

# **Minnesota Emergency Health Powers Act**

## *Report to the Minnesota Legislature 2003*

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**Minnesota Department of Health**

**February 14, 2003**



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# **Minnesota Emergency Health Powers Act**

## ***Legislative Report and Recommendations***

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## Executive Summary

The terrorist attacks of September 11 and the anthrax outbreak in the fall of 2001 raised questions about the threat of bioterrorism and other public health emergencies in Minnesota. Because of the potentially devastating community-wide consequences of such an event, government is responsible for limiting the impact of an event. In its statutorily defined role of protecting Minnesotans, the Minnesota Department of Health (MDH) is charged to plan for and oversee care for injured, ill or infectious individuals affected by a terrorism event.

Depending on the event, public health response activities may include any or all of the following:

- Recommending ways to prevent the further spread of disease
- Communicating directly with the public about things they can do to protect themselves and their family
- Issuing guidelines to health care professionals about effective treatment
- Working with health care providers to make antibiotics available
- Supporting local health officials to immunize large groups of people

If a health threat appears to be serious and widespread, MDH will coordinate response activities with the national Centers for Disease Control and Prevention, the Minnesota Department of Public Safety's Division of Emergency Management, local public health and emergency management officials, emergency medical service providers, physician clinics and hospitals across the state. This coordination requires advance planning and clarification of roles to avoid missteps or confusion during the health threat.

The 2002 legislature enacted the Minnesota Emergency Health Powers Act (MEHPA, Minnesota Statutes 2002 Chapter 402) to clarify and

strengthen Minnesota's preparedness and response to bioterrorism and other public health emergencies. The legislation required MDH to further study related issues and report findings and recommendations to the Legislature.

This report summarizes the work of the six months available for the study and the process of developing the report and publishing the resulting recommendations. This report concludes that MEHPA provides a good starting framework, that practical tests of the powers should be conducted during tabletops and field exercises in 2003, and that no new legislation is proposed for debate in the 2003 session. Most of the comments from participants in preparing this report centered around the benefits of how the powers would be used, rather than identifying new powers that are needed. Some recommendations call for continued study and dialogue, with legislative proposals to be made in the 2004 session.

### Study Process:

Meetings gathered health professionals, health care systems representatives, emergency managers, emergency responders, other state agencies and interest groups, and citizens to discuss the type of emergency health powers needed or desired. These meetings were held during the summer and fall of 2002 and provided the basis for the report and recommendations.

***Minnesota Statutes  
144.05, subdivision 1.  
General duties. The state  
commissioner of health  
shall have general  
authority as the state's  
official health agency  
and shall be responsible  
for the development and  
maintenance of an  
organized system of  
programs and services  
for protecting,  
maintaining, and  
improving the health of  
the citizens.***

# Minnesota Emergency Health Powers Act Study Recommendations

These recommendations are based on the topic areas identified in the study provisions of Chapter 402.

## *Liability, immunity and compensation concerns*

1. MDH needs to continue strategic discussions involving providers, health plans, hospitals, other private employers of health care providers, and their insurance carriers about concerns and options about liability, immunity and compensation. Input is needed from the Commerce Department, the Joint Underwriting Association established by the Legislature to deal with unusual risks, and the state, county, and city attorneys who have had the duty of protecting the public against tort claim actions. The trial lawyers who regularly represent personal injury plaintiffs should also participate in these discussions to identify gaps, possible solutions, and need for legislative or other action.
2. MDH should monitor ongoing federal legislative activity and interpretations of the Homeland Security Act for application to Minnesota's workers and volunteers, particularly the liability concerns of the volunteers and sponsoring government or nonprofit agencies.
3. MDH should request funding for a study on potential unmet needs in paying costs for acute care in a public health emergency. Such a study should also examine:
  - a. Compensation for victims of a public health emergency, especially those who have suffered additional injury or disability because of medical care that was lacking or deficient.
  - b. The implications of federal administrative compensation in lieu of tort litigation such as the September 11 Fund established for victims of the World Trade Center attacks and in the National Vaccine Adverse Effects

Compensation Program established to compensate persons suffering adverse effects from routine childhood vaccinations.

- c. The application of the Minnesota administrative compensation concept in the Harmful Substance Compensation Account under Minn. Stat. §§ 115B.25 – 115B.37.
- d. The results of anthrax studies conducted by the Centers for Disease Control and Prevention.

## *Dangerous facilities and materials*

4. The Minnesota Departments of Pollution Control, Public Safety and Health should jointly prepare or modify background information, plans, protocols, training and exercises for state and local agencies to provide opportunities to consider the possible range of radiological, chemical, and biological terrorism agents. These background materials should address response, recovery, clean-up and debris disposal procedures. These agencies should also review and modify hazardous material protocols to assure worker safety in all aspects of emergency response and recovery.
5. These same state agencies should do table top and field exercises to test their plans and identify additional protocols and training needs.

## *Control of medical supplies and facilities*

6. The Minnesota Departments of Health, Public Safety and the National Guard, and local public health agencies should update and clarify procedures and manpower needs for managing medical supplies from the National Pharmaceutical Stockpile as well as the need for and management of other medical supplies.

7. The Hospital Preparedness Grant program should identify health care system concerns and recommendations about access to supplies, issues about use of medical facilities, and views about alternative locations for patient care, including the special needs of people with disabilities.
8. MDH and local public health agencies should work with hospitals to use tabletop and field exercises to identify issues related to commandeering and compensating medical facilities caring for victims of a public health emergencies.

***Limiting public gatherings and transportation***

9. The Minnesota Departments of Health and Public Safety should jointly develop protocols and public information materials for limiting gatherings or transportation using the least restrictive means necessary.
10. MDH and local public health agencies should use tabletop and field exercises to evaluate the effectiveness of these protocols to protect the public's health and safety while assessing the impact on individual or group rights.

***Medical examinations, testing, collecting laboratory specimens and samples***

11. MDH and local public health should use tabletop and field exercises to identify problems and solutions related to testing, to collecting and handling laboratory specimens, and to health status examinations. They should also address methods to inform individuals of their rights to refuse testing and treatment that are practicable in a public health emergency.
12. MDH should gather information from surrounding states and bordering Canadian provinces to coordinate approaches to these issues and to determine what resources are available just beyond our borders to help resolve these issues.

***Isolation and quarantine and due process protections***

13. MDH and local public health agencies should include approaches to isolation and quarantine in state and local public health, hospital and first responder exercises to identify and clarify roles and procedures in the event isolation and quarantine is indicated.
14. MDH, Public Safety and the Attorney General's office should develop step-by-step procedural protocols for how the isolation and quarantine orders will be carried out with clarity about who's responsible for each of the steps, including enforcement. These protocols should include methods to rapidly obtain services of interpreters, including sign language interpreters, and translators when needed. The protocols should address the procedural and substantive rights of persons subject to the orders.
15. MDH and the Attorney General's office should develop training and delegation agreements with interested local public health agencies and county attorneys for managing the court order process for isolation and quarantine to be consistent with state procedures.
16. MDH should gather information from other states and Canadian provinces about their planning, rules, statutes, and protocols in this area. In particular how the states and provinces immediately adjoining Minnesota address these issues should be understood and ideally should be similar as differences in approaches will lead to confusion and reduce the public health benefit of particular recommendations or actions for isolation or quarantine.
17. MDH should gather information on the enhanced internal quarantine powers granted the federal government in the Public Health Security and Bioterrorism Preparedness Act of 2002, and coordinate Minnesota's efforts with federal planning.

## ***Vaccination and treatment***

18. MDH and local public health agencies should:
  - a. Identify problems and solutions for individuals who choose to decline vaccinations or treatment that may limit their capability to transmit a communicable disease, and
  - b. Evaluate the protocols for isolation and quarantine with the accompanying due process protections to determine methods to ensure health and safety while minimizing the impact on individual rights.
19. MDH should explore data management systems for tracking vaccinations and treatments that can support critical public health functions by sharing information in a secure, accurate manner.

## ***Definition of communicable disease***

20. MDH should propose changing the term “communicable disease” in Minnesota Statutes 144.419, subd. 1 (2) to “airborne transmissible disease”. This issue should be explored with the Board of Animal Health to identify and potential points of confusion.

## ***Enforcement methods for assuring compliance with emergency measures and measures to detect and prevent the spread of disease***

21. MDH should work with sponsors of local, regional and statewide exercises to include situations that explore enforcement challenges and report problems, suggested solutions and alternatives to the state. MDH should also confer with bordering states and provinces on lessons learned from their planning efforts.
22. MDH should review its communicable disease rules to assure they are up-to-date on risks from bioterrorism.
23. MDH should review current Division of Emergency Management procedures and

protocols for enforcing emergency provisions to identify problems and solutions that could be used in a public health emergency.

24. MDH should work with tribal governments, the Department of Public Safety and representatives of peace officers to develop training materials and work with local public health and others to provide training to peace officers about enforcement issues for a public health emergency.

## ***Preserving effectiveness of fluoroquinolones and other antibiotics***

25. MDH should continue collaborative efforts with other state agencies, provider groups, and coalitions to coordinate Minnesota efforts in research and surveillance of antibiotic resistance and to educate providers, and the public about the issue of antibiotic resistance and appropriate uses of antibiotics. MDH should provide information to groups such as the Veterinary School, Board of Animal Health and professional veterinary associations about the human health consequences of antibiotic-resistant foodborne pathogens for their use in educating food producers. MDH should provide information to groups such as the medical schools, health care providers, professional medical associations and the public about the human health consequences of over-prescription, improper disposal and non-judicious use of antibiotics, and the consequences of the spread of antibiotic-resistant pathogens in water, food and the environment.
26. MDH should continue to conduct monitoring of human disease and antibiotic resistance and make information available to provider groups, policy makers and the public. MDH should collaborate with animal health groups such as the veterinary school to evaluate potential animal sources of antibiotic resistant bacteria for humans. MDH should collaborate with human health groups such as the medical schools, health

care providers and professional medical associations to evaluate potential human sources of antibiotic resistant bacteria.

27. MDH and others working on antibiotic resistance issues should continue to provide Minnesota specific information to national policy makers and agencies.

***Impact of recommendations on constitutional and other rights of citizens***

28. MDH should work with the Commissioner's Task Force on Terrorism and Health to review reports from state, regional and local tabletop and field exercises to explore issues of constitutional and other rights that may arise in a public health emergency.
29. MDH should meet with representatives of various civil rights and other citizen groups, special populations such as disability organizations, and interested individuals throughout 2003 to continue to identify concerns about constitutional and other rights during a public health emergency and propose methods to address them.
30. MDH should monitor, and comment when appropriate, on federal DHHS quarantine regulation proposals under the expanded powers granted in the Public Health Security and Bioterrorism Preparedness Act of 2002.



## Background

The terrorist attacks of September 11 and the anthrax outbreak in October and November of 2001 raised many questions about the threat of bioterrorism and other public health emergencies in Minnesota. The public health system's role, lead by the Minnesota Department of Health (MDH) is to limit the impact of an event and to care for injured, ill or infectious individuals and communities affected by the event.

MDH has been working with other agencies to design a system for responding to a wide range of potential disasters, including bioterrorism. Our response to "regularly occurring" events such as flooding, tornadoes and disease outbreaks are examples of our readiness to respond to public health threats and provide a strong foundation upon which to develop the infrastructure for increased preparedness for widespread public health emergencies.

MDH operates one of the most sophisticated systems in the country for detecting unusual disease patterns. If a health threat shows up on our public health "radar screen," MDH's scientists begin investigating the threat and conducting lab tests to determine its origin.

Upon determination that a potential problem is emerging, MDH issues a health alert to local public health agencies located in every county and four of the major cities of the state. Those local agencies, in turn, notify health care providers, hospitals, clinics and others in their communities. MDH's alert explains the nature of the public health threat and how the state's public health system should respond to it. That response may come in various forms, depending on the nature of the problem. The response could include:

- Issuing guidelines to health care professionals so they know how to treat patients showing specific symptoms.
- Recommending ways to prevent the further spread of a disease.
- Communicating directly with the public about things they can personally do to

prevent problems from occurring or getting worse.

- Working with health care providers to make antibiotics available to people who need them.
- Supporting local health officials to immunize large groups of people.
- Coordinating with federal, state, and local emergency responders to provide a seamless response to an event that may include locating, transporting, evaluating, treating, and identifying a large number of ill, injured, or infectious people.

***Minnesota Statutes 144.05, subdivision 1. General duties. The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens.***

MDH will work closely with the national Centers for Disease Control and Prevention, the Department of Public Safety's Division of Emergency Management, emergency medical service providers, and clinics and hospitals across the state to help implement a comprehensive response. The state's emergency response system, including activation of the State Emergency Operations Center, will likely be set in motion, depending on the nature, location and extent of the emergency.

### Summary of 2002 Proposal and Session

The events of September 11—and the anthrax attacks that followed—illuminated the need to strengthen Minnesota's public health system, to support an effective response to emergencies like these that could have unprecedented scope and impact. The Centers for Disease Control and Prevention (CDC) contracted with Georgetown University to develop a model public health law

with an anticipated delivery date of Spring 2002. CDC shortened the timeline to prepare the model act and made it available to states on October 31, 2001. The Commissioner of Health convened a Terrorism and Health Task Force (membership listed in Appendix A) to assist in the review and preparation of a bill to propose to the 2002 Legislature. The Task Force met on December 11 and January 8 and gave significant input between meetings to review, debate, and modify the components of the bill. The Task Force gave general support to a draft bill, which was introduced as SF2669 by Senators Hottinger and Higgins on February 1, 2002, and HF3031 by Representatives Mulder, Huntley, and Bradley on February 7, 2002.

The legislation as introduced included clarification of the process and an outline of the criteria for declaring a public health emergency. It also provided a detailed enumeration of the powers and duties of the state health commissioner and additional powers for the governor in a declared emergency.

The parts of the legislation that passed and were signed into law are included in Appendix B and are described in the House Research Information Brief Appendix C. Highlights of the Minnesota Emergency Health Powers Act include:

- The Governor is authorized to declare a public health emergency when an illness or health condition is present in Minnesota or there is an imminent threat of an illness or health condition with specific characteristics: it must be caused by either bioterrorism or a new, novel, or previously controlled or eradicated airborne, infectious agent or airborne biological toxin and the situation will cause a large number of deaths, serious or long term disabilities, or widespread exposure to an airborne agent that poses a significant risk of substantial future harm to a large number of people. The declaration automatically terminates after 30 days unless it is renewed.
- The Governor must consult with the commissioner of public safety, the state director of homeland security, the commissioner of health, other experts and, if

the emergency is on tribal lands, with appropriate tribal authorities. The Governor may act without consultation if the situation requires it.

- The Act requires the Legislature to be called into session if it is not in session at the time the emergency is declared.
- The Governor may procure facilities, make arrangements and agreements with tribal authorities, determine occupancy of public places and facilities and control transportation and transfer the personnel or duties of state agencies for emergency response and recovery programs.
- During a declared emergency, the Governor may issue orders and rules that have the full force and effect of law during any type of emergency. The orders and rules must be approved by the executive council.
- During a declared emergency, the Governor or designated official may commandeer surplus supplies or facilities when necessary to save lives, property, or the environment. Chapter 12 includes provisions for just compensation if property is commandeered.
- During any type of declared emergency, the Governor may require services of any state or local emergency management organization or any non-military person and may commandeer property.
- During a public health emergency, the Governor has authority to identify and safely manage disposition of dead bodies.
- The Act confirms a person's right to refuse medical examinations, testing, and treatment during an emergency.
- The Act establishes isolation and quarantine standards and due process procedures.
- The Act requires a study and report with recommendations for statutory changes to the legislature.

The legislation went through a number of revisions during 11 committee hearings, several floor debates, and conference committee discussions. Because of the range of issues covered by the proposed legislation, the concerns raised by legislators and others that new or revised powers be balanced with careful review of the impact on civil liberties, the

legislature required additional review and study over the interim. The bill as passed included a number of the provisions of the original proposal, some modifications of other provisions and a study requirement. The bill was passed by both houses of the Legislature and signed into law by Governor Jesse Ventura on May 22, 2002.

### **Study Requirements**

The specific requirements of the study are quoted here from Chapter 402:

#### **Sec. 20. [STUDY OF EMERGENCY HEALTH POWERS ISSUES.]**

(a) The commissioner of health shall study and submit recommendations to the legislature on additional legislative changes needed to Minnesota Statutes, chapter 12 or 144, or other relevant statutes to strengthen the state's capacity to deal with a public health emergency, while protecting the constitutional and other rights of citizens. Before submitting the recommendations to the legislature, the commissioner shall publish the recommendations in the State Register and provide a period of not less than 30 days for the public to submit written comments to the commissioner regarding the recommendations. The report and recommendations, including written comments received by the commissioner, must be submitted to the legislature by January 15, 2003. The report and recommendations must address at least the following:

(1) provisions for immunity from liability for health care providers and others acting under the direction of the governor or a designee during an emergency declared due to a public health emergency;

(2) emergency measures concerning dangerous facilities and materials, the control of medical supplies and facilities, and limiting public gatherings and transportation;

(3) measures to detect and prevent the spread of disease, including requirements for medical examinations, testing, vaccination, treatment, isolation and quarantine, collecting laboratory specimens and samples, and an evaluation of the definition of communicable disease;

(4) due process protections to apply to persons under isolation or quarantine;

(5) enforcement methods to ensure compliance with emergency measures and measures to detect and prevent the spread of disease;

(6) ways to preserve the effectiveness of fluoroquinolones and other antibiotics that are vital to protecting human health; and

(7) the impact of each recommendation on the constitutional and other rights of citizens.

(b) In developing this report and recommendations, the commissioner shall consult with the commissioner of public safety, the state director of homeland security, and representatives of local government, tribal government, emergency managers, the board of animal health, health care provider organizations, emergency medical services personnel, and legal advocacy and civil liberties groups. All meetings with these representatives must be open to the public and adequate notice of the meetings must be provided to the public. The commissioner shall delineate and describe the impact of each recommendation on the constitutional and other rights of citizens.

## National and state activities and events since the end of the 2002 session

Many changes in the landscape of public health emergency preparedness have appeared since the Minnesota Emergency Health Powers Act (MEHPA) was signed into law. Not the least of these changes is the federal funding to support public health planning, preparedness, and response activities from the Centers for Disease Control and Prevention. In addition to funding activities at MDH, funds were distributed to local public health agencies and tribal governments to support initial efforts in assessing resources and needs in preparing an effective public health infrastructure to support preparedness. The companion funding for Hospital Emergency Preparedness provided the impetus to identify nine hospital regions and begin planning to care for a large number of injured, ill, or infectious patients. With this federal funding, enhanced local emergency management plans will be in place by June 2003 and a timeline for conducting field tests and drills of the plans must be developed. These practical tests will create the vehicle for exploring application of the powers in the MEHPA and will help to identify needed improvements.

Twenty-two states had passed legislation similar to MEHPA as of November 2002. Comparison of these laws requires looking both at the new statutes and the pre-existing laws in each state dealing with emergencies. For example, states such as Minnesota who already have a comprehensive data practices statute and a history of data collection, management, and analysis for infectious disease conditions didn't even discuss this as a component of the new legislation. Other states that do not have these provisions, had much more extensive inclusion of these issues in their emergency legislative proposal but maybe didn't address issues of public gatherings, for example. Thus, evaluation of how states are addressing these issues requires attention not only to the legislation that was passed, what was already on the books, and whether the state provides services directly or through a network of local health departments.

The Homeland Security Act passed in November 2002 included a number of provisions that are likely to impact Minnesota's approach to public health emergency preparedness. We are closely monitoring the interpretation of the immunity and liability provisions. The complete impact of the provisions is unknown at the time this report was prepared and will need further study to identify unmet needs and problems. The new Homeland Security Department may also have directions and priorities to be addressed and may be a vehicle to address issues all states have in common.

Continuing media discussion of bioterrorism as a weapon of mass destruction keeps this issue in the public's awareness. At this point, we have intelligence that identifies France, Iraq, Russia, North Korea, and the United States as possessing supplies of smallpox virus. The perpetrator of the anthrax situation on the East Coast has not been apprehended. There continues to be considerable speculation on how the bacteria was obtained and spread.

Finally, terrorism events around the world and ongoing conflict with Iraq and reports of increasing messages from Al Qaida make ongoing public health preparedness activities a priority that cannot be ignored. Starting in the fall of 2002 the federal Department of Health and Human Services and the CDC have directed Minnesota and other states to place the highest priority on preparing response plans for managing an outbreak of smallpox disease and for immunizing some public health, health care, and emergency workers in advance of any outbreak in order to enhance the system's readiness to respond if one should occur. This re-direction of resources to one specific area of concern has the potential of delaying our preparedness on the more comprehensive range of public health emergency issues.

## Process for obtaining community and partner input

The Legislature required that MDH consult with a variety of individuals and groups. Input and advice were obtained at following events, meetings, and activities:

### **Commissioner's Task Force on Terrorism and Health**

The Commissioner's Task Force on Terrorism and Health was the original community group to guide both the development of the Minnesota Emergency Health Powers Act and this study. The charge of the Task Force is to strengthen the preparedness of Minnesota's health system to respond effectively to acts of terrorism so that injury, illness, and/or loss of life are minimized. Membership has been open and at this point includes over 70 individuals and representatives of public health, emergency preparedness and response, health care providers, and citizen groups. (See Appendix A for membership list.)

The Task Force met on May 14, 2002 and heard an update on the progress of the bill through the Legislature, which was still in conference committee. The Task Force members were sent periodic email updates on progress of the bill and were sent the legislation and summary following the end of the legislative session. The Task Force met again on August 27, 2002 and discussed the legislation that passed and provided input on issues of concern. Many members participated in other meetings and all were notified of meetings and of opportunities to provide feedback and input.

The draft report was sent to everyone on the Task Force contact list for review and comment on December 16, 2002. Their comments are listed in Appendix D.

With the passage of the Minnesota Anti-Terrorism Act of 2002 (Chapter 401), the Homeland Security Advisory Council was established under the joint leadership of the Commissioner of Public Safety and Health. The Task Force on Terrorism and Health will serve as a subcommittee to this overarching group addressing all aspects of terrorism prevention, mitigation, response, and

recovery. The Homeland Security Advisory Council was also notified of meetings and discussions and was sent a copy of the draft report at the same time as the Task Force. (See Appendix E for membership.)

### **Working Conference on Public Health Emergency Powers**

A conference to discuss the details and many of the components of the Minnesota Public Health Emergency Health Powers Act was held on July 18, 2002 at the Earle Brown Continuing Education Center in St. Paul. Announcements of the event were sent to over 500 people and groups and the announcement was included on the Minnesota Department of Health Web site. About 150 people attended the daylong event. See Appendix F for agenda and meeting summary. Also included in Appendix F is a news story from the *St. Paul Pioneer Press* about the event.

