC agent. In contrast, abatement of a public health nuisance or imminent hazard may be ordered or undertaken by the secretary or a local health director only after determining that the nuisance or hazard *does* exist.

12. G.S. 130A-475(a)(3).

13. G.S. 130A-477.

14. G.S. 130A-19 (public health nuisance authority); 130A-20 (imminent hazard authority). The secretary of Environment and Natural Resources may also exercise public health nuisance and imminent hazard authority in order to enforce the provisions of the state public health laws governing sanitation, solid waste, drinking water, wastewater systems, and mosquito and vector control.

Also, the state health director need only conclude that the situation is likely to cause an immediate *risk* to human life or an immediate *risk* of serious physical injury, illness, or adverse health effects.¹⁵ In contrast, an imminent hazard is defined as a situation that is likely to cause an immediate *threat* to human life or health,¹⁶ and a public health nuisance action may require evidence that a condition actually endangers the public health.

Who bears the cost of abating a public health threat? The new law states that an owner, lessee, operator, or other person in control of the property who is innocent of culpability in the creation of the public health threat is not responsible for the costs of the abatement. This strongly suggests that a culpable owner, lessee, operator, or other person in control of the property *would* be responsible for the costs.

Powers over Persons and Animals

When the state health director reasonably suspects that there may be a public health threat caused by bioterrorism, he or she may exercise the following powers over persons and animals.

Power to require tests or examinations

The state health director may require any person or animal to submit to examinations or tests to determine possible exposure to an NBC agent.¹⁷

Powers to limit freedom of movement or action, or access to contaminated areas

The state health director may limit the freedom of movement or action of a person or animal that is contaminated with, or reasonably suspected of being contaminated with, an NBC agent that may be conveyed to others.¹⁸ The director also may limit access to: (1) an area or facility that is housing people or animals whose movement or action has been limited; or (2) an area or facility that is contaminated with, or reasonably suspected of being contaminated with, an NBC agent. However, the director may not restrict the access of authorized health care, law enforcement, or EMS personnel to the premises when

they are conducting their duties.¹⁹ Further, the director must consult with the state veterinarian in the Department of Agriculture and Consumer Services before applying any of these limitations to livestock or poultry.

Orders limiting access to contaminated places may not exceed ten days. Likewise, orders limiting the freedom of *movement* of contaminated persons or animals may not exceed ten days.²⁰ However, the ten-day limitation does not apply to an order limiting freedom of *action*.

What distinguishes an order limiting freedom of movement from an order limiting freedom of action? The law does not define those terms, but they have

19. This is, I believe, the best interpretation of a confusing sentence. The new provision actually states: “Nothing in this subdivision shall be construed to restrict the access of authorized health care, law enforcement, or emergency medical services (EMS) personnel to *quarantine or isolation* premises as necessary to conduct their duties.” G.S. 130A-475(a)(5) (emphasis added). The reference to “quarantine” and “isolation” in this context creates the confusion, as both of those terms have legal definitions that confine them to the communicable disease context—that is, situations in which an individual is *infected* with a communicable disease or has been exposed to an infectious agent that can be transmitted from person to person. See G.S. 130A-2(3a) and 130A-2(7a) (definitions of *isolation authority* and *quarantine authority*); see also G.S. 130A-2(1a) and (1b) (definitions of *communicable condition* and *communicable disease*). In contrast, the authority to limit access in G.S. 130A-475(a)(5) refers to areas that have been *contaminated* with an NBC agent or areas housing contaminated persons. Infection with a communicable agent and contamination with an NBC agent are different things. Given the placement of the statement, however, it seems likely that the legislature intended to preserve access to contaminated areas (or those housing contaminated persons) for authorized health care, law enforcement, and EMS personnel and that use of the terms *quarantine* and *isolation* was inadvertent. This conclusion is bolstered by another provision in the new law that authorizes either the state health director or a local health director to establish quarantine or isolation premises and to limit the access of persons to those premises (G.S. 130A-145(b)). That new subsection also states that it may not be construed to restrict the access of authorized health care, law enforcement, or EMS personnel to the quarantine or isolation premises. The statement in G.S. 130A-475(a)(5) would be a pointless duplication of the new provision in G.S. 130A-145(b) if it were not intended to do something different—that is, to apply the same principle to the different context.

