Nebraska Pandemic Bench Book

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Section 1.0 Introduction and Purpose

1.0.1 The goal of this Pandemic Bench book is to assist the judicial branch in preparing to face the issues that arise when a pandemic or other public health emergency impacts the ability to hold court. This resource will provide judges with practical suggestions and legal authorities as the branch strives to keep courts open during a pandemic. It also serves as a reference for the legal questions that may arise during public health threats and explains the role of the courts during such events.

1.0.2 Because of Nebraska's statutory scheme, this Pandemic Bench book is narrowly focused on the response of the DHHS and the LPHD to a pandemic public health crisis. This Bench book examines the authorization and parameters of a DHHS and LPHD response. The Division of Public Health of the Nebraska Department of Health and Human Services' website provides more information on ongoing public health surveillance and interventions.[1]

1.0.3 The assistance provided by the doctors at the University of Nebraska Medical Center was invaluable in the production of this Pandemic Bench book. The UNMC biocontainment unit continues to expand its capacity to provide expert care to quarantined victims of outbreaks world-wide.

Section 1.1 Terms and Definitions

The following terms and definitions are relevant to the subsequent sections contained within this Pandemic Bench book:

1.1.1 **Administrative Procedure Act ("APA")** means the Act that governs agencies, meaning each board, commission, department, officer, division, or other administrative office or unit of the state government authorized by law to make rules and regulations, except the Adjutant General's office as provided in Chapter 55, the courts including the Nebraska Workers' Compensation Court, the Commission of Industrial Relations, the Legislature, and the Secretary of State with respect to the duties imposed by the act. The APA includes the Department of Health and Human Services, the division of public health. [2]

1.1.2 **Chief Medical Officer/Director** performs certain duties within the DHHS. The Chief Medical Officer is usually also the Director of the Division of Public Health for the Department of Human Health and Services ("DHHS"), but not always.

Under Nebraska statutes, the Governor shall appoint a director for each of the following divisions within DHHS: (1) the Division of Behavioral Health, (2) the Division of Children and Family Services, (3) the Division of Developmental Disabilities, (4) the Division of Medicaid and Long-Term Care, and (5) the Division of Public Health.

If the Director of Public Health is licensed to practice medicine and surgery in the State of Nebraska, he or she shall also be the chief medical officer.

[1] See http://dhhs.ne.gov/publichealth/Pages/public_health_index.aspx
[2] See Neb. Rev. Stat. §§ 84-901 through 84-920.

If the Director of Public Health is not licensed to practice medicine and surgery in the State of Nebraska, the Governor shall appoint a chief medical officer in addition to the Director of Public Health. The chief medical officer shall be licensed to practice medicine and surgery in the State of Nebraska, shall serve at the pleasure of the Governor, and shall be subject to confirmation by a majority of the members of the Legislature.[3] For purposes of this Pandemic Bench book Chief Medical Officer and Director of DHHS shall be used interchangeably.

1.1.3 **Communicable disease, illness, or poisoning** means an illness due to an infectious or malignant agent, which is capable of being transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.

1.1.4 **Contested case** shall mean a proceeding before an agency in which the legal rights, duties, or privileges of specific parties are required by law or constitutional right to be determined after an agency hearing.

1.1.5 **Decontamination** means the removal or neutralizing of contaminating material, such as radioactive materials, biological materials, or chemical warfare agents, from a person or object to the extent necessary to preclude the occurrence of foreseeable adverse health effects. Decontamination includes remediation or destruction of sources of communicable disease or biological, chemical, radiological, or nuclear agents.

1.1.6 **Department of Health and Human Services Division of Public Health ("DHHS")** is the agency with the authority to order the restriction of the movement of persons, to order the closing of public places and schools, and to order the cancellation of mass gatherings.

1.1.7 **Directed Health Measure ("DHM")** means any measure, whether prophylactic or remedial, intended and directed to prevent or limit the spread of communicable disease or to prevent or limit public exposure to or spread of biological, chemical, radiological, or nuclear agents.

1.1.8 **Director of Health and Human Services of the division of public health ("Director")** is the person appointed by the governor to be the director of the public health services division, or a person acting on behalf of the Director as his or her designee. As described above, this director of the public health division may also be the chief medical officer, but not always.

1.1.9 **Ex parte** communication shall mean an oral or written communication which is not on the record in a contested case with respect to which reasonable notice to all parties was not given. Ex parte communication shall not include: (a) Communications which do not pertain to the merits of a contested case; (b) Communications required for the disposition of ex parte matters as authorized by law; (c) Communications in a ratemaking or rulemaking proceeding; and (d) Communications to which all parties have given consent.[4]

[3] See Neb. Rev. Stat. §§ 81-3113, 81-3115(1)-(2).

[4] See Neb. Rev. Stat. § 84-901(4).

1.1.10 **Health care facility** means any facility licensed under the Health Care Facility Licensure Act, and such additional clinics or facilities not licensed under that act as may be identified in specific orders issued pursuant to 173 Neb. Admin. Code Ch. 6.

1.1.11 **Health care provider** means any credentialed person regulated under the Uniform Credentialing Act, Neb. Rev. Stat. §§ Sections 38-101 to 38-1,142.

1.1.12 **Isolation** means the separation of people who have a specific communicable disease, illness or poisoning from healthy people and the restriction of their movement to stop the spread of that disease, illness or poison. In circumstances where animals are agents of spread of communicable disease, illness or poisoning, isolation may apply to such animals.

1.1.13 **Local public health department ("LPHD")** means a county, district, or city-county health departments; a governmental entity approved by the Department of Health and Human Services as a local full-time public health service which (a) utilizes local, state, federal, and other funds or any combination thereof, (b) employs qualified public health medical, nursing, environmental health, health education, and other essential personnel who work under the direction and supervision of a full-time qualified medical director or of a full-time qualified lay administrator and are assisted at least part time by at least one medical consultant who shall be a licensed physician, and (c) is operated in conformity with the rules, regulations, and policies of the Department of Health and Human Services. The medical director or lay administrator shall be called the health director[5]

1.1.14 **Municipality** means any City of the Metropolitan class,[6] Primary class,[7] First class,[8] Second class,[9] and Village,[10] and its governing officials.

1.1.15 **Personal protective equipment ("PPE")** means equipment ordered or used to protect an individual from communicable disease, illness or poisoning.

1.1.16 **Premises** means land and any structures upon it.

1.1.17 **Public health authority** means any individual or entity charged by law with a duty or authority to enforce or carry out a public health function.

1.1.18 **Quarantine directed to identified individuals or defined populations** means the restriction of, or conditions upon, the movement and activities of people who are not yet ill, but who have been or may have been exposed to an agent of communicable disease, illness, or poisoning and are therefore potentially capable of communicating a disease, illness, or poison. The purpose is to prevent or limit the spread of communicable disease, illness or poison. Quarantine of individuals or defined populations generally involves the separation of

[5] See Neb. Rev. Stat. § 71-1626.
[6] See Neb. Rev. Stat. § 14-101.
[7] See Neb. Rev. Stat. § 15-101.
[8] See Neb. Rev. Stat. § 16-101.
[9] See Neb. Rev. Stat. § 17-101.
[10] See Neb. Rev. Stat. § 17-201.

the quarantined from the general population. In circumstances where animals are agents of spread of communicable disease, illness or poisoning, quarantine may apply to such animals.

1.1.19 **Quarantine officer** means the statutorily established quarantine officer for a municipality or county, usually the chief executive or top law enforcement officer.

1.1.20 **Quarantine of premises** means restriction of the movement of all people and animals upon, into, or out from those premises to prevent or limit the spread of communicable disease or illness or to prevent or limit public exposure to or spread of biological, chemical, radiological, or nuclear agents.

1.1.21 **Note**: Many of the above definitions can be found within the Nebraska Administrative Code ("NAC").[11] Those that cannot or are located within a Nebraska Statute have been so noted.

Section 1.2 When Judges/Courts will be Impacted

In the case of a public health crisis, as outlined in detail in this resource, the Nebraska Statutory scheme provides the DHHS and the LPHDs with the authority to order the restriction of the movement of persons, to order the closing of public places and schools, and to order the cancellation of mass gatherings. [12] How the actions of the DHHS and the LPHDs impact the judges/courts is described below.

It is anticipated that the Courts will likely become involved under three primary circumstances:

1.2.1 **An APA Appeal**

A judge may be presented with an appeal resulting from an agency determination. For example, the DHHS may issue an Order that affects a complainant. If the complainant decides to challenge a determination or Order of the DHHS, the complainant will utilize the APA. After going through the requisite procedures to contest an agency determination or Order, the Order may be appealed to the district court of the county where the agency rendered its decision. This process is fully described in the subsequent paragraphs.

The Nebraska APA provides:

(1) Any person aggrieved by a final decision in a contested case, whether such decision is affirmative or negative in form, shall be entitled to judicial review under the Administrative Procedure Act. Nothing in this section shall be deemed to prevent resort to other means of review, redress, or relief provided by law.

(2)(a)(i) Proceedings for review shall be instituted by filing a petition in the district court of the county where the action is taken within thirty days after the service of the final decision by the agency. All parties of record shall be made parties to the proceedings for review. If an agency's only role in a contested case is to act as a neutral fact-finding body, the agency shall not be a party of record. In all other cases, the agency shall be a party of record. Summons shall be served within thirty days of the

[11] See 173 Neb. Admin. Code Ch. 6, 002.
[12] See Neb. Rev. Stat. § 71-502; 173 Neb. Admin. Code Ch. 6, 001.

filing of the petition in the manner provided for service of a summons in section 25-510.02. If the agency whose decision is appealed from is not a party of record, the petitioner shall serve a copy of the petition and a request for preparation of the official record upon the agency within thirty days of the filing of the petition. The court, in its discretion, may permit other interested persons to intervene.

(a)(ii) The filing of a petition for review shall vest in a responding party of record the right to a cross-appeal against any other party of record. A respondent shall serve its cross-appeal within thirty days after being served with the summons and petition for review.

(b) A petition for review shall set forth: (i) The name and mailing address of the petitioner; (ii) the name and mailing address of the agency whose action is at issue; (iii) identification of the final decision at issue together with a duplicate copy of the final decision; (iv) identification of the parties in the contested case that led to the final decision; (v) facts to demonstrate proper venue; (vi) the petitioner's reasons for believing that relief should be granted; and (vii) a request for relief, specifying the type and extent of the relief requested. [13]

The review shall be conducted by the court without a jury de novo on the record of the agency.

1.1.2. **A prosecution for ignoring an Order** **(mostly applicable to an LPHD order, see 2.1.3)**

If the LPHD issues an Order and that Order is ignored, this situation may find itself in front of a judge. In this scenario, the County attorney, in the county where the LPHD filed the Order, may try to enforce the LHPD Order by filing either a petition for misdemeanor prosecution or a petition seeking injunctive relief. The petition would be filed and litigated in court.

1.1.3. **A Petition for a Writ of Habeas Corpus**

A person who is quarantined by a DHHS Order, or an LPHD Order, may seek habeas corpus relief through a district court action.

Section 2.0 Public Health Actions

Nebraska law delegates considerable authority to DHHS and LPHD's to react and manage a pandemic public health crisis. These agencies are responsible for more than responding to a pandemic and use a wide variety of efforts to protect and promote the public's health, safety, and welfare.

DHHS and LPHD will utilize DHMS to respond to a pandemic health crisis. The authority of the DHHS and the LPHDs to issue DHMs and the procedures of issuing a DHM are outlined below.

Section 2.1 What is a DHM; and Who can issue a DHM

As discussed in the terms and definitions, a DHM is a tool of a public health agency, such as the DHHS and LPHDs, to respond to pandemic emergencies. Different organizations have the authority to issue a DHM.

2.1.1 DHHS has the ability to issue a DHM (For an example See "Appendix A" at page 39)

[13] See Neb. Rev. Stat. § 84-917 (1)-(2).

The DHHS is authorized to issue a DHM, ex parte. Parties affected by the DHM have the opportunity to challenge a DHM through the APA. The DHHS would hold a hearing over the contested case. The DHHS would then issue an Order regarding the contested case. If the parties did not agree with the DHHS' Order regarding the contested case, the next step is for that Order to be reviewed by a district county court. The parties have thirty days, from the service of the Order issued by the DHHS, to have the Order reviewed. The district court of the county where the agency is located is the district court responsible for reviewing the Order issued regarding the contested case. The DHHS is located in Lancaster County, meaning many of these cases will be handled by the District Court of Lancaster County. The review of the proceedings resulting from an appeal of an Order issued by the DHHS, or other agency, is de novo on the record. [14]

It is foreseeable that parties affected by a DHM may file petitions for habeas corpus or regarding indigent legal representation issues.

2.1.2 LPHDs have the authority to issue a DHM.

LPHD are specifically authorized by statute to adopt measures for the control of communicable disease and adopt DHM regulations.[15] These measures are required to be consistent with the state public health authority and require DHHS' approval. The model regulations adopted by the LPHDs allow them to "hand off" response to DHHS if desired. An "over-ride" by DHHS order is also possible.

LPHDs have extremely important roles in disease surveillance, reporting, and monitoring. In fact, under certain statutory authority, LPHDs are to enact rules and regulations, subsequent to a public hearing, held after due public notice, to enforce the same for the protection of public health and the prevention of communicable diseases within its jurisdiction, subject to the review and approval of such rules and regulations by the DHHS.[16]

LPHDs are required to make all necessary sanitary and health investigations and inspections and in counties having a population of more than four hundred thousand inhabitants as determined by the most recent federal decennial census, enact rules and regulations for the protection of public health and the prevention of communicable diseases within the district, except that such rules and regulations shall have no application within the jurisdictional limits of any city of the metropolitan class and shall not be in effect until (a) thirty days after the completion of a three-week publication in a legal newspaper, (b) approved by the county attorney with his or her written approval attached thereto, and (c) filed in the office of the county clerk of such county.[17]

Indeed, the LPHD must investigate the existence of any contagious or infectious disease and adopt measures, with the approval of the DHHS, to arrest the progress of the same.[18]

[14] See Neb. Rev. Stat. § 84-917.
[15] See Neb. Rev. Stat. §§ 71-501 and 71-1631(7) and (9) (except for Lincoln-Lancaster County at Neb. Rev. Stat. § 71-1630(4) and Omaha- Douglas County at Neb. Rev. Stat. § 71-1631(9)).
[16] See Neb. Rev. Stat. §§ 71-501; 71-1631(7)-(10); 71-1626 through 71-1366.
[17] Id.
[18] Id.

There is statutory authority regarding LPHDs and how they create a board of health, a district health department, a city-county board of health, and measures the different boards can take as well as the requirements to establish such boards, and even guidance for mayors in appointing health directors of such boards.[19]

An LPHD shall make and enforce regulations to prevent the introduction and spread of contagious, infectious, and malignant diseases in the county or counties under its jurisdiction.[20]

The LPHD or the county board of health shall make rules and regulations to safeguard the health of the people and prevent nuisances and insanitary conditions and shall enforce and provide penalties for the violation of such rules and regulations for the county or counties under its jurisdiction except for incorporated cities and villages. If the local public health department or the county board of health fails to enact such rules and regulations, it shall enforce the rules and regulations adopted and promulgated by the DHHS.[21]

2.1.3 Implementation

As seen above, because there is authority for LPHDs to issue DHMs due to the LPHD's authority to protect the health, safety, and welfare of persons in the face of a pandemic, a person violating a DHM could face legal consequences.

Any person violating any rule or regulation that the LPHD is authorized to issue shall be guilty of a Class III misdemeanor and each day's violation shall be considered a separate offense. [22]

Moreover, a person violating a DHM could also be guilty of a Class V misdemeanor for each offense. The Attorney General or the county attorney may also be able to maintain an action in the name of the state against any person or any private or public entity violating such an order.[23]

It is foreseeable that parties affected by a LPHD issued DHM, and who are prosecuted for a violation of a DHM, may seek relief by a filing a petition for habeas corpus, an injunction, or a petition to challenge venue.

2.1.4 Inter-relation of LPHD and DHHS DHMs.

Under Neb. Rev. Stat. §71-1626(1) and §71-11628, in areas other than Lancaster and Douglas Counties, DHHS must approve LPHDs and the LPHD must operate in conformity with the rules, regulation and policies of DHHS.

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[19] See Neb. Rev. Stat. § 71-1630.
[20] See Neb. Rev. Stat. § 71-501.
[21] See, supra, ft. 20.
[22] See Neb. Rev. Stat. §§ 71-1631.01; and 71-1631(7),(9).
[23] See Neb. Rev. Stat. § 71-506 stating, "Any person violating any of the provisions of sections **71-501** to 71-505…shall be guilty of a Class V misdemeanor for each offense…The Attorney General or the county attorney may, in accordance with the laws of the state governing injunctions and other process, maintain an action in the name of the state against any person or any private or public entity for violating sections 71-501 to 71-505, 71-507 to 71-513, or 71-514.01 to 71-514.05 or section 71-531 and the rules and regulations adopted and promulgated under such sections." (emphasis supplied).

In Lincoln-Lancaster County [See 71-1630(4)] and Douglas County [see 71-1631(9)] § 71-1631(7) requires DHHS review and approve of LPHD regulations, including DHM regulations. Further, § 71-1631(10) requires DHHS approval of measures adopted by LPHDs, including DHMs, to arrest the progress of contagious or infectious disease.

Further, LPHDs must submit annual reports to DHHS, and DHHS funding supports LPHDs.[24]

DHHS created a template set of DHM regulations for the LPHDs to adopt.[25] To date, twelve LPHDs constituting 61% of Nebraska counties holding 81% of the population of Nebraska residents have adopted these regulations. Although procedural enforcement by LPHDs differs from the state's DHHS' scheme, the DHM's that are authorized are the same.

Exercise of these specific powers, even without a declaration of emergency, will allow the LPHDs to:

- Restrict the movement of persons,
- Close public places
- Dismiss schools
- Cancel mass gatherings

Finally, DHHS is required to approve the measures adopted by LPHDs, including DHMs, to arrest the progress of contagious or infectious disease.[26]

2.1.5 Statutes and specific populations

For specific statutes relating to DHMs, specific populations, and any emergency regulations that have been adopted to deal with the spread of communicable diseases or a pandemic, please see below:

- Counties, see Neb. Rev. Stat. §§ 23-174.10 and 71-501.

- Municipalities: Municipalities of various populations are authorized generally to adopt measures for the protection, preservation and promotion of the public health. These generally include measures to prevent the introduction or spread of contagious, infectious or malignant disease, and specifically include quarantine authority as noted by underlined sections.

- For cities or villages of the population:

    - 300,000 people and above (Omaha)- Neb. Rev. Stat. §§ 14-102, 14-103, and 14-219;
    - 100,000 - 299,999 people (Lincoln)- Neb. Rev. Stat. §§ 15-236, 15-403
        - In the Lincoln Municipal Code at section 8.16.030 the city has adopted isolation measures.

[24] See Neb. Rev. Stat. § 71-1628.05.
[25] See Directed Health Measures Handbook: Implementation Guidance for Local Health Departments for the Prevention of Spread of Communicable Disease, Illness or Poisoning at this link: http://publichealthne.org/phan-sections/emergency-response-section/
[26] See Neb. Rev. Stat. § 71-1631(10).

- 5001 - 100,000 people – Neb. Rev. Stat. §§ 16-238, 16-314, 16-321 and 16-405 (emergency measures).
- 801-5000 people – Neb. Rev. Stat. §§ 17-114, 17-121
- 100-800 people – Neb. Rev. Stat. §§ 17-207, 17-208, 17-568.01

Section 2.2 Procedure of Issuing a DHM

2.2.1 Overview:

Certain elements are required to be met by the DHHS before issuing a DHM. Essentially, when the Director of DHHS receives information that a member or members of the public have been, or may have been exposed to a communicable disease, illness, or poisoning by biological, chemical, radiological, or nuclear agents, the Director will utilize certain steps to determine if any DHM should be ordered. The information may come from, the United States Department of Health and Human Services Centers for Disease Control and Prevention, a LPHD; a communicable disease surveillance conducted by DHHS; a treating health care providers or health care facilities; or other public health, security, or law enforcement authorities. The Director will utilize the information and certain steps to determine if any DHM should be ordered. These steps are outlined in remainder of this section.[27]

2.2.1(a) First, before issuing a DHM, the Director must find:

1. That a member or members of the public have been, or may have been exposed; and
2. That a DHM will effectively prevent, limit, or slow the spread of communicable disease or illness or to prevent, limit, or slow public exposure to or spread of biological, chemical, radiological, or nuclear agents.

2.2.1(b) Second, the Director must find one or more of the following:

1. That the exposure presents a risk of death or serious long-term disabilities to any person;
2. That the exposure is wide-spread and poses a significant risk of harm to people in the general population; or
3. That there is a particular subset of the population that is more vulnerable to the threat and thus at increased risk.