After an overview of the legislation and priority issues by Jan Malcolm, Commissioner of Health, participants broke into groups. Each group worked on a particular topic area to identify the values and principles for the topic area, consider three different scenarios, and list the most important public health authorities for that topic area. The topic areas were:

- \* Isolation and Quarantine
- \* Vaccination and Treatment
- \* Limiting Public Gatherings and Transportation
- \* Managing Medical Examinations, Testing, and Collecting of Laboratory Specimens and Samples
- \* Control of Medical Supplies, Medical Personnel, Medical Facilities, Dangerous Facilities and Dangerous Materials

Detailed reports from the subgroups can be found at:

<http://www.health.state.mn.us/oep/advisors/meetings.htm#documents>

### **Community Health Conference**

This year's conference of over 400 state and local public health officials was devoted entirely to the topic of terrorism preparedness. County commissioners, state and local public health staff,

and community advisory committee members attended two breakout sessions addressing the Minnesota Emergency Health Powers Act. Following a discussion of the contents of the Act, participants described their concerns, issues and suggestions. An agenda and summary of the discussions can be found in Appendix G.

#### **Preserving Antibiotic Effectiveness Meeting**

On October 28, 2002, representatives of the Minnesota Departments of Health and Agriculture, the Minnesota Board of Animal Health, and the University of Minnesota presented information about current activities and issues of antibiotic use and antibiotic resistance in human and animal populations. The meeting notice was sent to approximately 280 people, was included on the MDH Web site, and was in the October 7, 2002 State Register. This specialized meeting was in response to the requirement to study ways to preserve the effectiveness of fluoroquinolones and other antibiotics that are vital to protecting human health. Approximately 70 people representing the animal production industry, the antibiotic development industry, health care providers, and others attended this afternoon session. See Appendix H for the agenda and meeting summary.

#### **Immunity, Liability and Compensation Meeting**

On October 31, 2002, representatives of the Minnesota Department of Health, the Joint Underwriters Association, the Division of Emergency Management, and the Attorney General's Office met with over 70 people representing state and local public health, health care providers and health care systems, private practice attorneys, and emergency responders to discuss current laws and protocols related to liability coverage, immunity, indemnification, and compensation issues in the event of a public health emergency. The discussion also included liability issues related to a pre-event smallpox immunization plan. The meeting notice was sent to approximately 300 people, was included in the MDH Web site, and was in the October 7, 2002 State Register. See Appendix I for agenda and meeting summary.

## Study Issues: Analysis and Recommendations

Much of the feedback and discussion in the various meetings held these last six months have focused on the procedural aspects of how these various powers and authorities will be used. Questions such as “Who has the authority to use these powers?”, “What reporting relationships exist or need to be developed?”, “How will information be shared and with whom?”, and “Who will provide leadership on the implementation of existing powers?” have been primary concerns. Very few additional statutory changes were identified during these discussions. Rather, participants recommended any additional statutory proposals should flow from information gathered from those who will have responsibility for protecting the public in the event of a public health emergency with review by interested groups and individuals. As a result, most of the recommendations are to continue to study these issues at a practical level - during tabletop or field exercises and in coordination with information from other states about their approach and solutions before proposing any changes or additions to Chapter 402 or other existing laws.

The provisions of the Minnesota Emergency Health Powers Act sunset on August 1, 2004. Prior to that date, the components of the Minnesota Emergency Health Powers Act should be reviewed based on information from exercises conducted during 2003. Using the coming year to better define and clarify which of these new powers are needed on an ongoing basis, which can be dropped, and what new issues need to be addressed means the proposal for the 2004 session will be better focused and informed.

Each of the requirements of the study provision is addressed in the following section.

### **Liability, Immunity and Compensation Concerns**

#### Definitions:

Liability means being legally obligated or responsible for the actions of oneself or one’s employees or for the outcome of those actions. In the event of a public health emergency issues of

concern include potential financial responsibility for injuries resulting from access to or denial of certain health care services, side effects from the use of a health protective measure such as immunization, or a disability as a result of exposure to infectious disease during an outbreak.

Immunity is the legal exemption from duties, penalties or liabilities, usually granted to a group. This could include the prohibition of suits against an individual or health care system for actions taken during a public health emergency.

Tort is damage, injury or wrongful act done willfully, negligently or in circumstances involving strict liability.

See Appendix J for a glossary for key terms including Duty to Defend, Immunity, Indemnity, Malpractice, Negligence and Gross Negligence, Wanton.

#### Analysis:

Health care providers, emergency responders, and volunteer organizers argue that risks of malpractice or other tort liability present strong disincentives to those persons who have the critical skills needed to respond to an outbreak of, or imminent threat of, a deadly communicable disease. The liability risks deter skilled volunteers, such as recently retired professionals, from offering their help and active personnel from offering to help beyond the ordinary scope of their employment. The following topic headings highlight some broad areas of concern, progress that has been made in addressing these concerns, and the argument for further protections.

### **A. Mass clinics for vaccinations against bioterrorism agents with risk of serious adverse reactions in certain individuals.**

The Minnesota Department of Health’s (MDH) work under the federal grant for Public Health Preparedness and Response to Bioterrorism has raised these questions:

- Who is liable for injuries from defective vaccine, or vaccine that fails to provide

effective protection from the disease for which it is administered?

- Who is liable if the person vaccinated inadvertently spreads disease to patients, other work contacts, or family members?
- Who is liable if the person vaccinated should have been determined through screening to be at high risk of adverse reaction; the high risk was not discovered or not effectively communicated to person vaccinated; and he or she suffers grave illness, disability, or death as a result of the vaccination?
- Who bears costs of acute care not covered by insurance for a person who becomes seriously ill under any of these mass vaccination scenarios?

As this report was in final draft, Congress passed a Homeland Security Bill that would provide certain liability protection to drug manufacturers, health care entities, and licensed providers called upon in a federally declared smallpox health emergency. While a significant step in removing liability risks from these essential actors, the federal bill gives uncertain compensation, possibly no compensation at all, to persons who suffer harm under any of these scenarios. It is not a complete solution to the range of concerns.

**B. Rationing of medical staff care, equipment, facilities, and drugs when overwhelming numbers of seriously ill patients, loss of medical staff to illness, or destruction/contamination of medical facilities make it impossible for health care providers and facilities to give the “standard of care accepted under normal conditions.”**

Since the time of the Civil War, American health care providers have not had to address situations in which the demand for acute medical care overwhelms the health care system's capacity. With modern hospitals now operating with little capacity to accommodate surges in patients, the risks of overwhelmed facilities in a public health emergency is substantial. It raises questions such as these:

- Who establishes “triage” rules for these circumstances? What legal authority is there

to do so? What liability attaches if triage rules later were shown to be inappropriate to the emergency circumstances?

- What standards of liability apply if shortage of health care providers requires available providers to provide medical services outside areas of customary practice, in assigned medical facilities away from places of employment, or in temporary field locations without customary support facilities and equipment.
- What are the standards of liability for health care providers who must leave their ill and hospitalized regular patients in order to provide emergency services?
- What are the liabilities of hospitals and other health care facilities that must relocate ill patients to lower levels of care in order to address those victims of the emergency requiring the higher levels of care?

MDH will be meeting with the Minnesota Hospital and Health Care Partnership (MHHP) and other interested parties to discuss these questions. They bring to the fore the tension between the values of holding persons responsible for their mistakes and of encouraging all providers, including volunteers, to offer everything within their skills and training to assist in a catastrophe.

**C. Use of medical corps volunteers and other volunteer providers of skilled care and unskilled services to respond to a public health emergency.**

As evidenced by the President's Medical Reserve Corps Program and a groundswell of local volunteer efforts around Minnesota in the wake of the attacks of September 11 and the anthrax mailings, volunteer organization, training, and deployment are key elements in preparedness for a public health emergency. The volunteer effort raises questions such as these:

- What standards of liability apply to “skilled volunteers”—retired professionals or others with relevant training but without current licenses—whose services are the “best available” in the emergency?
- What standards of liability apply to other volunteers without professional training and



skills but who are assisting in caring for victims at the direction of health care providers or skilled volunteers?

- What sources of payment will address injuries and illnesses suffered by volunteers while assisting in response work?

MDH plans to monitor a pilot Medical Reserve Corps grant recently awarded to Hennepin County and Minneapolis, under guidance from the state's Division of Emergency Management. It hopes some of these liability issues will be illuminated and solutions proposed. As noted in the next section, an expansion of Minnesota's Good Samaritan Law could be part of the solutions.

**D. Current state and municipal tort claim laws provide governmental defense and indemnity for state and local employees who are liable for torts so long as they were acting within the scope of their employment; did not commit malfeasance or neglect of duty; and did not act in a willful or wanton manner. Outside public employment, the liability situation for volunteers in a public health emergency needs clarification. Protection of volunteers, particularly in the health care area, under the Emergency Management Act, the Good Samaritan Law, and the recent Federal Volunteer Protection Act is less than clear and the possible liability exposure deters some skilled professionals from signing up to volunteer, or work outside their customary job assignments, in the event of a public health emergency.**

Liability protections afforded Minnesota state employees by Minn. Stat. § 3.736 and local government employees by Minn. Stat. Ch. 466 appear sufficient to protect those employees while performing their regular duties or specially assigned tasks during a public health emergency. Although §12.35, subd. 2, of the Minnesota Emergency Management Act appears on its face to give similar protection to private sector “emergency response personnel, while activated by the state,” its application in a public health emergency is not clear. As explained by the Department of Public Safety, this provision was enacted before general mutual aid statutes to deal with a narrow issue of assuring that fire departments trained to respond to nuclear power plant fires could assist at other such

plants outside their jurisdictions. Other provisions in section 12.35 are limited to government-to-government aid and no mention is made of private volunteers. “Activation by the state” may not be practicable in a widespread catastrophic event in which local emergency management, public health, and health care facilities would essentially fend for themselves and call upon all available volunteer help. Moreover, the section makes no express reference to the laws providing for governmental defense and indemnity of volunteers, as do laws in other states<sup>1</sup>. Even where it is clear that a health care professional enjoys the protections of the tort claims laws, the direction of court cases in Minnesota and nationally has been towards regarding medical malpractice by public providers as no different from similar malpractice by private providers. See, e.g., Terwilliger v. Hennepin County, 561 N.W.2d 909 (Minn. 1997). Section 12.35 will not provide adequate assurances to volunteers in a public health emergency unless clarified by the courts or the Legislature. Since courts do not give advisory opinions, only an experience under an actual emergency would give rise to interpretation of this section.

The Minnesota Good Samaritan Law in § 604A.01 provides immunity to volunteers “at the scene of an emergency or during transit to a location where professional medical care can be rendered.” It also excludes from the definition of “the scene of an emergency” hospitals, clinics, and other health care offices. Since in a public health emergency it may be that volunteer help is most needed by large numbers of ill or injured seeking aid at hospitals, clinics, and other health care offices, the current Good Samaritan Law would not provide adequate liability protection for health care volunteers. Other states have Good Samaritan laws that focus not on the chance event of where a provider volunteers emergency care, but on whether that care is provided in the ordinary course of paid practice.<sup>2</sup>

Finally, the Federal Volunteer Protection Act (42 U.S.C.A. § 14503) appears to offer some protection for volunteers assisting nonprofit or governmental

<sup>1</sup> See, e.g., Wash. Rev. Code Ann. §§ 4.92.130 *et seq.*

<sup>2</sup> Colo. Rev. Stat. Ann. § 13-21-108; Mass. Gen. Laws Ann. ch. 112, § 12B.

entities. It was enacted in 1997 and was driven by liability claims against Little League coaches and other volunteers for children's programs. It was intended to provide a floor of protection, to which the states could add. There has been little court interpretation of the act, and critics have questioned whether its protection is meaningful since a suit can still be brought against the entity whom the volunteer is assisting, and that entity may be able to add the volunteer back to the suit as a third-party defendant.

Recommendations:

MDH recognizes that it is essential to take advantage of all possible sources of health care services in the event of a catastrophe that overwhelms the capacity of our health care system. Providers who would be acting outside their customary fields of practice, and perhaps in makeshift settings lacking usual medicines and support facilities, have legitimate concerns. Volunteer programs, such as the new federal Medical Reserve Corps, likewise have legitimate concerns.

The areas of liability, legal immunities, and malpractice insurance coverage are outside the core competencies of MDH. Accordingly, MDH recommends:

1. MDH needs to continue strategic discussions involving health plans, hospitals, other private employers of health care providers, and their insurance carriers about concerns and options about liability, immunity and compensation. Input is needed from the Commerce Department, the Joint Underwriting Association established by the Legislature to deal with unusual risks, and the state, county, and city attorneys who have had the duty of protecting the public against tort claim actions. The trial lawyers who regularly represent personal injury plaintiffs should also participate in these discussions to identify gaps, possible solutions, and need for legislative or other action.
2. MDH should monitor ongoing federal legislative activity and interpretations of the

Homeland Security Act for application to Minnesota's workers and volunteers, particularly the liability concerns of the volunteers and sponsoring government or nonprofit agencies.

3. MDH should request funding for a study on potential unmet needs in paying costs for acute care in a public health emergency. Such a study should also examine:
  - a. Compensation for victims of a public health emergency, especially those who have suffered additional injury or disability because of medical care that was lacking or deficient.
  - b. The implications of federal administrative compensation in lieu of tort litigation such as the September 11 Fund established for victims of the World Trade Center attacks and in the National Vaccine Adverse Effects Compensation Program established to compensate persons suffering adverse effects from routine childhood vaccinations.
  - c. The application of the Minnesota administrative compensation concept in the Harmful Substance Compensation Account under Minn. Stat. §§ 115B.25 – 115B.37.
  - d. The results of anthrax studies conducted by the Centers for Disease Control and Prevention.

**Dangerous facilities and materials**

Definitions:

Dangerous facilities include buildings or locations contaminated with a known or unknown substance that can cause immediate or long-term hazards. An example would be a movie theater in which a chemical spill of chlorine occurred. For the purposes of an infectious disease, it would be a building (private or public, and may include as medical facility) in which organisms are present in such a way that disease transmission can occur.

Dangerous materials for an infectious disease event can include things such as bed linens, contaminated medical supplies and equipment or moveable

objects in or on which biological organisms are present in such a way that disease transmission can occur. These materials may also include chemical agents prepared expressly as a chemical weapon or intentional releases of chemical agents from industrial facilities and radiation sources.

Analysis:

Current Chapter 12 law addresses hazard mitigation and requires the Division of Emergency Management to develop a comprehensive hazard mitigation plan in coordination with federal and local plans. The MEHPA extends the provisions for managing dangerous facilities and materials to a national security or peacetime emergency declared due to a public health emergency. This extension assures the authority and clarity of implementation that may be needed to protect humans, animals, plants, buildings, supplies and the environment from biologic agents. Terrorism requires the planning process to consider new concerns and previously un-considered agents or exposures and to develop new protocols.

Recommendations:

4. The Minnesota Departments of Pollution Control, Public Safety and Health should jointly prepare or modify background information, plans, protocols, training and exercises for state and local agencies to provide opportunities to consider the possible range of radiological, chemical, and biological terrorism agents. These background materials should address response, recovery, clean-up and debris disposal procedures. These agencies should also review and modify hazardous material protocols to assure worker safety in all aspects of emergency response and recovery.
5. These same state agencies should do tabletop and field exercises to test their plans and identify additional protocols and training needs.

## **Control of medical supplies and facilities**

Definitions:

Medical supplies are under the control of and responsibility of the health care provider system. Most facilities use a “just-in-time” form of inventory—meaning they have about two days worth of supplies on hand as a means of keeping storage costs down. Most health care facilities also have limited specialized equipment or rent equipment from equipment supply houses. Chapter 402 defines medical supplies as: “any medication, durable medical equipment, instruments, linens, or any other material that a health care provider deems not essential for the continued operation of the provider’s practice or facility. The term medical supplies does not apply to medication, durable medical equipment, or other material that is personal property being used by individuals or that has been borrowed, leased, or rented by individuals for the purpose of treatment or care.”

Medical facilities include hospitals, clinics, nursing homes, urgent or surgical care centers, home care agencies, stand-alone laboratories, and specialist providers—such as physical therapy clinics. These facilities are required to meet national and state requirements for patient safety, documentation of patient care, monitoring of employee actions, and other means to assure patient quality of care. Chapter 402 defined facility as “any real property, building, structure, or other improvement to real property or any motor vehicle, rolling stock, watercraft, or other means of transportation. Facility does not include a private residence.”

Analysis:

Access to necessary medical supplies can be a matter of life or death. Since the original planning for the MEHPA, the Centers for Disease Control and Prevention have implemented a National Pharmaceutical Stockpile (NPS), a national repository of life-saving pharmaceuticals and medical supplies that can be delivered to the site of a chemical or biological terrorism event. The NPS is composed of pharmaceuticals, vaccines, medical supplies, and medical equipment to augment depleted state and local resources used in responding to terrorist attacks and other emergencies. The NPS will typically arrive by air or

ground in two phases. The first phase shipment is called a “12-hour Push Package.” It is called this because it will arrive in 12 hours or less; a state need only ask or “push” for help; and it contains a complete package of medical materiel. CDC will transfer authority for the NPS materiel to the state and/or local authorities once it arrives at the airfield. State and/or local authorities will then repackage and label bulk medicines and other NPS materiel according to their own terrorism contingency plans.

The NPS is deployed upon a request from the Governor for the assets based on the possibility and confirmation of a biological or chemical terrorism incident. (Source: *Volume Two: Homeland Security, A Governor's Guide to Emergency Management, NGA Center for Best Practices, Chapter 5: The Challenge of Bioterrorism.*)

Currently, the declaration of a national security or peacetime emergency authorizes the implementation of the state emergency operations plan. The description of supply management can include the commandeering, distribution, compensation for, and management of supplies, including medical supplies needed for responding to a public health emergency within the constraints of the exclusions described in Chapter 402.

Medical facilities operate within a complex system of regulations, requirements, standards of care and tradition. In the event of a public health emergency, a hospital or other health care facility may become the center of a community’s response, may be a partner in a regional response, or may be providing generalized care while other facilities manage victims of the public health emergency. In the event of a large-scale event where thousands of individuals are affected, alternative locations to provide care may be needed to house injured, ill, or infectious patients. Chapter 12 provides the governor with the authority to commandeer and compensate for private property necessary to care for patients.

Since the original bill was proposed, the Health Resources and Services Administration of the Department of Health and Human Services granted federal funds to improve hospital preparedness for terrorism events. The state has been divided into

eight regions with each region planning to manage an influx of 500 patients. Additional statutory or procedural action should be based in information about supplies and facility needs generated from this planning process.

Recommendations:

6. The Minnesota Departments of Health, Public Safety and the National Guard, and local public health agencies should update and clarify procedures and manpower needs for managing medical supplies from the National Pharmaceutical Stockpile as well as the need for and management of other medical supplies.
7. The Hospital Preparedness Grant program should identify health care system concerns and recommendations about access to supplies, issues about use of medical facilities, and views about alternative locations for patient care, including the special needs of people with disabilities.
8. MDH and local public health agencies should work with hospitals to use tabletop and field exercises to identify issues related to commandeering and compensating medical facilities caring for victims of a public health emergency.

**Limiting public gatherings and transportation**

Definitions:

Public gatherings could mean workplaces, schools, shopping centers, movie theaters, places of worship or other locations where people share air space. Limiting could mean recommendations that individuals with compromised immune systems (people with HIV or AIDS, cancer, and transplant patients who are taking certain immunosuppressive drugs, and those with certain inherited diseases) avoid contact with large groups of people. It could also mean closing some, many or all the possible places where any groups of people gather.

Transportation means any form of movement of people or vehicles—including planes, trains, automobiles, buses, and watercraft.

Chapter 12 as amended by Chapter 402 authorizes the Governor to direct the conduct of persons in the state and the movement and cessation of movement of pedestrians vehicular traffic and all forms of private and public transportation during, prior, and subsequent to drills or actual emergencies.

Analysis:

Limiting public gatherings can be an effective preventive measure for diseases that are transmitted through the air—especially for diseases that are transmitted by individuals with no symptoms. Often, public health experts recommend limiting exposures to others—such as frequently occurs during influenza season. There is a big difference between recommending limited public gatherings and enforcing a more specific and uniform requirement. In making a decision to close gathering places, the impact on economy, education, and access to food/water/other necessities needs to be balanced with the ability to effectively protect the public through such means. Limiting public gatherings may also function as “reverse quarantine” in which individuals who have not been exposed to a communicable disease are asked to stay home or otherwise limit their exposure to others who may be carrying a communicable disease. This technique was an important strategy in preventing transmission of influenza in 1918 and in the polio epidemic of the 1950s.

Limiting transportation can be an important component of preventing transmission of air-borne disease in several ways. Individuals with the disease can expose others in planes, trains, or buses through the limited air space of such vehicles. Individuals with the disease can use various types of transportation to move to other parts of the community state, nation, or world and either intentionally or inadvertently expose others during their travel or at their destination. The Governor has used the power to limit transportation in some previous emergencies by closing roads because of flooding or chemical spills. It is not certain how widespread transportation limitations would need to be to have an effect. On the other hand, it may be a critical tool to prevent individuals from leaving the state during an evaluation of a possible disease or terrorism evaluation.

Recommendations:

9. The Minnesota Departments of Health and Public Safety should jointly develop protocols and public information materials for limiting gatherings or transportation using the least restrictive means necessary.
10. MDH and local public health agencies should use tabletop and field exercises to evaluate the effectiveness of these protocols to protect the public’s health and safety while assessing the impact on individual or group rights.

**Medical examinations, testing, collecting laboratory specimens and samples**

Definitions:

Medical examinations to review symptoms, exposure, medical history, physical signs, and level of illness are important to diagnose the disease and to manage an individual’s health care. Results from these examinations are also critical to the public’s health when the information from one patient is combined with information from all other affected patients to evaluate what is known about transmission, to determine strategies to prevent further transmission, determine whether treatment protocols are effective and provide guidance for care of future patients. Often, additional questions about types or length of exposure, travel history, or food intake are needed to complete the picture of possible transmission issues.

Laboratory testing for infectious diseases varies by disease but frequently consists of testing body fluids: blood, sputum, cerebrospinal fluid, etc.) for the presence of the organism or evidence of the body’s efforts to fight the infection. Testing may also include other measures such as x-rays, neurological exams or tissue biopsies. Laboratory testing to identify the causative organism is important for diagnosis and treatment of an individual patient. Public health laboratory testing goes further to not only confirm the identity of the organism but also identify the “DNA fingerprint” of that organism. Such information can be used to find a common cause of the outbreak and can be the basis for prevention or control strategies.