20. G.S. 130A-475(b).

15. G.S. 130A-475(d).

16. G.S. 130A-2(3). The definition of *imminent hazard* also encompasses situations that pose a serious risk of irreparable damage to the environment.

17. G.S. 130A-475(a)(1).

18. G.S. 130A-475(a)(4).

existed in the state's communicable disease law for many years, in the statutory definitions of *quarantine authority* and *isolation authority*. The terms are generally understood by public health officials as follows: Limitations on freedom of movement require individuals to remain in a particular place, while limitations on freedom of action restrict individuals' behavior but not their ability to move freely in society. For example, a person with infectious tuberculosis may be subject to an isolation order limiting his freedom of *movement* by requiring him to stay at home until tests show no further risk of transmission.²¹ In contrast, an isolation order for a person with HIV may only limit freedom of *action*, by imposing restrictions on sexual behavior, prohibiting blood donation, and requiring or prohibiting other activities or behaviors specified in state regulations.²²

If the state health director determines that a limitation on freedom of movement or access must extend beyond ten days, he or she must ask a superior court to order an extension. If the court determines that continued limitation is necessary to prevent or limit the conveyance of NBC agents to others, the court will continue the limitation for up to thirty days. When necessary, the state health director may seek additional continuations of up to thirty days each.

A person who is substantially affected by an order limiting freedom of movement or access need not wait ten days to obtain a superior court's review. He or she may ask a superior court to review the limitation and the court must respond by holding a hearing within seventy-two hours (excluding Saturdays and Sundays). The new law does not explain what it means to be "substantially affected" by an order. It seems reasonable to assume that a person is substantially affected if the limitation applies directly to the person or to animals the person owns. There may also be other circumstances in which a court would conclude that a person is substantially affected.

A person who seeks a court's review is entitled to representation by counsel and will receive appointed representation if he or she is indigent. If, after the hearing, the court determines by a preponderance of the evidence that the limitation on freedom of movement or access is not necessary to prevent or limit the conveyance of NBC agents to others, the court will

reduce the limitation. The court may also apply any conditions to a limitation that it deems reasonable and necessary.

Public Health Access to Information

Before officials can respond to a public health threat caused by bioterrorism, they must know that the threat exists. But unlike most emergencies—which begin with a definite, identifiable act such as a fire, an explosion, or a plane crash—an act of bioterrorism may be covert and not recognized until people begin to fall ill. In those circumstances, health care providers may be the first to recognize that something is amiss. Therefore, several provisions of the 2002 Bioterrorism Act authorize public health officials to obtain confidential health information that can aid in the detection of bioterrorism. These provisions supplement, but do not replace, pre-existing communicable disease reporting laws.

Some health care providers or others who are "covered entities" under the federal Health Insurance Portability and Accountability Act (HIPAA) may wonder whether the HIPAA medical privacy rule permits them to disclose confidential health information to public health officials for the purposes described in this section.²³ The privacy rule does appear to allow all of these disclosures. This issue is analyzed in detail in the Appendix to this bulletin.

Communicable Disease Reporting Requirements

North Carolina's communicable disease laws require physicians and certain others to notify public health officials of all known or suspected cases of "reportable" diseases and conditions.²⁴ The list of reportable communicable diseases and conditions is established by the North Carolina Commission for Health Services and currently includes sixty-four diseases and conditions. Among them are several which the federal Centers for Disease Control considers likely choices of bioterrorists, including anthrax, botulism, plague, smallpox, and tularemia. Reporters must provide personally identifiable information about the individual who has (or is suspected of having) the disease or condition, including the individual's name and address. The communicable disease reporting requirements are summarized in Table 1 (next page).

21. 15A N.C. Admin. Code 19A.0205(f).

22. 15A N.C. Admin. Code 19A.0202(1). North Carolina law prohibits isolation orders that confine HIV-positive individuals to their homes or otherwise restrict their freedom of *movement*. 15A N.C. Admin. Code 19A.0201(d).