2.2.1(c) Third, the Director may make the following additional findings:

1. Whether the threat is from a novel or previously eradicated infectious agent or toxin; or
2. Whether the threat is or may be a result of intentional attack, accidental release, or natural disaster; or
3. Whether any person(s) or agent(s) posing the risk of communicating the disease are non-compliant with any measures ordered by a health care provider.[28]

2.2.2 If the above findings are made by the Director, and the Director further finds that a delay in the imposition of an effective DHM would significantly jeopardize the ability to prevent or

[27] See 173 Neb. Admin. Code Ch. 6, 003
[28] Id.

limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons, the Director may impose any of the types of DHMs further outlined below.[29]

Section 2.3 Types of DHM Orders

There are different types of DHMs based on the type of health threat facing a community. Types of DHM Orders include:

2.3.1 **Quarantine**. A quarantine could be of: 1. Individuals; 2. Defined populations; 3. Buildings and premises, or of defined areas, public and private, or 4. Animals.

A Quarantine may require the individual or population to remain within or outside of defined areas (cordon sanitaire) or restricted to or from specified activities, which may include "work quarantine" restricting individuals or defined populations to their residence or workplace.

If the quarantine of affected premises posing an immediate threat to the public health and safety is determined to be incapable of effective enforcement, the Department may act alone or in concert with any local jurisdiction having condemnation or nuisance abatement authority, to carry out measures effective to remove the threat, including safe demolition of the premises.[30]

2.3.2 **Isolation** of individuals. Individual may be isolated: 1. at home; 2. in a health care facility; or 3. in another designated area.[31]

2.3.3 **Decontamination**.[32]

2.3.4 Other measures identified as effective by public health authorities.[33]

2.3.5 Any DHM Order issued may include any of the following provisions:

- Temporary seizure or commandeering of personal or real property for public health purposes.
- Periodic monitoring and reporting of vital signs;
- Use of PPE for the performance of specified tasks or at specified premises; or
- Specific infection control measures including cleaning and disposal of specified materials.

Upon the Director making findings in accord with Section 2.2.1 above, and determinations pursuant Section 2.3.1-4 above, the Director will issue an Order directed to the affected individual, individuals, entity, or entities. Orders of the Director imposing DHMs are effective immediately.[34]

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[29] See 173 Neb. Admin. Code Ch. 6, 003.03.
[30] See 173 Neb. Admin. Code Ch. 6, 004.
[31] Id.
[32] Id.
[33] Id.
[34] 173 Neb. Admin. Code Ch. 6, 006.

Section 2.4 Nature, Scope, and Duration of a DHM

2.4.1 If the Director determines a DHM is needed and issues a type of DHM, the Director will consult with the Chief Medical Officer, if the Director is not a medical doctor, or other medical and communicable disease control personnel of the DHHS. The Director may make use of the expertise and observations of any health care provider who has treated a person for whom a DHM is being considered. The Director will also consider the directives and guidelines issued by the American Public Health Association and the United States Department of Health and Human Services Centers for Disease Control and Prevention or their successors, and may consider the directives and guidelines issued by similar public health authorities.[35]

2.4.2 In determining the nature, scope, and duration of the DHM ordered, the Director, based on the information available at the time of the determination, will:

2.4.2(a) Assess the situation and identify the least restrictive practical means of isolating, quarantining, or decontaminating an individual that effectively protects unexposed and susceptible individuals;

2.4.2(b) Select a place of isolation or quarantine that will allow the most freedom of movement and communication with family members and other contacts without allowing disease transmission to others and allow the appropriate level of medical care needed by isolated or quarantined individuals to the extent practicable;

2.4.2(c) For communicable diseases, order that the duration of the DHM should be no longer than necessary to ensure that the affected individual or group no longer poses a public health threat;

2.4.2(d) Give consideration to separation of isolated individuals from quarantined individuals. However, if quarantine or isolation is possible in the home(s) of the affected individual(s), individuals may be isolated with quarantined individuals; and

2.4.2(e) Give consideration to providing for termination of the DHM Order under the following circumstances:

1. If laboratory testing or examination is available to rule out a communicable condition, the Order may provide that proof of the negative result will be accepted to terminate a DHM; or

2. If treatment is available to remedy a communicable condition, the Order may provide that proof of successful treatment will be accepted to terminate a DHM.[36]

[35] 173 Neb. Admin. Code Ch. 6, 005.
[36] Id.

2.4.3 The DHM Order will contain the finding and determination set out above and will order the affected person or persons to comply with the terms of the Order, and will also include the following:[37]

2.4.3(a) Orders of Isolation will contain the following:

1. Name and identifying information of the individual(s) subject to the order;
2. Brief statement of the facts warranting the isolation;
3. Conditions for termination of the order;
4. Duration of isolation period;
5. The place of isolation;
6. Prohibition of contact with others except as approved by the Director or designee;
7. Required conditions to be met for treatment;
8. Required conditions to be met for visitation if allowed;
9. Instructions on the disinfecting or disposal of any personal property of the individual;
10. Required precautions to prevent the spread of the subject disease;
11. The individual's right to an independent medical exam at their own expense;
12. Provisions to ensure and monitor compliance; and
13. Procedure to request a hearing.[38]

2.4.3(b) Orders of Quarantine will contain the following:

1. Name, identifying information or other description of the individual, group of individuals, premises, or geographic location subject to the order;
2. Brief statement of the facts warranting the quarantine;
3. Conditions for termination of the order;
4. Specified duration of the quarantine;
5. The place or area of quarantine;
6. Prohibition of contact with others except as approved by the Director or designee;
7. Symptoms of the subject disease and a course of treatment;
8. Instructions on the disinfecting or disposal of any personal property;
9. Precautions to prevent the spread of the subject disease;
10. The individual's right to an independent medical exam at their own expense,
11. Provisions to ensure and monitor compliance; and
12. Procedure to request a hearing.[39]

2.4.3(c) Orders of Decontamination will contain the following:

1. Description of the individual, group of individuals, premises, or geographic location subject to the order;
2. Brief statement of the facts warranting the decontamination;
3. Instructions on the disinfecting or disposal of any personal property;
4. Precautions to prevent the spread of the subject disease; and

[37] 173 Neb. Admin. Code Ch. 6, 006.
[38] Id.
[39] Id.

5. Procedure to request a hearing.[40]

Section 2.5 Notice of DHMs

2.5.1 **Orders to Individuals**: Orders directed to individuals will be delivered in a manner reasonably calculated to give the individual actual notice of the terms of the Order consistent with the threat of communicable disease, illness, or poisoning.

Personal delivery may be attempted, except in cases when personal delivery would present a risk of spread of disease or exposure to agents that cannot be avoided by measures reasonably available.

Electronic transmission by e-mail or tele facsimile will be sufficient, provided that any available means of determining and recording receipt of such notice will be made. If electronic transmission is impossible or unavailable under the circumstances, oral communication by telephone or direct transmission of voice will be sufficient, and such communication will be memorialized at the time it is delivered.

2.5.2 **Orders to Groups**: Orders directed to groups of individuals or populations may be disseminated by mass media.

2.5.3 **Quarantine Orders Regarding Areas**: Orders directing the quarantine of premises or geographic locations may be disseminated by mass media and will be posted at or near the premises or geographic location in order to be visible and effective to achieve the intended purpose.

Copies of the Orders will be delivered to the owners or others in control of the premises, if known, in the same manner as Orders directed to individuals.

2.5.4 **Notice to Elected Officials**: Copies of all Orders will be provided if reasonably possible to the chief elected official(s) of the jurisdiction(s) in which the Order is implemented.[41]

Section 2.6 The Hearing Process - How a Person may contest a DHM

2.6.1 **Request for Hearing**: Any person subject to a DHM may request a contested case hearing to contest the validity of the DHM in accord with the Department's rules of practice and procedure adopted pursuant to the Administrative Procedure Act.

2.6.2 **Scheduling**: Upon request, the Department will schedule a hearing to be held as soon as reasonably possible under the circumstances. Unless the person subject to a DHM requests otherwise, the hearing will be scheduled no sooner than three days after the request is received by the Department. The hearing will be conducted in accord with the Department's rules of practice and procedure adopted pursuant to the APA.

[40] Id.
[41] 173 Neb. Admin. Code Ch. 6, 007.

2.6.3 **Parties to the Hearing**: The parties to the hearing will be limited to the Department and the subject person unless:

2.6.3(a) One or more additional persons have requested contested case hearings on substantially identical issues;
2.6.3(b) The interests of administrative economy require that the matters be consolidated; and
2.6.3(c) No party would be prejudiced by consolidation.

The parties may be represented by counsel at their own expense.

2.6.4 **Notice and Conduct of Hearing**: Reasonable prior notice of the time and place for hearing will be given to the parties. The hearing may be conducted in whole or in part by telephone or videoconference.

2.6.5 **Purpose and Decision**: The purpose of the hearing is to determine if the factual bases for the DHM to exist and the reasonableness of the DHM measures. The Director may affirm, reverse or modify the DHM by a written Findings of Fact, Conclusions of Law and the DHM to be issued as soon as reasonably possible after the hearing.

2.6.6 **Appeal of Hearing Decision**: An appeal to the District Court may be taken from the decision of the Director in accord with the APA, as previously outlined above in Section 1.2.[42]

2.6.7 Other items:

- In a scenario where a decision is appealed through the APA, the district court would look to the APA and the Nebraska Administrative Code for guidance when reviewing the DHM and appeal. The district court would look to see that all the procedures listed above to issue a DHM were followed and that the parties complied with the APA.

- If a LPHD issues a DHM and if the subject person or entity fails to comply, the person or entity could request a superseding DHM from DHHS, seek a criminal prosecution or an injunction,[43] or a criminal prosecution.[44]

    - In a scenario where a person or entity fails to comply with a DHM, the court would look to the Nebraska Administrative Code to ensure the DHM was issued in compliance with the Nebraska Administrative Code and statutes. The above sections can be used as guidance when reviewing the DHM.

<u>Section 2.7 Enforcement of DHMs</u>

2.7.1 ENFORCEMENT

[42] 173 Neb. Admin. Code Ch. 6, 008.
[43] Neb. Rev. Stat. §§ 71-501, 71-506.
[44] Neb. Rev. Stat. § 71-1631.01.

The Department may seek the assistance of the appropriate quarantine officer to enforce any DHM. Department personnel assigned to the enforcement of any DHM will promote the need for the DHM and encourage individuals to comply with all aspects of the DHM.

Any individual subject to a DHM may at any time present evidence to the Director to show that the DHM should be modified or terminated. The Director may or may not modify or terminate the DHM in his or her sole discretion.

In the event of noncompliance with the terms of a Department DHM,[45] law enforcement and other Municipal and LPHD personnel will be required to aid the Department in enforcement of the DHM.[46]

2.7.2 COOPERATION AND COORDINATION

The Department may assist or seek the assistance of quarantine officers, LPHDs, other public health authorities, and others authorized or required by law to carry out DHMs in carrying out those measures.

Treating Health Care Providers must follow and aid affected individuals and populations in compliance with ordered DHMs.[47]

2.7.3 REPORTING

Treating Health Care Providers, Health Care Facilities, and other persons must report any information known to them concerning any individual or entity subject to a DHM of quarantine, isolation, decontamination, or other DHM that is not in compliance with the Order/DHM. The report must be made to the Department and local law enforcement.[48]

For a sample DHM Order please see Appendix A.

Section 3.0 State Emergency Operations Plan ("SEOP") and Nebraska Emergency Management Act ("EMA")

While DHMs issued by DHHS may legally be implemented without a Governor-proclaimed emergency, emergency response in Nebraska is handled in accord with the State Emergency Operations Plan ("SEOP") created pursuant to the Nebraska Emergency Management Act ("EMA").[49] Nebraska is an "all-hazards" emergency response state, and the SEOP is a multi-hazard functional plan. Under the SEOP, DHHS is charged with Emergency Support Function 8 "Public Health and Medical Service."

3.0.1 Governor's authority under the EMA

[45] 173 Neb. Admin. Code Ch. 6-006, 009.
[46] Id.; Neb. Rev. Stat. § 71-502.
[47] 173 Neb. Admin. Code Ch. 6, 010.
[48] 173 Neb. Admin. Code Ch. 6, 011.
[49] See Neb. Rev. Stat. §§ 81-829.36 to 81-839.75.

The Governor is given plenary powers, subject to legislative override, specific to the EMA.[50] Under, the EMA, the Governor shall be responsible for meeting the dangers to the state and people presented by disasters, emergencies, and civil defense emergencies, and in the event of disaster, emergency, or civil defense emergency beyond local control, he or she may assume direct operational control over all or any part of the emergency management functions within this state. He or she shall have general direction and control of emergency management and the Nebraska Emergency Management Agency and shall be responsible for carrying out the provisions of the EMA.

In order to effect the policy and purposes of the EMA, the Governor may issue proclamations and make, amend, and rescind the necessary orders, rules, and regulations to carry out the act.

A state of emergency proclamation shall be issued by the Governor if he or she finds that a disaster, emergency, or civil defense emergency has occurred or that the occurrence or threat thereof is imminent. This could include a pandemic.

All proclamations issued under this subsection shall indicate the nature of the disaster, emergency, or civil defense emergency, the area or areas threatened, and the conditions which have brought about the state of emergency. All proclamations shall be disseminated promptly by means calculated to bring the contents to the attention of the general public and shall be promptly filed with the Nebraska Emergency Management Agency, the Secretary of State, and the clerks of the local governments in the area to which it applies. The proclamation shall continue in effect until the Governor finds that the threat or danger has passed or the disaster, emergency, or civil defense emergency has been dealt with to the extent that those conditions no longer exist and terminates the proclamation by letter of notice to such agency, the Secretary of State, and the clerks of the local governments in the area to which it applies. The Legislature by resolution may terminate a state of emergency proclamation at any time, whereupon the Governor shall terminate the proclamation by letter of notice to such agency, the Secretary of State, and the clerks of the local governments in the area to which it applies.

A state of emergency proclamation shall activate state, city, village, county, and interjurisdictional emergency management organizations and emergency operations plans applicable to the local government or area in question and shall be the authority for the deployment and use of any forces to which the plan or plans apply and for use or distribution of any supplies, equipment, materials, and facilities assembled, stockpiled, or arranged to be made available pursuant to the act or any other provision of law relating to disasters, emergencies, or civil defense emergencies.

During the continuance of any state of emergency, the Governor shall be commander in chief of the organized and unorganized militia and of all other forces available for emergency management duty. To the greatest extent practicable, the Governor shall delegate or assign command authority by prior arrangement embodied in appropriate proclamations, orders, rules, and regulations, but nothing shall restrict his or her authority to do so by orders issued at the time of the disaster, emergency, or civil defense emergency.

In addition to any other powers conferred upon the Governor by law, he or she may:

[50] See Neb. Rev. Stat. § 81-829.40.

- Suspend the provisions of any regulatory statute prescribing the procedures for conduct of state business or the orders, rules, or regulations of any state agency if strict compliance with the provisions of any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the disaster, emergency, or civil defense emergency;
- Utilize all available resources of the state government and of each political subdivision of the state as are reasonably necessary to cope with the disaster, emergency, or civil defense emergency;
- Transfer the direction, personnel, or functions of state departments and agencies or units thereof for the purpose of performing or facilitating emergency management;
- Subject to any applicable requirements for compensation under section 81-829.57, commandeer or utilize any private property if he or she finds this necessary to cope with the disaster, emergency, or civil defense emergency;
- Direct and compel the evacuation of all or part of the population from any stricken or threatened area within the state if he or she deems this action necessary for the preservation of life or other emergency management;
- Prescribe routes, modes of transportation, and destinations in connection with evacuation;
- Control ingress and egress to and from a disaster area, the movement of persons within the area, and the occupancy of premises in the area;
- Suspend or limit the sale, dispensing, or transportation of alcoholic beverages, explosives, and combustibles; and
- Make provisions for the availability and use of temporary emergency housing.

In the event of a civil defense emergency, the Governor shall assume direct operational control over all or any part of the emergency management functions within this state.[51] Exercise of these specific powers alone, without relying upon the authority of subordinate agencies will authorize the Governor to:

- Restrict the movement of persons,
- Close public places[52]
- Dismiss schools
- Cancel mass gatherings

3.0.2 Additional powers the EMA affords:

- liability protections for emergency management workers (which by definition, includes volunteers)
- licensure requirements for professional, mechanical or other skill do not apply to emergency management workers, and
- granting of powers, duties and immunities to emergency management workers from other jurisdictions responding pursuant to mutual aid agreements.[53]

[51] See Neb. Rev. Stat. § 81-829.40.

[52] See Neb. Rev. Stat. § 81-829.40(6)(d) which authorizes commandeering and use of private property subject to compensation.

[53] See Neb. Rev. Stat. § 81-829.55.

- Also, in conjunction with other statutes, workers compensation coverage is afforded to emergency management workers.

Section 3.1 Emergency Management Assistance Compact ("EMAC")

EMAC is a Compact signed by all 50 states, Washington D.C. Puerto Rico, Guam, and the U.S. Virgin Islands and ratified by Congress. It is the nation's state mutual aid system.[54] It allows cross border practice of professionals from responding states to requesting states. A Governor's declaration and request to other compact states and territories is required. Liability protection and workers compensation issues for responding emergency management workers are covered.

Federal Immunity during a Declared Emergency - Individuals and governmental actors providing assistance during a public health emergency are afforded broad immunity protections by federal law.[55]

Section 4.0 Constitutional Issues

It is important to note, as stated elsewhere in this Pandemic Bench book, individuals and governmental actors providing assistance during a public health emergency are afforded broad immunity protections by federal law.[56] However, it is important to keep in mind the constitutional issues that may arise with the implementation of DHMs, as well as the other required actions that the DHHS and the LPHDs might execute during a pandemic crisis.

Section 4.1 An Outline of the Federal Constitution with regard to Searches and Seizures

4.1.1 Fourth Amendment - Searches and Seizures Generally

The Federal Constitution protects against unreasonable searches and seizures. 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.[57]

Nebraska's constitutional provisions addressing unreasonable searches and seizures are substantially the same as those of the federal Constitution.[58] Article I, § 7, of the Nebraska Constitution protect individuals against unreasonable searches and seizures by the government. The Nebraska Supreme Court has construed article I, § 7, of the Nebraska Constitution to provide no greater rights than those afforded a defendant by the Fourth Amendment of the U.S. Constitution.[59]

4.1.2 Definitions.

[54] See Public Law 104-321.
[55] See Federal Public Readiness and Emergency Preparedness Act, 42 U.S.C. § 247d-6d, and the Federal Volunteer Protection Act, 42 U.S.C. § 14501, et seq.
[56] Id.
[57] Amend. IV, U.S. Constitution.
[58] Article I, § 7, of the Nebraska Constitution.
[59] See *State v. Smith*, 279 Neb. 918, 921, 782 N.W.2d 913, 921 (2010).

4.1.1(a) Search - A search occurs when government action infringes upon an expectation of privacy that society recognizes as reasonable.[60]

4.1.1(b) Seizure of an Individual - A seizure of an individual occurs when government action meaningfully interferes with an individual's freedom of movement.[61] The duration of the interference is irrelevant—any interference constitutes a seizure, "however brief."[62] Under this definition, the isolation or quarantine of an individual constitutes a seizure.

4.1.1(c) Seizure of Property - A seizure of property occurs when government action meaningfully interferes with an individual's possessory interest in that property.[63]

4.1.1(d) Government Action. The Fourth Amendment applies to the acts of all state officials, including both civil and criminal authorities.[64] State Hospital Employees as Government Actors. Staff at state hospitals are considered government actors and are therefore subject to Fourth Amendment requirements.[65]

4.1.1(e) Probable Cause. Probable cause exists when, under the circumstances, there are reasonable grounds for a belief of guilt that is particularized with respect to the person, place, or items to be seized.[66] The existence of probable cause must be determined by analyzing the totality of the circumstances surrounding the governmental intrusion, and involves a practical, common-sense review of the facts available to the government actor at the time of the search or seizure.[67]

4.1.3 Applicability of Fourth Amendment to Health and Safety Inspections. The protections of the Fourth Amendment apply to non-criminal searches and seizures such as health and safety inspections.[68]

4.1.4 Applicability of Fourth Amendment to Physical Evidence Obtained from Individual. The Fourth Amendment is implicated where the government seeks to obtain physical evidence from an individual.

4.1.4(a) Detention to Obtain Evidence. The detention of an individual necessary to produce the evidence sought is a seizure if it amounts to a meaningful interference with the individual's freedom of movement.[69]

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[60] See, e.g., United States v. Jacobson (1984), 466 U.S. 109.
[61] See, e.g., Michigan v. Summers (1981), 452 U.S. 692
[62] Id.
[63] See Jacobson, supra.
[64] See, e.g., New Jersey v. T.L.O. (1985), 469 U.S. 325.
[65] Ferguson v. City of Charleston (2001), 532 U.S. 67.
[66] See, e.g., Maryland v. Pringle (2003), 540 U.S. 366.
[67] See, e.g, U.S. v. Padro (6th Cir. 1995), 52 F.3d 120.
[68] See Torres v. Puerto Rico (1979), 442 U.S. 465; Marshall v. Barlow's Inc. (1978), 436 U.S. 307; Camara v. Municipal Court of San Francisco (1967), 387 U.S. 523.
[69] See, e.g., Skinner v. Railway Labor Executives' Assn. (1989), 489 U.S. 692 and Schmerber v. California (1966), 384 U.S. 757.