Analysis:

A mentally competent adult individual can make choices about the kind and amount of health care services he or she chooses. For example an adult can consent to surgery or decline, take medications for a particular disease or decide to let nature take its course, follow a health care provider's recommendations on methods to reduce symptoms of disease or injury or decide to wait it out. As long as that choice doesn't impact others, the decision is a private matter. However, when that choice has an affect on the health status of others, there are limited occasions when government intervenes. A primary example is that of a minor child with a life-threatening condition. Government has intervened to require surgery, blood transfusions, and other treatment when the life of a child is in danger. Similar intervention is possible for mentally incompetent or unconscious individuals.

During a public health emergency, particularly one caused by terrorism, a number of difficult situations around medical examinations and testing may develop for which a legal or procedural process or protocol is not immediately evident or easy. Generally, individuals with a serious illness want health care providers to conduct tests, take specimens, and do everything possible to accurately diagnose and therefore better treat the person. The original Emergency Health Powers Act introduced at the start of the 2002 session mandated tests and evaluations during a public health emergency. That part of the bill was not included in the final law that was passed.

At this time, we are uncertain how important this comprehensive government power is to prevent disease spread. We are certain, however, that it is a significant restriction on individual rights.

Recommendations:

11. MDH and local public health should use tabletop and field exercises to identify problems and solutions related to testing, to collecting and handling laboratory specimens, and to health status examinations. They should also address methods to inform individuals of their rights to refuse testing and treatment that are practicable in a public health emergency.

12. MDH should gather information from surrounding states and bordering Canadian provinces to coordinate approaches to these issues and to determine what resources are available just beyond our borders to help resolve these issues.

**Isolation and quarantine and due process protections**

Definitions:

Isolation means separation, during the period of communicability, of a person infected with a communicable disease, in a place and under conditions so as to prevent direct or indirect transmission of an infectious agent to others. It may mean extremely limited contact with an ill person who is diagnosed with or suspected of having a communicable disease. The isolation can occur in a hospital setting in a negative airflow room (prevents potentially contaminated air from going back into the hospital) for very infectious airborne diseases. Isolation usually requires health care providers and visitors to use clothing protectors, masks or respirators, goggles and gloves as a means of protecting the visitors but also to protect the patient from exposure to new diseases that their weakened immune system may not be able to overcome.

Quarantine means restrictions, during or immediately prior to a period of communicability, of activities or travel of an otherwise healthy person who likely has been exposed to a communicable disease. The restrictions are intended to prevent disease transmission during the period of communicability in the event the person is infected. This period is commonly known as the "incubation" period of a disease. This means they have been exposed to an individual with a communicable disease and may be developing the disease as well. Some diseases are not communicable until symptoms appear; other diseases may be communicable for hours or days before the person shows any signs of the disease. Quarantine can be accomplished by a variety of means including having the person stay in their own home and avoid contact with others (including family members) to having the person or group of persons stay in a

designated facility, to restricting travel out of an impacted area.

Analysis:

**Isolation:** The MEHPA details the due process protections for a person determined to have a communicable disease that is caused by a living organism or virus believed to be caused by bioterrorism or by a new or novel or previously controlled or eradicated infectious agent or biological toxin and that can be transmitted person to person, (with exclusion of diseases transmitted predominantly through sexual contact, contact with blood, or direct or intimate skin contact) and for which isolation is an effective control strategy. The Commissioner of Health or delegated local board of health can request the court to order the person to stay in isolation for up to 21 days. The court uses the standard of probable cause to determine whether to grant the order. The individual has the right to request a hearing at any time during the period of isolation regarding the need for isolation and the conditions under which the isolation is being managed. The individual subject to a court order must receive competent medical care, means of outside communication and other basic necessities.

When the time to obtain a court order would significantly jeopardize the ability to contain the disease, the Commissioner can issue a temporary order and then must seek a court order within 24 hours of the temporary order. The temporary order option cannot be delegated to local boards of health. The individual in isolation is likely to be quite ill and the need for isolation may be obvious and the patient may be very willing to be in isolation to protect family, friends and health care providers. A few individuals may not either see the need for isolation or have various reasons they believe they cannot comply with the isolation recommendation. Significant procedural questions include how to restrain individuals who are diagnosed or likely to be diagnosed with the disease before the temporary hold and assistance from local or state law enforcement is obtained, or whether the court order should be sought for all individuals with a particular disease or only for those who express concerns or opposition to the isolation recommendation.

**Quarantine:** Since individuals in quarantine are not likely to be ill and their future status somewhat uncertain, the decision to impose quarantine is more controversial. The process for quarantine and the standard of proof is similar to that of isolation. A further distinction from isolation is the number of people affected. For every person determined to have the disease, a much larger number of persons are likely to have been exposed to the individual. The MEHPA provided extensive and prompt due process provisions, but there are many procedural questions of how the court order or the Commissioner's temporary hold order would work, whether the timelines in statute are adequate, in which situations would home quarantine be adequate and effective and how to provide for groceries and other essential needs of home-quarantined persons. A further need is the issue of mental health and the anxiety people will face in being told they or their immediate family member might be developing a serious disease.

Recommendations:

13. MDH and local public health agencies should include approaches to isolation and quarantine in state and local public health, hospital and first responder exercises to identify and clarify roles and procedures in the event isolation and quarantine is indicated.
14. MDH, Public Safety and the Attorney General's office should develop step-by-step procedural protocols for how the isolation and quarantine orders will be carried out with clarity about who's responsible for each of the steps, including enforcement. These protocols should include methods to rapidly obtain services of interpreters, including sign language interpreters, and translators when needed. The protocols should address the procedural and substantive rights of persons subject to the orders.
15. MDH and the Attorney General's office should develop training and delegation agreements with interested local public health agencies for managing the court order

process for isolation and quarantine to be consistent with state procedures.

16. MDH should gather information from other states and Canadian provinces about their planning, rules, statutes, and protocols in this area. In particular how the states and provinces immediately adjoining Minnesota address these issues should be understood and ideally should be similar as differences in approaches will lead to confusion and reduce the public health benefit of particular recommendations or actions for isolation or quarantine.
17. MDH should gather information on the enhanced internal quarantine powers granted the federal government in the Public Health Security and Bioterrorism Preparedness Act of 2002, and coordinate Minnesota's efforts with federal planning.

## **Vaccination and treatment**

### Definitions:

Vaccination means the administration of a small amount of a killed or live disease organism or virus that stimulates the body's immune response to be prepared so that when the body is exposed to the disease, it can rapidly fight off the disease or reduce the seriousness of the disease. Some individuals are allergic to the components of the vaccine or otherwise have a reaction that would prohibit their use of the vaccine. Some individuals, whose immune systems are compromised from diseases such as HIV or taking chemotherapy for cancer, are not recommended to receive some vaccines.

Vaccines go through several years of trials to determine effectiveness and safety and are licensed at the national level following the trials and reviews. Vaccination is especially important for those diseases caused by viruses, as antibiotics are not effective treatment for viruses. Some of those diseases include smallpox and influenza.

Treatment for an infectious disease caused by bacteria usually is an antibiotic that kills the organism. The type and dosage of the antibiotic will depend on the organism and the characteristics of the person—age, size, allergic response, and

medical history. There are some diseases for which an antibiotic is not effective or only partially effective or for which the organism has become resistant. Other forms of treatment are supportive—assisting the body with breathing, taking in nourishment and fluids or pain control—while the body's systems work to fight off the infection.

### Analysis:

The original version of the MEHPA included language about requiring individuals to submit to vaccination or treatment. This provision was not included in the final law that was passed. The Minnesota childcare and school immunization law has always included an exemption for medical reasons and for religious (later changed to conscientious) reasons.

A mentally competent adult individual can make choices about the kind and amount of health care services he or she chooses as was described in the medical examinations, testing, collecting laboratory specimens and samples section. As long as that choice doesn't impact others, the decision is a private matter. However, when that choice has an affect on the health status of others, there are limited occasions when government intervenes. A primary example is that of the school immunization law. However, it is critical to point out the current Minnesota law requires documentation of immunizations or documentation that the individual declines one or more immunizations. The law does not require an individual to be immunized. There is also no similar requirement for accepting treatment, except in certain conditions involving life-threatening conditions for minor children or mentally incompetent adults.

Requiring submission to certain medical treatments involves balancing individual rights with benefits to the broader community. An alternative that is currently provided by the MEHPA is the ability to prevent transmission of a communicable disease by an individual who chooses to avoid immunization or treatment. Isolation or quarantine provides the safety net for the health of the broader public in this situation. We believe there is strong consensus that the benefits of some form of mandatory vaccination or treatment are far outweighed by the impact on individual rights.



A related challenge is that of rapidly and securely managing information about who has received vaccination or treatment for a particular disease. In a time of shortage, this capability becomes even more important to avoid wasting limited supplies. It may also be critical to track effectiveness of a particular vaccine or treatment or for monitoring production lots of medical supplies for problems and for side effects of these interventions.

Recommendations:

18. MDH and local public health agencies should:
  - a. Identify problems and solutions for individuals who choose to decline vaccinations or treatment that may limit their capability to transmit a communicable disease, and
  - b. Evaluate the protocols for isolation and quarantine with the accompanying due process protections to determine methods to ensure health and safety while minimizing the impact on individual rights.
19. MDH should explore data management systems for tracking vaccinations and treatments that can support critical public health functions by sharing information in a secure, accurate manner.

**Definition of communicable disease**

Definitions:

The MEHPA includes this definition of communicable disease in the section applying to isolation and quarantine. Communicable disease “means a disease caused by a living organism or virus believed to be caused by bioterrorism or by a new or novel or previously controlled or eradicated infectious agent or biological toxin and can be transmitted person to person and for which isolation is an effective control strategy, excluding a disease that is directly transmitted as defined under section 144.4172, subdivision 5” (*a disease predominately transmitted sexually; through contact with blood; or transmitted through direct or intimate skin contact*).

Analysis:

Other definitions of communicable disease include:

Merriam Webster Medical Dictionary (1997)  
**communicable disease:** an infectious disease transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means (as by a vector).

Miller Keane Medical Dictionary (2000)  
**communicable disease:** a disease the causative agents of which may pass or be carried from one person to another directly or indirectly. Modes of transmission include (1) direct contact with body excreta or discharges from an ulcer, open sore, or respiratory tract; (2) indirect contact with inanimate objects such as drinking glasses, toys, bed clothing, etc.; (3) vectors-flies, mosquitoes, or other insects capable of spreading the disease.

Dorland's Illustrated Medical Dictionary (2002)  
**communicable disease,** an infectious disease transmitted from one individual to another, either by direct contact or indirectly by means of a vector or fomites; the terms communicable and contagious are used synonymously.

The discussions at the legislature and in the study meetings identified concerns about a broad term that could be used without limits that could adversely affect people for whom isolation or quarantine was ordered. The compromise that emerged in the final bill used a tightly crafted definition of communicable disease. The issue may not be so much about the definition as in using the term “communicable disease” to apply to this section. An alternative term such as “airborne transmissible disease” may solve the discomfort of health care providers concerned about the current definition of communicable disease in statute that is in conflict with usual medical terminology and address the concerns of others that the isolation and quarantine provisions would be applied too broadly.

Recommendations:

20. MDH should propose changing the term “communicable disease” in Minnesota Statutes 144.419, subd. 1 (2) to “airborne transmissible disease”. This issue should be explored with the Board of Animal Health to identify and potential points of confusion.

## **Enforcement methods for assuring compliance with emergency measures and measures to detect and prevent the spread of disease**

### Definitions:

Enforcement methods include restraining individual, group or traffic movement from one area to another through roadblocks, placement of peace officers to re-direct traffic or pedestrians, or physically restraining an individual from entering or leaving a certain location. Effective enforcement to assure compliance with emergency measures relies on the awareness and knowledge of persons authorized to take action during an emergency.

Enforcement measures for detecting and preventing the spread of disease may arise during such routine matters as reporting a diagnosed or suspected case of infectious disease, cooperating with an investigation to gather information about the possible causes and transmission of a disease, or following recommended procedures for preventing further transmission, such as isolation or quarantine.

### Analysis:

The order for declaring a national security or peacetime emergency due to a public health emergency would address any unusual or special enforcement measures—such as one recommending only emergency traffic in certain areas of the state.

For enforcement measures regarding compliance with measures to detect and prevent the spread of disease, there is less certainty and experience to draw on. Current law requires licensed health care providers and entities to report certain communicable diseases to the Minnesota Department of Health. There is no specified legal consequence for not reporting. Newly developing communication tools, training, and proposed modifications to the communicable disease reporting rule can assist in removing barriers to effective reporting. Whether enforcement or consequence measures for failure to report would be useful is a matter of some debate. On one hand, it would stress the importance of this requirement. On the other hand, it may cause considerable duplication of efforts to assure reports are filed and increased tension with the private health care system who believe they are already in compliance.

Another type of enforcement dilemma is that raised by isolation and quarantine orders. The court order will describe the type of force and level of enforcement to be used by peace officers. Such enforcement for this type of problem will need to be balanced with attention to safety precautions and personal protective equipment for individuals charged with enforcing the court order.

During an emergency, the governor's declaration would need to be specific about what, if any, enforcement measures are necessary. Current declarations may provide some direction in this area and will be explored. In addition, issues and problems identified in tabletop and field exercises need to be identified.

### Recommendations:

21. MDH should work with sponsors of local, regional and statewide exercises to include situations that explore enforcement challenges and report problems, suggested solutions and alternatives to the state. MDH should also confer with bordering states and provinces on lessons learned from their planning efforts.
22. MDH should review its communicable disease rules to assure they are up-to-date on risks from bioterrorism.
23. MDH should review current Division of Emergency Management procedures and protocols for enforcing emergency provisions to identify problems and solutions that could be used in a public health emergency.
24. MDH should work with tribal governments, the Department of Public Safety and representatives of peace officers to develop training materials and work with local public health and others to provide training to peace officers about enforcement issues for a public health emergency.

## Effectiveness of fluoroquinolones and other antibiotics

### Definitions:

Ciprofloxacin or “cipro” is a form of the family of antibiotics known as fluoroquinolones. Cipro became a household word in the fall of 2001 because of its use during the anthrax outbreak on the East coast. Thousands of individuals who worked in buildings in which the contaminated letters were distributed, postal workers who may have come in contact with the letters or the sorting machines, and others who may have had exposure to the anthrax spores were recommended to take the medication for as long as 60 days.

The characteristics of the bioterrorism agent or of the new or novel infectious agent that is the cause of a public health emergency will determine the type of antibiotics or other medications that can be useful for either treatment or prevention. Some common antibiotics that would be indicated for the Category A bioterrorism agents are listed in the table below:

Biologic agent	Disease	Preventive antibiotic	Treatment antibiotic
<i>Bacillus anthracis</i>	Anthrax	ciprofloxacin doxycycline	ciprofloxacin doxycycline amoxicillin
<i>Clostridium botulinum</i>	Botulism	None	None
<i>Yersinia pestis</i>	Plague	tetracycline chloramphenicol	streptomycin gentamicin tetracyclines chloramphenicol
variola major	Smallpox	None	None
<i>Francisella tularensis</i>	Tularemia (rabbit fever)	N/A	aminoglycosides, macrolides, chloramphenicol and fluoroquinolones
filoviruses [e.g., Ebola, Marburg] and arenaviruses [e.g., Lassa, Machupo]	Viral Hemorrhagic Fevers	None	ribavirin (antiviral)

Antibiotic use promotes development of antibiotic-resistant bacteria. Antibiotic resistance occurs when bacteria change in some way that reduces or eliminates the effectiveness of drugs, chemicals, or

other agents designed to cure or prevent infections. The bacteria survive and continue to multiply causing more harm. Widespread use of antibiotics promotes the spread of antibiotic resistance. While antibiotics should be used to treat bacterial infections, they are not effective against viral infections like the common cold, most sore throats, and the flu. (CDC Web Site, “Promoting Appropriate Antibiotic Use in the Community” Division of Bacterial and Mycotic Diseases, August 1, 2002

<http://www.cdc.gov/drugresistance/community/>)

### Analysis:

The growth of antibiotic resistance has prompted calls to reduce unnecessary antibiotic use and to improve treatment protocols to maximize the lifespan of these drugs. Since antibiotics can be important to treating diseases in humans and animals, this approach needs to apply to antibiotic use whether the patient is a human or an animal.

The “Preserving Antibiotic Effectiveness” meeting described in Appendix H highlighted a variety of activities taking place at the Minnesota Departments of Health and Agriculture, the Minnesota Board of Animal Health, University of Minnesota, Minnesota Antibiotic Resistance Coalition, and food animal producers to increase awareness of the problems of antibiotic resistance and methods to prevent it. Federal agencies and Congress have also taken steps to address antibiotic use and misuse. Regulation of food production occurs at the national level and independent state action is therefore difficult to implement.

The combined efforts of the Minnesota Departments of Health and Agriculture led to research information on antibiotic resistance in chickens. This study<sup>3</sup> was part of the rationale used by the Food and Drug Administration to recommend changes in antibiotic-containing feeds designed for poultry that could be linked to increases in antibiotic resistant disease in humans. This is an example of the significant impact targeted studies

<sup>3</sup>Smith KE et al. 1999. Quinolone-resistant *Campylobacter jejuni* infections in Minnesota, 1992-1998. New England Journal of Medicine 340:1525-1532.

and attention to sharing the results with policy makers.

Recommendations:

The participants in the October 28, 2002 meeting discussed current activities and possible additional actions. While there were many perspectives and concerns expressed, there was agreement that continued efforts to increase awareness of this problem for patients, health care providers (including veterinarians), animal producers and the general public was a critical activity.

25. MDH should continue collaborative efforts with other state agencies, provider groups, and coalitions to coordinate Minnesota efforts in research and surveillance of antibiotic resistance and to educate providers, and the public about the issue of antibiotic resistance and appropriate uses of antibiotics. MDH should provide information to groups such as the Veterinary School, Board of Animal Health and professional veterinary associations about the human health consequences of antibiotic-resistant foodborne pathogens for their use in educating food producers. The MDH should provide information to groups such as the medical schools, health care providers, professional medical associations and the public about the human health consequences of over-prescription, improper disposal and non-judicious use of antibiotics, and the consequences of the spread of antibiotic-resistant pathogens in water, food and the environment.

26. MDH should continue to conduct monitoring of human disease and antibiotic resistance and make information available to provider groups, policy makers and the public. MDH should collaborate with animal health groups such as the veterinary school to evaluate potential animal sources of antibiotic resistant bacteria for humans. MDH should collaborate with human health groups such as the medical schools, health care providers and professional medical associations to evaluate potential human sources of antibiotic resistant bacteria.

27. MDH and others working on antibiotic resistance issues should continue to provide Minnesota specific information to national policy makers and agencies.

**Impact of recommendations on constitutional and other rights of citizens**

Definitions:

The Bill of Rights from the United States Constitution and Article I, Bill of Rights from the Minnesota Constitution are in Appendix K. Those rights of particular relevance to emergency health powers are included below.

U.S. Constitution

Amendment I Congress shall make no law...prohibiting the free exercise [of religion]...or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

Amendment IV The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Amendment IX The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

Amendment X The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.

**Minnesota Constitution Article I BILL OF RIGHTS**

Sec. 2. **RIGHTS AND PRIVILEGES.** No member of this state shall be disfranchised or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land or the judgment of his peers. ...

**Sec. 8. REDRESS OF INJURIES OR WRONGS.**

Every person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property or character, and to obtain justice freely and without purchase, completely and without denial, promptly and without delay, conformable to the laws.

**Sec. 10. UNREASONABLE SEARCHES AND SEIZURES PROHIBITED.**

The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures shall not be violated; and no warrant shall issue but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched and the person or things to be seized.

**Sec. 13. PRIVATE PROPERTY FOR PUBLIC USE.** Private property shall not be taken, destroyed or damaged for public use without just compensation therefore, first paid or secured.

**Sec. 16. FREEDOM OF CONSCIENCE; NO PREFERENCE TO BE GIVEN TO ANY RELIGIOUS ESTABLISHMENT OR MODE OF WORSHIP.** ... The right of every man to worship God according to the dictates of his own conscience shall never be infringed;... nor shall any control of or interference with the rights of conscience be permitted,...but the liberty of conscience hereby secured shall not be so construed as to ...justify practices inconsistent with the peace or safety of the state.

Analysis:

A comprehensive list of constitutional and other rights of citizens on which there is total agreement is not easy to assemble. In this report, attention is given to rights that are particularly related to the declaration of a public health emergency and those issues that were identified during the various meetings and discussions of emergency powers. Additional issues are likely to be identified in more detailed planning. Attention to this issue will be critical to gaining support and compliance from the public for whose protection the emergency is declared.

The issues center around five main points:

1. **Right to assemble, including right to attend worship services.** Included in both the U.S. and Minnesota constitution however, the Minnesota constitution includes a clause that prohibits practices that are inconsistent with the peace or safety of the state.

During a public health emergency, the governor may limit public gatherings or transportation or movement of individuals or groups of people during the emergency. The emergency needs to state the nature of the limitations and the reasons and duration of the limitation. This so-called “reverse quarantine” was credited with limiting the spread of the Spanish Influenza in the 1918 epidemic and the 1950 polio epidemic in Minnesota. Philip D. Jordan, The People’s Health Minnesota Historical Society, 1953 pp. 410 to 415 Supporting susceptible populations to avoid contact with others can be an important strategy to prevent harm to individuals who have not been exposed to an infectious agent or chemical or radiological agent.

2. **Unreasonable search and seizure, and security of homes and possessions.** In order to conduct an investigation of exposure to a bioterrorism agent or to identify the source and related transmission issues, or to determine methods to contain the spread of an infectious agent, the commissioner may need to gather human specimens or environmental samples. As described earlier, an individual may refuse to submit to medical testing. The commissioner would be required to show reasonable cause to obtain a warrant for environmental sampling if an individual refused to grant access. In addition, Minnesota Statutes Section 12.46 (1) Limitation of powers prohibits the governor or the director of the division of emergency management from using a subpoena or otherwise requiring any person to appear before any person or to produce any records for inspection by any person, or to examine any person under oath. However, the Commissioner of Health has subpoena

power in the event of a serious “health threat” Minnesota Statutes Section 144.054.