23. 45 C.F.R. § 164.500 et seq.

24. See G.S. 130A-135 through 130A-139.

Table 1. Summary of Communicable Disease/Condition Reporting Requirements

Reporter	What to report	To whom to report	N.C.G.S.
Physicians	Any instance in which the physician has reason to suspect that a person about whom the physician has been professionally consulted has a reportable communicable disease or condition	Local health director	130A-135
School principals and operators of child day care facilities	Any instance in which the principal or operator has reason to suspect that a person in the school or child care facility has a reportable communicable disease or condition	Local health director	130A-136
Operators of restaurants and other food/drink establishments	Known or suspected outbreaks of food-borne illnesses among customers or employees, and known or suspected food-borne illnesses in food handlers	Local health director	130A-138
Persons in charge of laboratories	Positive tests for certain communicable diseases (specified in 15A N.C. Admin. Code 19A.0101(c))	Local or state public health officials	130A-139
Local health directors	Communicable diseases, conditions, and positive laboratory findings that are reported to the local health director	N.C. Department of Health and Human Services; in some instances, other local health directors	130A-140

New Reporting Provisions

The new law contains two reporting provisions designed to provide information to public health officials about suspicious symptoms, syndromes, or trends. One of the provisions gives health care providers and certain others legal *permission* to make voluntary reports, while the other authorizes the state health director to issue a temporary order *requiring* health care providers to report information. For the purposes of these provisions, the term *health care provider* is defined to include physicians, pharmacists, dentists, physician assistants, nurses, chiropractors, respiratory care therapists, emergency medical technicians, and other persons who are licensed, certified, or credentialed to practice or provide health care services.²⁵

Voluntary reports

New G.S. 130A-476(a) authorizes health care providers, people in charge of health care facilities,

and units of state or local government to make voluntary reports of certain health information to the state health director or a local health director. The reports may cover any event that may indicate the existence of an illness, condition, or health hazard that may have been caused by bioterrorism. The events that may be reported include unusual types or numbers of symptoms or illnesses, unusual trends in health care visits, or unusual trends in prescriptions or purchase of over-the-counter pharmaceuticals.

It appears that the legislature intended to protect the identity of patients whose information is used in these voluntary reports in most cases. The new provision states: “[t]o the extent practicable, a person who makes a report under this subsection shall not disclose personally identifiable information.” The provision does not define or describe “personally identifiable information.” The reference to what is “practicable” seems to recognize the possibility that some circumstances might require that a patient’s identity be disclosed; however, a reporter’s starting assumption should be that a report should not contain information that personally identifies a patient.

²⁵ G.S. 130A-476(g)(1).

A health care provider who makes a voluntary report in good faith is immune from liability that might otherwise arise under state law. A health care provider who fails to make a report is also immune from liability, unless the provider had actual knowledge that a condition or illness was caused by use of a nuclear, biological, or chemical weapon of mass destruction.

Mandatory reports

New G.S. 130A-476(b) authorizes the state health director to issue a temporary order *requiring* health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information. The state health director may issue an order when it is necessary to the conduct of an investigation or surveillance of an illness, condition, or health hazard that may have been caused by bioterrorism. The order must specify which health care providers must report, what information they must report, and the period of time for which reporting is required, not to exceed ninety days. If a longer period of time is necessary to protect the public health, the Commission for Health Services may adopt rules to continue the reporting requirement.

A temporary order requiring the reporting of symptoms or syndromes would supplement but not replace the legal requirement to report communicable diseases. Health care providers would still need to report all known and suspected cases of reportable communicable diseases and conditions.