4.1.4(b) Obtaining and Examining Evidence. Obtaining and examining physical evidence from an individual are searches if the acts infringe upon an expectation of privacy recognized by society as reasonable.[70]

4.1.4(c) Physical Characteristics Exposed to Public. Individuals have no Fourth Amendment reasonable expectation of privacy in physical characteristics constantly exposed to the public, such as fingerprints, facial features, and vocal tones.[71]

4.1.4(d) Invasive Intrusions and Emerging Procedures. Obtaining physical evidence through invasive personal intrusions like surgery must be determined on a case-by-case basis.[72]

4.1.4(d)(i) Factors for reasonableness test. The Supreme Court has identified factors to consider when determining the reasonableness of invasive procedures to obtain physical evidence.

- The existence of probable cause to believe that relevant medical information will be revealed;
- Whether a warrant has been obtained;
- The extent to which the intrusion may threaten the individual's health and safety;
- The extent of the intrusion upon the individual's dignitary interests in privacy and bodily integrity;
- The community's interest in accurately determining the presence of disease or other medical threat; and
- The availability of other evidence.[73]

4.1.4(e) Lack of Physical Intrusion into Persons or Premises. The Fourth Amendment applies to information obtained from persons or premises even when acquired without physical intrusion.[74] In the case of premises, the nature of the premises (home v. business) may trigger Fourth Amendment protections.[75]

4.1.4(f) Character of Technology Employed to Obtain Information. Fourth Amendment protections are more likely implicated where information is obtained through the use of technology not in general public use.[76]

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[70] See Ferguson, supra.

[71] See Davis v. Mississippi (1969), 394 U.S. 721 (addressing fingerprints); United States v. Doe (2nd Cir. 1972), 457 F.2d 895 (addressing facial features); United States v. Dionsio (1973), 410 U.S. 1 (addressing voice exemplars).

[72] See Winston v. Lee (1985), 470 U.S. 753. For guidance, the Winston Court found the surgical removal of bullet from an individual's chest unreasonable under Fourth Amendment.

[73] Id.

[74] See, e.g., Kyllo v. United States (2001), 533 U.S. 27 (use of thermal imaging scanner outside home implicated Fourth Amendment as a search).

[75] Compare Kyllo, supra, with Dow Chemical Co. v. United States (1986), 476 U.S. 227 (use of aerial surveillance of business complex did not implicate Fourth Amendment).

[76] See Kyllo, supra ("We think that obtaining by sense-enhancing technology any information regarding the interior of the home that could not otherwise have been obtained without physical intrusion into a constitutionally

4.1.4(g) Analyzing the "Reasonableness" of Searches and Seizures. The "reasonableness" of government action is assessed by balancing the intrusion upon the individual's Fourth Amendment interests against the legitimate governmental interests promoted by the action.[77]

(i) Context. The reasonableness of a search or seizure depends upon the context in which it occurs.[78]

(ii)Government Not Required to Employ Least-Restrictive Means. The reasonableness of a search or seizure does not hinge upon the government's use of least-restrictive means. A search or seizure may be reasonable despite the availability of less restrictive means.[79]

4.1.5 The Warrant Requirement. Generally, government searches and seizures conducted without a valid warrant are presumptively unreasonable.[80]

4.1.5(a) Location of Search or Seizure Irrelevant to Warrant Requirement. The consent or warrant requirement applies equally to searches of and seizures on both residential and commercial property.[81]

4.1.5(b) Validity of Warrants. To be valid, a warrant must be supported by probable cause as determined by a neutral and detached magistrate.[82]

4.1.5(c)The Probable Cause Requirement Applies to Individuals. Probable cause to search or seize one individual does not, in and of itself, provide probable cause to search or seize another individual.[83]

4.1.6 Exceptions to the Warrant Requirement. The general requirement that searches and seizures be accompanied by a valid warrant is subject to several exceptions relevant to the public health context. The state bears the burden of proving an exception from the warrant requirement by a preponderance of the evidence.[84]

4.1.6(a) Consent Exception. Knowing and voluntary consent provided by an individual with actual or apparent authority over the premises to be searched or items to be seized obviates the need for a warrant.[85]

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protected area constitutes a search—at least where (as here) the technology in question is not in general public use.").

[77] See, e.g., New Jersey v. T.L.O. (1985), 469 U.S. 325 and Delaware v. Prouse (1979), 440 U.S. 648.

[78] See T.L.O., supra.

[79] See, e.g, Veronica School Dist. v. Acton (1995), 515 U.S. 646.

[80] Camara v. Municipal Court (1967), 387 U.S. 523 (warrant required for housing code inspections)

[81] See Camara, supra (search of residence) and See v. City of Seattle (1967), 387 U.S. 541 (search of commercial property).

[82] See, e.g., Maryland v. Pringle (2003), 540 U.S. 366.

[83] Ybarra v. Illinois (1979), 444 U.S. 85.

[84] See U.S. v. Matlock (1974), 415 U.S. 164.

[85] Illinois v. Rodriguez (2000), 497 U.S. 177, see also State v. Myers (1997), 119 Ohio App.3d 376; State v. Sisler (1995), 114 Ohio App.3d 337.

- Voluntariness Requirement. "Voluntariness" is fact specific, and must be evaluated in light of all surrounding circumstances.
- Scope of Consent. The permissible scope of a warrantless consent search or seizure is limited to the scope of the consent provided.[86]

4.1.6(b) Special Needs Exception. Warrants are unnecessary when special needs beyond those ordinarily necessary for law enforcement are implicated.[87]

- Test. To meet the special needs exception, the warrantless search or seizure must be reasonable under all the circumstances. This determination is made by balancing the privacy interests of the individual against the legitimate interests of the government.[88]
  - Careful Review of Government Action. The court may conduct a "close review" of evidence relevant to the government's alleged "special needs" and the efficacy of the government action.[89]
  - Law Enforcement Purposes. For the "special needs" exception to apply, the primary and immediate purpose of the government action cannot involve the generation of evidence for law enforcement purposes.[90] Where promotion of the public health or prevention of epidemic or pandemic conditions is clearly the primary concern of a search or seizure, the "special needs" exception should be applicable.
  - Exemption. The Fourth Amendment is not violated by mandatory legal and ethical reporting requirements imposed on medical personnel regarding certain information learned during treatment. This is true even if the information reported is ultimately provided to law enforcement.[91]
  - Unsuitability of Probable Cause Requirement. The probable cause standard is often ill-suited to circumstances of "special needs" occurring outside of the criminal context.[92] This is particularly true in instances where the government seeks to prevent the development of hazardous conditions or detect latent or hidden health-related violations.[93]
  - Finding of Individualized Suspicion Not Always Required. Under the "special needs" exception, sufficient governmental safety and

[86] Florida v. Jimeno (1991), 500 U.S. 248; Painter v. Robertson (6th Cir. 1999), 185 F.3d 557.

[87] For general discussion regarding the applicability of the "special needs" exception to the warrant requirement, see Bd. of Education v. Earls (2002), 536 U.S. 822 (warrantless random drug tests administered to students participating in extracurricular activities upheld as "special need") and T.L.O., supra (upholding warrantless searches of public school student property by school officials). In the realm of public health, see, e.g., Love v. Superior Court of San Francisco (1990), 226 Cal.App.3d 736 (upholding warrantless HIV testing of prostitutes as "special need" to protect public health); Glover v. E. Neb. Comm. Office of Retardation (8th Cir. 1989), 867 F.2d 461 (Fourth Amendment violated by required HIV and hepatitis testing for agency employees where risk of transmission was virtually non-existent).

[88] See Earls, supra.

[89] See, e.g., Ferguson v. City of Charleston (2001), 532 U.S. 67.

[90] See Id. ("special needs" exception inapplicable where involuntary drug testing accompanied by substantial police and prosecutorial involvement and threats of arrest and prosecution).

[91] Id.

[92] See Natl. Treasury Employees Union v. Von Raab (1989), 489 U.S. 656.

[93] See, e.g., Earls, supra and Von Raab, supra.

administrative interests may obviate the need for a finding of individualized suspicion.[94]

- Suspension of the individualized suspicion requirement may occur when: -The privacy interests implicated by the government actions are minimal; -An important governmental interest furthered by the search and seizure would be jeopardized by a reasonable suspicion requirement; and -Other available safeguards assure that the individual's reasonable expectation of privacy is not subject to the discretion of their officials in the field.[95]
    - In cases where individualized suspicion is not practical, membership in a suspicious class may provide sufficient justification for a search or seizure under the "special needs" exception.[96]
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4.1.6(c) Administrative Warrants and Modified Probable Cause Standard. Administrative inspections implicate protected Fourth Amendment interests and require a warrant.[97] However, they may be issued based upon a modified probable cause standard.

- Test. This standard is satisfied by a showing of:
    - Specific evidence of an existing violation; or
    - Reasonable legislative or administrative standards for conducting an inspection of a particular individual or establishment.[98]

4.1.6(d) Heavily Regulated Industries Exception. Warrantless searches of businesses within certain industries are permitted on the basis that their extensive history of governmental oversight and heavy regulations prevents a reasonable expectation of privacy in their products.[99]

- Test. Such warrantless inspections are deemed reasonable if:
    - A substantial governmental interest informs the regulatory scheme under which the inspection is made;
    - The inspection is necessary to further the regulatory scheme; and

[94] See Earls, supra, and See, e.g., Skinner v. Railway Labor Executives' Assn. (1989), 489 U.S. 692

[95] See Skinner, supra and T.L.O., supra

[96] Dunn v. White (C.A. 10 1989), 880 F.2d 1188 (testing of persons within suspicious class justified on public health grounds); People v. Adams (Ill. 1992), 597 N.E.2d 331 (upholding mandatory HIV testing for prostitutes).

[97] See, e.g., Marshall v. Barlow's Inc. (1978), 436 U.S. 307 (warrant required for business inspections by OSHA) and Camara v. Municipal Court (1967), 387 U.S. 523 (warrant required for housing code inspections).

[98] See Barlow's Inc., supra (warrant for OSHA inspection could properly issue upon showing of administrative plan derived from neutral sources such as a desired frequency of inspections for certain types of businesses); Camara, supra (warrant for housing code inspection could properly issue upon showing of factors such as the nature of the building, passage of time, and condition of surrounding area rather than specific knowledge of a particular building's condition).

[99] See, e.g., New York v. Burger (1987), 482 U.S. 692 (junkyards); Donovan v. Dewey (1981), 452 U.S. 594 (stone quarries); U.S. v. Biswell (1972), 406 U.S. 311 (firearms); Colonnade Catering Corp. v. U.S. (1970), 397 U.S. 72 (alcoholic beverages).

- The regulatory inspection program provides a constitutionally adequate substitute for a warrant in terms of its certainty and regularity of application.[100]

- Narrow Construction of Exception. The heavily regulated business exception to the warrant requirement is narrowly construed, and hinges on the history of governmental supervision providing notice to those entering the industry. Those choosing to enter a heavily regulated industry effectively consent to the regulation.[101]
- Insignificant Issues. If the regulatory scheme at issue serves legitimate regulatory purposes, the following issues lack constitutional significance:
  - The jurisdiction's penal laws address the same problem and goals addressed by the regulatory scheme;
  - Discovery of criminal evidence while enforcing the administrative scheme; and
  - Performance of the inspection by police officers rather than administrative inspectors.[102]

4.1.6(e) Checkpoints and Blanket Searches for Limited Safety-Related Purposes. Government actors may conduct warrantless and suspicionless checkpoints to ensure public safety.[103]

- Test. The reasonableness of warrantless and suspicionless checkpoints is determined by balancing the nature of the threatened privacy interests and their connection to the particular law enforcement practices at issue.[104]

4.1.6(f) Threat to Public Safety Not Dispositive of Means Utilized. The level of the threat to public safety is not dispositive of the means properly used by law enforcement officials.[105] However, urgent public safety considerations may require loosening the normal constraints upon law enforcement.[106]

- Primary Purpose Inquiry. Courts may inquire into and assess the primary purposes of warrantless and suspicionless checkpoints when assessing their validity under the Fourth Amendment.[107]

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[100] See Burger, supra. To provide an adequate substitute for a warrant, the regulatory scheme must advise the owner of the premises that that search of defined scope is being made pursuant to law and limit the discretion of the inspecting officers.

[101] Barlow's Inc., supra, see also Burger, supra (discussing long history of extensive regulations applicable to junkyards).

[102] See Burger, supra and Ferguson, supra. However, such inspections may not be used as a pretext to an intended criminal investigation. U.S. v. Johnson (C.A. 10 1993), 994 F.2d 740 (warrantless inspection of taxidermy shop involving federal anti-smuggling agent not excepted from warrant requirement).

[103] Where the risk to public safety is substantial and real (in places such as borders, airports, and government buildings), limited searches calibrated to the risk are permitted. See City of Indianapolis v. Edmond (2000), 531 U.S. 32 and Chandler v. Miller (1997), 520 U.S. 305; Michigan Dept. of State Police v. Sitz (1990), 496 U.S. 444 (upholding suspicionless vehicle sobriety checkpoints); State v. Goines (1984), 16 Ohio App.3d 168 (calculated pattern of inspecting motor vehicles at a designated checkpoint does not violate Fourth Amendment).

[104] Edmond, supra; State v. Eggleston (1996), 109 Ohio App.3d 217.

[105] Id.

[106] See Edmond v. Goldsmith (C.A.7 1999), 183 F.3d 659.

[107] See Edmond, supra.

- No Pretextual Use of Checkpoints. The pretextual use of checkpoints for the primary purpose of uncovering criminal evidence violates the Fourth Amendment.[108]

4.1.6(g) Searches Incident to Lawful Arrest. Warrantless searches incident to lawful arrest are permitted if reasonable under the circumstances.[109]

- Test. Searches incident to arrest must be justified by a need to either ensure the arresting officer's safety or prevent the destruction of evidence.[110]

4.1.6(h) Investigatory Stops Based on Reasonable Suspicion. Warrantless stops and "pat downs" are permissible if based upon reasonable suspicion of criminal activity.[111]

- Test. "Reasonable suspicion" exists when there is a particularized and objective basis to suspect criminal activity based on specific and articuable facts and the rational inferences drawn from them.[112]

4.1.6(i) Exigent Circumstances Exception. Warrantless searches are permissible if the delay associated with obtaining a warrant is likely to lead to injury, public harm, or the destruction of evidence.[113]

- Limitations on Scope of Search. A search conducted pursuant to the exigent circumstances exception is limited in scope to the exigencies justifying its initiation.[114]

Section 4.2 An Outline of the Federal Constitution with regard the Fifth Amendment

The Fifth Amendment to the U.S. Constitution guarantees that no person "shall be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation." Pursuant to its eminent domain power, the government must provide just compensation when it takes private property for public use. This constitutional guarantee of compensation is "designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole."[115] The government taking must substantially advance legitimate state interests to be constitutional.[116]

4.2.1 Types of Taking

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[108] Id.

[109] See Schmerber v. California (1966), 384 U.S. 757 (blood sample obtained without warrant or consent deemed minor intrusion and reasonable where probable cause existed to believe that defendant was driving while intoxicated and delay to secure warrant may have led to destruction of evidence) and Cupp v. Murphy (1973), 412 U.S. 291 (warrantless scraping of fingernails deemed minor intrusion and reasonable where threat existed that evidence would be destroyed).

[110] See, e.g., Marifam v. Buil (1990), 494 U.S. 325.

[111] See, e.g., Terry v. Ohio (1968), 392 U.S. 1; State v. Gonsior (1996), 117 Ohio App.3d 481.

[112] See Terry, supra

[113] See Schmerber v. California (1966), 384 U.S. 757, and Mincey v. Arizona (1978), 437 U.S. 385 (fire constitutes exigent circumstances sufficient to permit reasonable entry without warrant).

[114] See Mincey, supra.

[115] *Penn. Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 123-24 (1978) (citing *Armstrong v. U.S.,* 364 U.S. 40, 49 (1960)).

[116] See, e.g., *Lingle v. Chevron U.S.A., Inc*., 544 U.S. 528, 531 (2005) (citations omitted).

4.2.1(a) Takings *per se* entitle the property owner to compensation without a case-specific inquiry. There are two types of taking *per se*:

(i) Physical invasions occur when the government physically takes possession of an individual's private property for public purposes.[117]

(ii) When a government's regulation result in a permanent denial of all economically beneficial or productive use of the property.[118] This is known as a regulatory taking.

4.2.1(b) Case-specific takings. When government regulation denies some, but not all, economically beneficial or productive uses of private property, a taking may nonetheless exist if the impact of the regulation on the property is sufficiently severe.[119] Government action that is found to be a case-specific taking, rather than a *per se* taking, may be subject to the compensation rule.

4.2.1(c) Consideration of the following factors are necessary in making case-specific taking determinations:

(i) the economic impact of the regulation on the property owner;

(ii)The extent to which the regulation has interfered with reasonable investment-backed expectations; factors to determine that are:

- The character of the governmental action;
- What uses the regulation permits;
- Whether inclusion of the protected property was arbitrary or unreasonable; and
- Whether judicial review of the agency decision was available.[120]

4.2.2 When must the government compensate the property owner for a taking?

Government is not obligated to compensate a property owner for abatement or destruction of property pursuant to police power in cases of emergency.[121] Government must compensate property owner for per se taking pursuant to police power unless proscribed conduct or use was restriction inherent in owner's original title.[122] Government is, as a general rule, not obligated to compensate property owner for other regulations that affect property value for public benefit pursuant to police power.[123]

Section 4.3 Nebraska State Constitution

Nebraska's constitutional provisions addressing unreasonable searches and seizures are substantially the same as those of the federal Constitution.[124] Article I, § 7, of the Nebraska Constitution protects individuals against unreasonable searches and seizures by the government. The Nebraska Supreme Court has

[117] *Tahoe-Sierra Pres. Council v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 322 (2002).
[118] *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003, 1018 (1992).
[119] See *Penn. Cent. Transp. Co*., 438 U.S. at 136; *Penn. Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922) ("while property may be regulated to a certain extent, if the regulation goes too far it will be recognized as a taking").
[120] *Penn Central Transp. Co*., 438 U.S. at 136-37; see *Tahoe-Sierra Pres. Council*, 535 U.S. at 330-32.
[121] See *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003, 1029, n. 16 (1992); *Bowditch v. Boston*, 101 U.S. 16, 18 (1879) (destruction of building to prevent spread of fire does not entitle building owner to compensation).
[122] See Lucas, 505 U.S. at 1026-27.
[123] See *Lucas*, 505 U.S. at 1023-24.
[124] Article I, § 7, of the Nebraska Constitution.

construed article I, § 7, of the Nebraska Constitution to provide no greater rights than those afforded a defendant by the Fourth Amendment of the U.S. Constitution.[125]

As illustrated above, the Nebraska state statutes and Administrative Code give broad powers to the DHHS, the LPHDs, and the governor (in certain situations) to enact rules or regulations or take actions, such as DHMs, when faced with a pandemic crisis that that threatens the public health, safety, and welfare of a community. Outlined in this section are the Fourth and Fifth Amendment issues as they relate to Nebraska statutes and the Administrative Code in the context of a pandemic crisis. Also discussed are general privacy concerns, and other rights of citizens.

4.3.1 Inspection warrants

In the context of the Fourth Amendment, there are some specific Nebraska state statutes describing inspection warrants. These warrants would most likely be the warrants issued to deal with a pandemic crisis and relied upon by the above agencies in implementing DHMs and other public health actions to ensure the healthy, safety, and welfare of the affected community, while maintaining a citizen's fourth Amendment protections as outlined above.

4.3.1(a) Inspection warrant defined

An inspection warrant is an order in writing in the name of the people, signed by a judge of a court of record, directed to a peace officer and commanding him to conduct any inspection required or authorized by state or local law or regulation relating to health, welfare, fire or safety.[126]

What is a peace officer - All state, county, city and village officers and their agents and employees, charged by statute or municipal ordinance with powers or duties involving inspection of real or personal property, building premises and contents, including but not limited by enumeration to housing, electrical, plumbing, heating, gas, fire, health, food, zoning, pollution, water, and weights and measures inspections, shall be peace officers for the purpose of applying for, obtaining and executing inspection warrants.[127]

4.3.1(b) Inspection warrant, when issued

Inspection warrants shall be issued only upon showing that consent to entry for inspection purposes has been refused. In emergency situations neither consent nor a warrant shall be required.[128]

4.3.1(c) Procedure to issue an inspection warrant

An inspection warrant shall be issued only by a judge of a court of record upon reasonable cause, supported by affidavit describing the place and purpose of inspection. The judge may examine the applicant and other witnesses, on oath, to determine sufficient cause for inspection.[129]

[125] See *State v. Smith*, 279 Neb. 918, 921, 782 N.W.2d 913, 921 (2010).
[126] Neb. Rev. Stat. § 29-830.
[127] Neb. Rev. Stat. § 29-831.
[128] Neb. Rev. Stat. § 29-832.
[129] Neb. Rev. Stat. § 29-833.

4.3.1(d) Laws applicable to inspection warrants and violations

All general laws pertaining to search warrants, including but not limited to the filing costs involved and the conditions and time for return, shall be applicable to inspection warrants, unless in conflict with the statutes dealing with inspection warrants.[130]

Any person who willfully refuses to permit, interferes with, or prevents any inspection authorized by inspection warrant shall be guilty of a Class III misdemeanor.[131]

4.3.2 Public Health Surveillance

There are two types of public health surveillance – passive and active. In passive surveillance, health departments gather information about disease occurrence within a population primarily through disease reporting by hospitals, physicians, and other community sources.[132]

In active surveillance, health departments take measures to identify all cases of disease, primarily by contacting and soliciting information from physicians, hospitals, clinics, laboratories, and other sources. Active surveillance is most commonly used to identify cases of infectious disease.

