

DISTRICT OF COLUMBIA



PUBLIC HEALTH EMERGENCY LAW MANUAL

SEPTEMBER 2023

UPDATED 2ND EDITION

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2nd Edition | Revised September 2023

FOREWORD



September 14, 2023



I am pleased to release the 2023 version of the *Public Health Emergency Law Manual*, a tool that has proven invaluable in the District's response to public health emergencies. The COVID-19 pandemic, the first public health emergency declared in the District of Columbia, really shed light on the need for a publication like this which covers most of the relevant laws, regulations, and authorities applicable to a public health emergency.

One of the primary functions of DC Health is to ensure readiness for public health events of varying magnitude. When we are collectively prepared, we are closer to achieving our vision of making the District the healthiest city

in the nation. The material covered in this Manual not only reflects our efforts in public health preparedness, but also provides ready access to information that is useful in our daily approach to sound public health policy and guidance. This tool is a living document that will be updated as needed to assist in delivering public health services in an equitable manner.

As we approach the 10th Anniversary of the Manual, we look to continued collaboration with the various partners who have contributed to developing this resource, including lessons learned from its practical application over the past several years. It is my hope that this tool is helpful, keeping us abreast of legal matters, as we continue our efforts to address public health emergencies.

Ayanna Bennett, MD, MSPH, FAAP
Acting Director

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE ATTORNEY GENERAL**



**ATTORNEY GENERAL
BRIAN L. SCHWALB**



September 15, 2023

I am proud to extend the District's Updated Public Health Emergency Law Manual which provides guidance to health practitioners, public officials, lawyers, and judges on how best to protect the District and its residents during a public health emergency. The manual describes the responsibilities, structure, and specific operations designed to navigate through a public health crisis. As we witnessed during the recent pandemic, preparedness and resources are vitally important to addressing any public health crisis.

The great work and collaboration reflected in this Updated Manual will help keep the District a safe place to live and visit.

Sincerely,

A handwritten signature in blue ink that reads "Brian L. Schwalb".

Brian L. Schwalb
Attorney General for the District of Columbia



**Superior Court of the District of Columbia
Washington, D.C. 20001**

Anita M. Josey-Herring

(202) 879-1600

Chief Judge



September 11, 2023

The recent COVID-19 pandemic highlighted the importance of preparing for public health emergencies to protect the health and safety of the residents of the District of Columbia and the community we serve. The lessons learned during the recent public health emergency will serve us well in the event of a future emergency. The Public Health Emergency Law Manual is designed to provide a guide for public health practitioners, lawyers, and judges to assist in preparing for public health emergencies in the District of Columbia and evaluating public health measures when encountering events such as a widespread outbreak of an infectious disease or chemical exposure.

While the statutes and principles discussed in this manual may not be definitive in nature, the intent for this guide is to assist in future research and understanding of this area of law. Given the ever-evolving nature of emerging public health issues, this area of law will inevitably continue to change.

I am pleased the District of Columbia Courts were part of this important collaboration and am certain the manual will continue to prove valuable for years to come.

A handwritten signature in cursive script that reads "Anita Josey-Herring".

Anita Josey-Herring
Chief Judge of the Superior Court
Of the District of Columbia

PREFACE TO THE 2ND EDITION

Note: Certain sections of the District of Columbia Public Health Emergency Law Manual were updated in May 2020 and September 2023 to include information related to the Coronavirus Disease 2019 (COVID-19) pandemic and Monkey Pox (Mpox).

We are pleased to present the updated 2nd Edition of the District of Columbia Public Health Emergency Law Manual (the Manual or the D.C. PHELM), with several new chapters, including *Emerging and Re-Emerging Infectious Diseases*, *Federal Control of Communicable Diseases*, *At-Risk Populations*, and a *Glossary* for quick reference, as well as revisions and updates to the existing material.

In preparation for the 57th Presidential Inaugural in January 2013, it occurred to me that should a public health emergency arise, and experienced legal counsel be unavailable to provide necessary legal guidance as response efforts were deployed, senior leadership would need to have quick and immediate access to critical legal preparedness information. The result was a 19-page Public Health Emergency Legal Guide, which contained a summary of the District and federal authorities, templates for administrative orders, and messaging required to effectively carry out the Department of Health's responsibilities under Emergency Support Function #8 (ESF#8). That document was the model used in developing the *District Preparedness System Legal Handbook*, published by the District's Homeland Security and Emergency Management Agency (HSEMA) in May 2014.

In 2014, we also embarked on a project to educate the District's legal community, and the judiciary in particular, regarding public health emergency preparedness. The goal was to provide legal authorities to support community mitigation strategies or non-pharmaceutical interventions that can prevent and control the spread of communicable diseases. According to Centers for Disease Control and Prevention (CDC), non-pharmaceutical interventions are actions, other than vaccinations or medicines, that people and communities can take to reduce the spread of diseases such as Ebola, measles, or pandemic flu. We set out to create a bench book that could be utilized by judges during a public health emergency in guiding their decisions, when time is of the essence.

To demonstrate the importance of legal preparedness for public health emergencies, we facilitated "Public Health Law and Science: What Judges Need to Know," a training for District judges, court staff, and attorneys in 2015, in collaboration with the University of Pittsburgh Center for Public Health Practice (CPHP). Based on the positive responses received, we pivoted to capture the needs of the judiciary, public health officials, healthcare providers, and their counsel, all in one document. The Advisory Committee and others who are listed in the Introduction to the 1st Edition, worked diligently to ensure that we included all necessary information, culminating in the D.C. PHELM, released in June 2017. DC Health then offered a series of training programs in collaboration with CPHP, CDC's Public Health Law Program, and the D.C. Bar in 2017, 2018, and 2019.

This update would not have been possible without the contributions of individuals in District and federal government: Mathew McCullough, Julia Wohlhandler & team in the D.C. Office of

Disability Rights; Monica Brown & Robert Warren in the D.C. Department of Human Services; Nikea Bradley, Delores Scott & Sarah Case-Herron at D.C. Homeland Security and Emergency Management Agency; Dr. Roger Mitchell, D.C. Chief Medical Examiner; Laura Newland & Adam Mingal at the D.C. Department of Aging and Community Living; Liz Sutton, Neha Patel & Crystal Thomas at the Department on Disability Services; Brooke Courtney, at the Office of Counterterrorism and Emerging Threats, United States Food and Drug Administration; Matthew Penn, Montrece McNeil-Ransome, Gregory Sunshine & Abigail Ferrell at CDC Public Health Law Program; as well as Tina Batra Hershey, Elizabeth Van Nostrand, Wendy Braund, and Alyssa Johnston at CPHP, and University of Pittsburgh Law School intern, Sabrina Lew.