A person who makes a report pursuant to the state health director's temporary order is immune from any liability that might otherwise arise under North Carolina law.²⁶

Emergency Department Surveillance Pilot Program

The new law directs the state health director to develop a voluntary pilot program that would use emergency department data to conduct public health surveillance.²⁷ The state health director is working with the North Carolina Emergency Department Database project (NCEDD) to set up the pilot. Hospitals and urgent care centers that participate in the program are authorized to provide data that includes individually identifiable health information. Upon receipt of the data, the director is required to remove the following direct identifiers of patients or their

relatives, employers, or household members: postal address information other than city, state, and five-digit zip codes; geocode information; telephone numbers; fax numbers; e-mail addresses; social security numbers; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; device identifiers and serial numbers; URLs; Internet protocol address numbers; biometric identifiers, including finger and voice prints; and full-face photographic images and other comparable images.

Protection of Confidential Health Information

All of the access-to-information provisions described above involve the disclosure of individuals' confidential health information to public health officials. The 2002 Bioterrorism Act contains several provisions designed to prevent public health officials from further disclosing that information, except when redisclosure is necessary to control a public health threat. The act creates new protections for information related to bioterrorism and clarifies older laws pertaining to the confidentiality of communicable disease information and emergency medical services data.

New protections

When the state health director or a local health director receives confidential or protected health information in accordance with a voluntary report, an ordered report, or the emergency department surveillance pilot, he or she must keep the information confidential. The information may be released only if the release is (1) made pursuant to any other provision of law; (2) made to another federal, state, or local public health agency for the purpose of preventing or controlling a public health threat; or (3) made to a court or law enforcement official for the purpose of enforcing the public health laws or for the purpose of investigating a bioterrorist incident. A court or law enforcement official who receives the information must not disclose it further except (1) when necessary to the investigation of the bioterrorist incident, or (2) when the state health director or a local health director seeks the court or law enforcement official's assistance in preventing or controlling the public health threat and authorizes the disclosure for that purpose.²⁸

26. G.S. 130A-476(d).

27. G.S. 130A-476(f).

28. G.S. 130A-476(e).

Amendments to communicable disease confidentiality law

A terrorist incident using biological agents could cause cases or outbreaks of communicable diseases or conditions that are reportable under North Carolina law. A strict state law predating the 2002 Bioterrorism Act offers additional protection to confidential health information that identifies a person who has or is suspected of having a reportable communicable disease or condition. G.S. 130A-143 prohibits any person who has information or records identifying such a person from disclosing that information in most circumstances. The information may be disclosed with the person's written permission or in ten other circumstances that are specified in the statute. Among other things, the law permits disclosure of the information when it is necessary to protect the public health and is made according to the Commission for Health Services' communicable disease rules.

The 2002 Bioterrorism Act amends two subsections of the communicable disease confidentiality law. G.S. 130A-143(7) authorizes the disclosure of communicable disease information to a court or law enforcement official for the purpose of enforcing the communicable disease laws. An amendment authorizes disclosures to court or law enforcement officials for the additional purpose of enforcing the new bioterrorism provisions. The law enforcement official may not further disclose the information except in three circumstances: (1) when necessary to enforce the public health laws regarding bioterrorism or communicable disease control, (2) when necessary to investigate a bioterrorist incident, or (3) when the state Department of Health and Human Services (DHHS) or a local health department seeks the official's assistance in preventing or controlling the spread of disease and expressly authorizes the disclosure for that purpose.

The new law also amends G.S. 130A-143(8), which authorizes DHHS or a local health department to disclose information to another state or local public health agency for the purpose of preventing or controlling the spread of disease. The amendment extended this authority to permit disclosures to federal public health agencies as well.

Clarification of EMS confidentiality law

In 2001, the General Assembly enacted G.S. 143-518, which made the medical records and data of emergency medical services (EMS) confidential and authorized their release only under a narrow set of circumstances. The list of circumstances did not provide for the release of EMS information to other

authorities, even when other laws required those releases. For example, G.S. 130A-383 states that EMS providers must notify the medical examiner when a person dies of certain causes or under circumstances that are specified in the statute, but G.S. 143-518 did not appear to permit this release. The 2002 Bioterrorism Act amends the EMS confidentiality law to authorize the disclosure of confidential EMS patient information "pursuant to any other law."²⁹ The amendment cures the conflict with other laws requiring the release of EMS information and also permits EMS providers to disclose confidential information to public health officials in accordance with the provisions regarding access to information described above.