4.3.2(a) Disease Investigation, Contact Tracing and Patient Privacy

When a patient infected with a communicable disease is reported, a disease investigation begins. DHHS and LPHDs are vested with the power to perform investigations of communicable disease infections to prevent transmission of the disease.

DHHS is an administrative department of the State of Nebraska and is given general supervision and control over matters relating to public health.[133] DHHS is specifically empowered with supervision and control of communicable disease.[134]

Laboratories[135] and physicians[136] are required to notify the DHHS and to report to the DHHS diseases, illnesses, or poisonings specified in the Nebraska Administrative Code.[137] DHHS will investigate reports and notifications of communicable diseases.[138]

Hospitals are required to perform syndromic surveillance and to report, monitor, detect, and investigate of public health threats from (a) intentional or accidental use or misuse of chemical, biological, radiological, or nuclear agents, (b) clusters or outbreaks of infectious or communicable diseases, and (c) noninfectious causes of illness.[139]

[130] Neb. Rev. Stat. § 29-834; and Neb. Rev. Stat. §§ 29-830-833.
[131] Neb. Rev. Stat. § 29-835.
[132] 173 Neb. Admin. Code Ch. 1
[133] Neb. Rev. Stat. § 81-601.
[134] See Neb. Rev. Stat., Chapter 71, Article 5, Contagious, Infectious and Malignant Diseases.
[135] Neb. Rev. Stat. § 71-502.04.
[136] Neb. Rev. Stat. § 71-503.
[137] See 173 Neb. Admin. Code Ch. 1.
[138] Neb. Rev. Stat. §§ 81-601 and 71-503.01(3).
[139] Neb. Rev. Stat. § 71-552

This information acquired from laboratories, physicians, and hospitals and sent to DHHS are not considered public records.[140] Further, disclosure of the materials is prohibited, and disclosure is subject to criminal sanctions.[141]

4.3.3 Mandatory/Involuntary Testing and Treatment for Communicable Diseases

Citizens have a right to refuse medical treatment. However, this right can be outweighed by the government interest in protecting the public health and safety. It is within the police power of the state to require mandatory vaccinations.[142] The state cannot force any individual to receive a vaccination if it would be unsafe for that individual.[143]

As set out in the Nebraska Administrative Code, Nebraska's approach is to order DHMs other than involuntary vaccination or treatment. Meaning an individual would instead be subject to isolation, quarantine, etc. However, if the subject individual voluntarily undertakes effective vaccination or treatment or submits to testing showing the absence of a communicable condition, the DHM will be lifted.[144]

4.3.4 Limitations on Property and Economic Interests

A public nuisance is an unreasonable interference with a right common to the general public.[145] In the context of public health, public nuisances are those actions or uses of property that significantly interfere with the public's health or safety.[146] Pursuant to their police powers, state and local government entities may require remediation of public nuisances.[147]

DHHS lacks general nuisance abatement authority, but is empowered to take steps regarding subject property. [148] LPHDs have authority to addresses nuisances.[149] The DHHS and LPHDs also have powers over subject property in DHM regulations.

4.3.5 Limitations on Privacy – HIPPA

4.3.5(a) HIPPA

The federal Health Insurance Portability and Accountability Act of 1996 [HIPAA] proscribes "individually identified health information . . . created or received by a health care provider, health plan, employer or health care clearinghouse" from being disclosed to others without the written authorization of the individual, except for disclosures for certain specified purposes, such as treatment, payment and health care operations.[150]

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[140] Neb. Rev. Stat. §§ 84-712, 84-712.01 and 71-503.01.
[141] Neb. Rev. Stat. §§ 71-503.01; NEB. REV. STAT. § 71-506.
[142] See *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905).
[143] Id.
[144] 173 Neb. Admin. Code Ch. 6
[145] See Restatement (Second) of Torts § 821B(1) (1979).
[146] See generally Restatement (Second) of Torts § 821(B)(2)(a) (1979).
[147] See *Lawton v. Steele*, 152 U.S. 133, 136 (1894).
[148] 173 Neb. Admin. Code Ch. 6.
[149] Neb. Rev. Stat. § 71-1626.
[150] 42 U.S.C. § 1320d(6)(A); 45 CFR §§ 164.502, 164.508, 164.510.

Covered entities include:

- Health Plans. HIPAA applies to individual or group plans that provide or pay the cost of medical care.
- Health Care Clearinghouses. HIPAA applies to public or private entities that process or facilitate the processing of health information.
- Health Care Providers. HIPAA applies to providers of medical or health services or any person or organization that furnishes, bills, or is paid for health care in the normal course of business.[151]

Public Health Departments are covered entities under HIPAA because they offer health care services. However, public health departments may designate themselves as "hybrid entities" and designate those portions of their organizations which provide health care services. HIPAA applies to the designated portions of the organization, but the non-designated portions of the organization need not comply with HIPAA's privacy requirements.[152]

Courts records are not covered under HIPPA because a court is not a covered entity under HIPAA. While 45 CFR § 164.512(e) contains special requirements for covered entities in the production of personal health information in response to a trial subpoena or discovery request, once the information becomes part of the court record it is no longer subject to HIPAA.

Covered entities may disclose protected health information without authorization to the following persons or officials for public health purposes:

- Public Health Authority; Disease Prevention and Control. Protected health information may be disclosed to a public health authority authorized by law to collect such information to prevent or control disease, injury, or disability.[153]
- Certain Foreign Government Agency Officials. Protected health information may be disclosed to officials of foreign government agencies acting in collaboration with a public health authority.[154]
- Exposed Persons; If Otherwise Legally Authorized. Protected health information may be disclosed to persons who may have been exposed to communicable diseases or who are at risk of contracting or spreading a disease if the covered entity is otherwise authorized by law to notify such a person as necessary in the conduct of a public health intervention or investigation.[155]
- Employers. Protected health information may be disclosed to an employer if such information is related to workplace medical surveillance.[156]
- Additional Uses of Protected Health Information. Covered entities may disclose protected health information without an individual's consent or authorization for additional purposes included in 45 C.F.R. § 164.512.

HIPAA preempts contrary state laws unless a specific exception applies, including

[151] 45 C.F.R. §§ 160.102 and 160.103.
[152] 45 C.F.R. § 164.504.
[153] 45 C.F.R. § 164.512(b)(1)(i).
[154] 45 C.F.R. § 164.512(b)(1)(i).
[155] 45 C.F.R. § 164.512(b)(1)(iv).
[156] 45 C.F.R. § 164.512(b)(1)(v).

- Compelling Need. The state law serves a compelling need related to public health, safety or welfare.[157]
- More Stringent State Law. The state law provides more stringent privacy protections for health information than the applicable HIPAA provisions.[158]
- Reporting. The state law provides for the reporting of disease, injury, child abuse, birth, death, or other public health surveillance or investigation.[159]
- Audits; Monitoring. The state law requires health plans to report or provide access to health information for purposes of financial audits or other program monitoring.[160]

4.3.5(b) Medical Information and Privacy Law

See the previous discussion that empowers DHHS and LPHDs to investigate communicable disease, illness or poisonings[161] and that such information is not a public record under Nebraska law and is confidential, not subject to subpoena, and privileged and inadmissible in evidence in any legal proceeding of any kind or character.[162] In addition, the public records statutes contain a *permissive* withhold of medical records for records that are otherwise public.[163]

Provided, the DHM authority of DHHS and LPHDs allow disclosure of individual's or entities' identities (only) if necessary to respond to communicable disease, illness or poisoning. This would be done – only if necessary - as part of the public health investigation without involving the judiciary.[164]

In addition, these privacy standards could be affected by a Governor's proclamation of emergency under the Nebraska Emergency Management Act.[165]

Section 4.3.6 Rights of the Petitioners

4.3.6(a) Writ of Habeas Corpus

Individuals subjected to quarantine or isolation can rely on a petition for a writ of habeas corpus to challenge the state's actions of quarantine or isolation.

See Appendix G for more information on Habeas Corpus Petitions

4.3.6(b) Right to Counsel

[157] 45 C.F.R. § 160.203(a)(1)(iv).
[158] 45 C.F.R. § 160.203(b).
[159] 45 C.F.R. § 160.203(c).
[160] 45 C.F.R. § 160.203(d).
[161] See Neb. Rev. Stat. §§ 71-501, 71-502, 71-503.01, 71-1626, 71-1630, 71-1631, and 81-601.
[162] See Neb. Rev. Stat. §§ 71-503.01, 84-712, and 84-712.01.
[163] Neb. Rev. Stat. § 84-712.05.
[164] See Neb. Rev. Stat. § 71-503.01.
[165] See Neb. Rev. Stat. § 81-829.40 (6)(a).

In order to comply with due process requirements, individuals subjected to isolation or quarantine should be provided the right to counsel. Many states have statutes that expressly provide for a right to counsel in quarantine and isolation cases.[166] At least one state has statutory authority that provides a right to counsel in mandatory vaccination cases.[167]

4.3.6(c) Food, Medicine and Necessities.

The governmental unit ordering isolation or quarantine has been recognized as having a duty to furnish food and other necessities during the period of quarantine if the restricted individual cannot afford the items.[168]

4.3.6(d) Loss of Income and Ether Expenses.

In addition to expenses connected with food, medicine and other necessities, confined individuals could experience financial changes due to loss of income. The government could be responsible.[169]

Section 4.3.7 Special Populations

4.3.7(a) Americans with Disabilities Act

The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. The right of access to the courts falls under the Title II Public Services, Section A of the ADA.[170] In 2004 the U.S. Supreme Court held that "Title II, as it applies to the class of cases implicating the fundamental right of access to the courts, constitutes a valid exercise of Congress' § 5 authority to enforce the guarantees of the Fourteenth Amendment."[171] As such the states are not immune from Title II lawsuits under the Eleventh Amendment. Title II of the ADA ensures that the earlier nondiscrimination requirements of section 504 of the Rehabilitation Act of 1973 that applied to public entities receiving federal financial assistance now apply to all state public entities including courts. States may also have disability rights legislation or court rules that are broader than Title II. States must comply with Title II, the Rehabilitation Act and their own state laws or court rules.[172]

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[166] For example, see Oregon Revised Statute 433.466, Right to Legal Counsel by Persons Subject to Public Health Measure.

[167] See Connecticut General Statutes § 19a-131e(d).

[168] *See, e.g. Commonwealth v. Irwin*, 1904 WL 2601 (CCP Venango, 1904) and *Zellinger v. Allentown*, 18 C.C. 162; 1896 WL 3663 (CCP Lehigh County, 1896). *See also Hutchinson v. Carthage*, 73 A. 825 (Me. 1909)(a town was obligated to pay the expenses of a man who took care of a quarantined family), *Loudoun v. Merrimack County*, 53 A. 906 (NH 1902)(a county was liable for reimbursing a town for the costs of medicine, medical assistance, and "necessaries" furnished to "paupers" who were quarantined with diphtheria), and *Hudgins v. Carter County*, 72 SW 730 (KY 1903)(where the court held that a physician could recover from the county money for the services he rendered to individuals who were quarantined with small pox).

[169] *See Phelps v. School District*, 221 Ill. App. 500 (Ill. Ct App 4th Cir. 1921) where a teacher was awarded compensation for her salary when a school was closed for two months due to an influenza epidemic.

[170] Americans with Disabilities Act of 1990 42 U.S.C. §§ 12101 et seq.

[171] *Tennessee v. Lane*, 541 U.S. 509 (2004) at 1994.

[172] See also Smith, Deborah. "The ADA and the Courts". National Center for State Courts, Knowledge and Information Services Memo (forthcoming).

The Americans with Disabilities Act Amendments Act of 2008 (ADAAA) was enacted in September of 2008 and took effect in January of 2009. The ADAAA ensures that the definition of disability is construed as broadly as possible. The three-prong definition of the ADA remains in effect, but the ADAAA ensures that the definition of disability is construed as broadly as possible. The person must otherwise be a "qualified individual" or eligible for the services or program. Disability is defined as:

1) A physical or mental impairment that substantially limits major life activities;
2) A record of impairment; or
3) Being regarded as having the impairment.

Major bodily functions are included in the definition of major life activities so the effects on internal organs and systems must be considered. The definition of major life activities includes learning, reading, concentrating, thinking, and communicating. An impairment "substantially limits" a major life activity if the person cannot perform a major life activity the way an average person in the general population can, or is significantly restricted in the condition, manner or duration of doing so. The final ADA Title II regulations went into effect in March of 2011. These regulations specify the circumstances under which a public entity does not have to provide a specific action as a "reasonable accommodation." These include an "undue financial or administrative burden" or a "fundamental alteration" of the service or program. The burden is still on the public entity to prove that compliance would pose this burden or alteration. In addition, the public entity has to provide an alternative to comply with the nondiscrimination requirement.

Two legal questions that should be addressed by bench book drafters include: (1) Does an individual's infectious disease make them qualified under the ADA?; and (2) According to disability law, what does the court need to do to provide reasonable accommodations to disabled persons subject to isolation and quarantine proceedings?

4.3.7(b) Minors

The DHM regulations of DHHS and LPHDs contain provisions allowing a DHM to specify access by parents and caregivers. The authority over medical and legal decisions for minors would follow existing law, with the proviso that a NEMA proclamation or *parens patriae* could apply.

4.3.7(c) Native Americans within Indian Country

State laws may be enforced against Native Americans on Indian lands only if expressly provided by Congress. Congress has authorized the adoption of rules for state officials and employees to enter Indian country to enforce state health laws, including isolation and quarantine laws. However, no such rules have been adopted.[173] The Federal government may place a Native American who is afflicted with a contagious or infectious disease in isolation or quarantine, to protect the health of the Native American or others.[174]

4.3.7(d) Non-English Speaking Persons

In situations where a person is subject to isolation or quarantine that does not speak English or is subject to a communication-related disability interpreters through the language line should be used

[173] 25 U.S.C.S § 231(1) (2015).
[174] 25 U.S.C.S. § 198 (2015).

to ensure the protection of Due Process rights. Assistance with interpreters is available through the Administrative Office of the Courts by calling 402-471-8854.

Section 5.0 Operation of the Courts during a pandemic

This section is intended to provide guidance on how a court stays open and operates in times of a pandemic crisis. This section is to give guidance to judges on how to manage court when facing a pandemic crisis.

5.0.1 Powers of the Nebraska Chief Justice and Supreme Court

The judicial power of the state shall be vested in a Supreme Court, an appellate court, district courts, county courts, in and for each county, with one or more judges for each county or with one judge for two or more counties, as the Legislature shall provide, and such other courts inferior to the Supreme Court as may be created by law. In accordance with rules established by the Supreme Court and not in conflict with other provisions of this Constitution and laws governing such matters, general administrative authority over all courts in this state shall be vested in the Supreme Court and shall be exercised by the Chief Justice. The Chief Justice shall be the executive head of the courts and may appoint an administrative director thereof.[175]

5.0.2 Appearance of Individuals Posing a Potential Threat to Public Health

A court may be unwilling to permit an infected or potentially infected individual to appear in person because of the health threat such an individual poses. Litigants may also be physically unable to attend a hearing in person due to illness. Given that the goal is to provide due process to litigants the use of video conferencing, telephonic and remote hearings should be utilized in the event an individual is not able or permitted to attend proceedings in person. Nebraska law allows for remote hearings using telephones and video conferencing for all nonjury matters upon judicial order and stipulation of the parties. §24-303. Courts should consider alternative appearance methods such as telephone appearances or videoconferences whenever live appearance is not feasible. The Administrative office of the Courts will provide assistance in setting up links for the use of distance technology to conduct hearings.

5.0.3 Juror Management Considerations

The capacity to conduct jury trials during a public health threat will likely be impacted. Civil trials may be continued, however, the constitutional right to a speedy trial and an impartial jury requires courts to continue to perform this function. Two jury trial management issues that could arise during a pandemic include: Because the Nebraska constitution requires a 12 person jury in non-misdemeanor cases unless waived by the defendant, it will be necessary to consider protecting a full jury from contamination when trials are held. The AOC has technology that would allow trial by a defendant who is remotely participating.[176]

5.0.4 Additional Judicial Personnel

[175] Neb. Const. art. VI, sec. 1 (1875).

[176] For example, see Virginia's benchbook section 7- http://www.courts.state.va.us/programs/pfp/benchbook.pdf.

The Chief Justice will assign additional judicial resources to areas when a need arises due to a public health threat. Presiding judges will notify the Chief Justice of the need for additional resources. In the case of a wide spread impact of a pandemic the Chief Justice will consult with the heads of the other branches of government to create an executive order and appointment of additional judges where needed.

The State Court Administrator will allocate additional court resources to areas impacted by a public health threat. That may include the use of distance based assistance if feasible. Additional Court resources will be appointed if all areas of the state are threatened.

5.0.5 Consolidation of Cases

It has been suggested that in some circumstances health departments may find it expeditious to bring a judicial action to enforce isolation or quarantine orders against numerous individuals as a class action.[177] However, given the extensive intrusions upon individual liberties that isolation and quarantine may entail and the limited opportunity that class certification affords affected individuals to present their case to the court, class certification should be implemented only when no other feasible procedure exists for efficiently adjudicating all matters pending before the court."[178]

5.0.6 Emergency Court Closure

In the event of a court closing due to a public health threat the presiding Judge of the jurisdiction should notify the Chief Justice of the Nebraska Supreme Court and the Administrative Office of the Courts immediately to discuss the nature of the closure.

5.0.7 Relocation of Judges

It can be necessary to relocate Judicial personnel to another jurisdiction due to a public health threat. The Power of the Supreme Court to order relocation of a Court is found in Article V. Section 12 of the Nebraska Constitution. Which provides that the judges of the District Court may hold court for each other and shall do so when required by law or when ordered by the Supreme Court. Litigants cannot be ordered to appear outside of the district for trial, so other means are necessary to provide Court resources to hold hearings locally absent consent of the parties. Those resources include using technology for hearings and using substitute judges. In the event a court building cannot be used due to a public health threat the Chief Justice of the Nebraska Supreme Court will work with the local judiciary and Counties to find adequate court room space.

5.0.8 Limiting Public Access to the Courts

In the event of pandemic or public health threat, the court may find it necessary to limit public access to the courthouse to protect the health of court staff, judicial officers and litigants. Judges needing to restrict media and access in the event there is a health threat should discuss the restrictions with the Administrative Office of the Courts and the Chief Justice so that coordination of public notices may

[177] Public Health Law Judicial Reference Guide for Kentucky Courts, at 122. (August 2006) <https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at_download/file>.
[178] Id.

take place. All orders limiting access to the courts shall be forwarded to the Chief Justice and the Administrative Office of the Courts.

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Directed Health Measure Order

Pursuant to Neb. Rev. Stat. §§ 71-502 and 81-601 and Title 173 Neb. Admin. Code Ch. 6 the Nebraska Department of Health and Human Services (Hereafter "Department") may exercise its authority to order Directed Health Measures necessary to prevent the spread of communicable disease, illness or poisoning.

Findings:
The Department has received information that a member or members of the public have been, or may have been exposed to a communicable disease, illness or poisoning by biological, chemical, radiological, or nuclear agents, to wit:
_____
_____
_____

The Directed Health Measure or Measures ordered below will effectively prevent, limit or slow the spread of _____.

The exposure presents one or more of the following:

¦ the exposure presents a risk of death or serious long-term disabilities to any person; to wit: _____

¦ the exposure is wide-spread and poses a significant risk of harm to people in the general population; to wit: _____

¦ there is a particular subset of the population that is more vulnerable to the threat and thus at increased risk; to wit: _____

A delay in the imposition of an effective Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons.

Optional Findings:

¦ the threat is from a novel or previously eradicated infectious agent or toxin;
¦ the threat is or may be a result of intentional attack, accidental release, or natural disaster;
¦ the following person(s) or agent(s) posing the risk of communicating the disease are non-compliant with any measures ordered by a health care provider: _____

Directed Health Measure ordered:
¦ Quarantine
¦ Isolation
¦ Decontamination
¦ Other: _____

This Directed Health Measure is effective immediately and applies to the following: persons, property and area: _____

The Components of this Directed Health Measure include:

1. Your movements are restricted to _____

2. The Directed Health Measure will last until:

⁋ _____(date) at _____(time)

⁋ until laboratory testing or examination is available to rule out a communicable condition or once successful treatment has been given to remedy the communicable condition.

You have a right to obtain an independent medical exam at your own expense.

3. If you need food or other necessities during the duration of this order, and you are not allowed to shop, the Department will assist you in obtaining necessities.

4. The Department will communicate with you and your physician of choice on a regular basis, if you do not have a regular physician you may choose from a list of local providers.

5. If your condition worsens or you develop any of the following symptoms _____ _____ call your physician or _____ immediately.

6. During the period of the Directed Health Measure visitors, besides health care professionals:

⁋ are not restricted

⁋ are not allowed

⁋ are limited to the following: _____

To help protect your family and the community a sign may be placed upon your entry door for visitors to follow.

7. You must follow instructions on disinfecting or disposal of soiled personal items and household wastes and any other measures as set out in any attachment included with this order.