Special acknowledgment is given to the DC Health's Public Health Emergency Preparedness and Health Team in the Health Emergency Preparedness and Response Administration for sponsoring this update to the D.C. PHELM. Funding for this update was made possible through the US Department of Health and Human Services, CDC Public Health Emergency Preparedness Funding, Grant No. 6 NU90TP922023-04-02.

This manual is available electronically at <https://dchealth.dc.gov/DCPHELMManual>. A downloadable version is available at the same website for printing. The D.C. PHELM does not represent an official legal opinion of the District of Columbia and does not constitute legal advice; therefore, users should consult with a licensed attorney and conduct further research to account for specific factual scenarios as well as changes in law made after publication of this resource. While every effort was made to ensure the accuracy and completeness of the D.C. PHELM, no warranty is made that this information is accurate or complete.

Marie-Claire Brown
Senior Assistant General Counsel
D.C. Department of Health
September 2023

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1.0 INTRODUCTION AND ACKNOWLEDGMENTS

Public health emergencies may arise due to the emergence of a novel disease in another continent that makes its way to the United States (U.S.), an act of terrorism involving an improvised nuclear device, or a severe hurricane or other weather event. No matter the cause, the government must be prepared to address resulting legal issues. Indeed, the outbreak of Ebola in 2014 brought new awareness of the importance of legal preparedness for public health emergencies.

The District of Columbia Public Health Emergency Law Manual (the Manual or the D.C. PHELM) is a living document, intended to serve as a resource for public health practitioners, lawyers, and judges, to assist them in preparing for public health emergencies in the District of Columbia (D.C. or District). Because laws are constantly being modified and changed, users of this Manual should access relevant statutory and regulatory provisions and case law to ensure up-to-date information.

Each section of the Manual is designed to be read alone; however, for a more in-depth understanding of the potential legal issues that may be encountered, it is advisable to review the entirety of the Manual. To facilitate your understanding of these legal issues, cross-references are provided throughout the Manual. In addition, comment boxes can be found throughout the Manual, classified into the following three categories:



General – comments that are broadly applicable



Judge – comments that may be particularly relevant to the judiciary



Caution – comments that indicate potential areas of concern or liability

This manual is available electronically at <https://dchealth.dc.gov/DCPHELMManual>. A downloadable version is available at the same website for printing.

We are grateful to the writers of public health emergency law manuals, bench guides, and bench books in jurisdictions around the country for their aid and inspiration as we drafted the Manual, available at <https://www.cdc.gov/php/publications/topic/benchbooks.html>. Where possible, links to cases are provided by the Legal Information Institute at Cornell Law School under Creative Commons license NC-SA 2.5. Links to the District Code are provided courtesy of the District of Columbia Council (D.C. Council) web site, currently in beta mode. Links to the District Municipal Regulations and Mayor's Orders are provided courtesy of a web site maintained by the Secretary of the District of Columbia Office of Documents and Administrative Issuances.

The Manual does not represent an official legal opinion of the District of Columbia and does not constitute legal advice. Users of the Manual should consult with a licensed attorney and conduct further research to account for specific factual scenarios as well as changes in law made after publication of this resource. While every effort was made to ensure the accuracy and completeness of this Manual, no warranty is made that this information is accurate or complete.

The Manual, written in collaboration with the Center for Public Health Practice at the University of Pittsburgh Graduate School of Public Health (Principal Investigator, Tina Batra Hershey, JD, MPH), was made possible with funding from the United States Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), Hospital Preparedness-Public Health Emergency Preparedness Cooperative Agreement.

This effort would not have been possible without the Advisory Committee, who volunteered time amid their busy schedules to meet, review, edit, and provide expertise on the content and format of the inaugural Manual. Current and former members include:

Crystal L. Banks
Deputy Director for Training, District of Columbia Courts

Elaine Block
Ethics Officer, Office of the Attorney General for the District of Columbia

Mikelle L. DeVillier
General Counsel, Office of the Chief Medical Examiner for the District of Columbia

H. Clifton Grandy
Senior Court Manager, District of Columbia Courts

The late Fernando Rivero
Assistant Attorney General, Office of the Attorney General for the District of Columbia

Kenneth H. Rosenau
Private Bar Member

Rudolf L. (Rudi) Schreiber, Sr.
Deputy General Counsel, DC Health

Teresa D. Spada
General Counsel, District of Columbia Courts

I would like to acknowledge the following persons DC Health who provided tremendous support to this update: Anil T. Mangla (State Epidemiologist); Jacqueline A. Watson (Interim HEPRA Senior Deputy Director); Phillip L. Husband (General Counsel); Trevor Rhodes (PHEP Coordinator); C. Anetta Arno (Office on Equity); and Brian W. Amy (Chief Medical Officer), who had the vision to initiate this Manual.

Marie-Claire Brown
Senior Assistant General Counsel
DOH Health Emergency Preparedness and Response Administration
Chair, PHELM Advisory Committee

2.0 ROLES AND RESPONSIBILITIES

2.1 Summary

Protecting the health and safety of the public in the District requires action by all branches of government. Many government agencies have specific responsibilities in relation to public health emergencies. It is important that these agencies coordinate their efforts when preparing for, responding to, and recovering from disasters and emergencies.

2.2 The Mayor of the District of Columbia

Under the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 803; [D.C. Official Code § 1-201.01](#) et seq. (2012 Repl.)), the Mayor of the District of Columbia (Mayor) has executive power over the District and is the chief executive officer of the District government. The Mayor is responsible for properly executing all laws relating to the District. [D.C. Official Code § 1-204.22](#).

The Mayor has broad powers in public health emergencies, including the ability to detain individuals having or suspected of having a communicable disease, as well as the ability to declare public emergencies and public health emergencies. Many of these authorities have been delegated to DC Health.

Executive Office of the Mayor, <http://mayor.dc.gov>.

2.3 Council of the District of Columbia

The Council of the District of Columbia (D.C. Council) has legislative power in the District. Subject to certain limitations, the D.C. Council has authority to create, abolish, or organize any office, agency, department, or instrumentality of the District government and to define the powers, duties, and responsibilities of any such office, agency, department, or instrumentality. [D.C. Official Code § 1-204.04](#). The D.C. Council's central role as a legislative body is to make laws. However, its responsibilities also include oversight of multiple agencies, commissions, boards, and other instruments of District government. The D.C. Council is composed of 13 members and led by the D.C. Council Chairman.

The D.C. Council has the power to extend Mayoral emergency declarations by adopting emergency acts.

Council of the District of Columbia, <http://dccouncil.us/pages/council-101>.

2.4 DC Health

DC Health promotes and protects the health, safety, and quality of life of residents, visitors, and those conducting business in the District. In doing so, DC Health has numerous responsibilities related to public health emergencies, including:

- Identifying health risks;
- Preventing and controlling the spread of disease;
- Preventing injuries and exposure to environmental hazards; and

- Educating and communicating with the public.

