

## **NC Communicable Disease Law**

### **Chris Hoke, JD**

#### **SLIDE 1**

Hey, I'm Chris Hoke. I'm an attorney and I'm head of Regulatory and Legal Affairs for the Division of Public Health. I'm happy to be here to talk to you about communicable disease law.

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I'll help you understand how communicable disease law works with you to help protect North Carolinians from communicable disease and communicable conditions. I work in the state Health Director's office for the Division of Public Health, and we in North Carolina are fortunate to have very good legal resources for the state and local public health communicable disease workers. We have folks at the School of Government at UNC-Chapel Hill and we have attorneys in the Attorney General's office in the Health Division there that are available to help and assist in whatever ways we can to support you in doing your job as communicable disease experts.

#### **SLIDE 3**

The communicable disease law is found in the Public Health law of North Carolina, which is Chapter 130A of the General Statutes. There's a whole article on communicable disease and it's Article 6 of that chapter. We have published a book, Public Health and Related Laws. This is the 2007 edition. We update these from time to time when resources allow because they're not a cheap books. It's a resource where you can find the law.

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The important part of communicable disease law is implementing rules that have been adopted to implement the provisions of the communicable disease statutes. So we have statutes that are adopted by the North Carolina General Assembly of elected officials. They essentially serve as a skeletal framework. They give authority and they set guiding principles. But much of the detail of communicable disease law is delegated and left to rulemaking, and that rulemaking authority in our communicable disease law is delegated to the Commission for Public Health and that used to be called the state Board of Health. It's essentially the counterpart to local Boards of Health that serve county health departments.

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The Commission for Public Health has state-wide rulemaking authority and they are the body that adopts the specific requirements to fill in that skeleton, so you have a whole body of law that supports you in the work you do to protect North Carolina citizens. The state Commission for Public Health is over 100 years old, well over a hundred years old; it's very professional. It's required to have 4 physicians elected by the North Carolina Medical Society and, like local Boards of Health, it has professional members like nurses, dentists, pharmacists, and other professionals, so it's a very professional body. It's wonderful because it means that the law and policy that's set in North Carolina for communicable disease control largely stays out of the political realm and it is very

scientifically based and appropriate. And that's one of the reasons why we set up our law so that most of the detail is delegated to rulemaking — to keep it as professional and scientifically supported as possible. The other reason is that typically rulemaking can occur very quickly. Sometimes rulemaking has gotten more complicated and is a longer process lately as state legislatures have become more concerned about the delegation of rulemaking to non-elected boards. But even with that, rulemaking bodies can act quickly when there's a public health emergency, when there's a new disease like SARS, when there are new issues dealing with a flu pandemic. Because we have a law that's structured to delegate much policymaking to our Commission for Public Health, they can act quickly, adopt emergency rules, and have rules in place much quicker than we could if we had to wait until the legislature was in session; not to speak of the fact, as I said before, avoid a lot of the politics that get involved by having policy set by elected officials exclusively. Alright...the communicable disease law...what does that skeleton do? Of course, it gives authority to the Commission for Public Health to decide what diseases are reportable to public health so we can know about them, so we can intervene and make sure that appropriate control measures have been followed to protect the public.

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The law itself designates who is to report—physicians, school principals, child care operators; medical facilities may report, and operators of restaurants, and laboratories (for instance, persons in charge of laboratories). The law also gives a basic framework for the sharing of information between the state and local health departments, so that appropriate action can be taken. Then, probably the most critical provision in the communicable disease law, is 130A-144, and that is where the General Assembly gives the Commission for Public Health authority to adopt specific control measures for all communicable diseases, not just reportable ones, but all communicable diseases and conditions. The Commission for Public Health then adopts rules that establish the particular requirements for communicable disease control. So, now we've talked about where you find the statutory law. The rules are easily accessible online. There is an office of Administrative Hearings. That is the state agency body that codifies and preserves and makes available to the public all rules in all of state government. If you go to the website, they have Administrative rules online.