8. In order to prevent the spread of disease, illness, or poisoning to others you must follow these personal guidelines:

_____ _____

9. Failure to comply with this order will result in legal action for enforcement by civil and/or criminal remedies.

You may request a contested case hearing to contest the validity of the Order. Your request must be addressed to DHHS Legal Services, P.O. Box 95026, Lincoln, NE 68509-5026, or faxed to (402) 742-2374 or sent by e-mail to DHHS.HearingOffice@nebraska.gov

Upon request, the Department will schedule a hearing to be held as soon as reasonably possible under the circumstances. Unless you request otherwise, the hearing will be scheduled no sooner than three days after the request is received by the Department. The hearing will be conducted in accord with the Department's rules of practice and procedure adopted pursuant to the Administrative Procedure Act.

The parties to the hearing will be limited to the Department and you unless one or more additional persons have requested contested case hearings on substantially identical issues; the interests of administrative economy require that the matters be consolidated; and no party would be prejudiced by consolidation, in which case you will be notified of the consolidation.

You may be represented by counsel at your own expense, or you may represent yourself.

Reasonable prior notice of the time and place for hearing will be given to you. The hearing may be conducted in whole or in part by telephone or videoconference.

The purpose of the hearing is to determine if the factual bases for the Order exist and the reasonableness of the ordered measures. The Director may affirm, reverse or modify the Order by a written Findings of Fact, Conclusions of Law and Order to be issued as soon as reasonably possible after the hearing.

_____ _____

For the Nebraska Department of Health and Human Services Date

Appendix B – PUBLIC HEALTH PRIMER

Public health primers are included in many pandemic bench books and address such topics as (1) defining public health; (2) identifying the essential public health activities; (3) providing a brief history of public health in the United States; and (4) discussing the role of government in public health.[83]

The Health Law and Policy Institute of the University of Houston Law Center has drafted summaries of several infectious diseases that provide an excellent primer for use in pandemic bench books, and they are reproduced with permission below.[84]

I. Ebola

Epidemiology

The largest Ebola outbreak occurred in 2014-2015 in West Africa, particularly in Guinea, Sierra Leone, and Liberia. According to the Centers for Disease Control and Prevention (CDC), at least 28,652 cases of Ebola Virus Disease (EVD) occurred in these three nations, resulting in at least 11,325 deaths. Additionally, there were approximately 20 cases confirmed in Nigeria, all stemming from a single traveler returning from Liberia, but prompt recognition and isolation measures prevented further spread of the disease in Nigeria. The 2014-2015 outbreak dwarfed, in size and scope, the previous 24 known outbreaks, which, when combined, resulted in approximately 1600 deaths.

Disease process, diagnosis, and treatment

There are five Ebola virus species, of which four are known to infect humans. Ebola viruses require special containment measures and barrier protection.

The virus can survive in liquid or dried material for many days. The virus may be inactivated with gamma radiation, heating for an hour at 60° C, or boiling for 5 minutes. Freezing or refrigeration does not kill the virus. The virus is sensitive to bleach and other disinfectants.

The natural reservoir for Ebola virus is not known. It infects humans through close contact with infected animals, including chimpanzees, fruit bats, forest antelopes or other bush meat as well as contact with the blood, bodily fluids or skin of humans infected with Ebola. It is not spread through water, or in most cases, food, unless it is infected animal tissue. Transmission via inanimate objects contaminated with infected bodily fluids is possible.

The incubation period is usually 4 to 10 days but can range from 2 to 21 days. There is no evidence of communicability during the incubation period in nonafebrile, asymptomatic individuals. The main routes of infection are through mucous membranes (the nose, mouth, and rarely, the genital tract), the eyes, and small skin breaks. Airborne transmission of the virus alone has not been demonstrated but aerosolized droplets of contaminated body fluids are infectious.

While the course varies from patient to patient, a typical EVD victim may progress through There are four phases of the disease: an initial period of non-specific influenza-like acute phase; a pseudo remission (which is not present in all patients; and aggravation. The influenza-like syndrome includes sudden fever, intense weakness, muscle aches, joint pain, nausea and vomiting, headache and a sore throat. In the acute phase (days 1 through 6), there is persistent fever, headache, intense fatigue, vomiting, diarrhea, and abdominal pain. In the false or pseudo remission phase (days 7 to 8), the patient may feel slightly better and ask for food. Some patients recover during this phase and survive the disease. In the

aggravated phase (day 9) the patient gets worse. They may develop red or purple spots that represent bleeding into the skin, a diffuse skin rash, difficulty breathing, cough, hiccups, throat and chest pain, and ultimately, cardiovascular compromise and shock.

The virus spreads throughout the body and kills cells and tissues of the liver, spleen, kidney, lymph nodes, testicles and ovaries. It damages the blood vessels and platelet cells in the blood stream, ultimately leading to widespread hemorrhage. While Ebola is classified as a 'Viral Hemorrhagic Fever', the degree of hemorrhage varies widely among patients, and death typically results from organ failure rather than uncontrollable bleeding.

The virus also compromises and suppresses the patient's immune system overall, increasing the risk of secondary infections developing. Ebola virus has a high fatality rate.

At the onset of symptoms, Ebola may mimic malaria, typhoid fever, influenza, or other disease. This may delay recognition and the use of prompt isolation measures.

Diagnosis of the disease is based on specific isolation of the virus or detection of specific immune substances in the blood.

There is no proven virus-specific treatment and in most settings, care is supportive in nature. Providing fluids, maintaining good oxygen levels and blood pressure levels and treating other infections if they occur may significantly improve the chances of survival.[85] Efforts are underway to develop Ebola vaccines and clinical trials to test vaccine candidates are ongoing.

Ebola is considered a potential biologic weapon. Development of treatment and prevention strategies is considered to be an urgent matter. Of note, an investigational vaccine candidate was recently shown to be 100% effective in preventing Ebola among contacts of disease victims in a large trail in Africa.

CDC protocol for Emergency Room and Hospital triage and care of suspected cases

The cornerstone of controlling an Ebola outbreak is interrupting the transmission chain.

This requires several strict public health measures that must be instituted quickly and includes: isolation of patients, barrier precautions, and identification and tracking of all patient contacts.

In light of the success of specialized facilities at the University of Nebraska, Emory University, Bellevue Hospital in New York, and the National Institutes of Health in caring for Ebola victims, the CDC and Department of Health and Human Services have developed a three-tiered system to screen and manage potential Ebola victims. Under this system, additional specialized capability would be developed by tertiary care facilities, which would then be designated as 'Ebola Treatment Centers' (ETC). As of this writing, approximately 55 such centers have applied for designation and funding; among them are ten designated as regional referral centers by DHHS (one in each of its 10 geographic regions). In addition, other hospitals would be designated as 'Ebola Assessment Hospitals' (EAH), able to manage and isolate persons under investigation until a diagnosis of EVD can be confirmed or refuted. Finally, remaining hospitals ('Frontline Facilities') would receive training in order to improve their ability to isolate potential Ebola victims until they could be transferred to an EAH or ETC.

A patient presenting to an emergency room with possible risk factors for Ebola should undergo a standardized sequential screening protocol and a positive result should trigger the use of personal

protective equipment, avoidance of close patient contact, , and removal to a designated isolation area within the emergency room. Patients with suspicious symptoms, as well as appropriate risk factors (such as travel to an endemic area within the previous 21 days) are considered to be under investigation. When a person is under investigation, has had signs or symptoms for fewer than 3 days, and has a negative preliminary diagnostic test, this poses a challenge for health care facilities because the patient must still be kept in isolation for an additional 72 hours pending a second negative diagnostic test. During these intervening 72 hours, if the patient develops other manifestations of the underlying disease, they will need evaluation to rule out other causes, as well as monitoring for the diagnosis of Ebola.

Patients who refuse to comply with recommended isolation and testing represent a significant safety risk to others in the health care facility and public at large. A meeting with local law enforcement, county and state health department officials, hospital leaders, security and risk management is required. It is important for all involved to agree to a specific plan of action because making legal decisions at the bedside of an evolving medical condition is almost impossible.

Patients who are competent but refuse to stay at the hospital are allowed to leave via a route that is isolated from emergency department staff and other patients. The county health director and county attorney are immediately contacted for an isolation hold order; once verbally received it is also sent via other means such as personal delivery, fax or other electronic media. Local law enforcement is then contacted to enforce the order, return the patient to the hospital and remain in isolation until all testing is negative or Ebola is confirmed and they are moved to a biocontainment unit. Law enforcement will need to wear full personal protective equipment prior to and during all contact with the patient under investigation.

If the patient is incompetent, the treating physician may order a temporary medical hold order and hospital security in full personal protective equipment must escort the patient to the designated isolation area.

II. Middle Eastern Respiratory Syndrome (MERS)

Epidemiology

The first case of MERS occurred din 2012 in Saudi Arabia. MERS is caused by a virus and is associated with high mortality rates, particularly in patients with pre-existing diabetes or renal failure. The largest outbreak has occurred in the Arabian Peninsula although since May 2015 there has been an ongoing outbreak in the Republic of Korea.

A persons should be placed under investigation for possible MERS if they have fever and pneumonia or acute respiratory distress syndrome, along with a history of recent travel to countries in or near the Arabian Peninsula within the 14 days prior to symptoms or if they have had contact with a traveler from this region who developed a respiratory illness and fever.

MERS is caused by a coronavirus. This family of viruses causes illnesses ranging from the common cold to Severe Acute Respiratory Syndrome (SARS). Coronaviruses have high rates of genetic mutation and change and a tendency to cross from one species to another, for example, from animals to humans. The exact source and mode of transmission of MERS to humans is not known although in the current outbreak it is believed to have ‘jumped’ from camels to humans either through direct contact or through unpasteurized camel milk.[87]

MERS cases are reported throughout the year, although the disease is seasonal.

Human to human transmission does occur, either through respiratory droplets or direct contact, although only to a limited extent. Close contact appears to be necessary for human to human transmission. The risk of infection from inanimate surfaces is not well understood although under controlled laboratory conditions, the virus has been recovered from surfaces after 48 hours.[88]

Prevention of MERS transmission relies primarily on droplet precautions (wearing a surgical mask) or contact precautions (wearing a gown and gloves when caring for a patient or in the room). Eye protection is advisable as well.

- Vaccinations -- There are currently no vaccines against MERS.
- Disease process, diagnosis, and treatment

MERS is transmitted through respiratory droplets. Infected patients may have no symptoms or have an acute illness with fever or an upper respiratory infection. In its worst form, MERS causes a highly lethal pneumonia and/or multi-organ failure.[89] The case-fatality rate of MERS is approximately 35%.

The incubation period for MERS is estimated as 2 to 14 days, with a mean of 5. Initially patients may develop symptoms of fever, cough, chills, sore throat, muscle and joint aches. These may progress to pneumonia within the first week and may require ventilator support. About one third of patients will also develop gastrointestinal symptoms such as vomiting or diarrhea.

Diagnosis is made either on blood work or detection of the virus in bodily fluid specimens.

The highest concentrations of virus are in fluids in the lungs, sputum, or the deep throat (trachea) so it is best to obtain specimens from these areas.

There is no specific treatment for MERS; supportive therapy is the cornerstone of management.

III. Pandemic Influenza

Epidemiology

Influenza epidemics typically occur in the fall and winter months in the United States, as well as in other areas with temperate climates. Worldwide, influenza epidemics result in approximately 3 to 5 million cases of severe illness and 250,000 to 500,000 deaths every year.

Influenza viruses are extremely diverse and are divided into three major groups: A, B, and C, with A being the most notorious for its ability to recombine its genes and produce new variants of flu virus, a process known as ‘antigenic shift’. This antigenic shift results in a novel virus to which even previously immunized persons would typically be susceptible. For this reason, Influenza A type is associated with global pandemics.[90]

A separate phenomenon seen among Influenza A viral strains involves ‘antigenic drift’, wherein minor mutations accumulate over time. This results in changes to the virus’s genetic makeup over time and is the reason that yearly re-immunization is necessary.

Type A influenza infections are typically transmitted from human-to-human, but novel strains can emerge from animal reservoirs (such as birds and swine) In birds, influenza is often a highly lethal disease, and, although most bird strains are not pathogenic in humans, fears over avian influenza involve the possibility that a strain may someday emerge that combines the contagiousness of a human strain with the lethality

of a bird strain. Type A influenza viruses are subtyped by two proteins, hemagglutinin (H) and neuraminidase (N). While most currently-circulating human strains are of the H1N1 or H3N2 lineage, recent avian influenza alarms have involved H5N1 or H7N9 variants. Although these variants have only infected small numbers of humans, their lethality has been quite high.

The most serious influenza pandemic in recorded history occurred in 1918 and 1919 and was called the "Spanish flu" which killed over 50 million people worldwide.[92] This pandemic was caused by the H1N1 strain. Other pandemics occurred in 1957 and in 1968; these involved different flu strains.

In 2009, type A influenza (H1N1) caused the first influenza pandemic of the 21st century.

It affected over 24 countries, and caused an estimated 285,000 deaths, with most deaths occurring in young, previously healthy adults.[93] However, this death toll may be a falsely low estimate. An exhaustive review of the 2011 H1N1 pandemic showed the worldwide fatalities due to this virus were understated by a magnitude of ten-fold.[94] The 2009 pandemic also disproportionately affected pregnant women. Household transmission of pandemic flu had an attack rate of up to 45%.[95] Household attack rates are highest among children and adolescents.

In 2013, the H7N9 influenza virus emerged in China. Infections in poultry and wild life were not obvious but it causes severe respiratory disease in humans. Control of this strain has been achieved by closing live poultry markets.[96]

Current viral threats include re-emergence of H2N2 (not seen in humans for about 50 years), or mutation of the H5N1 or H7N9 strains to the point of being transmissible from humans to humans, in lieu of current animal to human transmission.

Vaccination

Vaccination is done annually for influenza because of the antigenic drift described above; this drift allows the virus to escape the immune response created by prior vaccinations or infections. Each year, a new influenza vaccine is released, which includes coverage for the dominant viral forms of the previous year and forms considered to be at high risk for occurring in the new flu season. The World Health Organization has been remarkably accurate in predicting which dominant circulating strains will emerge over the last 45 years. Only twice, in in 1997 and 2003, has the recommended strain not matched the one that emerged.[97]

Efforts are underway to develop a 'universal' influenza vaccine but it is not clear how long such a vaccine would provide protection. A universal vaccine would help circumvent the problem that occurs whenever a pandemic is identified: the need to determine the specific genetic code of the pandemic strain quickly to allow for production of the necessary substances in a vaccine form for immunization against the (ongoing) pandemic strain.

In addition to preventing the pulmonary complications of influenza, the vaccine can prevent medical disasters that may be triggered by influenza such as heart attack and stroke.[98]

Disease process, diagnosis, and treatment

The pandemic influenza virus behaves similarly to other influenza viruses. A large number of influenza infections are asymptomatic or associated with mild disease that does not require medical attention. Risk

factors for severe disease include the extremes of age, chronic underlying medical illness, pregnancy, and, in an unexpected finding during the H1N1 pandemic, obesity.

There are few clinical features to help distinguish between pandemic flu and other causes of influenza-like illness. Symptoms usually occur within a week of exposure and people with the virus are infectious for about 8 days after the onset of symptoms. Common symptoms include the abrupt onset of fever, runny nose, fatigue, sore throat, cough, generalized muscle aches or headache. Some people may also have diarrhea and vomiting.

Cultures are best for diagnosis if they are obtained in the first 2 to 3 days after the onset of symptoms. Rapid detection tests have been developed but their accuracy is still not optimal.

The treatment of influenza continues to be antiviral medications although resistance to components of these drugs is known, and with the ability of the flu virus to modify its genes, resistance is inevitable. The need for continued development of effective antivirals remains urgent.

Complications

Most people infected with influenza recover, although severe cases, particularly severe viral pneumonia, may require hospitalization and significant supportive care. Rarely, influenza may cause inflammation of the heart, seizures triggered by fever, inflammation of the brain and spinal cord, damage to the brain and liver (Reye's syndrome), inflammation with damage of muscles, or cause the immune system to attack the nervous system resulting in progressive paralysis (Guillain-Barré syndrome). Secondary bacterial infections, such as bacterial pneumonia, may occur as well. Influenza can be fatal, especially for persons at both extremes of the age spectrum, and is a frequent initiating event in the demise of elderly persons.

IV. Measles

Epidemiology

Prior to the availability of a vaccine to prevent measles (rubeola), 90% of Americans had been infected by the time they were 15 years old.[99]

Of the over half people annually infected in the years immediately preceding the vaccine, 400 to 500 died; 150,000 had respiratory problems; and 4,000 developed swelling of the brain (encephalitis) from the disease. Infants and young children are the most susceptible to measles, with the highest attack rate occurring between the ages of 5 to 9 years of age.[100]

While thought of as a childhood disease, the demographics of measles have shifted. Since 2001, half of the reported cases in the U.S. occurred in people 20 years of age and older.[101]

Vaccination effectiveness

The measles vaccine is extremely effective at preventing the disease. One dose of the measles vaccine is 93% effective in preventing the disease if in those exposed and two doses is 97% effective in preventing the disease if exposed to the virus. Approximately 3 out of 100 people vaccinated against measles can still contract the virus; the reason for this is not known. If a person has received two doses of the vaccine, no booster shots are necessary.

The vaccine is safe to give to egg-allergic children. Administration of the vaccine may prevent the disease if it is given within 72 hours of exposure.

When a critical portion of a community is vaccinated against a contagious disease, most members in that community are protected and there is little chance for an outbreak to occur. Even those who are ineligible for the vaccine(s) get some protection because they are surrounded by a large portion of the community that will neither contract nor spread the disease. This is known as community or herd immunity and is applicable to a variety of diseases for which there are vaccines, e.g., measles, influenza, mumps, pneumococcal disease. In a setting where large portions of the population are immune to a disease, chains of infection are likely to be disrupted, a process that slows or stops the spread of disease. The more people in a community who are immune, the smaller the chance that those who are not immune will come into contact with an infectious individual.[102]

In 2000, the CDC declared measles to be 'eliminated' in the United States.[103] Elimination is defined as the absence of continuous disease transmission for 12 months or more in a specific geographic area; the disease is no longer endemic or constantly present in the U.S. Measles does continue to occur, however, and the incidence has been increasing in the United States since 2000. It is believed to be brought into the U.S. by unvaccinated travelers (Americans or foreign visitors) who contract the virus abroad, and then transmit it to others who are not vaccinated.

Disease process, diagnosis, and treatment

Measles the most contagious virus known and humans are its only reservoir. It is transmitted by respiratory droplets and the virus may survive on contaminated surfaces for an hour. The disease has four distinct stages: incubation, prodromal (catarrhal), rash (exanthematous), and recover. The incubation period is 8 to 12 days and people are most infectious 1 to 2 days before they have any symptoms. The infectiousness peaks about 3 days before a rash develops. Patients remain contagious until about 4 days after the rash appears.

After the incubation period, the person enters the prodromal or catarrhal stage. The classic trio of symptoms includes cough, inflammation of the lining of the nasal cavities (similar to a cold), and reddened eyes (conjunctivitis). Sensitivity to light may be present. Fever, loss of appetite, and a general sense of not feeling well are common as well. One unique feature, although not readily seen in all patients, involves the blue-white spots' of measles, lesions on the inner surfaces of the cheeks, known as Koplik spots. These, appear 1 to 2 days before a generalized rash and are found on the inside of the cheeks, often across from the molars.[104] They and last for 1 to 3 days; and, given their short duration and hidden location, they are often not seen appreciated and diagnosis may thus be delayed until the more obvious rash appears.

The rash or exanthematous stage starts at the top of the body and spreads down over about a day; it typically does not involve the palms of the hands or soles of the feet. The rash lasts 3 to 7 days, may turn from reddish to brownish in color, and the skin on top of the rash may start to peel, in the same pattern as the rash appeared.[105] During the rash stage, the person may have enlarged lymph nodes, an enlarged spleen, enlarged lymph nodes deep in the abdomen, and abdominal pain. Ear infections, pneumonia, and diarrhea may also occur during the rash phase; they are more common in infants.

Recovery and clinical improvement may be seen 48 hours after the rash starts. The cough may last for several weeks. Even after the disease is resolved, the person has a weakened immune system and increased susceptibility to other bacterial and viral infections, which lead to increased measles related morbidity and mortality.

Diagnosing measles requires either satisfying CDC clinical criteria or showing laboratory evidence of the virus.

There is no specific antiviral treatment for measles. Supportive therapy addresses fever, keeping the person well hydrated, and promptly treating complications, such as pneumonia. Antibiotics are recommended only to treat secondary bacterial infections.

The World Health Organization recommends vitamin A therapy for children with measles as pre-existing vitamin A deficiency (uncommon in the United States) may worsen the prognosis. Because of the highly contagious nature of measles, persons suspected of having it or having been exposed to it (without prior immunization or naturally occurring infection) should be isolated. Confirmed cases should be reported to the local health department.