See Appendix 4.0 of the Manual for a DC Health organizational chart.

The DC Health Director has broad authority to detain individuals for the purposes of quarantine, isolation, treatment, and examination if they have, or are suspected of having, a communicable disease. In addition, the DC Health Director is the conduit for all reporting related to communicable disease and has power to inspect public and private property during communicable disease investigations.

DC Health, <https://dchealth.dc.gov/>.

2.4.1 Health Emergency Preparedness and Response Administration

The Health Emergency Preparedness and Response Administration (HEPRA), part of DC Health, is responsible for ensuring the delivery of the highest quality emergency medical and trauma care services through regulatory oversight of all emergency medical services provided in the District. In addition, HEPRA is responsible for planning, implementing, and directing public health emergency preparedness and response for the District.

HEPRA is the lead for [Emergency Support Function \(ESF\) #8](#) – Public Health and Medical Services – under the [District Response Plan](#) (DRP). [ESFs](#) are mechanisms for grouping governmental and certain private sector capabilities into an organizational structure to coordinate federal support to states after an incident. There are 15 ESFs under the [National Response Framework](#). [ESF #8](#) provides the mechanism for coordinated federal assistance to supplement state, tribal, and local resources in response to the following:

- Public health and medical care needs;
- Veterinary and/or animal health issues in coordination with the United States Department of Agriculture (USDA);
- Potential or actual incidents of national significance; and
- A developing potential health and medical situation.

HEPRA works to ensure that DC Health and its partners are prepared to respond in accordance with all functions under [ESF #8](#), including:

- Assessment of public health/medical needs;
- Public health surveillance;
- Medical care personnel;
- Medical equipment and supplies;
- Patient movement;
- Hospital care;
- Outpatient services;

- Victim decontamination;
- Safety and security of human drugs, biologics, medical devices, veterinary drugs, etc.;
- Blood products and services;
- Food safety and security;
- Agriculture feed safety and security;
- Worker health and safety;
- All hazard consultation and technical assistance and support;
- Mental health and substance abuse care;
- Public health and medical information;
- Vector control;
- Potable water/wastewater and solid waste disposal, and other environmental health issues;
- Victim identification/mortuary services; and
- Veterinary services.

DC Health, Health Emergency Preparedness and Response Administration, <https://dchealth.dc.gov/page/health-emergency-preparedness-and-response-administration>.



The [DRP \(Emergency Operations Plan\)](#) is updated every five years. The District is in the process of updating the DRP as of this publication.

2.4.2 District of Columbia Emergency Support Function #8 DC Health, Health and Medical Coalition

The District of Columbia ESF #8 DC Health, Health and Medical Coalition (DC Health-HMC) is the strategic planning committee and advisor to the DC Health Director. Its purpose is to:

- Foster partnerships with government agencies, healthcare providers, and community partners working together to promote, consolidate, and coordinate a unified response to emergencies affecting the District and to promote the emergency preparedness and response capabilities of District health and medical entities by strengthening medical surge capacity and capabilities;
- Build relationships and partnerships for community resiliency;
- Facilitate communication, information, and resource sharing;
- Maximize movement and utilization of limited existing resources; and

- Coordinate training, drills, and exercises between local, state, and federal partners.

2.5 District of Columbia Homeland Security and Emergency Management Agency

The District of Columbia Homeland Security and Emergency Management Agency (HSEMA) is responsible for leading the planning and coordination of homeland security and emergency management efforts to ensure that the District is prepared to prevent, protect against, respond to, mitigate, and recover from all threats and hazards. HSEMA is responsible for coordinating the delivery of federal assistance to District agencies.

District of Columbia Homeland Security and Emergency Management Agency, <http://hsema.dc.gov>.

2.6 District of Columbia Office of the Attorney General

The District of Columbia Office of the Attorney General (OAG) advises and provides legal representation to District agencies, officers, and employees. OAG attorneys are responsible for ensuring that governmental actions are legally permissible, and for bringing certain actions related to protection of the public health in the District of Columbia Superior Court (Superior Court) (e.g., detaining individuals).

District of Columbia Office of the Attorney General, <https://oag.dc.gov/>.

2.7 District of Columbia Office of the Chief Medical Examiner

The District of Columbia Office of the Chief Medical Examiner (OCME) is responsible for investigating all deaths in the District that occur as the result of violence or injury, as well as those that occur unexpectedly, without medical attention, in custody, or pose a threat to public health.

District of Columbia Office of the Chief Medical Examiner, <https://ocme.dc.gov/page/about-ocme>.

2.8 District of Columbia Courts

The District courts are comprised of the Superior Court and the District of Columbia Court of Appeals (Court of Appeals). The Superior Court has jurisdiction of any civil action or other matter (at law or in equity) brought in the District and of any criminal case under any law applicable exclusively to the District. Under District law, the Superior Court has jurisdiction over cases involving the detention of individuals and groups. See, e.g., [D.C. Official Code § 7-134](#). The Court of Appeals has jurisdiction of appeals from the Superior Court and, to the extent provided by law, may review orders and decisions of the Mayor, the Council, or any agency of the District. [D.C. Official Code § 1-204.31](#).

Counsel may be appointed by the court for individuals in all cases where an individual faces a loss of liberty and the United States Constitution or any other law requires such appointment of counsel. [D.C. Official Code § 11-2602](#).

District of Columbia Courts, <https://www.dccourts.gov/>.

3.0 JURISDICTION

3.1 Summary

The United States Congress may act only pursuant to those powers enumerated in the United States Constitution. There is no express constitutional authority for federal or state governments to engage in public health issues. Implicit authority for federal intervention is found under the Commerce Clause, General Welfare Clause, and Necessary and Proper Clause of the United States Constitution. The District's authority to protect public health comes from the doctrine of police power derived from the Tenth Amendment to the United States Constitution and, historically, under judicial interpretation of case law. While the United States Constitution gives the United States Congress exclusive jurisdiction over the District, the [District of Columbia Home Rule Act](#) delegates certain authority to District government, including issues with public health significance.

3.2 Source of Federal Public Health Authority

3.2.1 Explicit Constitutional Authority

There is nothing explicit in the United States Constitution that gives the federal government authority to intercede in public health matters.

3.2.2 Implicit Constitutional Authority

A. The Commerce Clause – The Commerce Clause gives the United States Congress the power to regulate commerce with foreign nations, between the states, and with tribal nations. [U.S. Const. art. I, § 8, cl. 3](#). As the United States Constitution does not define what is meant by “commerce,” the United States Supreme Court has considerable latitude to decide whether legislation falls within the federal government's authority to regulate under this clause.