3. **Other rights not specifically identified and deprivation of those rights** can only be considered with specific reference to law. Although this element is difficult to analyze, since it is so broad. Privacy of health data would certainly be one important concern. In regard to other rights, it would be necessary for the commissioner or the governor to clearly state the need for and the scope of the action to be taken to assure they are “reasonable under the circumstances”
4. **Entitlement to redress for wrongs.** Nothing in the emergency powers of the state takes away individual rights to sue the government or an agent of the government for redress of wrongs. Again, the standard of “reasonable under the circumstances” would be used to balance the rights of an individual and the public good to determine if any remedy is required. The new federal Homeland Security Act appears to provide some restrictions on tort claims during the DHHS Secretary’s emergency declaration period.
5. **Compensation for use of private property.** Minnesota Statutes 12.34 subd. 2 describes the process of compensation in that the owner of commandeered property must be promptly paid just compensation for its use and all damages done to the property while so used for emergency management purposes. It includes an appeal process.

Recommendations:

28. MDH should work with the Commissioner's Task Force on Terrorism and Health to review reports from state, regional and local tabletop and field exercises to explore issues of constitutional and other rights that may arise in a public health emergency.
29. MDH should meet with representatives of various civil rights and other citizen groups, special populations such as disability organizations, and interested individuals

throughout 2003 to continue to identify concerns about constitutional and other rights during a public health emergency and propose methods to address them.

30. MDH should monitor, and comment when appropriate, on federal DHHS quarantine regulation proposals under the expanded powers granted in the Public Health Security and Bioterrorism Preparedness Act of 2002.

## **Summary of public comments received during the required public comment period**

For the complete set of comments, please see Appendix M. The following is a summary of the comments received during the comment period from December 16 to January 17, 2002.

Comments were received in two main areas:

### 1) antibiotic resistance and preserving effectiveness of antibiotics

Minnesota Veterinary Medical Association  
Minnesota Turkey Growers Association  
Broiler and Egg Association of Minnesota  
Minnesota Agri-Growth Council

Recommended including language that addresses human use of antibiotics and efforts to limit over-prescription or non-judicious use through collaboration with human health groups and public education.

### 2) civil liberties issues

Minnesota Civil Liberties Union

Recommended additional legal analysis of the specific constitutional standards that the State is required to meet with respect to civil liberties affected by the Minnesota Emergency Health Powers Act.

## Appendices

- A. Commissioner's Task Force on Terrorism and Health Contact list
- B. Minnesota Statutes 2002 Chapter 402 - Minnesota Emergency Health Powers Act
- C. The Minnesota Emergency Health Powers Act Information Brief, Minnesota House of Representatives Research Department
- D. Terrorism and Health Task Force comments on draft report and recommendations
- E. Homeland Security Advisory Council Membership
- F. Agenda and Summary of Working Conference on Public Health Emergencies July 18, 2002.  
Pioneer Press Article about the Conference
- G. Community Health Conference September 13, 2002 Breakout Session
- H. Agenda and Summary of Antibiotic Effectiveness meeting October 28, 2002
- I. Agenda and Summary of Immunity, Liability and Compensation meeting October 31, 2002
- J. Legal Glossary of Terms
- K. United States Constitution Amendments I through X (Bill of Rights) and Minnesota Article I Bill of Rights
- L. State Register Notice of December 16, 2002
- M. Public Comments Received during notice period



# **Minnesota Emergency Health Powers Act**

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## *Appendices*

## *Appendix A*

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*Appendix B*

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**Minnesota Statutes 2002 Chapter 402 -  
Minnesota Emergency Health Powers  
Act**



## Minnesota Session Laws 2002, Chapter 402

Minnesota Session Laws – 2002

Key: ~~language to be deleted~~...new language

### CHAPTER 402-H.F.No. 3031

An act relating to public health; establishing the Minnesota Emergency Health Powers Act; modifying provisions for declaring national security and peacetime emergencies; providing for declaration and termination of emergencies due to a public health emergency; granting certain emergency powers; preserving certain rights of refusal; providing for the isolation and quarantine of persons; requiring a study; amending Minnesota Statutes 2000, sections 12.03, by adding subdivisions; 12.21, subdivision 3; 12.31, subdivisions 2, 3; 12.32; 12.34, subdivision 1; 13.3806, by adding subdivisions; Minnesota Statutes 2001 Supplement, section 12.31, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 12; 144.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [TITLE.] Sections 1 to 21 may be cited as the "Minnesota Emergency Health Powers Act."

Sec. 2. Minnesota Statutes 2000, section 12.03, is amended by adding a subdivision to read:

Subd. 1c. [BIOTERRORISM.] "Bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population.

Sec. 3. Minnesota Statutes 2000, section 12.03, is amended by adding a subdivision to read:

Subd. 4d. [FACILITY.] "Facility" means any real property, building, structure, or other improvement to real property or any motor vehicle, rolling stock, aircraft, watercraft, or other means of transportation. Facility does not include a private residence.

Sec. 4. Minnesota Statutes 2000, section 12.03, is amended by adding a subdivision to read:

Subd. 6a. [MEDICAL SUPPLIES.] "Medical supplies" means any medication, durable medical equipment, instruments, linens, or any other material that a health care provider deems not essential for the continued operation of the provider's practice or facility. The term medical supplies does not apply to medication, durable medical equipment, or other material that is personal property being used by individuals or that has been borrowed, leased, or rented by individuals for the purpose of treatment or care.

Sec. 5. Minnesota Statutes 2000, section 12.03, is amended by adding a subdivision to read:

Subd. 9a. [PUBLIC HEALTH EMERGENCY.] "Public health emergency" means an occurrence or imminent threat of an illness or health condition in Minnesota:

(1) where there is evidence to believe the illness or health condition is caused by any of the following:

(i) bioterrorism; or

(ii) the appearance of a new or novel or previously controlled or eradicated airborne infectious agent or airborne biological toxin; and

(2) the illness or health condition poses a high probability of any of the following harms:

(i) a large number of deaths in the affected population;

(ii) a large number of serious or long-term disabilities in the affected population; or

(iii) widespread exposure to an airborne infectious or airborne toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.

Sec. 6. Minnesota Statutes 2000, section 12.21, subdivision 3, is amended to read:

Subd. 3. [SPECIFIC AUTHORITY.] In performing duties under this chapter and to effect its policy and purpose, the governor may:

(1) make, amend, and rescind the necessary orders and rules to carry out the provisions of this chapter and section 216C.15 within the limits of the authority conferred by this section, with due consideration of the plans of the federal government and without complying with sections 14.001 to 14.69, but no order or rule has the effect of law except as provided by section 12.32;

(2) ensure that a comprehensive emergency operations plan and emergency management program for this state are developed and maintained, and are integrated into and coordinated with the emergency plans of the federal government and of other states to the fullest possible extent;

(3) in accordance with the emergency operations plan and the emergency management program of this state, procure supplies ~~and~~, equipment, and facilities, institute training programs and public information programs, and take all other preparatory steps, including the partial or full activation of emergency management organizations in advance of actual disaster to ensure the furnishing of adequately trained and equipped forces of emergency management personnel in time of need;

(4) make studies and surveys of the industries, resources, and facilities in this state as may be necessary to ascertain the capabilities of the state for emergency management and to plan for the most efficient emergency use of those industries, resources, and facilities;

(5) on behalf of this state, enter into mutual aid arrangements or cooperative agreements with other states, tribal authorities, and ~~with~~ Canadian provinces, and coordinate mutual aid plans between political subdivisions of this state;

(6) delegate administrative authority vested in the governor under this chapter, except the power to make rules, and provide for the subdelegation of that authority;

(7) cooperate with the president and the heads of the armed forces, the emergency management agency of the United States and other appropriate federal officers and agencies, and with the officers and agencies of other states in matters pertaining to the emergency management of the state and nation, including the direction or control of:

(i) emergency preparedness drills and exercises;

(ii) warnings and signals for drills or actual emergencies and the mechanical devices to be used in connection with them;

(iii) shutting off water mains, gas mains, electric power connections and the suspension of all other utility services;

(iv) the conduct of persons in the state, including entrance or exit from any stricken or threatened public place, occupancy of facilities, and the movement and cessation of movement of pedestrians ~~and~~, vehicular traffic, and all forms of private and public transportation during, prior, and subsequent to drills or actual emergencies;

- (v) public meetings or gatherings; and
- (vi) the evacuation, reception, and sheltering of persons;

(8) contribute to a political subdivision, within the limits of the appropriation for that purpose, not more than 25 percent of the cost of acquiring organizational equipment that meets standards established by the governor;

(9) formulate and execute, with the approval of the executive council, plans and rules for the control of traffic in order to provide for the rapid and safe movement over public highways and streets of troops, vehicles of a military nature, and materials for national defense and war or for use in any war industry, for the conservation of critical materials, or for emergency management purposes, ~~and~~; coordinate the activities of the departments or agencies of the state and its political subdivisions concerned directly or indirectly with public highways and streets, in a manner that will best effectuate those plans;

(10) alter or adjust by executive order, without complying with sections 14.01 to 14.69, the working hours, work days and work week of, and annual and sick leave provisions and payroll laws regarding all state employees in the executive branch as the governor deems necessary to minimize the impact of the disaster or emergency, conforming the alterations or adjustments

to existing state laws, rules, and collective bargaining agreements to the extent practicable;

(11) authorize the commissioner of children, families, and learning to alter school schedules, curtail school activities, or order schools closed without affecting state aid to schools, as defined in section 120A.05, subdivisions 9, 11, 13, and 17, and including charter schools under section 124D.10, and elementary schools enrolling prekindergarten pupils in district programs; and

(12) transfer the direction, personnel, or functions of state agencies to perform or facilitate response and recovery programs.

Sec. 7. Minnesota Statutes 2001 Supplement, section 12.31, subdivision 1, is amended to read:

Subdivision 1. [DECLARATION OF NATIONAL SECURITY EMERGENCY.] When information from the President of the United States, the Federal Emergency Management Agency, the Department of Defense, or the National Warning System indicates the imminence of a national security emergency within the United States, which means the several states, the District of Columbia, and the Commonwealth of Puerto Rico, or the occurrence within the state of Minnesota of a major disaster or public health emergency from enemy sabotage or other hostile action, the governor may, by proclamation, declare that a national security emergency exists in all or any part of the state. If the legislature is then in regular session or, if it is not, if the governor concurrently with the proclamation declaring the emergency issues a call convening immediately both houses of the legislature, the governor may exercise for a period not to exceed 30 days the powers and duties conferred and imposed by sections 12.31 to 12.37 and 12.381. The lapse of these emergency powers does not, as regards any act occurring or committed within the 30-day period, deprive any person, political subdivision, municipal corporation, or body politic of any right to compensation or reimbursement that it may have under this chapter.

Sec. 8. Minnesota Statutes 2000, section 12.31, subdivision 2, is amended to read:

Subd. 2. [DECLARATION OF PEACETIME EMERGENCY.] (a) The governor may declare a peacetime emergency. A peacetime declaration of emergency may be declared only when an act of nature, a technological failure or malfunction, a terrorist

incident, a public health emergency, an industrial accident, a hazardous materials accident, or a civil disturbance endangers life and property and local government resources are inadequate to handle the situation. ~~It~~ A peacetime emergency must not be continued for more than five days unless extended by resolution of the executive council up to 30 days. An order, or proclamation declaring, continuing, or terminating an emergency must be given prompt and general publicity and filed with the secretary of state.

(b) This paragraph applies to a peacetime emergency declared as a result of a public health emergency. If the legislature is sitting in session at the time of the emergency declaration, the governor may exercise the powers and duties conferred by this chapter for the period allowed under paragraph (a). If the legislature is not sitting in session when a peacetime emergency is declared or renewed, the governor may exercise the powers and duties conferred by this chapter for the period allowed under paragraph (a) only if the governor issues a call convening both houses of the legislature at the same time the governor declares or renews the peacetime emergency.

Sec. 9. Minnesota Statutes 2000, section 12.31, subdivision 3, is amended to read:

Subd. 3. [EFFECT OF DECLARATION OF PEACETIME EMERGENCY.] A declaration of a peacetime emergency in accordance with this section authorizes the governor to exercise for a period not to exceed the time specified in this section the powers and duties conferred and imposed by this chapter for a peacetime emergency and invokes the necessary portions of the state emergency operations plan developed pursuant to section 12.21, subdivision 3, relating to response and recovery aspects and may authorize aid and assistance under the plan.

Sec. 10. [12.311] [DECLARATION DUE TO A PUBLIC HEALTH EMERGENCY.]

(a) Before the governor declares a national security emergency due to a public health emergency or peacetime emergency due to a public health emergency, the governor or state director of emergency management shall consult with the commissioner of public safety, the state director of homeland security, the commissioner of health, and additional public health experts and other experts. If the public health emergency occurs on Indian lands, the governor or state director of emergency management shall consult with tribal authorities before the governor makes such a declaration. Nothing in this section shall be construed to limit the governor's authority to act without such consultation when the situation calls for prompt and timely action.

(b) Upon the declaration of an emergency due to a public health emergency, the governor and the commissioner of health must immediately report to the leadership in the house of representatives and senate, as well as the chairs and ranking minority members of the judiciary and health committees, regarding the imposition of the public health emergency and how it may affect the public.

Sec. 11. [12.312] [TERMINATION OF DECLARATION; PUBLIC HEALTH EMERGENCY.]

Subdivision 1. [AUTOMATIC TERMINATION; RENEWAL.] Notwithstanding any other provision of this chapter, a national security emergency declared due to a public health emergency or peacetime emergency declared due to a public health emergency is terminated automatically 30 days after its original declaration unless the emergency is renewed by the governor using the procedure specified in section 12.31, subdivision 2, paragraph (b). Any renewal is terminated automatically after 30 days unless again renewed by the governor.

Subd. 2. [TERMINATION BY LEGISLATURE.] By a majority vote of each house of the legislature, the legislature may terminate a national security emergency declared due to a public health emergency or peacetime emergency declared due to a public health emergency at any time from the date of original declaration. A termination by the legislature under this subdivision overrides any renewal by the governor under subdivision 1.

Sec. 12. Minnesota Statutes 2000, section 12.32, is amended to read:

12.32 [GOVERNOR'S ORDERS AND RULES, EFFECT.] Orders and rules promulgated by the governor under authority of section 12.21, subdivision 3, clause (1), when approved by the executive council and filed in the office of the secretary of state, have, during a national security emergency, peacetime emergency declared due to a public health emergency, or energy supply emergency, the full force and effect of law. Rules and ordinances of any agency or political subdivision of the state inconsistent with the provisions of this chapter or with any order or rule having the force and effect of law issued under the authority of this chapter, is suspended during the period of time and to the extent that the emergency exists.

Sec. 13. Minnesota Statutes 2000, section 12.34, subdivision 1, is amended to read:

Subdivision 1. [EMERGENCY POWERS.] When necessary to save life, property, or the environment during a national security emergency or during a peacetime emergency declared due to a public health emergency, the governor, the state director, or a member of a class of members of a state or local emergency management organization designated by the governor, may:

(1) require any person, except members of the federal or state military forces and officers of the state or a political subdivision, to perform services for emergency management purposes as directed by any of the persons described above; and

(2) ~~commandeer, during a national security emergency~~ for emergency management purposes as directed by any of the persons described above, any motor vehicle, tools, appliances, medical supplies, or other personal property and any facilities.

Sec. 14. [12.381] [SAFE DISPOSITION OF DEAD HUMAN BODIES.]

Subdivision 1. [POWERS FOR SAFE DISPOSITION.] Notwithstanding chapter 149A and Minnesota Rules, chapter 4610, in connection with deaths related to a public health emergency and during a national security emergency declared due to a public health emergency or peacetime emergency declared due to a public health emergency, the governor may:

(1) direct measures to provide for the safe disposition of dead human bodies as may be reasonable and necessary for emergency response. Measures may include, but are not limited to, transportation, preparation, temporary mass burial and other interment, disinterment, and cremation of dead human bodies. Insofar as the emergency circumstances allow, the governor shall respect the religious rites, cultural customs, family wishes, and predeath directives of a decedent concerning final disposition. The governor may limit visitations or funeral ceremonies based on public health risks;

(2) consult with coroners and medical examiners, take possession or control of any dead human body, and order an autopsy of the body; and

(3) request any business or facility authorized to embalm, bury, cremate, inter, disinter, transport, or otherwise provide for disposition of a dead human body under the laws of this state to accept any dead human body or provide the use of its business or facility if the actions are reasonable and necessary for emergency management purposes and are within the safety precaution capabilities of the business or facility.

Subd. 2. [IDENTIFICATION OF BODIES.] A person in charge of the body of a person believed to have died due to a public health emergency shall maintain a written record of the body and all available information to identify the decedent, the circumstances of death, and disposition of the body. If a body cannot be identified, a qualified person shall, prior to disposition and to the extent possible, take fingerprints and one or more photographs of the remains and collect a DNA specimen from the body. All information gathered under this subdivision, other than data required for a death certificate under Minnesota Rules, part 4601.2550, shall be death investigation data and shall be classified as nonpublic data according to section 13.02, subdivision 9, or as private data on decedents according to section 13.10, subdivision 1. Death investigation data are not medical examiner data as defined in section 13.83. Data gathered under this subdivision shall be promptly forwarded to the commissioner of health. The commissioner may only disclose death investigation data to the extent necessary to assist relatives in identifying decedents or for public health or public safety investigations.

Sec. 15. [12.39] [TESTING AND TREATMENTS.]

Subdivision 1. [REFUSAL OF TREATMENT.] Notwithstanding laws, rules, or orders made or promulgated in response to a national security emergency, peacetime emergency, or public health emergency, individuals have a fundamental right to refuse medical treatment, testing, physical or mental examination, vaccination, participation in experimental procedures and protocols, collection of specimens, and preventive treatment programs. An individual who has been directed by the commissioner of health to submit to medical procedures and protocols because the individual is infected with or reasonably believed by the commissioner of health to be infected with or exposed to a toxic agent that can be transferred to another individual or a communicable disease, and the agent or communicable disease is the basis for which the national security emergency, peacetime emergency, or public health emergency was declared, and who refuses to submit to them may be ordered by the commissioner to be placed in isolation or quarantine according to parameters set forth in sections 144.419 and 144.4195.

Subd. 2. [INFORMATION GIVEN.] Where feasible, before performing examinations, testing, treatment, or vaccination of an individual under subdivision 1, a health care provider shall notify the individual of the right to refuse the examination, testing, treatment, or vaccination, and the consequences, including isolation or quarantine, upon refusal.

Sec. 16. Minnesota Statutes 2000, section 13.3806, is amended by adding a subdivision to read:

Subd. 1a. [DEATH INVESTIGATION DATA.] Data gathered by the commissioner of health to identify the body of a person believed to have died due to a public health emergency as defined in section 12.03, subdivision 9a, the circumstances of death, and disposition of the body are classified in and may be released according to section 12.381, subdivision 2.

Sec. 17. Minnesota Statutes 2000, section 13.3806, is amended by adding a subdivision to read:

Subd. 10a. [ISOLATION OR QUARANTINE DIRECTIVE.] Data in a directive issued by the commissioner of health under section 144.4195, subdivision 2, to isolate or quarantine a person or group of persons are classified in section 144.4195, subdivision 6.

Sec. 18. [144.419] [ISOLATION AND QUARANTINE OF PERSONS.]

Subdivision 1. [DEFINITIONS.] For purposes of this section and section 144.4195, the following definitions apply:

(1) "bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population;

(2) "communicable disease" means a disease caused by a living organism or virus and believed to be caused by bioterrorism or a new or novel or previously controlled or eradicated infectious agent or biological toxin that can be transmitted person to person and for which isolation or quarantine is an effective control strategy, excluding a disease that is directly transmitted as defined under section 144.4172, subdivision 5;

(3) "isolation" means separation, during the period of communicability, of a person infected with a communicable disease, in a place and under conditions so as to prevent direct or indirect transmission of an infectious agent to others; and

(4) "quarantine" means restriction, during a period of communicability, of activities or travel of an otherwise healthy person who likely has been exposed to a communicable disease to prevent disease transmission during the period of communicability in the event the person is infected.

Subd. 2. [GENERAL REQUIREMENTS.] (a) The commissioner of health or any person acting under the commissioner's authority shall comply with paragraphs (b) to (h) when isolating or quarantining individuals or groups of individuals. (b) Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a communicable or potentially communicable disease to others and may include, but are not limited to, confinement to private homes or other private or public premises.

(c) Isolated individuals must be confined separately from quarantined individuals.

(d) The health status of isolated and quarantined individuals must be monitored regularly to determine if they require continued isolation or quarantine. To adequately address emergency health situations, isolated and quarantined individuals shall be given a reliable means to communicate 24 hours a day with health officials and to summon emergency health services.

(e) If a quarantined individual subsequently becomes infectious or is reasonably believed to have become infectious with a communicable or potentially communicable disease, the individual must be isolated according to section 144.4195.

(f) Isolated and quarantined individuals must be immediately released when they pose no known risk of transmitting a communicable or potentially communicable disease to others.

(g) The needs of persons isolated and quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication between those in isolation or quarantine and those outside these settings, medication, and competent medical care.

(h) Premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to persons isolated and quarantined.

Subd. 3. [TERMINATION.] The isolation or quarantine of a person must terminate automatically on the expiration date of a court order authorizing isolation or quarantine that is issued according to section 144.4195, or before the expiration date if the commissioner

of health determines that isolation or quarantine of the person is no longer necessary to protect the public.

Subd. 4. [RIGHT TO REFUSE TREATMENT.] Any person who is isolated or quarantined according to this section and section 144.4195 has a fundamental right to refuse medical treatment, testing, physical or mental examination, vaccination, participation in experimental procedures and protocols, collection of specimens, and preventive treatment programs. A person who has been directed by the commissioner of health or any person acting under the commissioner's authority to submit to medical procedures and protocols because the person is infected with or reasonably believed by the commissioner or by the person acting under the commissioner's authority to be infected with or exposed to a communicable disease and who refuses to submit to them may be subject to continued isolation or quarantine according to the parameters set forth in section 144.4195.

Subd. 5. [CITIZEN RIGHT TO ENTRY.] (a) No person, other than a person authorized by the commissioner of health or authorized by any person acting under the commissioner's authority, shall enter an isolation or quarantine area. If, by reason of an unauthorized entry into an isolation or quarantine area, a person poses a danger to public health, the person may be subject to isolation or quarantine according to this section and section 144.4195.

(b) A family member of a person isolated or quarantined has a right to choose to enter into an isolation or quarantine area. The commissioner of health must permit the family member entry into the isolation or quarantine area if the family member signs a consent form stating that the family member has been informed of the potential health risks, isolation and quarantine guidelines, and the consequences of entering the area. The family member may not hold the department of health, the commissioner of health, or the state responsible for any consequences of entering the isolation or quarantine area. If, by reason of entry into an isolation or quarantine area under this paragraph, a person poses a danger to public health, the person may be subject to isolation or quarantine according to this section and section 144.4195.