Disease complications

The most common complications of measles are diarrhea and ear infections; the most common cause of death is pneumonia. Other complications include a croup-like cough, diarrhea and dehydration. Complications involving the brain and nervous system may result in febrile seizures or swelling of the brain (encephalitis). Encephalitis usually occurs 2 to 5 days after the rash has started and is more common in older adults and children. It is thought to result from direct viral infection of the brain tissue.[106]

A rarer complication (known as subacute sclerosing panencephalitis) involving the brain leads to progressive behavioral and cognitive deterioration and, ultimately, death occurs 8 to 10 years after the acute infection. Measles may also lead to eye complications including acquired blindness; this is more commonly seen in countries where vitamin A deficiency is common.[107]

Women who develop measles during pregnancy have a higher risk of pneumonia, preterm labor, miscarriage and lower birth weight babies.

V. Tuberculosis and Multi-Drug Resistant Tuberculosis

Epidemiology

Tuberculosis (TB) is caused by a mycobacterium and strains that are resistant to anti-TB drugs have been reported worldwide.[108] The emergence of these multi-drug resistant TB (MDR-TB) and extensively drug resistant (XDR-TB) strains is one of the most dangerous threats to global TB control. Some XDR-TB strains are resistant to all available and effective antibiotic options.

In 2012, there were 8.6 million cases of TB and 1.3 million deaths worldwide attributed to the disease.[109] The proportion of MDR-TB cases is steadily increasing and it is estimated that there are over 500,000 cases annually worldwide, and growing.[110]

Modelling shows that maintenance of current TB rates requires each TB case to infect 20 contacts.[111]

Recent studies show that each TB index case usually infects 2.6 to 5.9 contacts so this model may overestimate the number of contacts needed to maintain current rates of TB infection in a population.[112]

TB occurs in a higher percentage of at a higher rate in blacks in the US; the reasons for this are unclear.

There is also a higher incidence of TB among people who are incarcerated (4% to 5% of TB cases occur in this population), the homeless, residential care facilities, nursing homes, those infected with HIV, those with cancer or diabetes, and among travelers to or from high burden countries.

Multi-drug resistant TB (MDR-TB) refers to TB strains resistant to drugs commonly used to treat TB. Treatment outcomes for MDR-TB are worse than those for patients with non-resistant TB, with less than half of all cases successfully treated. Globally it is estimated that there are 350,000 to 610,000 cases of MDR-TB, with 9% of those cases being extensively drug resistant.[113]

Most MDR-TB cases result from a large gap between diagnosis and treatment, incomplete treatment, and poor treatment outcomes. Once drug- resistance develops, the risk of transmission of the same drug-resistant strain is possible; half of MDR-TB cases occur through this way.

Vaccines

The only licensed vaccine for TB is BCG (bacille Calmette-Guerin). The vaccine was created over 75 years ago and it provides a variable degree of protection against pulmonary disease. It does, however, provide consistent and reliable protection against disseminated disease in childhood. Revaccination during adolescence does not provide improved protection. BCG vaccination in the U.S. is only for people who meet very specific criteria and with the recommendation for vaccination from a TB expert.

Disease symptoms, diagnosis, treatment

TB is primarily a disease of the lungs and it is transmitted by respiratory droplets through coughing, talking, breathing, and sneezing. Coughing seems to produce the most airborne particles. TB mycobacterium may survive from 1 day to 4 months on dry surfaces. Disinfection is done with special cleaning agents such as glutaraldehyde or a hypochlorite solution.

Exposure to TB often results in latent TB infection which has a 5% to 10% lifetime risk of progressing to active TB. Most active TB cases occur within the first 2 years after infection. Latent TB is considered a reservoir for new disease and ongoing TB transmission within a community.

Latent TB does not have any active disease signs or symptoms.[114] It is diagnosed either through tuberculin skin testing or other methodologies through the measurement of gamma-interferon in blood. The skin test is usually positive within 3 to 6 weeks of infection, although it may take up to 3 months in some patients.

Once a skin test is positive, it remains so throughout one's life, even after treatment. Those who have received the BCG vaccine for TB will always have a positive skin test. A variety of factors may lead to a falsely positive, or falsely negative, skin test. A chest x-ray may also be used to confirm the diagnosis of TB.

Diagnosis of latent TB does not provide any information about the duration or activity of the latent infection, which is an infection localized to an area within the lungs.

Latent infection may reflect a state where the infection is actively replicating organisms ('percolating') or it may reflect a state where the infection has been cleared and immunity to TB has developed in the person. People with suspected latent TB are treated to prevent further possible spread of the disease as well as to diminish the risk for progression from latent disease to active disease. Contacts of latent TB cases need to undergo history and physical examination, chest x-ray and provide a sample of sputum for testing for culture tests.

Patients with latent TB and who are asymptomatic but have growth of TB on their sputum culture are reclassified from latent infection to asymptomatic or subclinical disease infection. This occurs often in

children and in patients with compromised immune systems. Patients with positive cultures are more likely to have lung lesions or tumors (e.g., Ghon's complex) on chest x-ray. They are also more likely to have a cough that may be severe and, through coughing, are more capable of infecting others.

Factors that influence progression of TB from latent to active states include age, immune system status, and both the nature of the exposure and infectious level of the index case. Any condition that affects the immune system, such as HIV, old age, cancer, malnutrition, immunosuppressive drugs, may lead to reactivation of the TB bacterium or secondary disease.[115] It is not readily possible to distinguish between reactivation of disease and re-exposure and reinfection.

Infants and children have immature immune systems and are may not be able to control initial or latent TB infection well. They may shed TB organisms even though they have no symptoms and abnormalities on chest x-rays are common. The risk for developing TB infection outside of the lungs in children under one year of age is extremely high.

Active TB may be due to active infection of the lungs or infection in other areas of the body such as lymph nodes, skin, joints and bones, the lining of the brain and spinal cord, the abdomen, the genitourinary tract, or lymph nodes. Some patients may have both active lung infection as well as active infection in other parts of the body. Active infection of the lungs is the most common type of active TB. Active TB may cause symptoms such as severe and frequent coughing, coughing up blood, night sweats, pain in the lining of the lungs, fever, weight loss, night sweats, and muscle wasting. It is this wasting away of patients that led to TB's moniker, consumption.

Diagnosis of active TB may include culture or biopsy of either lung lesions or lesions in other parts of the body. Drug susceptibility testing should be done in all patients with TB although in low-resource countries, this is quite difficult.

Active disease is commonly treated for 6 to 9 months with the caveat that if the infected person does not take the drugs correctly, or stops them too soon, they may develop bacteria that are resistant to therapy and they will become sick with TB. Treatment of MDR-TB is difficult; it often requires the use of less effective drugs that are more costly, toxic, and must be taken for prolonged periods of time. Monitoring of treatment is cumbersome and treatment success ranges from 36% to 79%; for strains resistant to an extensive number of drugs (XDR-TB) treatment is even less successful.[116]

Failure to detect drug resistance leads to improper therapy, premature death, increased resistance among TB strains, and ongoing infection in a community. While strides are being made to develop cheap and accurate tests for easier diagnosis of MDR-TB, international availability and accessibility to newer tests remains a barrier to their use.

Complications

Although TB disease is often subacute, it may present as sudden shock due to widespread infection (sepsis) and respiratory failure. There is also a known paradoxical reaction where patients actually get worse during treatment of disease, and this is thought to be due to an exaggerated immune response of the body.

Patients may have massive bleeding in the lungs which is believed to occur when a TB lung infection erodes into a blood vessel in the lungs.

Brain and spinal cord lesions may result in swelling of the brain, seizures, and death.

Infection and inflammation of the lining around the heart may lead to heart attacks or heart failure. Other complications depend on which organ system is involved.

Corresponding footnotes:

83. See Indiana, Kentucky, Michigan and Oregon bench books.

84. These summaries were drafted by Research Professor Allison Winnike, JD and Dr. Michele Curtis, M.D., M.P.H.

85. WORLD HEALTH ORGANIZATION, CLINICAL MANAGEMENT OF PATIENTS WITH VIRAL HAEMORRHAGIC FEVER: A POCKET GUIDE FOR THE FRONT-LINE HEALTH WORKER (Apr. 2014), http://www.who.int/csr/resources/publications/clinical-management-patients/en/.

86. Centers for Disease Control and Prevention, Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation (PUIs) or with Confirmed Ebola Virus Disease (EVD): A Framework for a Tiered Approach (Feb. 20, 2015), http://www.cdc.gov/vhf/ebola/hcp/us-hospital-preparedness.html.

87. See, e.g., Chantal Bernadette Reusken et al., Middle East respiratory syndrome coronavirus neutralising serum antibodies in dromedary camels: a comparative serological study, 13(10) LANCET INFECT. DIS. 859 (Oct. 2013), http://dx.doi.org /10.1016/S1473-3099(13)70164-6; Chantal Bernadette Reusken et al., Middle East Respiratory Syndrome coronavirus (MERS-CoV) serology in major livestock species in an affected region in Jordan, June to September 2013, 18(50) EUROSURVEILLANCE 20662 (Dec. 12, 2013), http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20662; Chantal Bernadette Reusken et al., Middle East respiratory syndrome coronavirus (MERS-CoV) RNA and neutralising antibodies in milk collected according to local customs from dromedary camels, Qatar, April 2014, 19(23) EUROSURVEILLANCE 20829 (Jun. 12, 2014), http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20829.

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Appendix C – Listing of Nebraska Health Departments

Current through June 27, 2017

NEBRASKA HEALTH DEPARTMENTS
COUNTY HEALTH DEPARTMENTS

Clay County Health Department
Laurie Sheridan, Director
209 North Calvary Avenue
Clay Center, NE 68933-1200
Phone: (402) 762-3571
Fax: (402) 762-3573
Email: claycohealth@windstream.net
Web site: www.claycounty.ne.gov
(Clay County/Clay Center)

Dakota County Health Department
Tiffany Hansen, Director
1601 Broadway Street/Box 155
Dakota City, NE 68731-5065
Phone: (402) 987-2164
Fax: (402) 987-2163
Email: tpaulson@dakotacountyne.org
Web site: www.dakotacountyne.org
(Dakota County/Dakota City)

Douglas County Health Department
Adi Pour, Director
1111 South 41st Street
Omaha, NE 68105-1803
Phone: (402) 444-7471
Fax: (402) 444-6267
Email: adi.pour@douglascounty-ne.gov
Web site: www.douglascountyhealth.com
(Douglas County/Omaha)

Polk County Health Department
Darla Winslow, Director
330 North State Street/Box 316
Osceola, NE 68651-5522
Phone: (402) 747-2211
Fax: (402) 747-7241
Email: darlawins@yahoo.com
(Polk County/Osceola) 2 Revised 6/23/2017

Red Willow County Health Department
Pamela Harsh, Director
1400 West 5th
McCook, NE 69001-2664
Phone: (308) 345-1790
Fax: (308) 345-1794
Email: rwchdpam@mccooknet.com
Web site: http://redwillowhealth.com
(Red Willow County/McCook)

Scotts Bluff County Health Department
Paulette Schnell, Director
1825 10th Street
Gering, NE 69341-2445
Phone: (308) 436-6636; Cell: (308) 631-6074
Fax: (308) 436-6638
Email: pschnell@scottsbluffcounty.org
Web site: www.scottsbluffcounty.org/health/health.htm
(Scotts Bluff County/Gering)

CITY-COUNTY HEALTH DEPARTMENT
Lincoln-Lancaster County Health Department
Charlotte Burke, Interim Health Director
3140 “N” Street
Lincoln, NE 68510-1523
Phone: (402) 441-8011
Email: cburke@lincoln.ne.gov
Web site: www.lincoln.ne.gov/city/health
(Lancaster County/Lincoln)

DISTRICT HEALTH DEPARTMENTS
Central District Health Department
Teresa Anderson, Director
1137 South Locust Street
Grand Island, NE 68801-6771
Phone: (308) 385-5175 x178; Toll Free: (877) 216-9092
Fax: (308) 385-5181
Email: tanderson@cdhd.ne.gov
Web site: www.cdhd.ne.gov
(Hall County/Grand Island, Hamilton County/Aurora, Merrick County/Central City) 3 Revised 6/23/2017

East Central District Health Department
William Rodgers, Interim Health Director
4321 41st Avenue/Box 1028
Columbus, NE 68602
Phone: (402) 562-8950
Fax: (402) 564-5714
Email: wrodgers@ecdhd.ne.gov
Web site: http://ecdhd.ne.gov
(Boone County/Albion, Colfax County/Schuyler, Nance County/Fullerton, Platte County/Columbus)

Elkhorn Logan Valley Public Health Department
Gina Uhing, Director
Box 779
Wisner, NE 68791-0779
Phone: (402) 529-2233; Toll-Free: (877) 379-4400; LHD 24/7 Cell: (402) 841-8110
Fax: (402) 529-2211
Email: gina@elvphd.org
Web site: www.elvphd.org
(Burt County/Tekamah, Cuming County/West Point, Madison County/Madison, Stanton County/Stanton)

Four Corners Health Department
Laura McDougall, Executive Director
2101 North Lincoln Avenue
York, NE 68467-1027
Phone: (402) 362-2621; Toll-Free: (877) 337-3573; Cell: (402) 366-6485
Fax: (402) 362-2687
Email: lauram@fourcorners.ne.gov
Web site: www.fourcorners.ne.gov
(Butler County/David City, Polk County/Osceola, Seward County/Seward, York County/York)

Loup Basin Public Health Department
Chuck Cone, Director
934 "I" Street/Box 995
Burwell, NE 68823-0995
Phone: (308) 346-5795; Toll-Free: (866) 522-5795; Cell: (308) 214-1066
Fax: (308) 346-9106
Email: ccone@nctc.net
Web site: www.loupbasinhealth.com
(Blaine County/Brewster, Custer County/Broken Bow, Garfield County/Burwell, Greeley County/Greeley, Howard County/St Paul, Loup County/Taylor, Sherman County/Loup City, Valley County/Ord, Wheeler County/Bartlett) 4 Revised 6/23/2017

North Central District Health Department
Roger Wiese, Director
422 East Douglas Street
O'Neill, NE 68763-1852
Phone: (402) 336-2406; Toll Free: (877) 336-2406; Cell: (402) 340-3086
Fax: (402) 336-1768
Email: roger@ncdhd.ne.gov
Web site: www.ncdhd.ne.gov
(Antelope County/Neligh, Boyd County/Butte, Brown County/Ainsworth, Cherry County/Valentine, Holt County/O'Neill, Keya Paha County/Springview, Knox County/Center, Pierce County/Pierce, Rock County/Bassett)

Northeast Nebraska Public Health Department
Julie Rother, Director
215 North Pearl Street
Wayne, NE 68787-1975
Phone: (402) 375-2200
Fax: (402) 375-2201
Email: phndirector@nnphd.org
Web site: www.nnphd.org
(Cedar County/Hartington, Dixon County/Ponca, Thurston County/Pender, Wayne County/Wayne)

Panhandle Public Health District
Kim Engel, Director
808 Box Butte Avenue
Box 337
Hemingford, NE 69348-9700
Phone: (308) 487-3600; Cell: (308) 760-2415
Fax: (308) 487-3682
Email: kengel@pphd.org
Web site: www.pphd.org
(Banner County/Harrisburg, Box Butte County/Alliance, Cheyenne County/Sidney, Dawes County/Chadron, Deuel County/Chappell, Garden County/Oshkosh, Grant County/Hyannis, Kimball County/Kimball, Morrill County/Bridgeport, Scotts Bluff County/Gering, Sheridan County/Rushville, Sioux County/Harrison) 5 Revised 6/23/2017

Public Health Solutions District Health Department
M Jane Ford Witthoff, Health Director
995 East Highway 33/Suite 1
Crete, NE 68333-2551
Phone: (402) 826-3880; Cell: (402) 730-4829
Fax: (402) 826-4101
Email: jfordwitthoff@phsneb.org
Web site: www.phsneb.org
(Fillmore County/Geneva, Gage County/Beatrice, Jefferson County/Fairbury, Saline County/Wilber, Thayer County/Hebron)

Sarpy/Cass Department of Health and Wellness
Shavonna Lausterer, Director
701 Olson Drive/Suite 101
Papillion, NE 68046-4797
Phone: (402) 339-4334; Toll Free: (800) 645-0134
Fax: (402) 339-4235
Email: slausterer@sarpy.com
Web site: www.sarpycasshealthdepartment.org
(Cass County/Plattsmouth, Sarpy County/Papillion)

South Heartland District Health Department
Michele Bever, Executive Director
606 North Minnesota/Suite 2
Hastings, NE 68901-5256
Phone: (402) 462-6211; Toll Free: (877) 238-7595
Fax: (402) 462-6219
Email: michele.bever@shdhd.org
Web site: www.southheartlandhealth.org
(Adams County/Hastings, Clay County/Clay Center, Nuckolls County/Nelson, Webster County/Red Cloud)

Southeast District Health Department
Kevin Cluskey, Director
2511 Schneider Avenue
Auburn, NE 68305-3054
Phone: (402) 274-3993; Toll Free: (877) 777-0424; Cell: (402) 274-8158
Fax: (402) 274-3967
Email: kevin@sedhd.org
Web site: www.sedhd.org
(Johnson County/Tecumseh, Nemaha County/Auburn, Otoe County/Nebraska City, Pawnee County/Pawnee City, Richardson County/Falls City) 6 Revised 6/23/2017

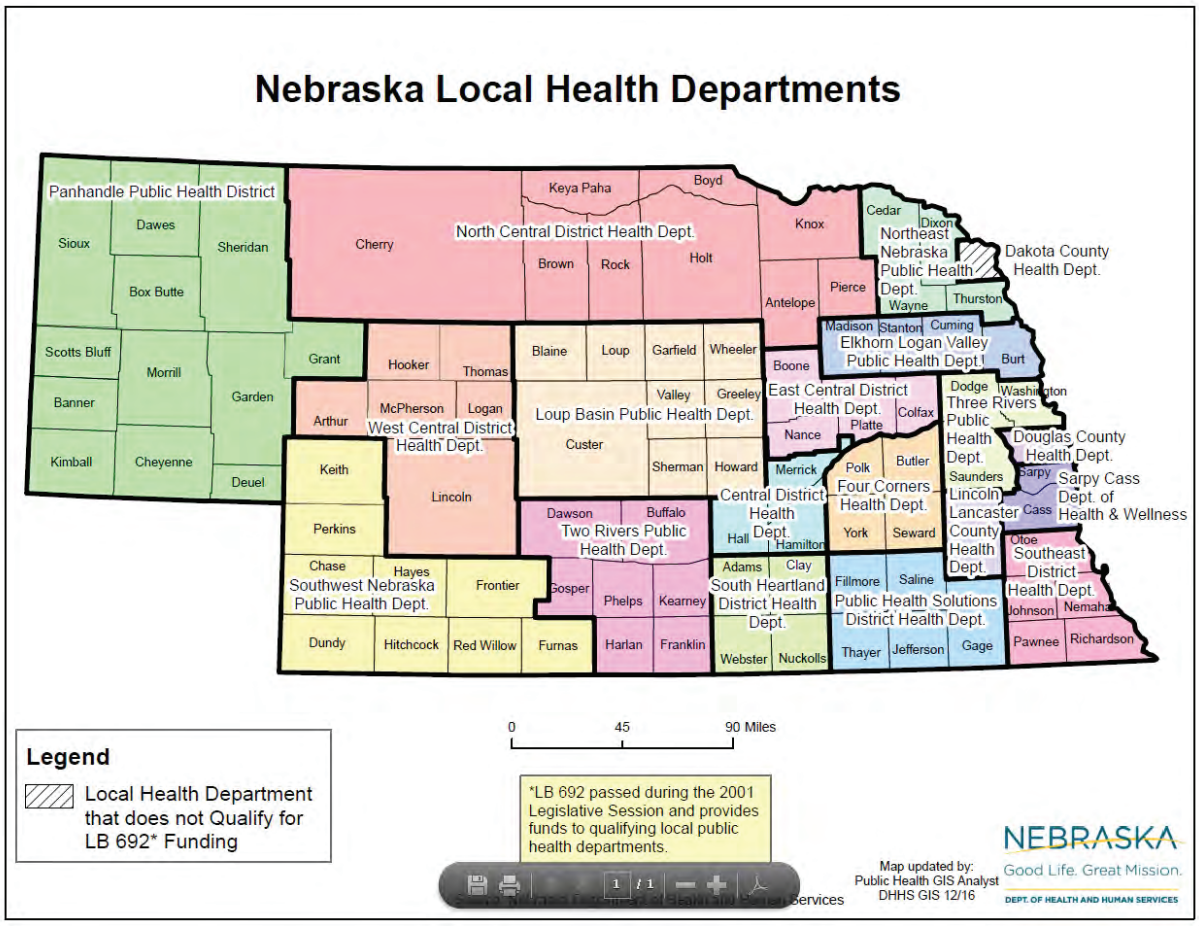
Southwest Nebraska Public Health Department
Myra Stoney, Director
404 West 10th Street/P O Box 1235
McCook, NE 69001-2911
Phone: (308) 345-4223; Cell: (308) 340-2642
Fax: (308) 345-4289
Email: director@swhealth.ne.gov
Web site: www.swhealth.ne.gov
(Chase County/Imperial, Dundy County/Benkelman, Frontier County/Stockville, Furnas County/Beaver City, Hayes County/Hayes Center, Hitchcock County/Trenton, Keith County/
Ogallala, Perkins County/Grant, Red Willow/McCook)

Three Rivers Public Health Department
Terra Uhing, Director
2400 North Lincoln Street
Fremont, NE 68025-2461
Phone: (402) 727-5396; Toll Free: (866) 727-5396; Cell: (402) 317-8841
Fax: (402) 727-5399
Email: terra@3rphd.org
Web site: http://threeriverspublichealth.org
(Dodge County/Fremont, Saunders County/Wahoo, Washington County/Blair)

Two Rivers Public Health Department
Jeremy Eschliman, Director
701 4th Avenue/Suite 1
Holdrege, NE 68949-2255
Phone: (308) 995-4778; Toll Free: (888) 669-7154; Cell: (308) 999-7093
Fax: (308) 995-4073
Email: jeschliman@trphd.org
Web site: www.trphd.org
(Buffalo County/Kearney, Dawson County/Lexington, Franklin County/Franklin, Gosper County/Elwood, Harlan County/Alma, Kearney County/Minden, Phelps County/Holdrege)

West Central District Health Department
Shannon Vanderheiden, Director
111 N Dewey/Suite A
North Platte, NE 69103-5439
Phone: (308) 696-1201; Cell: (308) 520-0158
Fax: (308) 696-1204
Email: vanderheidens@wcdhd.org
Web site: www.wcdhd.org
(Arthur County/Arthur, Hooker County/Mullen, Lincoln County/North Platte, Logan County/Stapleton, McPherson County/Tryon, Thomas County/Thedford)

NOTE: After each county name is the county seat.