The United State Congress has relied upon the Commerce Clause to enact a wide range of laws with public health implications, including food safety initiatives by the United States Food and Drug Administration (FDA), United States Department of Agriculture (USDA), and the United States Environmental Protection Agency (EPA), federal quarantine laws administered by the United States Centers for Disease Control and Prevention (CDC), as well as occupational safety provisions promulgated by the United States Department of Labor (DOL).

B. The General Welfare Clause – The General Welfare Clause allows the United States Congress to levy and collect taxes for the general welfare of the U.S. [U.S. Const. art. I, § 8, cl. 1](#). The United States Congress uses this power to tax behaviors that have potentially harmful effects, such as cigarette smoking, and rewards behaviors that it seeks to promote, like giving individuals tax credits for purchasing health insurance.

C. The Necessary and Proper Clause – In general, the Necessary and Proper Clause enables the United States Congress to select means reasonably adapted to effectuate its powers. [U.S. Const. art. I, § 8, cl. 18](#). In [United States v. Comstock, 560 U.S. 126 \(2010\)](#), the United States Supreme Court examined the interplay between the

Commerce Clause, the Necessary and Proper Clause, and the ability of the federal government to isolate infectious individuals. In part, the issue before the court was whether the federal government could civilly commit certain sex offenders after they had completed their federal prison sentences. The Court recognized that, if a federal prisoner is infected with a communicable disease that could be a threat to others, it may be “necessary and proper” for the federal government to take action even if there is not an interstate threat, such as an epidemic that would cross state borders. [Comstock, 560 U.S. at 142](#) (dictum).

3.3 Source of State Public Health Authority

3.3.1 Explicit Constitutional Authority

There is nothing explicit in the United States Constitution that gives the District or any state the authority to intercede in public health matters.

3.3.2 Implicit Constitutional Authority

The Tenth Amendment to the United States Constitution reserves to the states those powers not specifically delegated to the federal government. [U.S. Const. amend. X](#).

3.3.3 The Doctrine of Police Power

The doctrine of “police power” emanates from English common law principles that allow state governments to restrict certain individual and private rights when such limitation is necessary for the preservation of the common good. Case law has extended this principle to public health, and the United States Supreme Court has acknowledged that the government has authority to protect the public’s safety, health, and morals by restraining the use of liberty and property. See [Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 \(1996\)](#).

In *Huffman v. D.C.*, the District of Columbia Court of Appeals (Court of Appeals) upheld, as a reasonable exercise of police power, a statute that authorized the District to issue regulations to prevent, investigate, control, and report communicable disease and permitted the detainment of infected individuals. *Huffman v. D.C.*, 39 A.2d 558, 561 (D.C. 1944).

The boundaries of police power are not limitless. When exercising its police powers, the state must be acting in the interest of all of its citizenry (as opposed to a particular class of people), the methods exercised must be reasonably designed to prevent or ameliorate a threat, the means used must be reasonably necessary to accomplish its goal, and the methods cannot be unduly oppressive. See [Lawton v. Steele, 152 U.S. 133, 137 \(1894\)](#); see also [Jacobson v. Massachusetts, 197 U.S. 11, 25 \(1905\)](#).

3.3.4 States Have Historically Assumed a Primary Role in Public Health Issues

In [Jacobson v. Massachusetts](#), the plaintiff objected to a smallpox vaccine that the Commonwealth of Massachusetts required for adults. The United States Supreme Court upheld the constitutionality of the mandatory vaccine and emphasized that “[t]he safety and the health of the people . . . [are] for [the] Commonwealth to guard and protect. They

are matters that do not ordinarily concern the National Government.” [Jacobson, 197 U.S. at 38.](#)

3.4 The District of Columbia Home Rule

The United States Constitution mandates that the United States Congress has exclusive jurisdiction over the District. [U.S. Const. art. I, § 8, cl. 17.](#) However, under the District of Columbia Home Rule Act ([D.C. Official Code § 1-201.01 et seq.](#)), the United States Congress has delegated some of its authority to the local government. Some of the areas in which the District has authority to intercede in matters with public health implications include the following:

- Communicable disease reporting and investigation;
- Quarantine of individuals or groups of individuals who may be affected with communicable disease;
- Isolation of individuals or groups of individuals who are known to be affected with communicable disease;
- Compulsory medical examination of individuals or groups of individuals;
- Compulsory medical treatment of individuals or groups of individuals;
- Declaring emergencies;
- Inspecting, seizing, and destroying property; and
- Domestic animals that cause disease.

See, e.g., D.C. Official Code [§§ 7-131 to -144, 7-2301 to -2308.](#)

All legislation proposed by the District becomes law unless it is vetoed by the United States Congress. See [D.C. Official Code § 1-206.02.](#) Additionally, the United States Congress retains authority over the District’s Budget. [D.C. Official Code § 1-206.03.](#)



Generally, disasters and emergencies with public health implications are first addressed by local health departments. Exceptions to this premise are made when disasters occur on federal property (such as the Alfred P. Murrah Federal Building during the Oklahoma City bombing or military bases), or when the emergency is precipitated by acts of war or terrorism. In those matters, the federal government has primary jurisdiction. In the event of a public health crisis like Hurricane Katrina or Superstorm Sandy, federal, state, and local agencies would likely be required to work collaboratively.

4.0 DECLARATION OF EMERGENCIES

4.1 Summary

At the federal level, the [Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988](#) (Stafford Act), the [National Emergencies Act](#) (NEA), and the [Public Health Service Act](#) allow the federal government to declare emergencies under certain circumstances. Under District law, the Public Emergencies Act of 1980, [D.C. Official Code §§ 7-2301 to -2308](#), establishes a program of public emergency preparedness and provides the authority for emergency response. In the District, the Mayor has many of the powers reserved for Governors of states, including the authority to declare an emergency or a public health emergency in certain situations. Such declarations, upon publication, trigger powers that allow the District to address the emergency situation and are precursors to requesting federal aid.

District law authorizes the Mayor to issue two types of emergency declarations: public emergency declarations and public health emergency declarations. A public emergency involves situations arising from disasters, catastrophes, or other emergency circumstances, such as floods, earthquakes, fires, and serious civil disorders, that threaten the health, safety, or welfare of individuals in the District. A public health emergency is an emergency that involves a large number of deaths and/or serious human health disabilities in the District, widespread exposure to an infectious or toxic agent, use, dissemination, or detonation of a weapon of mass destruction, or another type of emergency event that requires the use of volunteer health practitioners. A public health emergency may not be declared unless a public emergency is also declared. In addition, the Mayor is authorized to declare a state of emergency for up to 30 days under the Natural Disaster Consumer Protection Act, [D.C. Official Code § 28-4102\(b\)\(1\)](#).