Sec. 19. [144.4195] [DUE PROCESS FOR ISOLATION OR QUARANTINE OF PERSONS.]

Subdivision 1. [EX PARTE ORDER FOR ISOLATION OR QUARANTINE.] (a) Before isolating or quarantining a person or group of persons, the commissioner of health shall obtain a written, ex parte order authorizing the isolation or quarantine from the district court of Ramsey county, the county where the person or group of persons is located, or a county adjoining the county where the person or group of persons is located. The evidence or testimony in support of an application may be made or taken by telephone, facsimile transmission, video equipment, or other electronic communication. The court shall grant the order upon a finding that probable cause exists to believe isolation or quarantine is warranted to protect the public health.

(b) The order must state the specific facts justifying isolation or quarantine, must state that the person being isolated or quarantined has a right to a court hearing under this section and a right to be represented by counsel during any proceeding under this section, and must be provided immediately to each person isolated or quarantined. The commissioner of health shall provide a copy of the authorizing order to the commissioner of public safety and other peace officers known to the commissioner to have jurisdiction over the site of the isolation or quarantine. If feasible, the commissioner of health shall



give each person being isolated or quarantined an estimate of the expected period of the person's isolation or quarantine.

(c) If it is impracticable to provide individual orders to a group of persons isolated or quarantined, one order shall suffice to isolate or quarantine a group of persons believed to have been commonly infected with or exposed to a communicable disease. A copy of the order and notice shall be posted in a conspicuous place:

(1) in the isolation or quarantine premises, but only if the persons to be isolated or quarantined are already at the isolation or quarantine premises and have adequate access to the order posted there; or

(2) in another location where the group of persons to be isolated or quarantined is located, such that the persons have adequate access to the order posted there.

If the court determines that posting the order according to clause (1) or (2) is impractical due to the number of persons to be isolated or quarantined or the geographical area affected, the court must use the best means available to ensure that the affected persons are fully informed of the order and notice.

(d) No person may be isolated or quarantined pursuant to an order issued under this subdivision for longer than 21 days without a court hearing under subdivision 3 to determine whether isolation or quarantine should continue. A person who is isolated or quarantined may request a court hearing under subdivision 3 at any time before the expiration of the order.

Subd. 2. [TEMPORARY HOLD UPON COMMISSIONER'S DIRECTIVE.] Notwithstanding subdivision 1, the commissioner of health may by directive isolate or quarantine a person or group of persons without first obtaining a written, ex parte order from the court if a delay in isolating or quarantining the person or group of persons would significantly jeopardize the commissioner of health's ability to prevent or limit the transmission of a communicable or potentially communicable disease to others. The commissioner must provide the person or group of persons subject to the temporary hold with notice that the person has a right to request a court hearing under this section and a right to be represented by counsel during a proceeding under this section. If it is impracticable to provide individual notice to each person subject to the temporary hold, notice of these rights may be posted in the same manner as the posting of orders under subdivision 1, paragraph (c). Following the imposition of isolation or quarantine under this subdivision, the commissioner of health shall within 24 hours apply for a written, ex parte order pursuant to subdivision 1 authorizing the isolation or quarantine. The court must rule within 24 hours of receipt of the application. If the person is under a temporary hold, the person may not be held in isolation or quarantine after the temporary hold expires unless the court issues an ex parte order under subdivision 1.

Subd. 3. [COURT HEARING.] (a) A person isolated or quarantined under an order issued pursuant to subdivision 1 or a temporary hold under subdivision 2 or the person's representative may petition the court to contest the court order or temporary hold at any time prior to the expiration of the order or temporary hold. If a petition is filed, the court must hold a hearing within 72 hours from the date of the filing. A petition for a hearing does not stay the order of isolation or quarantine. At the hearing, the commissioner of health must show by clear and convincing evidence that the isolation or quarantine is warranted to protect the public health.

(b) If the commissioner of health wishes to extend the order for isolation or quarantine past the period of time stated in subdivision 1, paragraph (d), the commissioner must petition the court to do so. Notice of the hearing must be served upon the person or

persons who are being isolated or quarantined at least three days before the hearing. If it is impracticable to provide individual notice to large groups who are isolated or quarantined, a copy of the notice may be posted in the same manner as described under subdivision 1, paragraph (c).

(c) The notice must contain the following information:

(1) the time, date, and place of the hearing;

(2) the grounds and underlying facts upon which continued isolation or quarantine is sought;

(3) the person's right to appear at the hearing; and

(4) the person's right to counsel, including the right, if indigent, to be represented by counsel designated by the court or county of venue.

(d) The court may order the continued isolation or quarantine of the person or group of persons if it finds by clear and convincing evidence that the person or persons would pose an imminent health threat to others if isolation or quarantine was lifted. In no case may the isolation or quarantine continue longer than 30 days from the date of the court order issued under this subdivision unless the commissioner petitions the court for an extension. Any hearing to extend an order is governed by this subdivision.

Subd. 4. [HEARING ON CONDITIONS OF ISOLATION OR QUARANTINE.] A person isolated or quarantined may request a hearing in district court for remedies regarding the treatment during and the terms and conditions of isolation or quarantine. Upon receiving a request for a hearing under this subdivision, the court shall fix a date for a hearing that is within seven days of the receipt of the request by the court. The request for a hearing does not alter the order for isolation or quarantine. If the court finds that the isolation or quarantine of the individual is not in compliance with section 144.419, the court may fashion remedies appropriate to the circumstances of the emergency and in keeping with this chapter.

Subd. 5. [JUDICIAL DECISIONS.] Court orders issued pursuant to subdivision 3 or 4 shall be based upon clear and convincing evidence and a written record of the disposition of the case shall be made and retained. Any person subject to isolation or quarantine has the right to be represented by counsel or other lawful representative. The manner in which the request for a hearing is filed and acted upon shall be in accordance with the existing laws and rules of the courts of this state or, if the isolation or quarantine occurs during a national security or peacetime emergency, any rules that are developed by the courts for use during a national security or peacetime emergency.

Subd. 6. [DATA PRIVACY.] Data on individuals contained in the commissioner's directive under subdivision 2 are health data under section 13.3805, subdivision 1.

Subd. 7. [DELEGATION.] The commissioner may delegate any authority prescribed in subdivision 1 or 3 to the local public health board, according to chapter 145A.

Sec. 20. [STUDY OF EMERGENCY HEALTH POWERS ISSUES.]

(a) The commissioner of health shall study and submit recommendations to the legislature on additional legislative changes needed to Minnesota Statutes, chapter 12 or 144, or other relevant statutes to strengthen the state's capacity to deal with a public health emergency, while protecting the constitutional and other rights of citizens. Before submitting the recommendations to the legislature, the commissioner shall publish the recommendations in the State Register and provide a period of not less than 30 days for the public to submit written comments to the commissioner regarding the recommendations. The report and recommendations, including written comments received by the

commissioner, must be submitted to the legislature by January 15, 2003. The report and recommendations must address at least the following:

(1) provisions for immunity from liability for health care providers and others acting under the direction of the governor or a designee during an emergency declared due to a public health emergency;

(2) emergency measures concerning dangerous facilities and materials, the control of medical supplies and facilities, and limiting public gatherings and transportation;

(3) measures to detect and prevent the spread of disease, including requirements for medical examinations, testing, vaccination, treatment, isolation and quarantine, collecting laboratory specimens and samples, and an evaluation of the definition of communicable disease;

(4) due process protections to apply to persons under isolation or quarantine;

(5) enforcement methods to ensure compliance with emergency measures and measures to detect and prevent the spread of disease;

(6) ways to preserve the effectiveness of fluoroquinolones and other antibiotics that are vital to protecting human health; and

(7) the impact of each recommendation on the constitutional and other rights of citizens.

(b) In developing this report and recommendations, the commissioner shall consult with the commissioner of public safety, the state director of homeland security, and representatives of local government, tribal government, emergency managers, the board of animal health, health care provider organizations, emergency medical services personnel, and legal advocacy and civil liberties groups. All meetings with these representatives must be open to the public and adequate notice of the meetings must be provided to the public. The commissioner shall delineate and describe the impact of each recommendation on the constitutional and other rights of citizens.

Sec. 21. [SUNSET.] Sections 1 to 19 expire August 1, 2004.

Sec. 22. [EFFECTIVE DATE.] Sections 1 to 21 are effective the day following final enactment.

Presented to the governor May 20, 2002

Signed by the governor May 22, 2002, 1:32 p.m.

## *Appendix C*

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# **The Minnesota Emergency Health Powers Act Information Brief, Minnesota House of Representatives Research Department**

## **INFORMATION BRIEF**

**Minnesota House of Representatives**  
**Research Department**  
600 State Office Building  
St. Paul, MN 55155  
Elisabeth Loehrke, Legislative Analyst  
651-296-5043 September 2002

# **The Minnesota Emergency Health Powers Act**

This information brief summarizes the Minnesota Emergency Health Powers Act, enacted in May 2002. The act expands the circumstances under which the governor may declare a national security emergency or peacetime emergency, increases the emergency management powers available to the governor and other officials, establishes standards and due process procedures for people being isolated or quarantined, and requires a study of other issues not resolved by the legislature.

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This publication can be made available in alternative formats upon request. Please call 651-296-6753 (voice); or the Minnesota State Relay Service at 1-800-627-3529 (TTY) for assistance. Many House Research Department publications are also available on the Internet at: [www.house.leg.state.mn.us/hrd/hrd.htm](http://www.house.leg.state.mn.us/hrd/hrd.htm).

## Overview

In May 2002 the Minnesota Emergency Health Powers Act was enacted, giving the governor, commissioner of health, and other officials tools to respond to a public health emergency in this state. (Laws 2002, ch. 402) Initial versions of the act were based on a proposal by the Minnesota Department of Health (MDH). The MDH proposal, in turn, was drawn from a Model State Emergency Health Powers Act prepared for the federal Centers for Disease Control and Prevention. The MDH proposal and the model act addressed a broad range of issues. The emergency health powers bills received substantial debate as they moved through the legislative process,<sup>1</sup> and the final act addresses fewer issues than the initial proposals. The act covers the following topics:

- When the governor may declare a public health emergency;
- Changes to the emergency management powers of the governor and other officials;
- A person's right to refuse medical examinations, tests, and treatment;
- Standards for isolation and quarantine, and due process procedures that apply to people who are isolated or quarantined; and
- Issues for the commissioner of health to study further and report on to the legislature in the 2003 session.

All provisions in the act became effective May 23, 2002, the day following final enactment. In addition, the act expires August 1, 2004. This sunset date gives the legislature two legislative sessions to modify and refine provisions in the act. If no legislative action is taken before the sunset date, the statutory changes made by the act will expire on that date.

## **The Act Authorizes the Governor to Declare a Public Health Emergency**

Provisions in Minnesota Statutes, chapter 12, specify when the governor may declare a national security emergency or a peacetime emergency. The governor has discretion in deciding when to declare a national security or peacetime emergency. During an emergency, the governor may exercise additional emergency management powers. The act expands the situations in which the governor may declare a national security or peacetime emergency, to allow either type to be declared when a public health emergency exists.

- A national security emergency may be declared when a public health emergency occurs in Minnesota that is caused by enemy sabotage or other hostile action.
- A peacetime emergency may be declared when a public health emergency endangers life and property, and local government resources are not adequate to handle the situation.

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<sup>1</sup> The various engrossments of the House file (H.F. 3031) and the Senate file (S.F. 2669) may be found on the Minnesota State Legislature web site at <http://www.leg.state.mn.us>, by clicking on the Legislation and Bill Status button.

**Definition of public health emergency.** For an emergency to be declared due to a public health emergency, there must be an illness or health condition present in Minnesota, or an imminent threat of an illness or health condition, that meets two specific criteria.

1. There must be evidence that the illness or health condition is caused either by:
  - bioterrorism;<sup>2</sup> or
  - a new, novel, or previously controlled or eradicated airborne, infectious agent or airborne, biological toxin; and
2. There must be a high probability that the illness or health condition will cause at least one of the following:
  - a large number of deaths;
  - a large number of serious or long-term disabilities; or
  - widespread exposure to an airborne agent that poses a significant risk of substantial future harm to a large number of people.

Determining whether these criteria are met will require the governor to exercise judgment. For instance, the governor must determine what constitutes a large number of deaths or disabilities, what level of exposure constitutes a significant risk, and what substantial future harm means.

**Requirements regarding consultation and notice.** Before the governor declares an emergency due to a public health emergency, the governor or the state director of emergency management must consult with the commissioner of public safety, the state director of homeland security, the commissioner of health, other experts, and, if the emergency occurs on Indian lands, the appropriate tribal authorities. However, the governor may declare an emergency without consultation if the situation requires it. When an emergency is declared due to a public health emergency, the governor and commissioner of health must notify legislative leaders, relevant committee chairs, and minority members on relevant legislative committees.

**Convening the legislature.** The act ensures that the legislature is in session when an emergency is declared due to a public health emergency. Prior existing law required the governor to call the legislature into session when the governor wanted to exercise emergency powers during a national security emergency. The act expands the governor's duty to convene the legislature so it applies to a peacetime emergency declared due to a public health emergency. Accordingly, if the governor wants to use the emergency powers conferred by chapter 12 during a peacetime emergency declared due to a public health emergency and the legislature is not in session, the governor must call the legislature into session. If the legislature is not called into session, the governor cannot exercise his or her emergency powers.

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<sup>2</sup> Bioterrorism is defined in part to mean the use of a microorganism, virus, infectious substance, or biological product to cause death, disease, or biological malfunction in a living organism. The agent must be intentionally used to influence the conduct of government or coerce a civilian population.

**Termination and renewal of a public health emergency.** The act provides that an emergency declared due to a public health emergency automatically terminates 30 days after it is declared. In addition, the legislature may terminate this emergency any time after it is declared. For the legislature to terminate an emergency, a majority in each body must vote to do so. The governor has authority to renew an emergency declared due to a public health emergency for 30-day periods. Termination of an emergency by the legislature overrides a renewal by the governor. Minn. Stat. §§ 12.03, subs. 1c, 9a; 12.31, subs. 1, 2; 12.311; 12.312

### **The Act Modifies Emergency Management Powers**

The emergency management powers of the governor, the executive council, and other officials are governed by provisions in chapters 9 and 12. The act expands the emergency management powers of the governor and others. Some of the expanded powers may be exercised only when an emergency has been declared, and some powers may be exercised in emergency and nonemergency situations to help train or prepare for future emergencies.

**New powers to be exercised in emergencies and nonemergencies.** The governor may exercise the following new powers in emergencies and nonemergencies.

- *Facilities:* The governor may procure facilities in accordance with the state's emergency operations plan and emergency management program.
- *Arrangements and agreements with tribal authorities:* The governor may enter into mutual aid arrangements or cooperative agreements with tribal authorities. This is in addition to the governor's existing power to enter into mutual aid arrangements or cooperative agreements with other states and Canadian provinces.
- *Occupying public places and facilities, using transportation:* Prior law authorized the governor to direct or control the conduct of people in the state and the movement of people and traffic before, during, and after drills and emergencies. The new law specifies that these powers include the authority to control who may enter or leave a stricken or threatened public place, who may occupy a facility, and all forms of public and private transportation.
- *State agency activities:* The governor may transfer the personnel or duties of state agencies to perform or facilitate emergency response and recovery programs.

**New powers to be exercised only during emergencies.** The following new powers may be exercised when an emergency has been declared.

- *Governor's orders and rules:* Prior law gave orders and rules adopted by the governor during a national security emergency the full force and effect of law; those orders and rules also had to be approved by the executive council and filed with the secretary of

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<sup>3</sup> Facility means any real property or any motor vehicle or other means of transportation. It does not include a private residence, so the governor does not have authority to procure private homes.



state. The act expands this law, to give the full force and effect of law to orders and rules adopted by the governor during a peacetime emergency declared due to a public health emergency; these orders and rules must also be approved by the executive council and filed with the secretary of state.

- *Commandeering medical supplies and facilities:* The governor, state director of emergency management, or a member of a state or local emergency management organization designated by the governor may commandeer medical supplies<sup>4</sup> and facilities<sup>5</sup> for emergency management purposes, when necessary to save lives, property, or the environment. These powers may be exercised during a national security emergency declared for any reason, or during a peacetime emergency declared due to a public health emergency.

- *Requiring service and commandeering property:* Prior law authorized the governor, state director of emergency management, or a member of a state or local emergency management organization designated by the governor to require, during a national security emergency, any person to perform emergency management services, if the person is not a member of the military and is not an officer of the state or a political subdivision. Prior law also authorized the governor, state director, or designated member to commandeer motor vehicles, tools, appliances, and other personal property during a national security emergency. The act expands this law, to allow these powers to also be exercised during a peacetime emergency declared due to a public health emergency.

- *Disposition of bodies:* During an emergency declared due to a public health emergency, the governor may exercise certain powers to ensure the safe disposition of dead human bodies. This applies only to deaths related to the public health emergency. The governor may ensure the safe disposition of bodies; take control of a dead human body and order an autopsy; and ask that any business or facility authorized to dispose of dead human bodies be allowed to be used during an emergency, if the actions are reasonable, necessary, and safe. Requirements for the identification of bodies are also established. Minn. Stat. §§ 12.03, subs. 4d, 6a; 12.21, subd. 3; 12.32; 12.34, subd. 1; 12.381

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<sup>4</sup> Medical supplies means any medication, durable medical equipment, instruments, or other material that a health care provider deems not essential to the continued operation of the provider's practice or facility. It does not include medication, durable medical equipment, or other material that is an individual's personal property being used by that individual or that an individual has borrowed, leased, or rented for treatment or care; these types of supplies cannot be commandeered.

<sup>5</sup> See footnote 3 for a definition of facility.

## **The Act Confirms a Person's Right To Refuse Medical Examinations, Testing, and Treatment During an Emergency**

The act specifies that during any type of emergency, a person may refuse medical examinations, testing, and treatment. However, if a person refuses any of these services after being directed to submit to them by the commissioner of health, the commissioner may order the person to be isolated or quarantined, in certain circumstances. When possible before examining, testing, or treating a person for a condition related to an emergency, the health care provider must notify the person to be examined, tested, or treated of the right to refuse and the consequences of refusal. Minn. Stat. § 12.39

## **The Act Establishes Isolation and Quarantine Standards and Due Process Procedures**

The act contains two provisions that refine and clarify the authority of the commissioner of health to isolate and quarantine individuals. One new section defines isolation and quarantine terms and establishes basic standards that the commissioner, or any person acting under the commissioner's authority, must follow when isolating or quarantining. This section also specifies when a person's isolation or quarantine must end, confirms the ability of isolated and quarantined persons to refuse medical testing and treatment, and governs who may enter isolation and quarantine areas. Another new section establishes due process procedures for isolated and quarantined persons. It should be noted that isolation and quarantine apply to different groups of people. A person may be isolated if the person has been infected with a communicable or potentially communicable disease. A person may be quarantined if the person is otherwise healthy but has likely been exposed to a communicable or potentially communicable disease.

**Application.** The new isolation and quarantine provisions apply to people who have or may have certain communicable or potentially communicable diseases believed to be caused by bioterrorism or a new, novel, or previously controlled or eradicated agent or toxin. However, they do not apply to people with communicable diseases that are directly transmitted from person to person.<sup>6</sup>

**Isolation and quarantine standards.** When the commissioner or another person acting under the commissioner's authority isolates or quarantines a person or group, the commissioner or other person must comply with certain basic standards. These standards include using the least restrictive means to isolate or quarantine, keeping isolated people separate from quarantined people, regularly monitoring their health status, moving quarantined individuals into isolation if they become infectious, immediately releasing individuals if they will not transmit a communicable or potentially communicable disease to others, addressing the physical needs of isolated and quarantined individuals, and isolating and quarantining people in safe, hygienic places.

**Right to refuse examination, testing, and treatment.** Any isolated or quarantined person may refuse medical treatment, testing, and examination. If a person refuses to be examined, tested, or treated as ordered by the commissioner or another person, the person may be subject to continued isolation or quarantine.

**Entering an isolation or quarantine area.** Only persons authorized by the commissioner or a person acting under the commissioner's authority may enter an isolation or quarantine area. The commissioner must allow a family member of an isolated or quarantined person to enter, if the family member signs a consent form. A person entering an isolation or quarantine area may be isolated or quarantined, if by entering the area the person poses a public health danger.

**Procedures for isolating or quarantining a person.** There are two procedures under which a person may be initially isolated or quarantined: court order and temporary hold.

- *Court order:* The commissioner or a local public health board may obtain a court order to isolate or quarantine a person for up to 21 days. In seeking this type of order, the commissioner does not need to give notice of the application to the person to be isolated or quarantined.

- *Temporary hold:* The commissioner may isolate or quarantine a person for up to 48 hours using a temporary hold issued by the commissioner, without obtaining a court order. If the commissioner uses a temporary hold, the commissioner must apply for a court order within 24 hours, and the court must decide whether to grant or deny the court order within 24 hours. If the court order is granted, the person may be isolated or quarantined for up to 21 days. If the order is denied, the person must be released.

A person who is isolated or quarantined may request and obtain a court hearing in some specific situations.

- An isolated or quarantined person may, at any time while under isolation or quarantine, request a court hearing to challenge it. This hearing must take place within 72 hours of the request.

- The commissioner or a local public health board must ask for a court hearing if the commissioner or board wants to continue a person's isolation or quarantine beyond the initial 21-day period. After this hearing, the court may order a person's isolation or quarantine to continue for up to 30 days, or may order the person to be released. For each additional 30-day period for which the person will be held, another court hearing must be held, and another court order must be obtained. If the court denies a request for continued isolation or quarantine, the person must be released.

- An isolated or quarantined person may request a court hearing to ask for changes to his or her treatment while isolated or quarantined or changes to the circumstances of isolation or quarantine. This hearing must be held within seven days of its request. The court may order changes to a person's treatment or circumstances of isolation or

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<sup>6</sup>A disease is directly transmitted if it is sexually transmitted, bloodborne, or transmitted through direct or intimate skin contact.

quarantine if the court decides that the person's isolation or quarantine does not comply with the standards described above.