Information about Certain Diseases in Animals

Before the 2002 Bioterrorism Act was passed, state law required all veterinarians practicing in North Carolina to report contagious or infectious diseases in livestock or poultry to the state veterinarian in the Department of Agriculture. The new law requires the state Board of Agriculture to develop a list of animal diseases and conditions that must be reported.³⁰ Another new provision prohibits the disclosure of animal disease diagnostic tests that identify the owner of the animal without the owner's permission, unless the state veterinarian determines that disclosure is necessary to prevent the spread of the disease or to protect the public health.³¹

Communication among State Officials

New G.S. 106-307.2(b) requires the state veterinarian to notify the state health director when the veterinarian receives a report indicating an occurrence or potential outbreak of any of the following diseases: anthrax, arboviral infections, brucellosis, epidemic typhus, hantavirus infections, murine typhus, plague, psittacosis, Q fever, hemorrhagic fever, virus infections, and any other disease or condition that is transmissible to humans and that may have been caused by a terrorist act.

When the state health director reasonably suspects that there is a public health threat that may have been caused by bioterrorism, the director must notify the governor and the secretary of Crime Control and

29. G.S. 143-518(a)(8).

30. G.S. 106-307.2 (as amended by S.L. 2002-179).

31. G.S. 106-24.1 (as amended by S.L. 2002-179).

Public Safety (CCPS). Likewise, when the secretary of CCPS reasonably suspects that there may be a public health threat caused by bioterrorism, he or she must notify both the governor and the state health director.³²

Changes to Quarantine and Isolation Authority

Under North Carolina communicable disease law, both the state health director and local health directors have the authority to impose quarantine or isolation when it is necessary to control the spread of a communicable disease or condition.³³ The 2002 Bioterrorism Act makes several significant changes to the quarantine and isolation authority.

First, the new law adds to the legal definition of quarantine. Previous law defined *quarantine authority* as (1) the authority to limit the freedom of movement or action of persons or animals that have been exposed to a communicable disease or condition in order to prevent the spread of the disease, and (2) the authority to limit the freedom of movement or action of persons who have not received immunizations that are required to control an outbreak of disease. The new law retains both of those definitions and adds a third: the authority to issue an order to limit access by any person or animal to an area or facility that may be contaminated with an infectious agent.³⁴ This parallels and to some extent overlaps with the state health director's new authority under G.S. 130A-475 to limit access to areas that may be contaminated with NBC agents. However, while quarantine authority may be exercised by either the state health director or a local health director, the authority to limit access under G.S. 130A-475 may be exercised only by the state health director. Also, this exercise of the quarantine authority applies only to *infectious agents*, an undefined term that probably refers to biological agents that cause diseases considered communicable under North Carolina law.³⁵

32. G.S. 130A-475(c).

33. G.S. 130A-145. Quarantine and isolation authority "shall be exercised only when and so long as the public health is endangered, all other reasonable means for correcting the problem have been exhausted, and no less restrictive alternative exists."

34. G.S. 130A-2(7a).

35. G.S. 130A-2(1b) defines *communicable disease* as "an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an

Second, the new law amends G.S. 130A-145, the law that authorizes the state health director and local health directors to impose isolation or quarantine. The amendment provides that no person may enter quarantine or isolation premises unless authorized by the state health director or the local health director.³⁶ However, the director may not restrict the access of authorized health care, law enforcement, or EMS personnel to the premises when they are conducting their duties. Another new provision requires the state health director or local health director to consult with the state veterinarian before applying quarantine or isolation authority to livestock or poultry.³⁷

Finally, the new law creates new protections for persons who are substantially affected by quarantine or isolation orders that restrict the freedom of movement of a person or animal, or that limit access to a person or animal whose freedom of movement has been limited. These new protections parallel those that apply to the state health director's orders limiting freedom of movement or access under G.S. 130A-475(a). Quarantine orders that limit access to an isolated or quarantined person or animal may not exceed ten days. Likewise, quarantine or isolation orders that limit the freedom of *movement* of persons or animals may not exceed ten days.³⁸ However, the ten-day limitation does not apply to an order limiting freedom of *action*. (For a discussion of the distinction between limitations on freedom of movement and limitations on freedom of action, see above section, "New Powers for State Health Director.")