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Our rules for communicable disease control are found in Title 10A, and then you'll see NCAC, that stands for North Carolina Administrative Code, and it's Chapter 41A, and the control measures are found in Section .0200. By the way, the list of Reportable Diseases and Conditions is found in that same subchapter in Section .0100, the chapter immediately before .0200, of course. .0200 sets out what the control measures are for each and every communicable disease. And what these rules do right off the bat is they adopt, by reference, two items. They adopt by reference the Control of Communicable Diseases Manual, published by the American Public Health Association (APHA), as the control measures for communicable disease. In addition, they adopt by reference the guidelines from the CDC in Atlanta. The guidelines from CDC take precedence over the Communicable Diseases Manual. There may be times where CDC doesn't have specific guidance on a communicable disease, then you would go directly to the

Communicable Diseases Manual for determining what the particular control measures are for that disease. Now, in addition to that, we have specifically adopted control measures for certain communicable diseases and it's typically the ones we end up having to use the law to get compliance are the ones we've specifically adopted in rule for control measures for that disease. HIV, hepatitis B, STDs and Tuberculosis (TB) all have their own specific rules adopted by the Commission for Public Health that detail out the control measures for those diseases. We have one for SARS. We have one for vaccinia when you're dealing with smallpox vaccination and, over time, we've continued to add. We're now in the process of adding one for hepatitis C. It's always better to have specific North Carolina language that we've written that's detailed that makes it easier for you to enforce and implement the requirements of the communicable disease law.

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And of course 130A -144 says that persons are required to comply with the control measures that have been adopted by the Commission for Public Health, and adopted by reference to the Communicable Diseases Manual or the CD guidelines and these specific control measures for HIV and hepatitis B have the force and effect of law. And when it says if you are a contact, if you have HIV and then you're required to get a TB test, then it's required by law and can be enforced by the public health law. When it says that a person is required, when there's a needlestick situation, (which is a significant exposure to blood or body fluids to non-intact skin in a manner that would present a significant risk of transmission of HIV or hepatitis B), if the source individual is infected, there are communicable disease control measure rules that require mandatory testing of the source in sharing that information with the exposed. Those are required by law and can be enforced through our law. The enforcement can either be in civil or criminal court. We have a criminal law in North Carolina and it applies to the whole public health law. It certainly applies to communicable disease and it says that a person who violates a provision of either the public health statutes or the rules adopted pursuant to the statute, is guilty of a misdemeanor and, with regard to communicable disease, can be punished up to 2 years in prison as a punishment for that violation. Now, of course in public health, we're not interested in punishing anybody, but we are interested in compliance. And we are interested in using that criminal sanction for violation of the public health law as a way to get compliance. We also have the authority in 130A -18 to go into civil court and get an injunction and get a judge to order compliance with the public health law and then, if they don't comply with the judge's order, they can be held in contempt of court and, again, imprisoned or fined until they do come into compliance. Now typically, like I said, we use these legal authorities as a way to motivate people to do the right thing and to comply with our requirements. They need to require they are compliant to protect others – in their family, people in the community – so that they're not hurt by communicable disease spread. And of course, our first line of defense is education. When these things are explained to them, people want to do the right thing. They understand public health law; public health requirements make sense to people—common sense—and typically we can get compliance. When necessary, we can also say, "Look, we don't want to have to do this; we don't want you to have a criminal record, but we will use public health law enforcement to get compliance if we need to." In most cases, when all that's explained, people do comply

and we get the protection we need, even if it goes so far as to go to court. We tell the judges that... because judges go, “Why is communicable disease treatment in my courtroom? Why is this being heard in my criminal court?” It’s an odd thing for judges. So we tell judges, “We’re here to protect the public. If indeed, they comply, we’ll be glad to drop the charges, even the sentence.” We’re happy typically to suspend the sentence based on their compliance. So, if they comply, they never have to be punished. Punishment is not our goal. Our goal is protection of the public health and compliance with our requirements.