The Mayor has established an agency, the District of Columbia Homeland Security and Emergency Management Agency (HSEMA), to ensure that the District is prepared to protect against, plan for, respond to, and recover from, natural and man-made hazards. In addition, the Mayor's Emergency Preparedness Council (EPC) and the National Capital Region Emergency Preparedness Council (NCREPC) provide assistance and policy recommendations regarding emergency preparedness issues.

The [District Response Plan](#) (DRP), created under the Mayor's authority to establish a public health preparedness plan, unifies and coordinates the efforts of District departments and agencies, as well as non-governmental and voluntary organizations and regional and federal partners, when responding to all hazards. The District of Columbia's Emergency Operations Center (EOC) is the central location where coordination efforts occur to ensure an effective response.

The Mayor is also authorized to enter into mutual aid agreements in response to emergencies and disasters. The District is a member of the Emergency Management Assistance Compact (EMAC), which provides for mutual assistance between jurisdictions in certain situations and when specified requirements have been met.



See section 16.4 for information regarding how emergency declarations were used during the COVID-19 pandemic.

4.2 Federal Declarations

4.2.1 The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988

[The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988](#) (the Stafford Act) is the broadest and most well-known of the federal government’s emergency programs. [42 U.S. Code § 5121 to 5207](#). The Federal Emergency Management Agency (FEMA) coordinates administration of disaster relief resources and assistance to states and localities. Before FEMA can provide any significant direct funding, however, a presidential declaration must occur.

The Stafford Act authorizes the President to issue two types of declarations: a “major disaster declaration” and an “emergency declaration.” Major disaster declarations authorize a wide range of federal assistance to states, local governments, tribal nations, individuals, households, and certain non-profit organizations to aid recovery from a catastrophic event. Major disaster declarations must be requested by the state governor, mayor, or tribal leader. Emergency declarations, which are issued by the President to protect property, public health, and safety, as well as lessen or avert the threat of a major disaster, authorize a more limited range of federal assistance. In most cases, the governor, mayor, or tribal leader must request the emergency declaration. The President, however, may declare an emergency without first receiving a gubernatorial, mayoral, or tribal leader request if the emergency involves an area of primary federal responsibility, (e.g., federal buildings or army bases).

FEMA issues recommendations to the President based on the severity of the catastrophe or emergency.

Under the Stafford Act, there are three types of disaster assistance programs offered by FEMA:

- **Individual Assistance:** provides aid to individuals and households
- **Public Assistance:** provides assistance to state and local governments and certain private non-profit organizations for emergency work and the repair or replacement of disaster-damaged facilities
- **Hazard Mitigation Assistance:** provides assistance to state and local governments for actions taken to prevent or reduce long-term risk to life and property from natural hazards



More information and a summary of these programs can be found at <https://www.fema.gov/disaster-declaration-process>.

4.2.2 Public Health Emergency Declarations

Under section 319 of the [Public Health Service](#) (PHS) Act, the United States Secretary of Health and Human Services (HHS Secretary) is authorized to declare a public health emergency if the HHS Secretary determines that a public health emergency exists. A public health emergency exists if:

- A disease or disorder presents a public health emergency; or
- A public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise occurs.

A public health emergency declaration is in effect until the HHS Secretary declares that the emergency no longer exists, or after 90 days (whichever occurs first). If the HHS Secretary finds that the public health emergency declaration should remain in effect because of a continuation of the original public health threat or the emergence of new circumstances, the HHS Secretary may renew the declaration for additional 90-day periods. The HHS Secretary has broad authority to “take such action as may be appropriate” and may use funds from the Public Health Emergency Fund to respond to the public health emergency.

4.2.3 The National Emergencies Act

[The National Emergencies Act](#) (NEA) allows the President to declare a “national emergency.” The NEA does not provide any specific emergency authority itself; instead, it relies on emergency authorities provided in other federal statutes and triggers statutory authorities as specifically identified in the President’s declaration.

A national emergency may be terminated when the President issues a proclamation or if Congress enacts a joint resolution terminating the national emergency. A national emergency will automatically terminate on the anniversary of the declaration unless renewed by the President.



During the H1N1 pandemic, President Obama signed a declaration under the NEA, which, together with the prior determination by the HHS Secretary of the existence of a public health emergency, allowed healthcare facilities to waive certain regulatory requirements while responding to the pandemic. This declaration can be accessed at <https://obamawhitehouse.archives.gov/realitycheck/the-press-office/declaration-a-national-emergency-with-respect-2009-h1n1-influenza-pandemic-0>.

4.3 Section 1135 Waivers

When the President declares a disaster or emergency under the Stafford Act or NEA and the HHS Secretary declares a public health emergency under Section 319 of the PHS Act, the HHS Secretary is authorized to take certain actions in addition to their regular authorities under [section 1135](#) of the Social Security Act (SSA). The HHS Secretary may waive or modify certain Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or Health Insurance Portability and

Accountability Act (HIPAA) requirements as necessary to ensure that sufficient healthcare items and services are available to meet the needs of individuals in the emergency area during the emergency time period. In addition, the waivers and modifications ensure that providers of such services who act in good faith and are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for non-compliance (other than acts of fraud or abuse).

An “emergency area” is defined as a geographical area in which an "emergency period" has been declared, during which an emergency or disaster exists that has been declared by the President under the NEA or the Stafford Act; and a Public Health Emergency declared by the Secretary under section 319 of the PHS Act.

For the purposes of 1135 waivers, the term “healthcare provider” refers to any entity that furnishes healthcare items or services (e.g., hospitals, nursing homes) healthcare facilities, or other providers of or supplier of healthcare items or services, a physician, or other healthcare practitioners or professionals.

Examples of 1135 waivers or modifications include:

- Conditions of participation or certification requirements, program participation, or similar requirements for individual healthcare providers or types of healthcare providers;
- Preapproval requirements;
- Requirements that physicians and other healthcare professionals hold licenses in the state in which they provide services if they have a license from another state for purposes of Medicare, Medicaid, and CHIP reimbursement only;
- Sanctions under the Emergency Medical Treatment and Active Labor Act (EMTALA) for redirection or reallocation of an individual to another location to receive a medical screening pursuant to an appropriate state emergency preparedness plan or a state preparedness plan for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared federal public health emergency. A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate on the basis of a patient’s source of payment or ability to pay;
- Sanctions under section 1877(g) (the Physician Self-Referral Law or the Stark Law) relating to limitations on physician referrals;
- Deadlines and time tables for performance of required activities to allowing of such deadlines to be modified;
- Limitations on payments for healthcare items and services to permit Medicare Advantage plan enrollees to use out-of-network providers in an emergency situation; and
- Sanctions and penalties arising from non-compliance with certain HIPAA privacy regulations. The waiver of HIPAA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient’s source of payment or ability to pay.