**Release from isolation or quarantine.** A person must be released from isolation or quarantine when the court order expires. In addition, the commissioner may release a person at any time if the commissioner determines isolation or quarantine is not needed to protect the public. Minn. Stat. §§ 144.419; 144.4195

### **The Act Requires a Study and Report to the Legislature**

At the end of the 2002 legislative session, many significant issues were not resolved. Legislators determined that a certain number of these issues needed to be examined further before taking action on them. Accordingly, the act directs the commissioner of health to study these issues and report on them to the legislature by January 15, 2003. Subjects that must be addressed include:

- Immunity for health care providers and others acting during a public health emergency;
- Emergency measures regarding dangerous facilities and materials, controlling medical facilities and supplies, and limiting public gatherings and transportation;
- Steps to detect and prevent the spread of disease;
- Due process protections to apply to isolated and quarantined people;
- Steps to ensure people comply with emergency measures, and with measures to detect and prevent the spread of disease;
- Ways to preserve the effectiveness of certain antibiotics to fight diseases; and
- The impact of the commissioner's recommendations on the constitutional and other rights of the public.

In developing recommendations on these issues, the commissioner is required to consult with several government agencies and private groups. Before submitting recommendations to the legislature, the commissioner must also publish the recommendations in the State Register and give the public at least 30 days to comment on them. The legislature may address these and other topics during the 2003 session. Laws 2002, ch. 402, § 20

*For more information about health issues, visit the health and human services area of our web site, [www.house.leg.state.mn.us/hrd/issinfo/hlt\\_hum.htm](http://www.house.leg.state.mn.us/hrd/issinfo/hlt_hum.htm).*

## *Appendix D*

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# **Terrorism and Health Task Force comments on draft report and recommendations**

The Commissioner's Task Force on Terrorism and Health reviewed the draft recommendations at the meeting on January 23, 2003. The group considered the proposed recommendations and made the following suggestions for change:

<u>Recommendation</u>	<u>Proposed change</u>
3	the study should also review information from the anthrax studies currently being conducted by CDC
4	ensure existing materials about use of dangerous chemicals and safety precautions are included
6	include local public health in the group of agencies to be involved
6	include concerns about manpower to carry out this recommendation
7	include concerns about caring for persons with disabilities
11	clarify language about individual rights
14	include the wording to address the need to rapidly access interpreters, including sign language interpreters and translators. Include language about procedural and substantive rights of persons subject to the orders.
18	remove the word "delegated"
20	consult with the Board of Animal Health before proposing this change to determine if it has any impact on their work
24	include tribal governments in the list of agencies to be involved
25 and 26	recommended including the wording proposed about education and monitoring antibiotic resistance related to human use
29	add disability organizations to the groups to be consulted

The Task Force briefly reviewed the written comments received by the deadline and recommended MDH staff meet with the staff of the Minnesota Civil Liberties Union to better understand and consider their comments. This information will be helpful in preparing for any proposed legislation in the future.

*Appendix E*

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**Homeland Security Advisory  
Council Membership**

## Homeland Security Advisory Council Members

<b>Agency/Organization:</b>	<b>Contact:</b>	<b>Phone:</b>
1. Dept. of Public Safety	Commissioner Charlie Weaver	651-296-6642
2. Dept. of Health	Commissioner Jan Malcolm	651-215-5806
3. Dept. of Transportation	Betsy Parker	651-296-3002
4. Dept. of Agriculture	Tom Masso	651-297-2414
5. Pollution Control Agency	Gordon Wegwart	651-296-7319
6. Dept. of Military Affairs	Gary Sigfrinius	651-282-4554
7. Dept. of Natural Resources	Kim Bonde	651-296-9556
8. Assoc. of MN Counties	Curt Yoakum	651-224-3344
9. Assoc. of MN Townships	David Fricke	763-497-2330
10. League of MN Cities	Roger Peterson	507-285-8260
11. PS Radio System Policy Group	on hold	
12. MN Sheriffs Assoc.	Larry Podany	651-451-7216
13. MN Chiefs of Police Assoc.	Dan Scott	612-861-9811
14. MN Police & Peace Ofcrs. Assoc.	Bill Gillespie	651-291-1119
15. MN Fire Chiefs Assoc.	Rocco Forte	612-673-2536
16. MN Professional Fire Fighter Assoc.	Mike Stockstead	763-545-8100
17. Assoc. of MN Emergency Managers	Jim Flanders	952-939-8334
18. MN Hospital & Healthcare Partnership	Laurel Anderson	651-641-1121
19. Local Public Health Assoc.	Jane Norbin	651-266-2410
20. MN Medical Assoc.	David Larson	612-910-4052
21. Federal Emergency Management Agency	David Dolinsky	312-408-5570
	Gary Stokes	312-408-5570
22. U.S. Attorney's Office	Mike Ward	612-664-5600
23. MN Ambulance Assoc.	Martin VanBuren	612-347-2172
24. MN Emergency Medical Services Regulatory Bd.	Mary Hedges	612-627-5424
25. MN Nurses Assoc.	Mary Jo George	651-646-4807
26. Indian Affairs Council	Sharon Romano	651-284-3567
27. Division of Emergency Management	Jerry Rosendahl	651-296-0450



*Appendix F*

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**Agenda and Summary  
Working Conference on Public  
Health Emergencies  
July 18, 2002**

**Pioneer Press article about the  
conference**

*Minnesota Department of Health*  
**Working Conference**  
**On**  
**Public Health Emergency Powers**

July 18, 2002  
8:45 a.m. to 4:15 p.m.  
*Earle Brown Conference Center*  
*St. Paul, Minnesota*

**AGENDA**

<b>Welcome and Overview</b>		<b>Room 135AC</b>	8:45 a.m.
Commissioner Jan Malcolm, Minnesota Department of Health Assistant Commissioner, Aggie Leitheiser Charlie Petersen, Management Analysis Division, Department of Administration Harry Hull, M.D., State Epidemiologist			
<b>BREAK</b>			9:30 a.m.
<b>Break-Out Group Discussions</b>			9:45 a.m.
Review of scenarios and key questions, discussion.			
<b>Group 1</b>	Control of medical Supplies, Personnel and Facilities	<b>Room 135B</b>	
<b>Group 2</b>	Limiting Public Gatherings and Transportation	<b>Room 32 (lower level)</b>	
<b>Group 3</b>	Requirements for Medical Examination, Testing, and Collection of Laboratory Specimens and Samples	<b>Room 155</b>	
<b>Group 4</b>	Requirements for Vaccination and Treatment, Including Informed Consent	<b>Room 156</b>	
<b>Group 5</b>	Requirements for Managing Communicable Disease-Related Isolation or Quarantine	<b>Room 135D</b>	
<b>LUNCH</b>			12:00 noon
<b>Break-Out Group Discussion, cont'd</b>			12:45 p.m.
<b>BREAK</b>			3:00 p.m.
<b>Plenary Session</b>		<b>Room 135AC</b>	3:15 p.m.
Reports form break-out groups, how information will be used, next steps Charlie Petersen, Commissioner Malcolm			
<b>Adjourn</b>			4:15 p.m.

*Please fill our your evaluation forms. Thank you!*

# Working Conference on Public Health Emergency Powers Overall Summary

JULY 18, 2002

## Values and Principles in considering Public Health Authority

*(NOTE: Lists are not in priority order)*

- Greatest good for greatest number - cost/benefit balance
- Treat people with fairness and equality
- Sharing open, honest, accurate and timely information
- Data privacy
- Fair compensation for work, services, and property with clear source of funds
- Shared responsibility, all levels – individual and group
- Individual choice, rights and responsibilities
- Build and preserve the public trust in decision-makers
- Decisions based on scientific and evidence based information
- Maintain global perspective
- Limits to authority with clear accountability (checks & balances)
- Measured action, least intrusive, prevent subsequent harm
- Public protection through limiting disease mortality and morbidity
- Special attention needed to protect vulnerable populations, including children
- Timeliness and effectiveness of actions
- Government responsibility to protect health and safety and “liberty and justice for all”
- Balance issues of health and safety with freedom of movement
- Caring and compassionate society
- Individual rights end when they harm the public - but must justify
- Maximum protection of those who will respond with options to decline.
- Acknowledge and appreciate cultural and religious difference
- Acknowledge differences rural versus urban – what some communities are capable of - one size doesn't fit all
- Don't adversely affect everyone for those who are “bad actors”
- Type and style of leadership (request vs. demands) and when to use
- Inter-governmental cooperation and clarity of role at different levels of government
- Develop advance framework of authorities/declarations and share with citizens
- Preserve ability for citizens to protect themselves

Most important public health authorities to respond to a public health emergency:

**Decision-making:**

- ❖ Maintain ability of Governor to declare public emergency and use general emergency powers
- ❖ Designate individuals and give necessary government authority to manage an event
- ❖ Set criteria with CDC or other group and implement and enforce criteria for response, including determining essential personnel
- ❖ Develop a process to determine overall issues or concerns for priority
- ❖ Overrule local authority decision if recommended by the State Epidemiologist.

**Enforcement:**

- ❖ Establish legal repercussions for hoarding, price gouging, not following materials guidelines or false reporting to obtain supplies or equipment
- ❖ Assure security of materials and people
- ❖ Assure enforcement is considered for each authority

**Gatherings and transportation:**

- ❖ Cancel large public gatherings and public events
- ❖ Establish locations for influx of people and “taking over” of existing locations
- ❖ Regulate transportation (includes ships and airports)
- ❖ Coordinate actions of local authorities and State authority to test or close restaurants and other private facilities.
- ❖ Work with other states and countries to close a private business or borders.

**Information**

- ❖ Provide for informed consent
- ❖ Assure data privacy
- ❖ Track vaccines and treatment, monitor antibiotic and drug supply
- ❖ Control media messages and establish rumor control procedures.
- ❖ Release information about where resources are and how they are being managed

**Investigate**

- ❖ Act on medical and scientific data quickly 24 hours a day/ 7 days a week
- ❖ Conduct disease investigation and decide who's exposed
- ❖ Require testing with need to consider accommodations for religious, health and cultural reasons
- ❖ Compel private companies to supply specimens/samples/isolates to evaluate accuracy of testing at labs or to conduct surveillance activities
- ❖ Gather relevant disease data, lab results, medical information from public and private providers with appropriate privacy protections
- ❖ Add diseases to reportable disease law with same effect as current law
- ❖ Shut down lab because of quality problems

**Isolation and/or quarantine**

- ❖ Allow or require unexposed individuals to leave current locations
- ❖ Delegate isolation and quarantine authority to locals as needed
- ❖ Hold on immediate basis for up to 72 hours
- ❖ Require law enforcement to protect rights and ensure compliance
- ❖ Establish due process for individual to challenge and require review of isolation or quarantine through administrative or court process
- ❖ Detain and quarantine suspected cases and release individuals if not at risk
- ❖ Isolate individuals until free of disease or no longer infectious
- ❖ Quarantine an entire city or geographic location

**Liability and reimbursement**

- ❖ Limit liability for personnel and hospitals responding to government requirements and directions.
- ❖ Provide just and fair compensation for commandeered materials, supplies, or services

**Resource reallocation**

- ❖ Reallocate qualified workers including doctors or military healthcare workers; reassign qualified state workers and volunteers; and distribute personal protective equipment to these workers
- ❖ Establish number of beds available in hospitals and move patients in and/or out of any hospital
- ❖ Develop a binding contractual agreement with hospitals and, if no contractual agreement can be reached, the authority to designate a facility (no consensus on last point)
- ❖ Use medical advisory input and national authority and advice to establish ethics protocol for distribution of staff, supplies, vaccine, equipment
- ❖ Let decisions be made at individual hospital levels as they are now, because any increase in government authority would result in too much expanded powers.

**Workforce**

- ❖ Require health care workers to work through use of disciplinary action (revoke or suspend licensure if they don't)
- ❖ Establish license reciprocity across states
- ❖ Require maximum protection and mandated information for health care workers and their families
- ❖ Rapidly consider health care worker credentials by Commissioner of Health [or hospital] and issue temporary license with details about allowable work

Posted on Fri, Jul.19,2002

## **Conferees plan for bioterror**

BY TOM MAJESKI

St. Paul Pioneer Press

A month ago, a New Yorker came down with a mysterious disease. Since then, 20,000 people have become ill and 5,000 have died. Now five cases have been confirmed in three Minnesota communities: St. Paul, Duluth and St. Peter. What do you do now?

It's a frightening but fictitious scenario. Throughout the day Thursday, 150 people—health care workers, lawyers and citizens—pondered the problems that could arise in a working conference on public health emergency powers organized by the Minnesota Health Department.

The goal: to prepare legislative proposals that give the department the ability to deal with bioterrorism.

Last legislative session the Health

Department presented a hurriedly prepared proposal, but lawmakers watered it down and instructed the department to study the issue further and report back, with recommendations, by Jan. 15.

"We need to figure out how to deal with massive casualties and the type of public panic we haven't seen in years," Health Commissioner Jan Malcolm told the group. "To what extent can a community expect public health to protect them from harm?"

A diverse group gathered at the Earle Brown Continuing Education Center at the University of Minnesota to consider several scenarios, providing perspectives from public health professionals, lawyers, health care workers, first responders, community groups, emergency managers, legislators, officials from other state agencies and members of the public.

During the conference, participants were divided into five working groups, each assigned a specific issue that likely would crop up during a real emergency:

- Control of medical supplies, personnel and facilities.
- Limiting public gatherings and transportation.
- Requirements for medical examination, testing and collection of laboratory specimens and samples.
- Requirements for vaccination and treatment, including informed consent.
- Requirements for managing communicable disease-related isolation or quarantine.

To heighten the challenge, each group was given three additional scenarios tailored to its particular topic and certain to raise some tough questions.

(St. Paul Pioneer Press  
Friday July 19, 2002 page 2)

Within minutes, participants were wrestling with a number of potentially deadly dilemmas, including a seaman in Duluth, Minn., who comes down with the illness after roaming the city for three days; a vaccine shortage when large groups of people are demanding to be immunized; and a hospital in St. Peter, Minn., that runs short of ventilators and can't get hospital officials in nearby Mankato, Minn., to give up theirs because they fear a flood of St. Peter refugees will arrive in their city looking for help.

As participants explored their options, it quickly became obvious that there was a shortage of easy answers but a surplus of concerns. Here's a small sample:

- With a shortage of staff and supplies, who decides who gets what?
- What are the incentives and penalties for staff working in a risky situation or choosing not to work?
- Who's in charge?
- How do you control hysteria?
- What about liability?
- Who has the authority to close a private business and quarantine a family?
- Who pays?
- If a school and day care are closed, where will the children go?
- How do you help people in need of support, such as the vulnerable and disabled?
- Can we keep sailors from other countries quarantined and can we require them to be tested?
- Who gets the vaccine first, doctors and nurses?
- How do you control the movement of people?

Health Department officials will analyze the information from the conference and then use it to develop the report and recommendations they must present to lawmakers early next year.

"We have to have a system that clearly lays out legal rights and limits," Malcolm told the participants.

Tom Majeski, who covers medical news, can be reached at [tmajeski@pioneerpress.com](mailto:tmajeski@pioneerpress.com) or (651) 228-5583.

*Appendix G*

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**Community Health Conference  
September 13, 2002  
Breakout Session**





***Community Health Services Conference***  
***September 13, 2002***  
***8:00 to 9:00 and 9:30 to 10:30***  
***Concurrent Session: Emergency Health Powers Act***

Summary of presentation and discussion:

The two sessions were attended by approximately 45 people for each section. Participants included county commissioners, local public health medical consultants, local advisory committee members, local emergency managers, local public health staff and state public health staff. Each session following the agenda with questions both during the presentations as well as during the question and discussion period.

Issues identified by the group included:

- Need to clarify role of local government in carrying out the powers and duties of the MEHPA. In particular, questions about the process for isolation and quarantine; how responsibilities are allocated; need for training and guidelines for carrying out the various aspects of the act.
- Importance of coordinating Minnesota's activities with bordering states and Canada to assure similar approaches are used in managing disease outbreaks and other forms of terrorism
- Guidance on whether and which local ordinances would be needed to assure adequate authority and clarity on who will be doing what. Need to coordinate with state level activities.
- Coordination of public health activities and authorities with currently existing emergency management duties and responsibilities. Clarity about how the new authorities in MEHPA will be integrated into ongoing activities.
- More information needed by local law enforcement and local county/city attorney's offices about the scope of the law and implementation procedures.
- Information is needed about national approaches to issues of powers and authorities but primarily Minnesota needs to work out internal procedures and protocols to make it effective for our systems.

## *Appendix H*

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### **Agenda and Summary Antibiotic Effectiveness meeting October 28, 2002**

**Minnesota Department of Health  
Preserving Antibiotic Effectiveness Meeting**

**October 28, 2002 1:00 to 4:00**

**Mississippi Room Snelling Office Park**

***Agenda:***

**1. *Welcome and Introductions***

***Minnesota Emergency Health Powers Act and Study Requirements***

*Aggie Leitheiser, Assistant Commissioner*

**2. *Current activities in antibiotic effectiveness and resistance***

**a. Minnesota Department of Health**

**i. Surveillance and laboratory testing**

*John Besser, Clinical Laboratory Manager*

*Kirk Smith, Foodborne, Vectorborne, Zoonotic Disease  
Unit Supervisor*

**ii. Minnesota Antibiotic Resistance Coalition**

*Ruth Lynfield, Medical Specialist*

**iii. Environmental Health Antibiotic Resistance Workgroup**

*Pam Shubat, Health Risk Assessment Unit*

**b. Minnesota Board of Animal Health**

*Keith Friendshuh, Veterinarian*

**c. Minnesota Department of Agriculture**

**i. Laboratory activities**

**ii. Coordinated activities with University of Minnesota**

*Perry Aasness, Assistant Commissioner*

**d. University of Minnesota**

*Jeff Bender, Veterinary Public Health*

**3. *National activities***

**a. United States Department of Agriculture**

**b. Food and Drug Administration**

**c. Council of State and Territorial Epidemiologists**

**d. Centers for Disease Control and Prevention**

**e. Pending Federal legislation**

**f. Association of Public Health Laboratories**

**g. Others**

**4. *Discussion of Recommendations for Minnesota***

**a. Education of providers and public**

**b. Monitoring of human and animal disease/contamination**

**c. Continued coordination of Minnesota efforts in research and surveillance**

**d. Using Minnesota information to guide public policy at the national level**

## Preserving Antibiotic Effectiveness Meeting Summary

The meeting was attended by approximately 70 persons representing the animal production industry, the antibiotic development industry, health care providers, the Minnesota Departments of Health and Agriculture, the Minnesota Board of Animal Health, and the University of Minnesota. The meeting started with background on the MEHPA and the purpose of the meeting to review issues and concerns about maintaining effectiveness of antibiotics important to protecting humans in the event of a terrorism attack.

Information was provided by the Minnesota Department of Health, the Minnesota Board of Animal Health, the Minnesota Department of Agriculture and the University of Minnesota on the variety and range of activities in monitoring and characterizing the issues of antibiotic effectiveness and antibiotic resistance. Some highlights of those presentations include:

- \* MDH antibiotic resistance program objectives include assessing the burden of illness in humans due to antibiotic resistant foodborne pathogens currently, and trends over time; to identify sources of antibiotic resistant foodborne pathogens for humans, and risk factors for acquisition and to generate sound scientific information on these issues.

- \* Minnesota belongs to the National Antimicrobial Resistance Monitoring System (NARMS) to monitor issues across the country. This system identified increasing antibiotic resistance of certain organisms to some antimicrobials. Minnesota is part of the multi-state Foodnet Case-Control Studies to identify risk factors especially for *Salmonella*, *Campylobacter*, *Enterococcus*, and *E. coli* through various methods, including retail meat surveys. MDH conducts some Minnesota specific studies of antimicrobial resistance in foodborne pathogens.

- \* Educational campaigns have been effective in reducing antibiotic prescriptions for outpatient respiratory infections (for example, Denver). Campaigns in Finland and Iceland to control antibiotic use were successful in dropping the proportion of antibiotic resistant group A *Streptococcus* and pneumococcus respectively.

- \* MDH shares information with national organizations, responds to national legislative proposals, and provides data to those who need to know, including health care providers, regulators, policy makers, and educators. Organizations such as the FDA have used Minnesota data to set positions.

- \* MDH produces a yearly state "antibiogram" to describe patterns of antimicrobial resistance and distributed to the health care system. This is a unique public health service as this pattern description is usually institutionally based.

- \* MDH is a leader in the Minnesota Antibiotic Resistance Collaborative which works with health care plans and other organizations to educate providers and the public about the dangers of overuse or misuse of antibiotics and encouraging use of alternatives – such as cough and cold kits for diseases where antibiotics are not effective.

\* The MDH Environmental Health Division hosted a series of discussion meetings earlier this summer to have in-depth discussions of the topic of antibiotic resistance, particularly in animal production. A copy of the result of those discussions that evaluates both the topic and the process by which the discussion occurred is available at:  
<http://www.health.state.mn.us/divs/eh/risk/antibiotic/index.htm>

\* The Minnesota Board of Animal Health is the animal disease control agency for the state of Minnesota. It has been actively reducing, controlling and eradicating specific livestock diseases for 100 years. Efforts are focused first on reducing disease through prevention by efforts such as controlling the importation of diseases and exposed animals into the state; promoting composting of animals that die on the farm; requiring garbage being fed to swine be cooked to 212 degrees Fahrenheit for 30 minutes to kill any bacteria or viruses. By reducing diseases, less antibiotics are needed for the treatment of animals and humans. The Board supports the judicious use of antibiotics in agriculture for animal health and well being, for food safety, and for public health.

\* The Minnesota Department of Agriculture, along with the University of Minnesota's Center for Animal Health and Food Safety, are meeting with representatives from each food producing industry to discuss current practices and issues around use of antibiotics in animals. A report on the results of those discussions will be available later in the year.

\* The University of Minnesota's Center for Animal Health and Food Safety is collaborating with both public health and agriculture to examine antimicrobial use and resistance issues. Two areas of emphasis include:

- > examining husbandry, hygiene, housing and nutrition strategies to improve animal health, reduce the occurrence of infections and disease and thereby reduce the use of therapeutic antimicrobials
- > investigating alternatives to the use of sub therapeutic levels of antimicrobials as growth promotants.

\* Information included information on the following groups and agencies:

- a. United States Department of Agriculture – Recent published articles on importance of judicious use of antibiotics
- b. Food and Drug Administration - In 1999, the FDA published the Framework for ensuring human safety of the use of antimicrobials in animals. In particular it prioritizes antimicrobials according to importance in human medicine. FDA will use information to establish required mitigation actions when resistance increases.
- c. Council of State and Territorial Epidemiologists – has a position similar to the World Health Organization about judicious use.
- d. Centers for Disease Control and Prevention – primarily focusing on judicious human use of antibiotics and monitoring human resistance.
- e. Pending Federal legislation – Kennedy (Senate) and Brown (House) have proposed legislation to stop all non-therapeutic antibiotic use in agriculture with a 2 year period to get there and 2) do away with fluoroquinolones in poultry. The fate of this legislation is uncertain.
- f. Association of Public Health Laboratories – monitor human disease to identify both sources of outbreaks as well as levels of antibiotic resistance

g. Other – industry efforts to reduce antibiotic use. An organization with almost 20 years of activity is the Alliance for Prudent Use of Antibiotics.