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Let’s talk about some of the other important provisions in our communicable disease law. We skipped 130A–143, an important provision in our law which protects confidentiality of communicable disease records. I’ve explained to people the way the law looks at this, confidentiality is a control measure. Us protecting people’s confidentiality enables us to get better cooperation with people. It helps us get sexual contacts, needle contacts, household contacts, because people and the communities know they can trust public health to protect that confidentiality in the strictest of ways unless it’s absolutely necessary to protect the public. We guard that carefully. There are lots of provisions in here that detail out when information can be shared and under what circumstances, and that law also incorporates provisions of the control measures because it clearly says that information can be released when it’s part of the requirement for control measures. So that when we notify a daycare operator of an outbreak or condition, it may be totally related to what exactly the control measure tells us to do in order to get compliance with the important provisions to protect the public. Other provisions in 130A-144...Often when public health practitioners are working on a communicable disease outbreak, they need information. They need to get to a private physician’s office; they need to go to a hospital and get records related to a communicable disease. We have that authority in 130A-144(b). It even extends to other persons, not just medical facilities and labs, but to restaurants. We may need to look at credit card receipts in order to identify who ate at a restaurant during this particular time period. Maybe we’ve got an outbreak of hepatitis A or some other foodborne disease. We need to contact those people for important interventions required by the control measures. It’s 130A–144(b) that gives us that authority. It’s very broadly written to allow us to get information. Even when we’re just investigating a suspected outbreak, it gives us very broad authority to get that information. We now have a federal law, HIPPA, with regard to protecting private medical records. One of the key provisions of HIPPA in protecting the privacy of medical records is to say that it doesn’t impact state’s authority, state public health agencies’ authority, to get information to protect the public health. So, our reporting laws are access to records under 130A –144b, and other provisions of the public health law that allow for public health to access private medical information are clearly exempt and recognized in HIPPA as an important exemption to confidentiality protections.

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Quickly, some other key provisions in the law are 130A–145...is our authority to quarantine and isolate persons. That language has been updated and modernized in recent years with regard to new threats of bioterrorism. We don’t have time to go into

the detail of that law, but we use it in HIV control to issue isolation orders to people with HIV infection. Quarantine and isolation is the authority to restrict freedom of movement or action. When we use it for HIV, we use it to restrict the freedom of action because there is no reason, and no scientific support, for needing to restrict freedom of movement of people with HIV infection. That raises an important provision in the quarantine/isolation law in that it says it can only be used and exercised when all other reasonable means for protecting the public have been exhausted and no less restrictive alternatives exist. We do use quarantine and isolation to restrict freedom of movement. In other words, someone with TB that's infectious and we want to isolate them in their home, that order can do that. Whatever disease we use quarantine and isolation to restrict freedom of movement, then the order is limited to 30 days. So the Health Director issues the order and the person under the order of restricting freedom of movement has the right to appeal that order, if they want to, to the court. The court will hear that appeal quickly— within 72 hours. We've never had one of these appeals, but it is called for in the law. TB is a little different. Let me just say that 30 days is a typical time period for most all communicable diseases in terms of a need to physically quarantine and isolate. If we have a cause or situation where we need to extend that, we have to go into court and ask the court to extend it. TB is different in that under any other disease, the court can only extend that for 30 days. Because of drug-resistant TB, we've gotten authority in our quarantine and isolation law that allows for the court to extend that order for up to a year. So, if you do have someone with drug-resistant TB that will need to be physically isolated, potentially for the rest of their life, if you had to extend that order, the court could extend it for a year.

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There are a lot of other important provisions of communicable disease law. One I'll mention quickly, 90–21.5, allows for minors to consent to prevention treatment of reportable communicable diseases on their own without parental consent. That's an important provision. Another word about consent is that when something is required by the control measure, such as mandatory testing for HIV when there's a needlestick situation, if it's mandated by law, we don't ask for consent in that situation. Now, we don't hold someone down and force them and draw blood. We never do that. But we don't ask for consent. We ask for their cooperation. "This is required by law. We need to draw your blood so we can test it for HIV." It's very different. We need their assent, but not their informed consent. That's a huge difference.

I've enjoyed talking to you about communicable disease law and rules. I started the talk by talking about the resources that we have, public health lawyers that are here to support you in your work. We enjoy doing that and look forward to working with you. Call us if we can ever be of assistance. Let us know—particularly, let me know, and the attorneys in the state Health Director's office, —when our law isn't working or when there are circumstances arising that just don't fit what our law is set out to do. The law and the rules are a living, breathing document and it's up to us to continually update them, scrutinize them, modernize them, and get them in shape so they can best support you in doing your job of protecting the public. Thank you.