If the state health director or local health director determines that a quarantine or isolation order limiting freedom of movement or access must extend beyond ten days, the director must ask a superior court to order an extension. If the court determines that continued limitation of movement or access is necessary to prevent or limit the conveyance of a communicable disease or condition to others, the court will continue the limitation for a period not to exceed thirty days. When necessary, the state health director or local health director may seek additional continuations of up to thirty days each.

intermediate animal, host or vector, or through the inanimate environment."

36. G.S. 130A-145(b). The local health director with the power to authorize entry into quarantine or isolation premises presumably would be the same local health director who ordered the quarantine or isolation, but this is not explicitly addressed by the statute.

37. G.S. 130A-145(c).

38. G.S. 130A-145(d).

A person who is substantially affected by a quarantine or isolation order limiting freedom of movement or access need not wait ten days to obtain a superior court's review. He or she may ask a superior court to review the limitation, and the court must respond by holding a hearing within seventy-two hours (excluding Saturdays and Sundays). A substantially affected person who seeks a court's review of an order is entitled to representation by counsel and will receive appointed representation if he or she is indigent. If, after the hearing, the court determines by a preponderance of the evidence that the limitation on freedom of movement or access is not necessary to prevent or limit the conveyance of NBC agents to others, the court will reduce the limitation. The court may also apply any conditions to a limitation that it deems reasonable and necessary.

Enforcing Limitations on Freedom of Movement or Access

Any violation of the state's public health laws—G.S. Chapter 130A, the rules of the Commission for Health Services, or the rules of a local board of health—is a misdemeanor.³⁹ Thus, a person can be criminally prosecuted for violating quarantine or isolation orders or orders of the state health director limiting freedom of movement or access under G.S. 130A-475(a). However, the arrest and detention of such a person creates public health concerns, since the person may be infected or contaminated with an agent that could cause illness in others.

To address these concerns, the 2002 Bioterrorism Act amends the state's criminal procedure laws to allow for arrests and detentions that minimize the exposure of others to the arrested person. A law enforcement officer who arrests an individual for violating an order limiting freedom of movement or access under G.S. 130A-145 or 130A-475(a) may detain the person in an area designated by the state health director or a local health director until the individual's first appearance before a judicial official.⁴⁰ In other words, the person need not be taken to the jail if the state health director or local health director orders the person detained in a different place. At the first appearance, the judicial official must consider whether the person poses a threat to the health and safety of others.⁴¹ If the judicial official

39. G.S. 130A-25.

40. G.S. 15A-401(b)(4).

41. G.S. 15A-534.5.

determines by clear and convincing evidence that the person does pose a threat, the official must deny pretrial release and order the person to be confined in an area the official designates after receiving recommendations from the state health director or local health director.

Other Changes to Public Health Laws

Changes to Imminent Hazard Law

The 2002 Bioterrorism Act makes two substantive changes to state law governing the abatement of imminent hazards. An *imminent hazard* is "a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken."⁴² Prior law authorized the secretary of Health and Human Services or a local health director to take any action necessary to abate an imminent hazard.⁴³ The new law retains this provision and adds that the secretary or a local health director may order the owner, lessee, operator, or other person in control of the property to abate the hazard. In other words, the secretary or local health director now has the option of ordering abatement actions or undertaking those actions directly.

Second, the new law modifies the property owner's or operator's responsibility for the costs of abating an imminent hazard in certain circumstances. G.S. 130A-20 establishes a lien on the property for the costs of abatement actions undertaken by the secretary or a local health director. An amendment to that statute allows the owner, lessee, operator, or other person in control of the property to defeat the lien by showing that he or she was not culpable in the creation of the imminent hazard.