Section 1135 waivers and modifications may be retroactive to the beginning of the emergency period. Waivers and modifications terminate either upon the termination of the emergency period or 60 days after the waiver or modification is first published (subject to 60-day renewal periods until termination of the emergency). Waivers of EMTALA (other than for a pandemic disease) or HIPAA requirements, however, are effective only for 72 hours after the implementation of a hospital disaster protocol. A waiver of EMTALA sanctions during pandemic disease is effective until the termination of the pandemic-related public health emergency.



The 1135 waiver authority applies only to federal requirements and does not apply to state requirements for licensure or conditions of participation.



Additional information regarding 1135 waivers, including required elements, can be found at <https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx>.

4.4 The Emergency Medical Treatment and Active Labor Act

EMTALA is a federal law that requires all Medicare-participating hospitals with dedicated emergency departments to provide appropriate medical screening exams to all individuals who come to the emergency department, regardless of ability to pay, to determine if the individual has an emergency medical condition. If an emergency medical condition is found, the hospital must either treat and stabilize the patient to the best of its ability or transfer the patient to another facility that has the capability and capacity to treat the patient. [42 U.S. Code § 1395dd](#).

Under EMTALA, an “emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably result in:

- Serious jeopardy to individual, woman, unborn child;
- Serious bodily function impairment;
- Serious bodily organ dysfunction;
- Not enough time to safely transfer a laboring woman before delivery; or
- Transfer may harm the laboring woman or unborn child.



A fact sheet addressing frequently asked questions regarding EMTALA and disasters can be found at [EMTALA and Disasters](#).



Hospitals have expressed concern regarding their ability to comply with EMTALA requirements during emergencies. In response to these concerns, the Centers for Medicare and Medicaid Services (CMS) published a fact sheet in 2009 during the H1N1 pandemic to clarify

options that are permissible under EMTALA. See [Centers for Medicare & Medicaid Services, Fact Sheet for Medicaid and CHIP Providers Influenza A \(H1N1\) Flu](#).

4.5 Mayoral Authority to Declare Emergencies

The Mayor has the authority to declare a public emergency under [D.C. Official Code § 7-2304](#) and a public health emergency under [D.C. Official Code § 7-2304.01](#). The Mayor is also authorized to declare a state of emergency in order to protect consumers from price gouging after natural disasters under [D.C. Official Code § 28-4102\(b\)](#).



See section 4.6 of the Manual.

4.5.1 Public Emergency

A. Emergency Executive Order Declaring a Public Emergency – In certain situations, the Mayor may issue an emergency executive order declaring the existence of a public emergency. [D.C. Official Code § 7-2304\(a\)](#).



See Appendix 2.0 for an example of a Mayor’s Declaration of a Public Emergency.

B. Public Emergency Defined – Public emergency is any disaster, catastrophe, or emergency situation where the health, safety, or welfare of persons in the District is threatened due to actual or imminent consequences within the District of:

- Enemy attack, sabotage, or other hostile action;
- Severe and unanticipated resource shortage;
- Fire;
- Flood, earthquake, or other serious act of nature;
- Serious civil disorder;
- Any serious industrial, nuclear, or transportation accident;
- Explosion, conflagration, or power failure;
- Injurious environmental contamination that threatens or causes damage to life, health, or property; or
- Outbreak of a communicable disease that threatens or causes damage to life, health or property.

[D.C. Official Code § 7-2301\(3\)](#).

C. Standard – The Mayor may declare a public emergency if the Mayor has the reasonable apprehension of the existence of a public emergency and determines that

the issuance of an order is necessary for the immediate preservation of the public peace, health, safety, or welfare. [D.C. Official Code § 7-2304\(a\)](#).

D. Content of Order – The order must state:

- The existence, nature, extent, and severity of the public emergency;
- The measures necessary to relieve the public emergency;
- The specific requirements of the order and the persons upon whom the order is binding; and
- The duration of the order.

[D.C. Official Code § 7-2304\(a\)](#).

E. Powers – The emergency executive order declaring a public emergency allows the Mayor to do the following:

- Expend funds to carry out public emergency service missions and responsibilities;
- Implement response plans without regard to normal operating procedures relating to the performance of public works, entering into contracts, incurring obligations, employment of temporary workers, rental of equipment, purchase of supplies and materials, and expenditure of public funds;
- Evacuate people to emergency shelters designated by the Mayor;
- Disconnect public utilities, such as gas and electric;
- Destroy or remove property that is contaminated, is an immediate or imminent danger to persons or property, and can prohibit persons from contacting or approaching such property;
- Issue orders or regulations to control, restrict, allocate, or regulate the use, sale, production, and distribution of food, fuel, clothing, and other commodities, materials, goods, services, and resources as required by the [District Response Plan](#) (DRP) or by any federal emergency plan;
- Direct the reduction or alteration of business hours;
- Institute a curfew to keep people off public streets;
- Establish public emergency services units as the Mayor deems appropriate;
- Expand existing departmental and agency units within District government concerned with public emergency services;
- Exercise operational direction over all District government departments and agencies for the duration of the emergency executive order;

- Procure supplies and equipment, institute training programs and public information programs, and take all other preparatory steps, including the partial or full mobilization of public emergency services units in advance of an actual disaster to ensure adequately trained and equipped personnel are available during a public emergency;
- Request federal disaster assistance, including pre-disaster assistance and certifying the need for federal disaster assistance;
- Commit District funds to alleviate damage, loss, hardship, and suffering as a result of the disaster;
- Prevent or reduce harmful consequences of the disaster; and
- Detain persons who are determined, with probable cause, to be affected with a communicable disease likely to cause death or seriously impair the health of others.

[D.C. Official Code § 7-2304\(b\)](#).

F. Duration – An emergency executive order declaring a public emergency issued by the Mayor under [D.C. Official Code § 7-2304\(a\)](#) is effective for no more than 15 calendar days from the day it is signed. If the Mayor determines that the public emergency no longer exists, the Mayor may rescind the order in whole or in part at an earlier date. [D.C. Official Code § 7-2306\(a\)](#).



See Appendix 2.0 for an example of a Public Emergency Declaration Rescission.

G. Extension – An emergency executive order declaring a public emergency may be extended for an additional 15-day period if the Mayor submits proposed emergency legislation to the Council of the District of Columbia (D.C. Council) and the D.C. Council enacts such legislation. If extenuating circumstances, such as death, destruction, or other perilous conditions prohibit the convening of at least two-thirds of the members of the D.C. Council for consideration of emergency legislation, the Mayor may decide to extend the emergency executive order up to 15 days after making a reasonable attempt to consult with the remaining members of the D.C. Council. [D.C. Official Code § 7-2306\(b\)-\(c\)](#).