Group discussion highlighted the following issues:

- \* Need to make the distinction between residue and resistance (don't need residue to show resistance.) Other terms needing careful definitions include agriculture vs. human health, judicious use, contaminants, and clinical picture.

- \* How is judicious use determined – would giving all members of a herd with one or two members with disease antibiotics as a preventive measure be considered judicious. (Some participants felt it would be necessary and others that alternative methods would suffice.)

- \* There are lots of activities and issues happening in many agencies of the state. Not sure there will be opportunities to address concerns at the Minnesota legislature as they are often national in scope and this year will be a difficult year with budget issues.

- \* In 1988, FDA required all antimicrobials for agricultural use that are new, to be by prescription only. This means that some are available in a more accessible fashion. There was discussion that it is unknown how much is being used, in what circumstances, and by which providers. Some believe that it may be due to small producers because larger producers have more ability to focus on other prevention strategies and also have more stringent record-keeping requirements but there are not hard data.

- \* Education is an important tool for producers, health care providers, and the public.

- \* We don't know the contribution of community and institutional use for humans and we don't know if for animals. We should recommend that everyone stop using so many antibiotics (and maybe antimicrobial soap as well). We should focus on where we can start reducing use rather than figuring out what's the biggest contributor.

- \* Food irradiation can be an important means to reduce disease – and therefore the need for antimicrobials. Another important intervention is vaccination to reduce disease and therefore the need for antibiotics.

- \* There was a question about whether there was resistance in anthrax and interactions with other existing disease.

- \* Some participants stated that the issue of antibiotic use requires careful definition, for example, by including ionophores as an antibiotic changes estimates of the amount of antibiotic used in animals dramatically. The FDA does not include them as antibiotics so considers agricultural antibiotic use to be approximately 17%. The USDA does include them so considers subtherapeutic agricultural antibiotic use to be approximately 80%.

- \* Veterinarians have the flexibility to use antibiotics for off-label uses particularly in companion animals. Uncertain about how frequent or widespread this issue is in food animals. There can be provisions for using antibiotics under auspices of veterinarians but there appears to be no repercussions if used incorrectly.

\* Monitoring antibiotic resistance in animals can be an important source of information – Resistance among *Salmonella* Typhimurium DT104 isolates is found even from animals in which antimicrobials are not being used.

\* There was general agreement that the recommendations from the agenda were important to pursue (education, monitoring of human and animal disease, continued coordination of Minnesota efforts in research and surveillance and using Minnesota information to guide public policy at the national level). There are significant information gaps but some members felt there was enough information to act to reduce use wherever possible.

*Participants were offered the opportunity to submit comments following the meeting. The following is a summary of the comments received from 3 individuals:*

\* There are three routes of administration (feed, water, and injection). Feed administration is tightly regulated; water and injection are essentially uncontrolled – for example, only Baytril requires a prescription in poultry.

\* Most efforts in human and animal medicine are directed at use of antibiotics leaving the transmission out of the equation altogether. More attention is needed on transmission of resistant bacteria from host to host.

\* States could support national legislation that holds imported food to the same standard of antibiotic use as homegrown food. We import food from countries where antibiotic use is practically unregulated.

\* Good risk assessment in the decision making process is needed when removing a product as the removal may cause a higher risk than the original risk from use of the antibiotic.

\* Veterinarians are aware of the need to limit the use of Baytril to prevent development of resistance, and alternatives are considered and used as a result.

\* Physicians should be basing their recommendations for patients on culture and sensitivity results to support their prescriptions. More attention to this issue can be an important contributor to preventing antibiotic resistance.

\* Information may not be readily available from producers because they are considered proprietary, not because they are trying to hide anything from the public.

\* If animal health is optimized by the use of antibiotics, healthier animals are presented for slaughter and fewer pathogens would be present to contaminate the final product. The European experience with the removal of antibiotic growth promotants (AGP), showed that more therapeutic antibiotics, those with direct human application – might be used, increasing the opportunity for resistance to develop to medically important human antibiotics.

\* Controlling over the counter sales of antibiotics for animals that would require a prescription if needed for humans can be an important means of reducing misuse.



*Appendix I*

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**Agenda and Summary  
Immunity, Liability and  
Compensation meeting  
October 31, 2002**

**Minnesota Department of Health  
Emergency Health Powers Act Study  
Issues of Liability, Immunity, and Insurance  
In Smallpox Planning, in Volunteer Proposals, and in a  
Catastrophic Public Health Emergency**

**October 31, 2002 8:30 a.m. to Noon  
Mississippi Room Snelling Office Park**

*Revised Agenda:*

1. *Welcome and Introductions*
2. *Requirements to Assess Legal Authorities from the Minnesota Emergency Health Powers Act and the CDC Cooperative Agreement for Public Health Preparedness.*
3. *Smallpox Planning by the Federal Department of Health and Human Services, the CDC, and its Advisory Committee on Immunization Practices, and Minnesota's Participation and Concerns*
4. *Envisioning Emergency; When a Catastrophic Attack or Outbreak Necessitates Rationing or a Lower Standard of Health Care*
5. *Smallpox Preparedness Liability: Federal Agency Silence, Congressional Trial Balloons, and Insuring Unusual Risks through the Minnesota Joint Underwriting Association*
6. *Federal "Citizen Corps" and "Medical Reserve Corps" Volunteer Initiatives and Implementation by the Minnesota Division of Emergency Management and its Local Partners.*
7. *Overview for Non-Lawyers of "Good Samaritan," volunteer protection and Other Laws Relating to Liability for Health Care Providers and Other Responders in an Emergency*
8. *Discussion of Possible Changes in Minnesota Law and Other Recommendations*

*Please send written comments to Steve Shakman at [steve.shakman@state.mn.us](mailto:steve.shakman@state.mn.us) or at Minnesota Department of Health, PO Box 65882, St. Paul, MN 55164-0882*

**Summary of Discussion**  
**Immunity, Liability and Compensation meeting**  
**October 31, 2002**

**Summary of Discussion**  
**Immunity, Liability and Compensation Meeting**  
**October 31, 2002**

Attendance: On October 31, 2002, representatives of the Minnesota Department of Health (MDH), the Joint Underwriters Association, the Division of Emergency Management, and the Attorney General's Office met with over 70 people representing state and local public health, health care providers and health care systems, private practice attorneys, and emergency responders to discuss current laws and protocols related to liability coverage, immunity, indemnification, and compensation issues in the event of a public health emergency.

Meeting Background: There were three main reasons for this meeting. In addition to the legislative mandate to look at immunity and liability issues via the Emergency Health Powers Act, the concerns of emergency room health care providers and federal initiatives for bioterrorism preparedness have focused MDH attention on these issues. Emergency room health care providers have expressed significant concern regarding standards of care and liability during a catastrophe when there are too many patients, not enough drugs, and not enough equipment. (Federal government grants for bioterrorism preparedness and the recent federal initiative for pre-event smallpox vaccinations of public health and initial response teams have raised additional liability, insurance, and compensation questions.)

The meeting started with background on the Minnesota Emergency Health Powers Act (MEHPA), MEHPA study requirements, and questions arising from initial preparedness efforts. MDH has learned from a survey of physicians across the state that providers are interested in helping with smallpox vaccination but have concerns about liability, immunity, and compensation. There is also concern regarding regular patient care and loss of compensation for providers whose time is taken away from their normal work for smallpox-related activities. The group had several questions about the scope of the proposed vaccination plan, liability issues, and safety risk of vaccination and possible exposure. This vaccine stands out from other vaccines as having a risk for adverse effects, especially in people that are immune suppressed. People who have certain skin conditions are also contra-indicated from receiving the vaccine, making a thorough screening program critically important.

Smallpox Background: The last naturally occurring case of smallpox occurred in Somalia in 1977, and the disease was certified as eradicated by the WHO in 1979. The medical community has felt comfortable that this disease was under control until the last two years. The federal Department of Health and Human Services began efforts to expand the supply of the smallpox vaccine even prior to September 11. Recently, the federal Advisory Committee on Immunization Practices (ACIP) recommended the use of the smallpox vaccine for expanded health care response teams and public health workers. Since the

vaccine uses live vaccinia virus, it can be spread from person to person unless precautions are taken.

The group was also given information about plans for response in case of a diagnosed case of smallpox in the world or in Minnesota, including issues about vaccinating a large number of the public. Recent discussions from the federal government have surrounded a phased approach to pre-event vaccination. Phase 1 would be a limited vaccination of public health response staff and staff at acute care hospitals with the available licensed vaccine. Phase 2, which would be a much larger pre-event vaccination, would then move on to all medical personnel and first responders and would again use licensed vaccine. None of the phases have been finalized and the discussions about vaccinating the general public are ongoing. For now, MDH is working on Phase 1 vaccination planning in all regions of the state.

Identified concerns:

- \* Who covers the risk of spreading the vaccine from a vaccinated person to a family member or another who has an adverse reaction?
- \* What liability does a person administering the vaccine have?
- \* What is the state's liability? Is there a way to protect the person administering the vaccine under the state's umbrella in terms of liability?
- \* If a hospital volunteers to do some vaccination of its own staff, what are the liabilities of the vaccinator?

Insurance Coverage: Representatives of the Joint Underwriting Association (JUA), an insurer of last resort created by state law, described its services and approaches to liability questions. The JUA is hoping that the federal government will approach this as a national issue and enact legislation. Otherwise, liability issues are going to be determined by individual circumstances. The JUA highlighted issues likely to arise.

It assumes health care professionals have some liability insurance coverage. Although each policy is different, a doctor's administration of the vaccine would typically be covered provided there are no express exclusions. A question was raised about authority of the Department of Commerce to order professional liability carriers not to exclude bioterrorism-related activities from future policies. For now, such coverage may be obtained through the private sector.

Minnesota malpractice premiums are one of the lowest in the country. A physician may say his or her premiums may go up if a problem is found, but expect judges and juries to apply a standard of care that is "reasonable under the circumstances".

Several additional concerns were identified in discussion:

- \* Who pays for the time off of the health care worker who gets immunized?
- \* What is the liability coverage of the volunteer?
- \* What is the possible liability from doing nothing?
- \* For private sector employees, it's likely the current policy provides coverage as it would for any other health care service. If there is not coverage available in the marketplace, the Joint Underwriters Association may be able to provide coverage.

- \* General liability policies have war risk exclusion, which could be applicable if a smallpox outbreak is determined to be an act of war.
- \* Malpractice policies usually don't have war risk exclusion.
- \* Can the state regulators prevent property insurance carriers from excluding coverage for terrorism?
- \* A local unit of government may be self insured, which can be an advantage as it spreads the risk across the entire population. There can be concerns when it is required to provide services to all, but can only spread risk to a certain segment of the population (for example, Hennepin County and federal EMTALA requirements).

Volunteer Issues: A discussion of volunteers started with an overview of volunteer programs sponsored by the federal government and being developed by the Department of Public Safety. Citizen/Medical Reserve Corps are particularly applicable to this discussion. If a person volunteers for working in the community, do they become unpaid employees of government and are there protocols in place to deal with the liability issues?

Minnesota Law on Liability and Indemnification: As explained by the Attorney General's Office, prior to 1975 Minnesota government had sovereign immunity. In 1975, the Minnesota Supreme Court eliminated sovereign immunity for state government. Sovereign Immunity was replaced with the Minnesota Tort Claims Act and similar statutes for local governments. Under the Tort Claims Act, the government is liable just as a private party would be with certain exceptions. There are so many exceptions that it cannot truly be said that the public and private sectors are in the same posture in terms of personal liability. In most cases, the State provides Attorney General defense for employees and will also indemnify (pay the judgment) if the employee is acting within the scope of their employment and are not engaged in egregious behavior. If the goal is to bring the state umbrella of liability protection over the people mobilized to deal with bioterrorism, it will be important to carefully define their official duties even if they are volunteers, or are being redirected from another state mission. In this way, the lawyers trying to defend them will be better able to demonstrate that they were acting within the scope of their official duties.

The Attorney General's Office addressed certain exceptions to liability applicable to government entities. For example, discretionary immunity applies to decisions grounded in policy making (planning). If the State were to be second-guessed about policy-making decisions, it would not act. This doctrine provides protection for those decisions. It's not clear how this doctrine will apply to bioterrorism.

One possible direction raised was the application of Minnesota Statutes §12.35 to provide governmental defense and indemnity for Hazmat Teams.

The group considered a variety of issues about immunity, liability, and compensation in the event of a public health emergency and determined the issues are complex and compelling and deserve further attention. Actions by the federal government and whether it will pass the proposed Homeland Security legislation may make some of these issues moot. How other states are approaching these issues may also be very important to Minnesota's ability to act effectively in this area.

## *Appendix J*

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### **Legal Glossary of Terms**

## LEGAL GLOSSARY OF TERMS

**Absolute immunity:** Absolute immunity has been applied to judges, prosecutors, public defenders, guardians ad litem, court appointed therapists, and probation officers. Absolute immunity protects a person from personal tort liability in all instances, including malicious and willful actions, as long as the official's actions that gave rise to the claim are cloaked within his/her prosecutorial or judicial duties. Judicial officers, including prosecutors, are absolutely immune for quasi-judicial or prosecutorial actions only.

**Actionable:** Furnishing the legal ground for a lawsuit or other legal action

**Discretionary immunity:** Discretionary (statutory) immunity applies to decisions grounded in policy making and protects the government (as an entity) as well as governmental decision-makers. It includes planning level decisions, which involve questions of public policy (e.g., the evaluation of factors such as the financial, political, economic, and social effects of a given plan or policy). For example, the decisions to parole inmates and to release mental patients are generally protected by discretionary immunity.

**Duty:** Any action, performance, task, or observance required by a person in an official or fiduciary capacity. A legal relationship arising from a standard of care, the violation of which subjects the actor to liability.

**Duty to defend:** The duty to defend obligates the insurer to take over the defense of any lawsuit brought by a third party against the insured on a claim that falls within the policy's coverage.

**Good Samaritan doctrine:** The principle from the English common law that a person who aids another in imminent danger will not be charged with contributory negligence unless the rescuer worsens the position of the person in distress. Minnesota has a Good Samaritan law, Minn. Stat. 604A.01 that supercedes the English common law doctrine and requires a person to come to the aid of another who is exposed to grave physical harm, if there is no danger of risk of injury to the rescuer. Under Minnesota law, the person is free of liability unless the person acts in a willful and wanton or reckless manner.

**Gross negligence:** A conscious, voluntary act or omission in reckless disregard of a legal duty and of the consequences to another party.

**Hold harmless:** To absolve another party from any responsibility for damage or other liability arising from the transaction.

**Indemnity:** The right of an injured party to claim reimbursement for its loss, damage or liability from a person who has such a duty. To indemnify means to reimburse a loss that someone has suffered because of another's act or default.

**Intentional:** An intentional act or conduct demonstrates a willingness to bring about something that one plans or foresees.

**Liability:** Liability is the quality or state of being legally obligated or responsible.

**Negligence:** The failure to exercise the standard of care that a reasonably prudent person would have exercised in the same situation.

**Official immunity:** Under official immunity, a public official charged by law with duties that call for the exercise of judgment or discretion is not personally liable for damages unless guilty of a willful or malicious wrong. Official immunity is intended to protect public officials from the fear or personal liability that might deter independent action. Official immunity does not shield a governmental employee from liability for performing ministerial duties, that is those that are certain and imperative. For example, much police conduct is protected by official immunity except for excessive force cases where the officer is arguably committing a malicious wrong.

**Reckless:** Conduct whereby the actor does not desire the consequence but nonetheless foresees the possibility and consciously takes the risk. It also describes the state of mind in which a person does not care about the consequences of his or her actions.

**Respondeat Superior:** ("let the master respond") This common law doctrine holds an employer or principal liable for an employee's or agent's actions committed during the scope of employment.

**Sovereign immunity:** A government's immunity from being sued in its own courts without its consent. This includes the State's immunity from being sued in federal court by the State's own citizens.

**Standard(s) of care:** Standard(s) of care refer to the law of negligence. It is the degree of care that a reasonable person should exercise under the circumstances of the case.

**Vicarious liability:** Liability that a supervisory party (e.g., an employer) bears for the actionable conduct of a subordinate or associate (e.g., an employee) because of the relationship between the two.

**Wanton:** Wanton behavior indicates that the actor is aware of the risks but is indifferent to the results.

**Willful:** Behavior that is voluntary and intentional, but not necessarily malicious.

**Worker's Compensation:** A system of providing benefits to an employee for injuries occurring in the scope of employment. Worker's compensation requires the employer to provide benefits to the employee, but, at the same time, replaces the employee's right to sue the employer.



*Appendix K*

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**United States Constitution  
Amendments I through X (Bill of  
Rights) and Minnesota Article I Bill  
of Rights**

## **United States Constitution Amendments I through X (Bill of Rights)**

### **Amendment I**

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

### **Amendment II**

A well regulated militia, being necessary to the security of a free state, the right of the people to keep and bear arms, shall not be infringed.

### **Amendment III**

No soldier shall, in time of peace be quartered in any house, without the consent of the owner, nor in time of war, but in a manner to be prescribed by law.

### **Amendment IV**

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

### **Amendment V**

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

### **Amendment VI**

In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial, by an impartial jury of the state and district wherein the crime shall have been committed, which district shall have been previously ascertained by law, and to be informed of the nature and cause of the accusation; to be confronted with the witnesses against him; to have compulsory process for obtaining witnesses in his favor, and to have the assistance of counsel for his defense.

### **Amendment VII**

In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise reexamined in any court of the United States, than according to the rules of the common law.

### **Amendment VIII**

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

### **Amendment IX**

The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

### **Amendment X**

The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.

# Minnesota Article I Bill of Rights

## ARTICLE I BILL OF RIGHTS

Section 1. **OBJECT OF GOVERNMENT.** Government is instituted for the security, benefit and protection of the people, in whom all political power is inherent, together with the right to alter, modify or reform government whenever required by the public good.

Sec. 2. **RIGHTS AND PRIVILEGES.** No member of this state shall be disfranchised or deprived of any of the rights or privileges secured to any citizen thereof, unless by the law of the land or the judgment of his peers. There shall be neither slavery nor involuntary servitude in the state otherwise than as punishment for a crime of which the party has been convicted.

Sec. 3. **LIBERTY OF THE PRESS.** The liberty of the press shall forever remain inviolate, and all persons may freely speak, write and publish their sentiments on all subjects, being responsible for the abuse of such right.

Sec. 4. **TRIAL BY JURY.** The right of trial by jury shall remain inviolate, and shall extend to all cases at law without regard to the amount in controversy. A jury trial may be waived by the parties in all cases in the manner prescribed by law. The legislature may provide that the agreement of five-sixths of a jury in a civil action or proceeding, after not less than six hours' deliberation, is a sufficient verdict. The legislature may provide for the number of jurors in a civil action or proceeding, provided that a jury have at least six members. [Amended, November 8, 1988]

Sec. 5. **NO EXCESSIVE BAIL OR UNUSUAL PUNISHMENTS.** Excessive bail shall not be required, nor excessive fines imposed, nor cruel or unusual punishments inflicted.

Sec. 6. **RIGHTS OF ACCUSED IN CRIMINAL PROSECUTIONS.** In all criminal prosecutions the accused shall enjoy the right to a speedy and public trial by an impartial jury of the county or district wherein the crime shall have been committed, which county or district shall have been previously ascertained by law. In all prosecutions of crimes defined by law as felonies, the accused has the right to a jury of 12 members. In all other criminal prosecutions, the legislature may provide for the number of jurors, provided that a jury have at least six members. The accused shall enjoy the right to be informed of the nature and cause of the accusation, to be confronted with the witnesses against him, to have compulsory process for obtaining witnesses in his favor and to have the assistance of counsel in his defense. [Amended, November 8, 1988]

Sec. 7. **DUE PROCESS; PROSECUTIONS; DOUBLE JEOPARDY; SELF-INCRIMINATION; BAIL; HABEAS CORPUS.** No person shall be held to answer for a criminal offense without due process of law, and no person shall be put twice in jeopardy of punishment for the same offense, nor be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty or property without due process of law. All

persons before conviction shall be bailable by sufficient sureties, except for capital offenses when the proof is evident or the presumption great. The privilege of the writ of habeas corpus shall not be suspended unless the public safety requires it in case of rebellion or invasion.

**Sec. 8. REDRESS OF INJURIES OR WRONGS.** Every person is entitled to a certain remedy in the laws for all injuries or wrongs which he may receive to his person, property or character, and to obtain justice freely and without purchase, completely and without denial, promptly and without delay, conformable to the laws.

**Sec. 9. TREASON DEFINED.** Treason against the state consists only in levying war against the state, or in adhering to its enemies, giving them aid and comfort. No person shall be convicted of treason unless on the testimony of two witnesses to the same overt act or on confession in open court.

**Sec. 10. UNREASONABLE SEARCHES AND SEIZURES PROHIBITED.** The right of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures shall not be violated; and no warrant shall issue but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched and the person or things to be seized.

**Sec. 11. ATTAINDERS, EX POST FACTO LAWS AND LAWS IMPAIRING CONTRACTS PROHIBITED.** No bill of attainder, ex post facto law, or any law impairing the obligation of contracts shall be passed, and no conviction shall work corruption of blood or forfeiture of estate.

**Sec. 12. IMPRISONMENT FOR DEBT; PROPERTY EXEMPTION.** No person shall be imprisoned for debt in this state, but this shall not prevent the legislature from providing for imprisonment, or holding to bail, persons charged with fraud in contracting said debt. A reasonable amount of property shall be exempt from seizure or sale for the payment of any debt or liability. The amount of such exemption shall be determined by law. Provided, however, that all property so exempted shall be liable to seizure and sale for any debts incurred to any person for work done or materials furnished in the construction, repair or improvement of the same, and provided further, that such liability to seizure and sale shall also extend to all real property for any debt to any laborer or servant for labor or service performed.

**Sec. 13. PRIVATE PROPERTY FOR PUBLIC USE.** Private property shall not be taken, destroyed or damaged for public use without just compensation therefor, first paid or secured.

**Sec. 14. MILITARY POWER SUBORDINATE.** The military shall be subordinate to the civil power and no standing army shall be maintained in this state in times of peace.

**Sec. 15. LANDS ALLODIAL; VOID AGRICULTURAL LEASES.** All lands within the state are allodial and feudal tenures of every description with all their incidents are prohibited. Leases and grants of agricultural lands for a longer period than 21 years reserving rent or service of any kind shall be void.