Religious Exemption from Immunizations

G.S. 130A-157 establishes an exemption from some immunization requirements for individuals whose bona

42. G.S. 130A-2(3).

43. G.S. 130A-20. The secretary of Environment and Natural Resources may also exercise imminent hazard authority in order to enforce the provisions of the state public health laws governing sanitation, solid waste, drinking water, wastewater systems, and mosquito and vector control.

vide religious beliefs are contrary to the requirements. Under previous law, the exemption applied only to childhood immunizations—those that are required before a person may attend a day care center, school, or college in North Carolina. The new law amends G.S. 130A-157 to extend the religious exemption to any immunization required under the authority of G.S. Chapter 130A. This means that the religious exemption would apply to immunizations that public health officials may require, including those that may be required as a communicable disease control measure in either a natural disease outbreak or an outbreak caused by bioterrorism.

Emergency Management Provisions

Role of State Health Director in Developing Emergency Operations Plan

There is an extensive statutory scheme in North Carolina for the management of emergencies and disasters.⁴⁴ A critical part of this scheme is the Emergency Operations Plan, which describes how the state will respond to man-made or natural disasters. State and local public health agencies have always played an important role in responding to health threats created by emergencies and disasters, and public health goals have been reflected in an annex to the plan. However, public health's role in developing the plan was never specified in law.

The 2002 Bioterrorism Act amends the state's emergency management laws to specify that the state's emergency management program officials must coordinate with the state health director to make amendments or revisions to the state Emergency Operations Plan regarding public health matters. At a minimum, the plan must provide for (1) epidemiologic investigation of known or suspected threats caused by NBC agents, (2) examination and testing of persons or animals that may have been exposed to NBC agents,

(3) procurement and allocation of immunizing agents and prophylactic antibiotics, (4) allocation of the National Pharmaceutical Stockpile, (5) appropriate conditions for quarantine and isolation, (6) immunization procedures, and (7) issuance of guidelines for prophylaxis and treatment of exposed and affected persons.⁴⁵

Use of Unlicensed Health Care Providers in Emergencies

The North Carolina Medical Board establishes licensure requirements for physicians and physician extenders to practice in this state. It is possible that bioterrorism or another emergency could overwhelm North Carolina's health care providers, and the state might seek assistance from unlicensed providers, such as retired physicians or those holding licenses from other states. New G.S. 90-12.2 authorizes the Medical Board to waive its licensure requirements in an emergency or disaster in order to permit the provision of emergency health services to the public. An amendment to G.S. 166A-14(a), the statute that provides immunity from liability for emergency management workers, makes clear that this immunity extends to persons performing emergency health services pursuant to a waiver of licensure requirements under G.S. 90-12.2.

Hazardous Materials Response Program Extended to Terrorist Incidents

Amendments to G.S. 166A-20 through 166A-26 extend the state's existing hazardous materials emergency response program to terrorist incidents. This means, among other things, that the program must have guidelines for responding to terrorist incidents. Also, the state's hazardous materials regional response teams are legally authorized to respond to terrorist incidents when they receive appropriate authorization.

44. North Carolina Emergency Management Act, G.S. Chapter 166A.

45. G.S. 166A-5(3)(b1).

Appendix

Does the HIPAA privacy rule permit health care providers to share confidential patient information with public health?

Some health care providers and others who are “covered entities” under the federal Health Insurance Portability and Accountability Act (HIPAA)^a may wonder whether the HIPAA medical privacy rule^b permits them to disclose confidential health information to public health officials for the purposes described in this bulletin. As a general rule, the HIPAA privacy rule requires covered entities to obtain a patient’s permission before disclosing any of the patient’s “protected health information.”^c However, there are exceptions to this general rule that permit each of the disclosures described in this bulletin. This discussion addresses each type of disclosure in turn.

Communicable Disease Reports

The HIPAA privacy rule clearly allows health care providers to make the communicable disease reports required by G.S. 130A-135 through 130A-140. Covered entities are permitted to disclose protected health information when the disclosure is required by other state and federal laws.^d Communicable disease reports containing protected health information are required by North Carolina’s communicable disease laws; therefore, the disclosure is permitted by HIPAA. Since HIPAA permits communicable disease reporting and state law requires it, physicians and others specified in Table 1 (page 6) *must* continue to make the reports.