Nebraska Local Health Departments
Panhandle Public Health District
Sioux
Dawes
Sheridan
Box Butte
Scotts Bluff
Morrill
Banner
Kimball
Cheyenne
Deuel
Garden
Cherry
Keya Paha
Boyd
North Central District Health Dept.
Brown
Rock
Holt
Knox
Cedar
Dixon
Northeast Nebraska Public Health Dept.
Dakota County Health Dept.
Antelope
Pierce
Wayne
Thurston
Grant
Hooker
Thomas
Blaine
Loup
Garfield
Wheeler
Madison
Stanton
Cuming
Elkhorn Logan Valley Public Health Dept.
Burt
Boone
Arthur
McPherson
Logan
West Central District Health Dept.
Loup Basin Public Health Dept.
Valley
Greeley
East Central District Health Dept.
Colfax
Dodge
Washington
Three Rivers Public Health Dept.
Nance
Platte
Custer
Sherman
Howard
Douglas County Health Dept.
Keith
Lincoln
Merrick
Polk
Butler
Saunders
Sarpy
Sarpy Cass Dept. of Health & Wellness
Four Corners Health Dept.
Lincoln
Lancaster County Health Dept.
Cass
Perkins
Dawson
Buffalo
Two Rivers Public Health Dept.
Central District Health Dept.
Hall
Hamilton
York
Seward
Otoe
Southeast District Health Dept.
Chase
Hayes
Southwest Nebraska Public Health Dept.
Frontier
Gosper
Phelps
Kearney
Adams
Clay
South Heartland District Health Dept.
Fillmore
Saline
Public Health Solutions District Health Dept.
Johnson
Nemaha
Dundy
Hitchcock
Red Willow
Furnas
Harlan
Franklin
Webster
Nuckolls
Thayer
Jefferson
Gage
Pawnee
Richardson
0
45
90 Miles
Legend
Local Health Department that does not Qualify for LB 692* Funding
*LB 692 passed during the 2001 Legislative Session and provides funds to qualifying local public health departments.
Map updated by:
Public Health GIS Analyst
DHHS GIS 12/16
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Appendix D – Selected Model Petitions, Affidavits, and Orders—Word versions are available through the Administrative Office of the Courts and Probation.

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA, Complainant, vs. _____, Respondent.	)	CASE NO. MOTION FOR ENFORCEMENT OF DIRECTED HEALTH MEASURE OF [*QUARANTINE, ISOLATION, DECONTAMINATION OR* _____]

COMES NOW _____ County Attorney for the State of Nebraska and moves this Court for an Order enforcing a Directed Health Measure of [Insert Local Health Department Name] for 1. Quarantine; 2. Isolation; 3. Decontamination, or 4. [*Other directed health measure, i.e. monitoring*], pursuant to Neb. Rev. Stat. §§71-501 and 71-1626 *et seq*.

In support of said Motion, the State shows by the Affidavit of Service, attached hereto and incorporated herein by this reference, that on _____[*date*]_____, [*insert name of Local Health Department*] issued the attached Directed Health Measure Order and Affidavit of Service for _____ to comply with the terms of that Order, necessary to protect the public's health.

The State further shows via the attached Affidavit of Non-compliance that the subject of the Order is non-complaint and further that a delay in the imposition of the Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons.

WHEREFORE, the State prays the Court order _____ to comply with the terms of the Directed Health Measure order of quarantine, isolation, decontamination, or _____ pursuant to Neb. Rev. Stat. §§71-501 and 71-1626 et. seq. and fur such other and further relief as the Court deems just and equitable.

_____
Attorney's name and contact information

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA, Complainant, vs. _____, Respondent.	)))))))))))	CASE NO. NOTICE OF HEARING and NOTICE OF RIGHTS

TO: _____

THIS notice is given that the County Attorney of _____ County has filed a Motion for Enforcement of a Directed Health Measure. The hearing on the Motion shall take place at _____ on the ____ day of _____, 20__ at __:__ __.m.

You are hereby notified that you have the following rights:

a. The right to be represented by an attorney;
b. The right to present evidence on your own behalf;
c. The right to compel the attendance of witnesses;
d. The right to confront and cross-examine witnesses; and
e. The right to appeal the final order.
f. If you and/or your attorney do not appear at the time and place indicated above, an Order of [*insert "isolation" or "quarantine" as applicable"*] will be issued against you as requested by the Motion for Enforcement of Directed Health Measure.
g. You have the right to appear at the hearing. Because of the risk of transmission of [*insert name of disease*], you may not appear in person, but may appear instead by [*remote method chosen by the Court, such as mobile telephone or video conference*.] If you choose to appear at the hearing, please call [*insert telephone number*] ten (10) minutes prior to the scheduled time of the hearing stated above.

Dated this _____ day of _____, 20__.

_____

Attorney's name and contact information

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA,	)	CASE NO.
	)	
Complainant,	)	
	)	
vs.	)	ORDER OF ENFORCEMENT
	)	OF ISOLATION
_____,	)	
	)	
	)	
Respondent.	)	

THIS MATTER comes before the Court on the State's Motion for an Order of Enforcement of a Directed Health Measure of isolation. Evidence was adduced and arguments heard. The Court being duly advised in the premises, hereby finds as follows:

1. The [*insert name of local health department*] has received reports of increasing numbers of ill people exhibiting symptoms of a disease that has in its common course severe disability or death.
2. That since [*insert date of first case report*] until the time at which a hearing on this matter was held, over [*insert applicable number*] people have been stricken with this disease and [*insert applicable number*] people have died.
3. The biological agent causing this disease has not been conclusively identified at this time.
4. The symptoms that characterize this disease include: [*list physical symptoms with specificity*].
5. Clear and convincing evidence shows that those people who are in physical contact with or in the proximity of [*insert applicable number*] feet or less of an individual infected with this disease are likely to exhibit symptoms within [*insert applicable number*] days, which period of time is referred to herein as the "incubation period." [*Insert any other known information about the method of disease transmission*]. Thus, the clear and convincing evidence suggests this disease is easily transmissible from person-to-person.
6. There are no known preventive medications for this disease at this time.
7. The most effective method currently known to medical science to contain and curtail

the spread of this disease is the isolation of anyone who has the symptoms identified above, and the quarantine of those who have been exposed to a person infected with this disease for the duration of the incubation period.

8. The testimony of qualified witnesses, including [*insert names and titles of relevant witnesses*], has indicated that [*insert individual's name*] is exhibiting the following symptoms: [*list individual's exhibited physical symptoms with specificity*].
9. The testimony of qualified witnesses, including [*insert names of relevant witnesses and describe their association with the individual*], has indicated that [*insert individual's name*] comes into contact with numerous individuals on a regular basis through his/her activities s [*list applicable profession or personal undertakings] and that [insert individual's name*] has undertaken these activities since becoming infected with this disease.
10. Due to [*insert individual's name*]'s display of the symptoms recited above, [*insert individual's name*] requires skilled medical care in an appropriate medical facility.
11. Isolation of [*insert individual's name*] in a medical facility will reasonably protect those with whom [*insert individual's name*] would otherwise come in contact from acquiring this disease from [*insert individual's name*].
12. The findings of the [*insert name of Local Health District*] Directed Health Measure dated _____ are valid and the Directed Health Measure ordered therein is necessary to protect the public's health.
13. That [*Individual's name*] is non-compliant with said Directed Health Measure Order; and
14. That a delay in the imposition of the Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or pose unacceptable risks to any person or persons.

WHEREFORE, the Court finds that it has jurisdiction over the parties and over the subject matter of this action and pursuant to Neb. Rev. Stat. §24-302 and that the [*insert name of local health department*] has the authority to issue the Directed Health Measure order pursuant to §§71-501 and 71-1626 *et seq*. and that Directed Health Measure for isolation is necessary to protect the

public's health.

IT IS THEREFORE ORDERED that [*insert individual's name*] be confined to a medical isolation unit at the [*insert medical facility name*] for a period for [*insert period of time based upon the incubation period of the communicable disease most closely resembling the disease at issue, as established by the testimony of qualified experts*] days.

IT IS FURTHER ORDERED that [*insert individual's name*]is enjoined from leaving the [insert medical facility's name] until this period of time has elapsed.

IT IS FURTHER ORDERED that upon the expiration of said period of time, [*insert individual's name*] shall be released from confinement and the [*insert local health department*] shall file a report regarding disposition of this matter with this Court.

This Order shall expire [*insert applicable number of days*] after its issuance.

IT IS SO ORDERED.

BY THE COURT:

_____
DISTRICT JUDGE

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA,	)	CASE NO.
	)	
Complainant,	)	
	)	
vs.	)	ORDER OF ENFORCEMENT
	)	OF QUARANTINE
_____,	)	
	)	
	)	
Respondent.	)	

THIS MATTER comes before the Court on the State's Motion for an Order of Enforcement of a Directed Health Measure of quarantine. Evidence was adduced and arguments heard. The Court being duly advised in the premises, hereby finds as follows:

1. The [*insert name of local health department*] has received reports of increasing numbers of ill people exhibiting symptoms of a disease that has in its common course severe disability or death.
2. That since [*insert date of first case report*] until the time at which a hearing on this matter was held, over [*insert applicable number*] people have been stricken with this disease and [*insert applicable number*] people have died.
3. The biological agent causing this disease has not been conclusively identified at this time.
4. The symptoms that characterize this disease include: [*list physical symptoms with specificity*].
5. Clear and convincing evidence shows that those people who are in physical contact with or in the proximity of [*insert applicable number*] feet or less of an individual infected with this disease are likely to exhibit symptoms within [*insert applicable number*] days, which period of time is referred to herein as the "incubation period." [*Insert any other known information about the method of disease transmission*]. Thus, the clear and convincing evidence suggests this disease is easily transmissible from person-to-person.
6. There are no known preventive medications for this disease at this time.
7. The most effective method currently known to medical science to contain and curtail

the spread of this disease is the isolation of anyone who has the symptoms identified above, and the quarantine of those who have been exposed to a person infected with this disease for the duration of the incubation period.

8. The testimony of qualified witnesses, including [*insert names of relevant witnesses and describe their association with the individual*], has indicated that [*insert individual's name*] has come with [*identify individual(s) infected with the disease*], who is infected with this disease, on [*insert date(s) of contact*] in the following manner: [*list means of contact in detail*].
9. The testimony of qualified witnesses, including [*insert names and titles of relevant witnesses*], has indicated that this contact is sufficient for [*identify individual(s) infected with the disease*] to have transmitted this disease to [*insert individual's name*].
10. The testimony of qualified witnesses, including [*insert names and describe their association with the individual*], has indicated that [*insert individual's name*] comes into contact with numerous individuals on a regular basis through his/her activities as [*list applicable profession or personal undertakings*] and that [*insert individual's name*] would otherwise come in contact with from acquiring this disease from [*insert individual's name*] in the event [*insert individual's name*] is infected with this disease.
11. The findings of the [*insert name of Local Health District*] Directed Health Measure dated _____ are valid and the Directed Health Measure ordered therein is necessary to protect the public's health.
12. That [*Individual's name*] is non-compliant with said Directed Health Measure Order; and
13. That a delay in the imposition of the Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or pose unacceptable risks to any person or persons.

WHEREFORE, the Court finds that it has jurisdiction over the parties and over the subject matter of this action and pursuant to Neb. Rev. Stat. §24-302 and that the [*insert name of local health department*] has the authority to issue the Directed Health Measure order pursuant to §§71-501 and 71-1626 *et seq*. and that Directed Health Measure for quarantine is necessary to protect

the public's health. The nature of the disease at issue, the Respondent's contact with individual's infected with the disease, and the conduct of the Respondent constitute clear and convincing evidence that [*insert individual's name*] must be placed under an Order of quarantine so as to protect the public's health.

IT IS THEREFORE ORDERED that [*insert individual's name*] be confined to [*insert appropriate site of confinement (e.g. the individual's home), as established by the testimony of qualified experts*] for a period of [*insert period of time based upon the incubation period of the communicable disease most closely resembling the disease at issue, as established by the testimony of qualified experts*] days.

IT IS FURTHER ORDERED that [*insert individual's name*]is enjoined from leaving the [*insert appropriate site of confinement*] until this period of time has elapsed.

IT IS FURTHER ORDERED that upon the expiration of said period of time, [*insert individual's name*] shall be released from confinement and the [*insert local health department*] shall file a report regarding disposition of this matter with this Court.

This Order shall expire [*insert applicable number of days*] after its issuance.

IT IS SO ORDERED.

BY THE COURT:

_____
DISTRICT JUDGE

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA,	)	CASE NO.
	)	
Complainant,	)	
	)	
vs.	)	ORDER TO PROCURE
	)	BIOLOGICAL EVIDENCE
_____,	)	
	)	
	)	
Respondent.	)	

THIS MATTER comes before the Court on the State's Verified Application for an Order to Procure Biological Evidence from an Individual's Person. The State is present by and through counsel, _____. The Respondent is/is not present with counsel, _____/ without counsel. Evidence is adduced and arguments heard.

The Court being fully advised in the premises finds as follows:

1. That [*insert name of Local Health District Officer and Title*] has reasonable grounds to believe [insert individual subject's name] is infected with [insert name of applicable communicable or dangerous disease].
2. That [*insert name of Local Health District Officer and Title*] has reasonable grounds to believe [*Individual name*] poses a serious and present threat to the health of others because [*Individual name*] has engaged in the following conduct: [*specifically list conduct showing behavior or threatened behavior capable of transmitting disease*].
3. That [*insert name of Local Health District Officer and Title*] has requested said testing by a Directed Health Measure pursuant to Neb. Rev. Stat. §§71-501 and 71-1631, *et seq*.
4. That [*Individual's name*] is non-compliant with said Directed Health Measure; and has refused said testing.
5. That a delay in the imposition of the Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons.

WHEREFORE, the Court finds that the Directed Health Measure order to procure biological evidence was entered according to the authority granted to the [*local health department*]

pursuant to §§71-501 and 71-1631 et. seq. and is necessary to protect the public's health.

IT IS SO ORDERED that the Directed Health Measure dated _____ is adopted the Court Orders _____ to obey all of the terms of the Directed Health Measure order dated _____.

IT IS FURTHER ORDERED that the sheriff of this County shall arrange for [*insert individual's name*] to be transported to the [*insert name of appropriate medical facility*], where a licensed medical doctor shall cause a [*insert type of sample (e.g., blood, fluid, tissue)*] sample to be removed from [*insert individual's name*]'s body and subjected to a test that has been scientifically demonstrated to reveal whether [*insert individual's name*] is infected with [*insert name of communicable or dangerous disease being screened for*].

IT IS FURTHER ORDERED that the sample procurement and test shall be conducted in the least intrusive manner reasonably possible under the circumstance.

IT IS FURTHER ORDERED that the results of this test shall be disclosed only to [*insert individual's name*], [*insert petitioner's name*], and other individuals legally authorized to access such information.

IT IS SO ORDERED.

BY THE COURT:

_____

DISTRICT JUDGE

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA, Complainant, vs. _____, Respondent.	))))))))))	CASE NO. ORDER OF ENFORCEMENT OF 1. QUARANTINE 2. ISOLATION 3. DECONTAMINATION 4. _____

THIS MATTER comes before the Court on the State's Motion for an Order of Enforcement of a Directed Health Measure of quarantine, isolation, decontamination or _____ and the Court being duly advised in the premises, hereby finds as follows:

1. That the findings of the [*insert name of Local Health District*] Directed Health Measure dated _____ are valid and the Directed Health Measure ordered therein is necessary to protect the public's health.
2. That [*Individual's name*] is non-compliant with said Directed Health Measure Order; and
3. That a delay in the imposition of the Directed Health Measure would significantly jeopardize the ability to prevent or limit the transmission of a communicable disease, illness, or poisoning or pose unacceptable risks to any person or persons.

WHEREFORE, the Court finds that the Directed Health Measure order for quarantine, isolation, decontamination, or _____ is necessary to protect the public's health and hereby adopts said directed health measures and Orders _____ to obey all of the terms of the Directed Health Measure order dated _____ including quarantine, isolation, decontamination, or_____.

IT IS SO ORDERED.

BY THE COURT:

_____

DISTRICT JUDGE

IN THE DISTRICT COURT OF _____ COUNTY, NEBRASKA

STATE OF NEBRASKA,)
)
COUNTY OF _____)

SEARCH WARRANT

TO: [*Insert names of applicable police departments*]
Or Any law enforcement officer
Or any physician or staff at [*insert name of applicable medical facilities*]
Or any employee or agent of [*insert names of applicable medical facilities*]
As required for assistance.

WHEREAS, [*insert name(s) of affiant(s)*] has made affidavit sworn to before me, the undersigned Judge, in and for the County of _____, State of Nebraska, and WHEREAS I am satisfied that there is probable cause to believe that grounds exist for issuance of a search warrant, based upon the sworn affidavit of *[insert name of affiant]*.

You are therefore commanded, with the necessary and proper assistance/and proper medical and/or together appropriate health care assistance to obtain and remove a [*insert sample type (e.g. blood, tissue)*] same from:

[*Insert name of individual*]

[*Insert individual's date of birth or other identifier*]

And to use reasonable force to obtain such sample. You are ordered to seize the sample obtained on such search and to forward it to an appropriate laboratory facility for chemical analysis and to make a return of this warrant to me within ten days after the date hereof.

Given under my hand this _____ day of _____, 20__.