H. Publication of Order – The emergency executive order declaring a public emergency must be published in the District of Columbia Register and in two daily local newspapers, as well as posted in public places in the District as determined by the Mayor, as soon as practicable. [D.C. Official Code § 7-2306\(d\)](#).

I. Violation of Emergency Order – An emergency executive order issued by the Mayor may provide for a fine of not more than \$1,000 for each violation. [D.C. Official Code § 7-2307](#).



See Appendix 3.0 for a declaration of a public emergency flowchart.

4.5.2 Public Health Emergency

A. Emergency Executive Order Declaring a Public Health Emergency – When the Mayor issues an emergency executive order declaring a public emergency, the Mayor may also issue an additional emergency executive order declaring a public health emergency. [D.C. Official Code § 7-2304.01\(a\)](#).



See Appendix 2.0 for an example of a Mayor's Declaration of a Public Health Emergency.

B. Standard – The Mayor may declare a public health emergency if the Mayor has reasonable cause to believe there is an imminent hazard or actual occurrence of any of the following:

- A large number of deaths in the District;
- A large number of serious or long-term human health disabilities in the District;
- Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the District;
- Use, dissemination, or detonation of a weapon of mass destruction, as defined by [D.C. Official Code § 22-3152\(12\)](#); or
- Other emergency events that create an acute and immediate need for volunteer health practitioners.

[D.C. Official Code § 7-2304.01\(a\)](#).

C. Content of Order – The order must specify:

- The existence, nature, extent, and severity of the public health emergency;
- The geographic areas subject to the declaration;
- The conditions that have brought about the public health emergency, if known;
- The measures necessary to relieve the public health emergency;
- The specific requirements of the order and the persons upon whom the order is binding; and
- The duration of the order.

[D.C. Official Code § 7-2304.01\(c\)](#).

D. Powers – The emergency executive order declaring a public health emergency may include the following terms:

- Require that healthcare providers licensed in the District reasonably assist and not unreasonably detract from the ability of the District government to successfully respond to and control the public health emergency in accordance with the provisions of the [DRP](#) and [D.C. Official Code §§ 7-131 to -144](#);
- Appoint licensed healthcare providers, either from the District or from other jurisdictions, as temporary agents of the District, provided that such appointments are in effect solely for the duration of the public health emergency, without compensation and for the purpose of assisting the District in implementing the provisions of the [DRP](#) and [D.C. Official Code §§ 7-131 to -144](#);
- Exempt licensed healthcare providers, either from the District or other jurisdictions, from civil liability for damages for any actions taken within the scope of the provider's employment or voluntary service to implement the provisions of the [DRP](#) and [D.C. Official Code §§ 7-131 to -144](#), (except in instances of gross negligence) for the duration of the public health emergency; and
- Waive any licensing requirements, permits, or fees otherwise required by District law to allow healthcare providers licensed in their home jurisdiction in their fields of expertise to be appointed as temporary agents to respond to the public health emergency.

[D.C. Official Code § 7-2304.01\(d\)](#).

E. Duration – An emergency executive order declaring a public health emergency issued by the Mayor [D.C. Official Code § 7-2304.01\(a\)](#) is effective for no more than 15 calendar days from the day it is signed. If the Mayor determines that the public emergency no longer exists, the Mayor may rescind the order in whole or in part at an earlier date. [D.C. Official Code § 7-2306\(a\)](#).



See Appendix 2.0 for an example of a Public Health Emergency Declaration Rescission.

F. Extension – An emergency executive order declaring a public health emergency may be extended for an additional 15-day period if the Mayor submits proposed emergency legislation to the D.C. Council and the D.C. Council adopts such legislation. If extenuating circumstances, such as death, destruction, or other perilous conditions prohibit the convening of at least two-thirds of the members of the D.C. Council for consideration of emergency legislation, the Mayor may decide to extend the emergency executive order by up to 15 days, after making a reasonable attempt to consult with the remaining members of the D.C. Council. [D.C. Official Code § 7-2306\(b\)-\(c\)](#).

G. Publication of Order – The emergency executive order declaring a public health emergency must be published in the District of Columbia Register and in two daily local newspapers, as well as posted in public places in the District as determined by the Mayor by regulation, as soon as practicable given the condition of the emergency. [D.C. Official Code § 7-2306\(d\)](#).



See Appendix 3.0 for a declaration of a public health emergency flowchart.



In the context of a public health emergency, it is foreseeable that a party could seek declaratory relief to determine whether certain information relating to the outbreak or emergency should be disclosed or to determine the appropriateness of a detention facility proposed by the DC Health Director. Moreover, a party might seek a declaratory judgment to revoke a declaration of emergency or public health emergency issued by the Mayor or emergency regulations adopted by the D.C. Council.

Under the District of Columbia Superior Court’s (Superior Court) rules of civil procedure, a party may seek a declaratory judgment to determine present and/or future rights. [Super. Ct. Civ. R. 57](#). Declaratory relief is appropriate if a party needs judicial guidance prior to taking future action rather than adjudicating a party’s past conduct. Granting declaratory relief is within the court’s discretion and is not mandatory. [Wilton v. Seven Falls Co., 515 U.S. 277, 288 \(1995\)](#).

Any party may request a trial by jury on the motion for declaratory judgment. [Super. Ct. Civ. R. 38, 39, 57](#). The party seeking the jury trial must serve the other parties with a written copy of the jury request. The jury request may be made any time after the commencement of the action but not later than 14 days after service of the last pleading. [Super. Ct. Civ. R. 38\(b\)](#). The court may also order a “speedy hearing” on a party’s motion for declaratory judgment. [Super. Ct. Civ. R. 57](#).

4.6 Natural Disaster Consumer Protection Act

4.6.1 State of Emergency

The Natural Disaster Consumer Protection Act provides additional emergency declaration authority to the Mayor to protect consumers from price gouging after natural disasters. Within 48 hours of a natural disaster, the Mayor may declare a state of emergency for not more than 30 days. This declaration must be published in the District of Columbia Register and in two daily newspapers of general circulation as soon as practicable after the declaration. [D.C. Official Code § 28-4102\(b\)](#).



D.C. Official Code §§ [7-2304](#) and [7-2304.01](#) supersede [D.C. Official Code § 28-4102\(b\)](#) in the event there are any inconsistencies between the laws.

4.6.2 Natural Disaster Defined

Natural disaster is the actual or imminent consequence of any disaster, catastrophe, or emergency, including fire (but not fire caused by human error or arson), flood, earthquake, storm, or other serious act of nature, that threatens the health, safety, and welfare of persons or causes damage to property in the District. [D.C. Official Code § 28-4101\(1\)](#).

4.6.3 Anti-Price Gouging

During a declared emergency, it is unlawful for any person to charge more than the normal average retail price for any merchandise or services sold during the declared emergency. [D.C. Official Code § 28-4102\(a\)](#).