Voluntary Reports of Symptoms, Syndromes, and Trends

The HIPAA privacy rule permits covered entities to make the voluntary reports of symptoms, syndromes, and trends authorized by new G.S. 130A-476(a). These reports are simply *permitted* and not *required*, so they do not fall within the HIPAA provision that allows covered entities to disclose protected health information when the disclosure is required by law. Nevertheless, as long as the reporter takes care to limit the disclosure of health information to that which is specifically authorized, the reporter should not run afoul of HIPAA, for several reasons. First, to the extent practicable, voluntary reports made under this provision should not disclose personally identifiable information. The HIPAA privacy rule may not apply to a disclosure that does not contain such information. The rule is inapplicable to health information that has been de-identified in accordance with HIPAA standards.^e But even if the information does not meet the de-identification standards, the disclosure still should be allowed under HIPAA. The privacy rule expressly permits disclosures of protected health information that are made to public health authorities for the purpose of public health surveillance, investigation, or intervention.^f G.S. 130A-476(a) appears to fit clearly within this privacy rule provision. The reports it authorizes are made to public health authorities—either the state health director or a local health director—and serve the purpose of public health surveillance by alerting those authorities to diseases or health hazards caused by bioterrorism. Finally, the privacy rule also permits disclosures that are necessary to avert serious threats to health or safety.^g It seems likely that disclosure of health information that could indicate that a bioterrorist incident has occurred would fit within this HIPAA provision as well.

Reports Required by the State Health Director’s Temporary Orders

As explained above, the HIPAA privacy rule allows health care providers to disclose protected health information when the disclosure is required by other laws.^h When the state health director issues a temporary order requiring reports under new G.S. 130A-476(b), those reports are mandatory under state law. Thus, the HIPAA privacy rule permits HIPAA-covered entities to make these reports.

Emergency Department Surveillance Pilot

Emergency departments that choose to participate in the pilot program authorized by new G.S. 130A-476(f) will be required to disclose protected health information to the state health director. Even though participation in the program requires disclosure of information, the disclosure itself probably would not be considered a legal requirement, because participation in the program is voluntary. Nevertheless, the disclosure of information still should be

permitted by HIPAA. The disclosures that will be required of pilot program participants appear to fit within the section of the privacy rule that authorizes covered entities to disclose protected health information without the individual's authorization for certain public health activities.ⁱ Among other things, a covered entity may disclose protected health information to "a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, or public health interventions." G.S. 130A-476(f) expressly authorizes a public health authority (the state health director) to receive this information for the express purpose of public health surveillance. It therefore appears to fit squarely within this section of the privacy rule.

a. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. "Covered entities" include health care providers who transmit health information electronically in connection with a HIPAA transaction. Most health care providers and health care facilities in North Carolina are covered entities. Many local government entities, such as health departments and emergency medical services departments, are covered entities. For more information about HIPAA covered entities, see Aimee Wall, *Forms of Covered Entities* (Institute of Government HIPAA Training, October 2002), available on the Internet at www.medicalprivacy.unc.edu.

b. 45 C.F.R. § 164.500 et seq.

c. *Protected health information* (PHI) means health information that identifies an individual (or from which an individual can be identified) and that relates to one of the following: the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual. See 45 C.F.R. §§ 164.501 (definition of *protected health information*) and 160.103 (definitions of *individually identifiable health information* and *health information*).

d. 45 C.F.R. § 164.512(a) authorizes disclosures that are required by law. *Required by law* is defined as a mandate contained in law that compels a covered entity to make a use or disclosure of PHI and that is enforceable in a court of law.

e. See 45 C.F.R. § 164.514(a).

f. 45 C.F.R. § 164.512(b). The HIPAA privacy rule defines *public health authority* as a government agency (or employee, officer, agent, or person acting under its authority) that is responsible for public health matters as part of its official mandate.

g. 45 C.F.R. § 164.512(j).

h. 45 C.F.R. § 164.512(a).

i. 45 C.F.R. § 164.512(b).

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Printed in the United States of America

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