BY THE COURT:

_____
DISTRICT JUDGE

Appendix E – Judicial Checklists and Other Tools

Many existing bench books include judicial tools such as checklists and quarantine process diagrams. The following are checklists from other states' bench books:

Figure 1. Texas Property Quarantine Process[179]

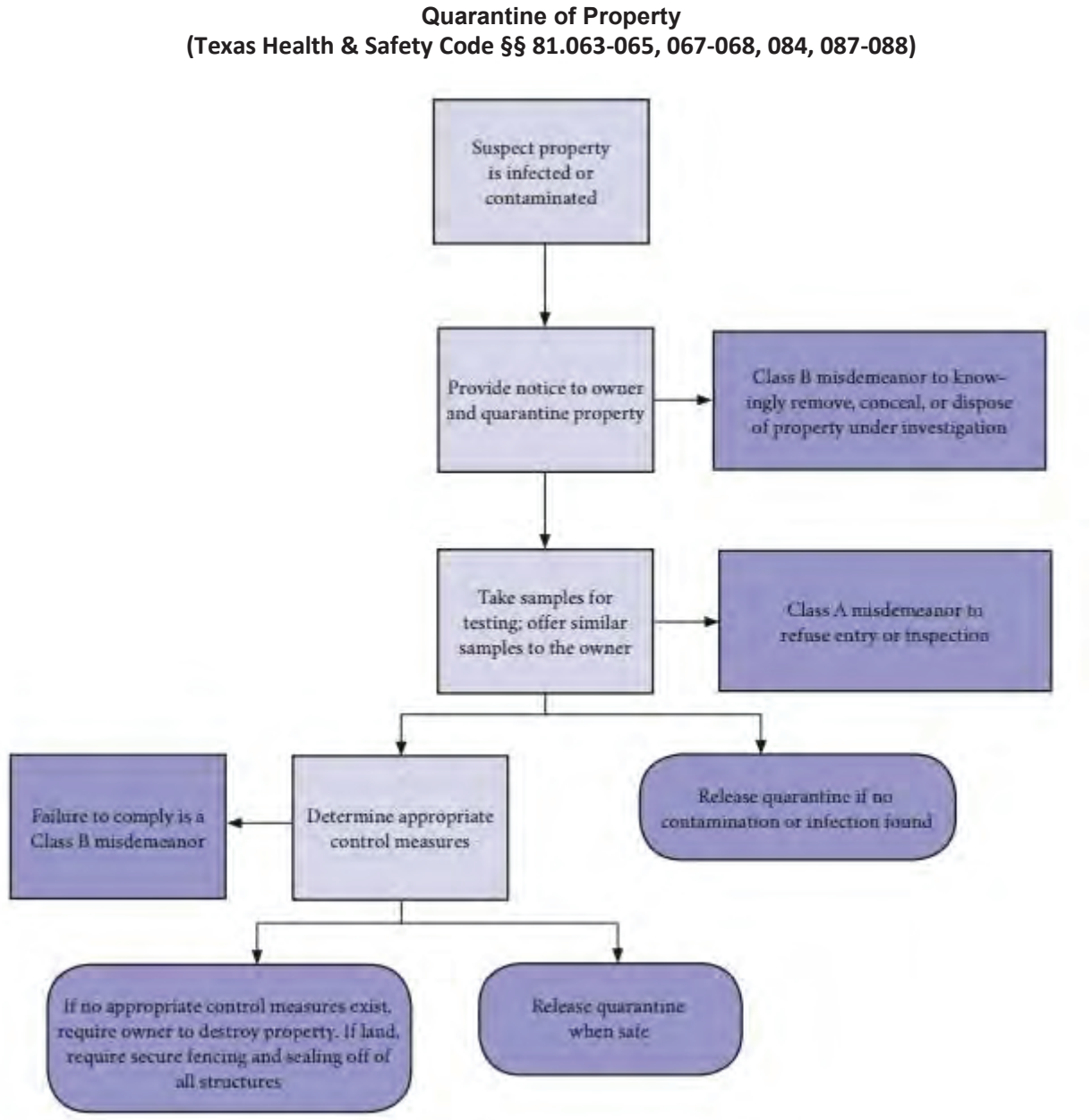


Figure 2. Oregon's Emergency Quarantine or Isolation Process[180]

[179] Control Measures and Public Health Emergencies: A Texas Bench Book (2014) http://www.law.uh.edu/healthlaw/2014-HLPIBenchBook-2.pdf

[180] Oregon Isolation and Quarantine Bench Book (2011) http://www.doj.state.or.us/pdf/oregon_isolation_and_quarantine_bench_book.pdf

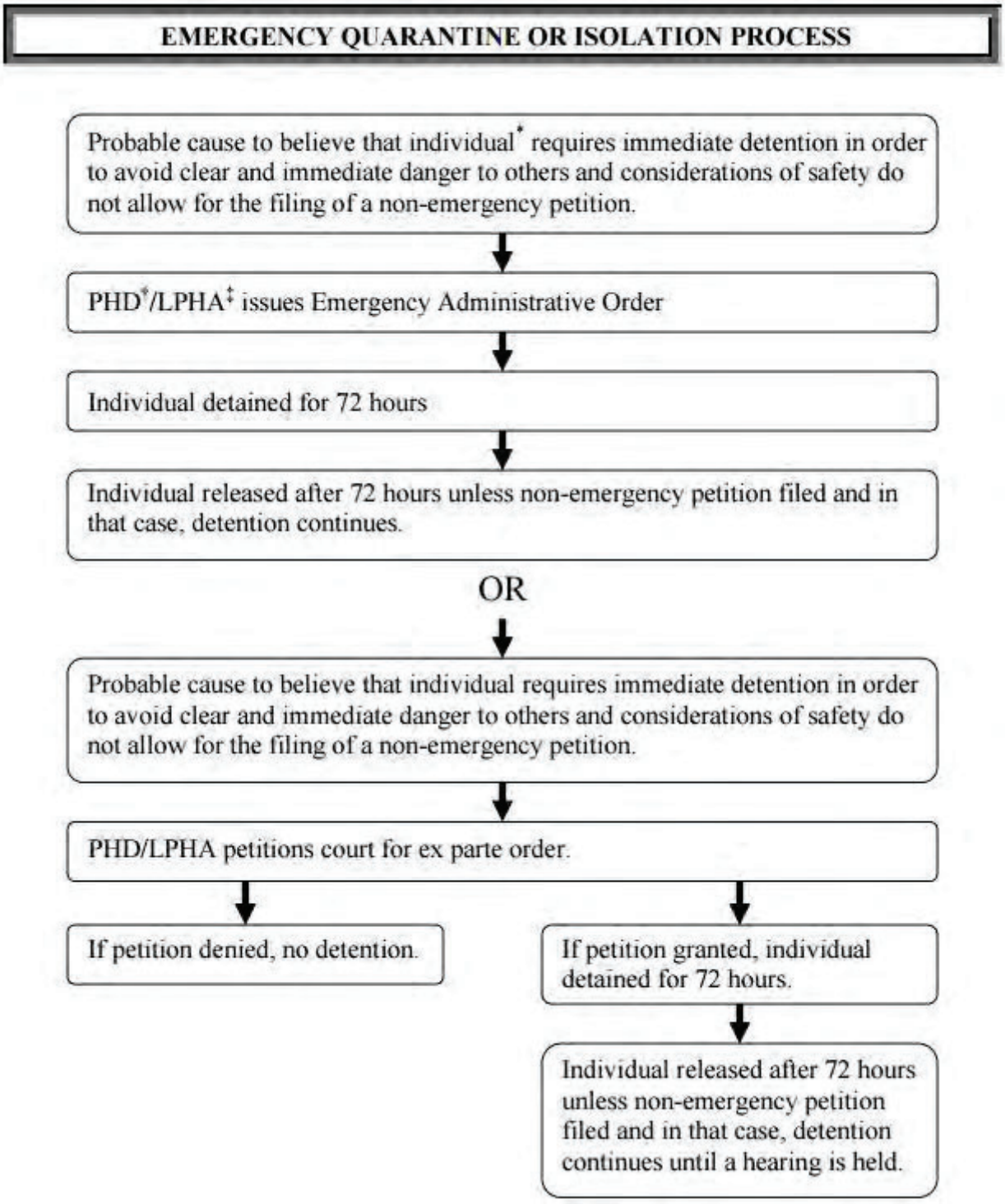


Figure 3. Oregon's Non-Emergency Quarantine or Isolation Process[181]

[181] Id.

NON-EMERGENCY QUARANTINE OR ISOLATION PROCESS

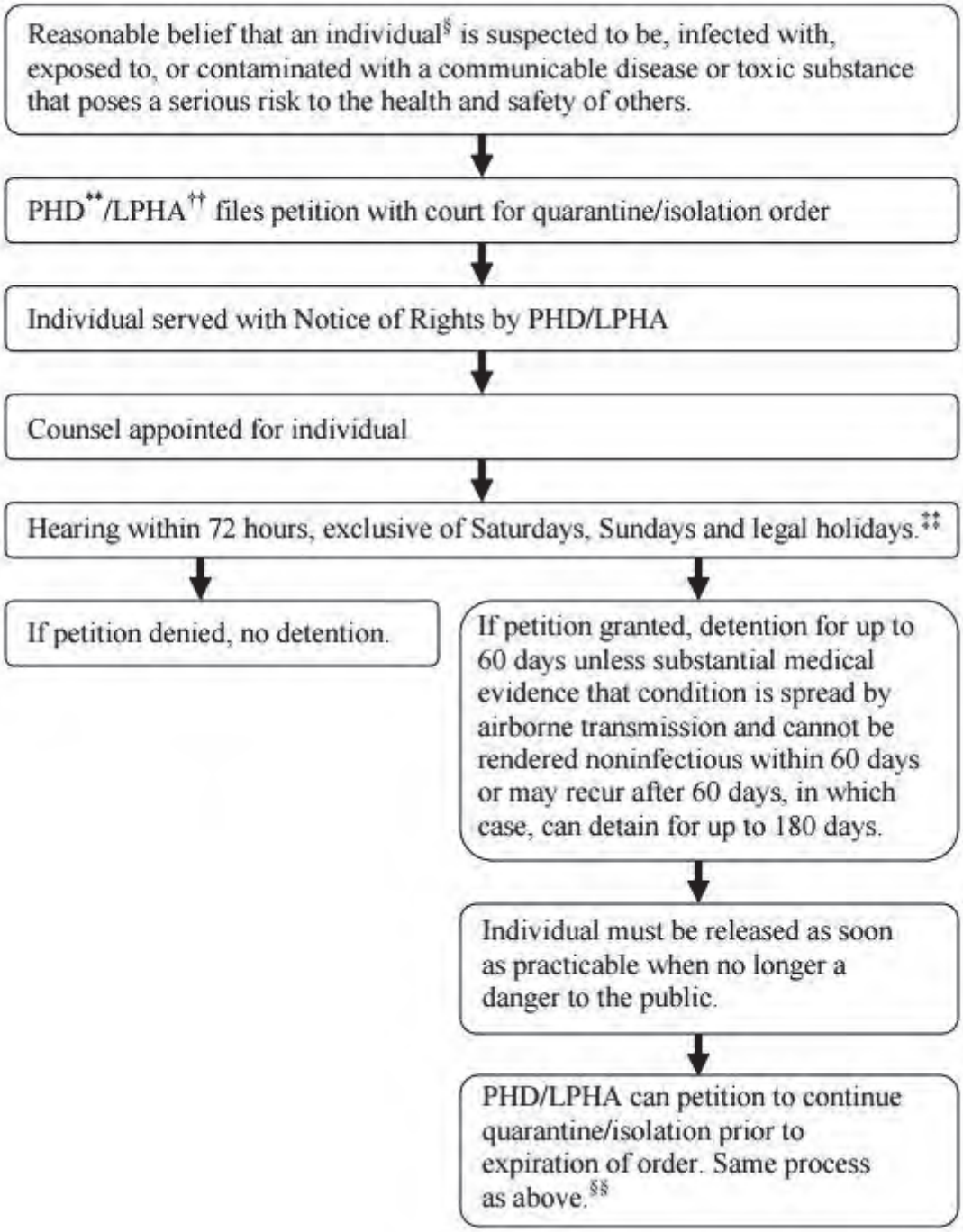


Figure 4. Florida Checklist for Habeas Corpus Hearing[182]
Purpose: to be used by judge for review of Quarantine (Exposed) / Isolation (Ill) Department of Health Orders.

GENERAL REQUIREMENTS:
1.You are an acting circuit judge, a circuit judge, a district court of appeal judge, or a supreme court justice.
2. The petition is filed in the jurisdiction of the quarantined person/animal/property.
3. No filing fee is required.
4. No administrative agency review is required.
5. Speedy review is important (summary review).
6. Petition must be verified. Note: Can be sworn before a judge.
7. Petition may be filed by a family member, legal guardian, or friend.

DEPARTMENT'S ORDER:
1. The order is signed by county health department director (medical doctor) or administrator (lay person).
2. The order concerns people or real property. Note: Goods/animals are handled by Department of Agriculture.
3. The person or property is sufficiently identified.
4. The medical need is articulated. The person or property poses "serious and present danger of harm to others."
5. The time period of the quarantine is defined.
6. Sufficient notice of time and place of this hearing was given.
7. Personal service was made.

HEARING:
1. There is means for making a record (recording device). *Note: No free copy unless indigent*.
2. Court, personnel, parties, etc., are protected for health.
3. Who can be present?
_____ Department of Health Representative
_____ Petitioner
_____ Counsel for Department [Dept. Atty. / Atty. General / County Atty. / State Atty.] _____ Counsel for Petitioner [Private / Legal Aid (civil) / Public Defender (criminal)] _____ Public / Press
Note: There is a right to counsel. If petitioner is indigent, supply counsel. (Quarantine is a deprivation of a petitioner's liberty.)
4. The medical rights of the petitioner are protected.
5. The Department carried the burden of proof, "clear and convincing evidence."
6. The Department did not carry the burden of proof, "clear and convincing evidence."

THINGS TO CONSIDER:
_____ 1. Was there exposure to contagious illness or is the petitioner ill (if reviewing isolation order)?
_____ 2. Is non-compliance conduct evident?

[182] Pandemic Influenza Bench guide: Legal Issues Concerning Quarantine and Isolation (2013) http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic_benchguide.pdf

_____ 3. Will petitioner's "freedom" endanger the public?
_____ 4. What is the severity of the "disease"?
_____ 5. What is the treatment method?
_____ 6. How is the infection spread?
_____ 7. What is the time frame of the course of the illness?
Key: Match the restrictions to the threat.
Goal: Prevent the spread of a communicable disease.

Note: Check for bias in drawing a quarantine perimeter. Ask the petitioner why the quarantine order is unfair.

COURT ORDER:
1. The order must be written.
2. The order must state detailed facts.
3. The order must define closure / area of quarantine-"restrict or compel movement or action" to "protect society." *Note: Must be "least restrictive possible."*
4. The order must give remedy. "Get medical test / obtain vaccine / finish treatment" by "any qualified person authorized by Department."
5. The order must make provision for "necessities" of food / safety / medical care to petitioner. *Note: But the provision of these necessities must not endanger others or degrade other services.*
6. The order must state expiration date or return date to court.
7. The order must state the penalty for violation of order – second degree misdemeanor.
8. The order must state the means of appeal.

Appendix F – Pandemic and Public Health Bench books of Other States

ARKANSAS
Public Health Bench book (2009)
http://www.healthy.arkansas.gov/aboutADH/RulesRegs/PublicHealthLawBenchBook2009.pdf

FLORIDA
Pandemic Influenza Bench guide: Legal Issues Concerning Quarantine and Isolation (2013)
http://www.flcourts.org/core/fileparse.php/304/urlt/pandemic_benchguide.pdf

GEORGIA
Pandemic Influenza Bench guide (2009)
http://www.georgiacourts.org/aoc/BenchGuide2009FIN.pdf

INDIANA
Public Health Law Bench book for Indiana Courts (2005)
http://www.georgiacourts.org/aoc/r_p_docs/INBenchBook.pdf

KENTUCKY
Public Health Law Judicial Reference Guide for Kentucky Courts (August 2006)
https://pda.louisville.edu/bioethics/public-health/KY%20Benchbook.pdf/at_download/file

MICHIGAN
Public Health Law Bench book for Michigan Courts (October 2007)
http://www.michigan.gov/documents/ag/Michigan_Public_Health_Bench_Book_221936_7.pdf

MINNESOTA
Isolation and Quarantine Bench book (November 2008)
http://www.mncourts.gov/Documents/0/Public/Isolation_and_Quarantine/Isolation_and_Quarantine_Benchbook.pdf

NEW YORK
New York State Public Health Legal Manual: A Guide for Judges, Attorneys and Public Health Professionals (2011)
https://www.nycourts.gov/whatsnew/pdf/PublicHealthLegalManual.pdf

NORTH CAROLINA
Pandemic Emergency Bench Book for Trial Judges (August 2009)
http://www.sog.unc.edu/sites/www.sog.unc.edu/files/PandemicEmergencyBenchBook_Dec2009.pdf

OHIO
Public Health Preparedness Bench book: Guide for the Ohio Judiciary & Bar on Legal Preparedness for Public Health Emergencies & Routine Health Cases
http://www.supremecourt.ohio.gov/Boards/courtSecurity/PandemicPrepareGuide.pdf

OKLAHOMA
District Court, 20th Judicial District Pandemic Influenza Bench book
http://www.ok.gov/health2/documents/EPRS-Pandemic%20Dist%20Ct%20Benchbook.pdf

OREGON
Oregon Isolation and Quarantine Bench Book (2011)
http://www.doj.state.or.us/pdf/oregon_isolation_and_quarantine_bench_book.pdf

PENNSYLVANIA
Pennsylvania Public Health Law Bench book (February 2007)
http://www.cphp.pitt.edu/upcphp/benchbook.pdf

SOUTH CAROLINA
Public Health Emergencies: A Resource for Bench and Bar (2012)
http://www.scdhec.gov/library/CR-010455.pdf

TEXAS
Control Measures and Public Health Emergencies: A Texas Bench Book (2014)
http://www.law.uh.edu/healthlaw/2014-HLPIBenchBook-2.pdf

UTAH
Judicial Review of Orders of Restriction (2008)
http://health.utah.gov/epi/diseases/TB/guidelines/judical_review.pdf

VIRGINIA
Pandemic Influenza Bench book
http://www.courts.state.va.us/programs/pfp/benchbook.pdf

WASHINGTON
Public Health Emergency Bench book
http://www.courts.wa.gov/manuals/?fa=manuals.showManualsPage&manualid=publicHealth&file=publicHealth-29

A. Other Resources

A Framework for Improving Cross-Sector Coordination for Emergency Preparedness and Response: Action Steps for Public Health, Law Enforcement, the Judiciary and Corrections. Centers for Disease Control and Prevention (U.S.); Mocking Consulting Corporation; Public Health/Law Enforcement Emergency Preparedness Workgroup; United States, Bureau of Justice Assistance (2008).
http://www.cdc.gov/phlp/docs/CDC_BJA_Framework.pdf

About Ebola. Centers for Disease Control.
http://www.cdc.gov/vhf/ebola/index.html

Guidelines for Pandemic Emergency Preparedness Planning: A Road Map for Courts. (April 2007).
https://www.american.edu/spa/jpo/upload/2091-2.pdf

Gorstein, Lawrence O. Public Health Law: Power, Duty, Restraint, 2nd ed. University of California Press, Ltd. (2008).

Stier, Daniel D., et al. The Courts, Public Health, and Legal Preparedness. Am J Public Health. 97 (Suppl. 1): S69–S73 (April 2007).

State Public Health Counsel Directory. Centers for Disease Control. http://www.cdc.gov/phlp/contacts/counsels_map.html

Appendix G - HABEAS CORPUS PETITIONS

Habeas Corpus is an appropriate remedy where a person is unlawfully restrained of his or her liberty.

Neb. Rev. Stat. §§ 29-2801 to 29-2824 outlines the process for H.C. in Nebraska

The Nebraska Constitution provides the remedy of habeas corpus, while the procedure for the writ is governed by statute, it is a special civil proceeding providing a summary remedy to persons illegally detained. A writ of habeas corpus challenges and tests the legality of a person's detention, imprisonment, or custodial deprivation of liberty. Eligibility for the writ is governed by the criteria set forth in § 29-2801

Jurisdiction: the location of confinement is the court with jurisdiction over the matter, so unlike an appeal under the APA, jurisdiction for this action lies with the court located where the quarantine victim is held.

The petition must set forth facts that establish an illegal restraint and should attach a copy of the commitment order, although that has been held to not be fatal to the petition.

If the judge reviews the petition and finds it is not defective on its face the writ shall be granted. Upon the granting of a writ of HC the restrained individual is to be brought to the Court for a hearing:

Whenever a habeas corpus shall be issued to bring the body of any prisoner committed as aforesaid, unless the court or judge issuing the same shall deem it wholly unnecessary and useless, the court or judge shall issue a subpoena to the sheriff of the county where such person shall be confined, commanding him to summon the witness or witnesses therein named to appear before such judge or court, at the time and place when and where such habeas corpus shall be returnable. It shall be the duty of such sheriff to serve the subpoena, if possible, in time to enable such witness or witnesses to attend.

If the Judge determines it is useless to bring the confined person to court he or she may determine not to subpoena the patient. However without such a determination the parties are to be subpoenaed by the court. If the person is alleged to be in need of quarantine the Court should set this hearing up through the use of distance technology for the protection of the public. The AOC will provide assistance in arranging for technology if that assistance is needed. "It shall be the duty of the judge or court who shall hear the same to examine the witness or witnesses aforesaid, and such other witnesses as the prisoner may request, touching any offense mentioned in the warrant of commitment, whether the offense be technically set out in the commitment or not." §29-2805 R.R.S. The writ is directed to the official entering the DHM and the hearing must include the department issuing the order.

Disposition

The Statutory language reads: When the judge shall have examined into the cause of the capture and detention of the person so brought before him, and shall be satisfied that the person is unlawfully imprisoned or detained, he shall forthwith discharge such prisoner from confinement. If it is determined that the person is lawfully detained the judge still has choices in a criminal matter: judge shall, at his discretion, commit, discharge or let to bail such person. In a public health matter that may mean determining a less restrictive alternative. There are few cases of HC in the public health realm. The correct disposition was addressed in Pauline Varholy v. RexSweat, 15So. 2d 267, 153 Fla.57 1(Fl

1943) “To grant release on bail to persons isolated and detained on a quarantine order because they have a contagious disease which makes them dangerous to others, or to the public in general, would render quarantine laws and regulations nugatory and of no avail. Our conclusion is that the lower court in this case was justified by the evidence (in ordering the patient quarantined in a county jail) and the order appealed from is hereby affirmed.”

In the 1919 habeas corpus case of Ex Parte Brown v. Manning Health Commissioner 103 Neb. 540 the petitioner was isolated in the detention home of the city of Omaha due to a communicable venereal disease. The Supreme Court faced an original application to the court for a writ of habeas corpus. The petitioner was quarantined under an Omaha ordinance, and the question presented was whether such detention, under the circumstances, was justifiable. The case was presented upon a stipulation of facts and without other evidence.

The parties agreed to the facts which alleviated the need to bring the infected person before the judges. In this case the stipulation shows that the petitioner was “found to be infected with communicable venereal virus,” and that she was only detained “for such reasonable time and in such reasonable manner as to prevent the danger of said petitioner from communicating such infection to others and until the danger of the infection should be removed.” There can be no doubt that under our statute (Rev. St. 1913, §§ 4082, 4094), the city could by ordinance provide for such detention, and the ordinance as quoted in the petitioner's brief provides for such detention. The writ was therefore denied.

Monetary Penalties

There are monetary penalties within the HC statues for failing to serve a writ, or failing to deliver the confined person, or for recommitting the person after a release order. These issues may be more likely to arise in the situation where an allegedly communicable person is the petitioner. See §29-2807 R.R.S et. seq.