**Sec. 16. FREEDOM OF CONSCIENCE; NO PREFERENCE TO BE GIVEN TO ANY RELIGIOUS ESTABLISHMENT OR MODE OF WORSHIP.** The enumeration of rights in this constitution shall not deny or impair others retained by and inherent in the people. The right of every man to worship God according to the dictates of his own conscience shall never be infringed; nor shall any man be compelled to attend, erect or support any place of worship, or to maintain any religious or ecclesiastical ministry, against his consent; nor shall any control of or interference with the rights of conscience be permitted, or any preference be given by law to any religious establishment or mode of worship; but the liberty of conscience hereby secured shall not be so construed as to excuse acts of licentiousness or justify practices inconsistent with the peace or safety of the state, nor shall any money be drawn from the treasury for the benefit of any religious societies or religious or theological seminaries.

**Sec. 17. RELIGIOUS TESTS AND PROPERTY QUALIFICATIONS PROHIBITED.** No religious test or amount of property shall be required as a qualification for any office of public trust in the state. No religious test or amount of property shall be required as a qualification of any voter at any election in this state; nor shall any person be rendered incompetent to give evidence in any court of law or equity in consequence of his opinion upon the subject of religion.

*Appendix L*

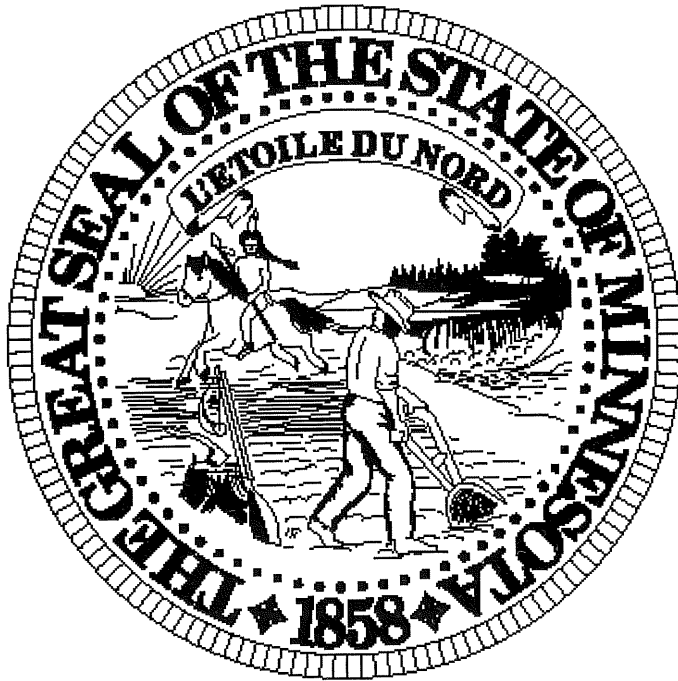
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**State Register Notice of  
December 16, 2002**

State of Minnesota

# State Register

Rules and Official Notices Edition



Published every Monday (Tuesday when Monday is a holiday) by the  
Department of Administration – Communications Media Division

Monday 16 December 2002  
Volume 27, Number 25  
Pages 855-940



## Minnesota Department of Health Notice of Request for Comments on Minnesota Emergency Health Powers Act Recommendations

The Minnesota Department of Health is soliciting comments from interested individuals, associations, or groups on proposed recommendations in response to *Minnesota Statutes 2002*, Chapter 402, Section 20. The following are the proposed recommendations.

**In order for comments to be included in the final report, the Agency Contact Person must receive them by 4:30 p.m. on January 17, 2003.** The entire draft report can be accessed by contacting the Agency Contact Person or through the MDH web page at: [www.health.state.mn.us/oep/legislative.htm](http://www.health.state.mn.us/oep/legislative.htm)

**Agency Contact Person.** Written or oral comments, questions, and requests for more information on these proposed recommendations should be directed to:

Yvette Young

Minnesota Department of Health

85 E. 7th Place, Suite 400

P.O. Box 64882

St. Paul, Minnesota 55164-0882

**Phone:** (651) 215-5805

**Fax:** (651) 215-5801

**Email:** [Yvette.Young@health.state.mn.us](mailto:Yvette.Young@health.state.mn.us)

**MDH Web Site:** [www.health.state.mn.us](http://www.health.state.mn.us)

**TTY users** may call the Department of Health at (651) 215-8980

**Alternative Format:** Upon request, this Request for Comments can be made available in an alternative format, such as large print, or cassette tape. To make such a request, please contact the agency contact person at the address or telephone number listed above.

### Minnesota Emergency Health Powers Act Study Recommendations

#### *Liability, immunity and compensation concerns*

1. MDH needs to continue strategic discussions involving providers, health plans, hospitals, other private employers of health care providers, and their insurance carriers. Input is needed from the Commerce Department, the Joint Underwriting Association established by the legislature to deal with unusual risks, and the state, county, and city attorneys who have had the duty of protecting the public against tort claim actions. The trial lawyers who regularly represent personal injury plaintiffs should also participate in these discussions to identify gaps, possible solutions, and need for legislative or other action.
2. MDH should monitor ongoing federal legislative activity and interpretations of the Homeland Security Act for application to Minnesota's workers and volunteers, particularly the liability concerns of the volunteers and sponsoring government or nonprofit agencies.
3. MDH should request funding for a study on potential unmet needs in paying costs for acute care in a public health emergency.

Such a study should also examine:

- a. Compensation for victims of a public health emergency, especially those who have suffered additional injury or disability because of medical care that was lacking or deficient.
- b. The implications of federal administrative compensation in lieu of tort litigation such as the September 11 Fund established for victims of the World Trade Center attacks and [Janna12@@](mailto:Janna12@@)

### Official Notices

PAGE 915 (CITE 27 SR 915) *State Register*, Monday 16 December 2002

- c. The National Vaccine Adverse Effects Compensation Program established to compensate persons suffering adverse effects from routine childhood vaccinations.
- d. The application of the Minnesota administrative compensation concept in the Harmful Substance Compensation Account under *Minnesota Statutes* §§ 115B.25 - 115B.37.

***Dangerous facilities and materials***

4. The Minnesota Departments of Pollution Control, Public Safety and Health should jointly prepare background information, plans, protocols, training and exercises for state and local agencies that consider the possible range of terrorism agents in radiological, chemical, and biological areas. These background materials should address response, recovery, clean-up and debris disposal procedures for these hazards. These agencies should also review and modify hazardous material protocols to assure worker safety in all aspects of emergency response and recovery.

5. These same state agencies should do table top and field exercises to test their plans and identify additional protocols and training needs.

***Control of medical supplies and facilities***

6. The Minnesota Departments of Health, Public Safety, and the National Guard should update and clarify procedures for managing medical supplies from the National Pharmaceutical Stockpile as well as the need for and management of other medical supplies.

7. The Hospital Preparedness Grant program should identify health care system concerns and recommendations about access to supplies, issues about use of medical facilities, and views about alternative locations for patient care.

8. The MDH and local public health agencies should work with hospitals to use tabletop and field exercises to identify issues related to commandeering and compensating medical facilities caring for victims of a public health emergency.

***Limiting public gatherings and transportation***

9. The Minnesota Departments of Health and Public Safety should jointly develop protocols and public information materials for limiting gatherings or transportation using the least restrictive means necessary.

10. MDH and local public health agencies should use tabletop and field exercises to evaluate the effectiveness of these protocols and to identify methods to minimize any impact of such limitations on individual or group rights while considering health and safety issues.

***Medical examinations, testing, collecting laboratory specimens and samples***

11. MDH and local public health should use tabletop and field exercises to identify problems and solutions related to testing, to collecting and handling laboratory specimen, and to health status examinations. They should also address methods to reduce the impact on individual liberties while considering health and safety issues.

12. MDH should gather information from surrounding states and bordering Canadian provinces to coordinate approaches to these issues and to determine what resources are available just beyond our borders to help resolve these issues.

***Isolation and quarantine and due process protections***

13. MDH and local public health agencies should include approaches to isolation and quarantine in state and local public health, hospital and first responder exercises to identify and clarify roles and procedures in the event isolation and quarantine is indicated.

14. MDH, Public Safety and the Attorney General's office should develop step-by-step procedural protocols for how the isolation and quarantine orders will be carried out with clarity about who's responsible for each of the steps, including enforcement.

15. MDH and the Attorney General's office should develop training and delegation agreements with interested local public health agencies and county attorneys for managing the court order process for isolation and quarantine to be consistent with state procedures.

16. MDH should gather information from other states and Canadian provinces about their planning, rules, statutes, and protocols in this area. In particular how the states and provinces immediately adjoining Minnesota address these issues should be understood and ideally should be similar as differences in approaches will lead to confusion and reduce the public health benefit of particular recommendations or actions for isolation or quarantine.

17. MDH should gather information on the enhanced internal quarantine powers granted the federal government in the Public Health Security and Bioterrorism Preparedness Act of 2002, and coordinate Minnesota's efforts with federal planning.

## Official Notices

### *Vaccination and treatment*

18. MDH and delegated local public health agencies should:
  - a. Identify problems and solutions for individuals who choose to decline vaccinations or treatment that may limit their capability to transmit a communicable disease, and
  - b. Evaluate the protocols for isolation and quarantine with the accompanying due process protections to determine methods to ensure health and safety while minimizing the impact on individual rights.
19. MDH should explore data management systems for tracking vaccinations and treatments that can support critical public health functions by sharing information in a secure, accurate manner.

### *Definition of communicable disease*

20. MDH should propose changing the term "communicable disease" in *Minnesota Statutes* 144.419, subd. 1 (2) to "airborne transmissible disease".

### *Enforcement methods for assuring compliance with emergency measures and measures to detect and prevent the spread of disease*

21. MDH should work with sponsors of local, regional and statewide exercises to include situations that explore enforcement challenges and report problems, suggested solutions and alternatives to the state. MDH should also confer with bordering states and provinces on lessons learned from their planning efforts.
22. MDH should review its communicable disease rules to assure they are up-to-date on risks from bioterrorism.
23. MDH should review current Division of Emergency Management current procedures and protocols for enforcing emergency provisions to identify problems and solutions that could be used in a public health emergency.
24. MDH should work with the Department of Public Safety and representatives of peace officers to develop training materials and work with local public health and others to provide training to peace officers about enforcement issues for a public health emergency.

### *Preserving effectiveness of fluoroquinolones and other antibiotics*

25. MDH should continue collaborative efforts with other state agencies, provider groups, and coalitions to coordinate Minnesota efforts in research and surveillance of antibiotic resistance and to educate providers, and the public about the issue of antibiotic resistance and appropriate uses of antibiotics. MDH should provide information to groups such as the Veterinary School, Board of Animal Health and professional veterinary associations about the human health consequences of antibiotic-resistant foodborne pathogens for their use in educating food producers.
26. MDH should continue to conduct monitoring of human disease and antibiotic resistance and make information available to provider groups, policy makers and the public. MDH should collaborate with animal health groups such as the veterinary school to evaluate potential animal sources of antibiotic resistant bacteria for humans.
27. MDH and others working on antibiotic resistance issues should continue to provide Minnesota specific information to national policy makers and agencies.

### *Impact of recommendations on constitutional and other rights of citizens*

28. MDH should work with the Commissioner's Task Force on Terrorism and Health to review reports from state, regional and local tabletop and field exercises to explore issues of constitutional and other rights that may arise in a public health emergency.
29. MDH should meet with representatives of various civil rights and other citizen groups, special populations, and interested individuals throughout 2003 to continue to identify concerns about constitutional and other rights during a public health emergency and proposed methods to address them.
30. MDH should monitor, and comment when appropriate, on federal DHHS quarantine regulation proposals under the expanded powers granted in the Public Health Security and Bioterrorism Preparedness Act of 2002.

## *Appendix M*

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### **Public comments received during notice period**

Ms. Yvette Young  
Minnesota Department of Health  
85 East Seventh Place, Suite 400  
P.O. Box 64882  
St. Paul, MN 55164-0882

Jan. 17, 2003

***Re: Legislative Report and Recommendations (December 16, 2002 Draft  
Minnesota Emergency Health Powers Act***

Dear Ms. Young

This letter sets forth the position of the Minnesota Veterinary Medical Association on the use of antibiotics in animal agriculture which was part of the above-referenced Minnesota Department of Health document, "Minnesota Emergency Health Powers Act: Legislative Report and Recommendations". We believe that the use of antibiotics in human medicine is an important factor in maintaining effectiveness and the report recommendations should have reflected that fact. Aside from that specific comment, for the record, the MVMA position is as follows:

**The Minnesota Veterinary Medical Association (MVMA)**

**Position on Use of Antibiotics in Animals**

1. MVMA supports the AVMA position on judicious therapeutic antibiotic use, specifically with three objectives:
  - a. Safeguarding public health
  - b. Safeguarding animal health
  - c. Continued availability of effective therapeutic antimicrobials
2. Antibiotic use in animal must be used under a valid veterinarian/client/patient relationship.
3. Effective antibiotics must be available for both animal as well as human use.
4. Strongly support the prudent and judicious use of antibiotics in animals.
5. Support the position that antibiotic availability is a Federal rather than a State issue and should not be restricted at a State level.
6. MVMA must be proactive in supporting the availability of antibiotics for animal use.

Sincerely,

Dr. Tom Haggerty, D.M.V.  
Minnesota Veterinary Medical Association

108 Marty Drive  
Buffalo, MN 55113  
Ph: (763) 682-4171  
Fax: (763) 682-5546  
www.minncosotaturkeys.com

# Turkey

Growers Association

January 17, 2003

Ms. Yvette Young  
Minnesota Department of Health  
85 East Seventh Place, Suite 400  
P.O. Box 64882  
St. Paul, MN 55164-0882

**Re: Minnesota Emergency Health Powers Act  
Legislative Report and Recommendations (December 16, 2002 Draft)**

Dear Ms. Young:

On behalf of the Minnesota Turkey Growers Association (MTGA), I am writing today with our comments on the above-referenced Minnesota Department of Health document, "Minnesota Emergency Health Powers Act: Legislative Report and Recommendations (Draft, 12/16/02)" (hereinafter, "Draft Report"). Our comments focus on the portion of the Report that addresses ways to preserve the effectiveness of fluoroquinolones and other antibiotics that are vital to protecting human health.

The Draft Report initially summarizes the public meeting on October 28, 2002 as indicating a general agreement among participants that "continued efforts to increase awareness of this problem for patients, health care providers (including veterinarians), animal producers and the general public was a critical activity." (Draft Report, at 32-33). The actual recommendations, however, focus on use of antibiotics in animals, without setting forth any clear recommendations as to human antibiotic use. (see, e.g., Draft Report, at 33 (Recommendations 25 and 26)).

To be inclusive and best confront the concern raised by the Legislature, the MTGA believes strongly that the Draft Report should include recommendations as to appropriate use of antibiotics in humans and how to address the problem of over-use, over-prescription and proper disposal (when necessary) of antibiotics by humans. As such, Recommendations 25 and 26 should be changed to add the following statements.

25. *"The Minnesota Department of Health should provide information to groups such as the medical schools, health care providers, professional medical associations and the public about the human health consequences of over-prescription, improper disposal and non-judicious use of antibiotics, and the consequences of the spread of antibiotic-resistant pathogens in water, food and the environment."*
26. *"The Minnesota Department of Health should collaborate with human health groups such as the medical schools, health care providers and professional medical associations to evaluate potential human sources of antibiotic resistant bacteria."*



*Dedicated to fostering a successful Minnesota turkey industry and its ability to make positive contributions to consumers, the economy and the environment.*

Jan. 17 2003 04:22PM P2

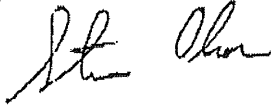
FAX NO. 6516464554

FROM MN TURKEY GROWERS ASSN

The best manner to preserve the effectiveness of fluoroquinolones and other antibiotics is to promote judicious use of antibiotics in all areas of our society. To focus primarily on antibiotic use in animals – as the Draft Report apparently does – ignores other areas where antibiotics are used and does not fully address the interest raised by the Legislature.

Please include these comments with the final report to the Legislature, and please feel free to call or email me if you have any questions. I can be reached at 763/682-2171 or [steve@minnesotaturkeys.com](mailto:steve@minnesotaturkeys.com). Thank you.

Sincerely,



Steven H. Olson  
Executive Director  
Minnesota Turkey Growers Association

Jan 17 2003 04:23PM P3

FAX NO. 6516464554

FROM: MN TURKEY GROWERS ASSN



**Broiler and Egg Association of Minnesota**

108 Marly Drive, Buffalo, Minnesota • Phone: 763-682-2171 • Fax: 763-682-5546

January 17, 2003

Ms. Yvette Young  
Minnesota Department of Health  
85 East Seventh Place, Suite 400  
P.O. Box 64882  
St. Paul, MN 55164-0882

**Re: Minnesota Emergency Health Powers Act  
Legislative Report and Recommendations (December 16, 2002 Draft)**

Dear Ms. Young

On behalf of the Broiler and Egg Association of Minnesota (BEAM), I am writing today with our comments on the above-referenced Minnesota Department of Health document, "Minnesota Emergency Health Powers Act: Legislative Report and Recommendations (Draft, 12/16/02)" (hereinafter, "Draft Report"). Our comments focus on the portion of the Report that addresses ways to preserve the effectiveness of fluoroquinolones and other antibiotics that are vital to protecting human health.

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Please include these comments with the final report to the Legislature, and please feel free to call or email me if you have any questions. I can be reached at 763/682-2171 or [steve@minnesotaturkeys.com](mailto:steve@minnesotaturkeys.com). Thank you.

Sincerely,



Steven H. Olson  
Executive Director  
Broiler and Egg Association of Minnesota

Jan 17 2003 04:23PM P6

FRX NO. 6516464554

FROM: MN TURKEY GROWERS ASSN



# Minnesota Agri-Growth Council

408 SAINT PETER ST, SUITE 20 o SAINT PAUL, MN 55102 • PHONE (651) 905-8900 • FAX (651) 905-8902

January 17, 2003

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MYRON JUST

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Ms. Yvette Young  
Minnesota Department of Health  
85 East Seventh Place, Suite 400  
P.O. Box 64882  
St. Paul, MN 55164-0882

**Re: Minnesota Emergency Health Powers Act  
Legislative Report and Recommendations (December 16, 2002 Draft)**

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Please include these comments with the final report to the Legislature, and please feel free to call me if you have any questions. Thank you.

Very truly yours

Myron Just

Minnesota  
**MnCLU**  
Civil Liberties Union



Michael Golciner  
*President*

Charles E. Samuelson  
*Executive Director*

Teresa J. Nelson  
*Legal Counsel*

January 17, 2003

Yvette Young  
Minnesota Department of Health  
85 E. 7th place, Suite 400  
P.O Box 64882  
St. Paul, MN 55164-0882  
Fax: (651) 215-5805

RE: Critique of the Minnesota Department of Health's Recommendation for improving the Draft of Minnesota State Emergency Health Powers Act.

The Emergency Health Powers Act Draft report appears to give only a fleeting reference to the civil liberties concerns implicated by the Minnesota State Emergency Health Powers Act (MSEHPA). The analysis and recommendations, while citing constitutional rights, do not contain any legal analysis of the specific constitutional standards that the State is required to meet with respect to those rights. The recommendations should include the obtaining of legal opinions as to the constitutional requirements that must be met in each instance.

With regard to specific provisions of the MSEHPA, the MnCLU has a number of civil liberties concerns. The MSEHPA contains both actions that the Minnesota Department of Health (MDH) -must undertake to improve public health and safety on an ongoing basis and what it must do to respond on an emergency basis. It also outlines what the MDH must do to prepare and responded to bio-terrorism. Moreover, the

MSEEPa gives new powers to the Governor and the Commissioner of Health to respond to acts of nature, technological failures or malfunction, terrorist incident, a public health emergency, an industrial accident, hazardous materials accident, civic disturbance that endangers life and property or when local government resources are inadequate to handle the situation. This overbroad category of emergencies and the overlapping powers may lead to confusion at one end and abuse of power at the other.

First, the MSEEPa curtails the constitutional requirement of separation of powers and checks and balances. The MSEBPA allows the Governor to declare a public health emergency that does not terminate for 30 days. The act also provides for the Governor to call the legislature into session if not in session. However, there is no process by which citizens can have the judicial review when the acts of both the State Legislature and the Governor find there is no emergency or that the putative emergency no longer poses a threat. This should be amended so that the judiciary becomes immediately involved in an oversight capacity over the acts of the executive and legislature.

Furthermore, the MSEHFA empowers the Commissioner of Health to use police powers without proper judicial oversight. The act allows state and local health officers to detain citizens without probable cause for 21 days. Although, the commissioner must obtain an ex parte court order within 24 hours, this procedure is inherently coercive for citizens who refuse to get vaccinated or receive some prescribed medical treatment or who cannot be vaccinated because of compromised immune systems (persons with IEV or persons undergoing chemotherapy). This should be amended to provide an appeals process so that citizens are not coerced into treatment they don't want, vaccinated, isolated, quarantined or possibly jailed.

In addition, the MSEHPA provides for isolation or quarantine of persons who refuse vaccination because of religious or conscientious objections to medical treatment and vaccines. This must be amended to include a clause such as "without risk of detention" similar to school immunization laws.

Third, the MSEHPA allows the collection of personal medical information, testing of blood, sputum, cerebrospinal fluid and even DNA. It also requires pharmacies to report increases in prescriptions and over the counter remedies and requires them to report the name, address, date of birth, etc. of the purchaser. This violates basic notions of privacy. Furthermore, the act allows the most personal medical information to end up in state and federal databases. It can potentially be used by insurers to deny coverage and by police in criminal investigations. This should be amended to require written consent before protected health information may be disclosed, and criminal sanctions and civil remedies for those whose privacy has been violated

Finally, the MSEHPA allows the government to disallow public gatherings when it would be an effective preventative measure for diseases that are transmitted through the air. The First Amendment to the United States Constitution allows the interference with the right to assemble only when there is compelling governmental reason and when the act that the government takes is narrowly tailored. Therefore, the MSENPA should be amended to limit this power only to instances where there is an airborne disease and limited to a particular place and at a particular time,

The foregoing civil liberties concerns, while not exhaustive, indicate the need for additional attention to the specific constitutional issues implicated by the MSEHPA.

Future drafts should included procedure for citizens to challenge the state of emergency, limitation on the police powers of by the Commissioner of Health, stricter data collection and management practices and legal analysis of the specific constitutional standards that the State is required to meet with respect to the First Amendment. We strongly urge you to consult with your attorneys so that the MSEHPA does not make us safe at the expense of being free.

Sincerely,

Charles Samuelson

Executive Director