4.6.4 Penalties

Violators of the Natural Disaster Consumer Protection Act may be fined up to \$1,000 and may have their license, permit, or certificate of occupancy revoked, suspended, or limited. [D.C. Official Code § 28-4103](#).

4.7 Emergency Management

4.7.1 District of Columbia Homeland Security and Emergency Management Agency

The Mayor has established the District of Columbia Homeland Security and Emergency Management Agency (HSEMA) to support and coordinate homeland security and emergency management efforts, ensuring that the District's all-hazards emergency operations are prepared to protect against, plan for, respond to, and recover from natural and man-made hazards. [D.C. Official Code § 7-2202\(a\)](#).



A special event is a significant domestic or internal event, occurrence, contest, activity, or meeting that, by virtue of its profile and/or status, represents an attractive target for a terrorist attack. See [32 C.F.R. § 183.3](#). A national security special event (NSSE) is an event of national significance that, by virtue of its political, economic, social, or religious significance, may be the target of terrorism or other criminal activity. See *Id.* Examples of special events and NSSEs include presidential inaugurations, major international summits held in the U.S. (typically in the District), major sporting events, and presidential nominating conventions. More information about special events and NSSEs in the District can be found at <https://hsema.dc.gov/page/msetg-special-events-calendar>.

4.7.2 Mayor's Emergency Preparedness Council

The Mayor is authorized to establish the [Mayor's Emergency Preparedness Council](#) (EPC) to continually re-examine the overall state of emergency and disaster readiness of the District, to provide a consistent network of District agency expertise to make the District a national leader in comprehensive emergency management and homeland security, and to make recommendations on improving District planning for, response to, and recovery

from emergency and disaster events as well as emerging threats. [Mayor's Order 2012-82 \(June 15, 2012\)](#).

4.7.3 National Capital Region Emergency Preparedness Council

The National Capital Region Emergency Preparedness Council (NCREPC) is an advisory body which reports to the Metropolitan Washington Council of Governments (MWCOG) Board of Directors. MWCOG is an independent, nonprofit association that brings area leaders together to address major regional issues in the District, suburban Maryland and Northern Virginia. MWCOG's membership includes 300 elected officials from 22 local governments, the Maryland and Virginia state legislatures, and the United States Congress. NCREPC derives its authority from a Charter adopted by the MWCOG Board on November 13, 2002.

The NCREPC makes policy recommendations to the MWCOG Board through the Public Safety Policy Committee and makes procedural or other recommendations to the MWCOG Board or, through the MWCOG Board, to various regional agencies with emergency preparedness responsibilities or operational response authority. The NCREPC oversees and implements the Regional Emergency Coordination Plan (RECP); coordinates activities of the various Regional Emergency Support Function (RESF) Working Groups as they develop specific procedures and relationships; oversees the development of plan annexes and establishes such additional plan annexes as may be desirable; and develops training or tests of various components of regional emergency preparedness in conjunction with MWCOG's Chief Administrative Officers Committee (CAO).



For more information on MWCOG and the National Capital Region (NCR), see section 4.10.1 of the Manual.

4.7.4 District of Columbia Emergency Support Function #8 DC Health, Health and Medical Coalition

DC Health, Health and Medical Coalition (DC Health-HMC) serves as a strategic planning committee and advisor to the DC Health Director. As such, it fosters partnerships among government agencies, healthcare providers, and community partners to strengthen the District's response to emergencies. DC Health-HMC facilitates information, communication and resource sharing and works to maximize the utilization of limited existing resources. It also coordinates training, drills, and exercises between state, local, and federal partners.

4.8 Emergency Planning

4.8.1 District Response Plan and Program

The Mayor has authority to establish a public health preparedness plan and program that utilizes the services of all appropriate District agencies. [D.C. Official Code § 7-2302\(a\)](#). The [DRP](#) was created pursuant to this authority to prepare for and respond to emergencies

and disasters. The DRP unifies and coordinates the efforts of District departments and agencies, non-governmental and voluntary organizations, and regional and federal partners that may be involved in emergency management and homeland security to protect life and property and ensure public safety.

4.8.2 Emergency Support Function #8 – Health and Medical Services

[Emergency Support Function](#) (ESF) #8 – Health and Medical Services provides coordinated District medical assistance and resources to respond to public health and medical care needs following a public emergency. Assistance provided under [ESF #8](#) is directed by the Health Emergency Preparedness and Response Administration (HEPRA) and is supported by several District agencies and private health service providers.



See sections 2.4.1 and 2.4.2 of the Manual for additional information regarding [ESF #8](#).

4.8.3 Emergency Support Function #13 – Law Enforcement

[ESF #13](#) – Law Enforcement provides for the safety of citizens and security of property during public emergencies. It prescribes the procedures for the command, control, and coordination of District ESF #13 agencies to conduct emergency operations in the District. It also establishes interagency relationships with the [ESF #13](#) federal law enforcement. In the District, [ESF #13](#) is directed by the Metropolitan Police Department (MPD).

During public emergency operations, [ESF #13](#) manages and coordinates law enforcement activities, and provides personnel and equipment resources to execute response activities in the public safety and security area. Examples of the support provided under [ESF #13](#) include:

- Supporting public safety and security operations in the field;
- Enhancing situational awareness at operations centers; and
- Aiding planning and decision making by the Consequence Management Team (CMT).

4.9 Emergency Operations Center

The Emergency Operations Center (EOC) integrates regional, federal, and local information and communications on a daily basis, and serves as the main operational command and control center for consequence management during an emergency, disaster, special event, and NSSE in the District. During events or incidents that impact the NCR, the EOC ensures information-sharing, coordination and communications with NCR jurisdictions utilizing a variety of communication tools.

The EOC maintains direct contact with NCR jurisdictions and federal counterparts via landlines, hotlines, radio, WebEOC, closed-circuit television (CCTV), and other non-secure systems to ensure constant receipt and dissemination of information.

4.10 Mutual Aid

The Mayor may enter into interstate civil defense compacts with other jurisdictions to provide mutual aid to meet any emergency or disaster from enemy attack or other cause, natural or otherwise. The form of the compact is specified in [D.C. Official Code § 7-2209\(a\)](#).



See section 12.6 of the Manual for information about mutual aid agreements related to mass fatality incidents.

4.10.1 National Capital Region

The NCR was granted authority to establish mutual aid agreements in the NCR with certain liability protection by the [Intelligence Reform and Terrorism Prevention Act of 2004, Public Law 108-458](#), as amended by [Senate Report 110-237, S. 1245](#) (IRTPA). The NCR Mutual Aid Agreement (NCR-MAA) supports all mutual aid generally provided between and among units of NCR jurisdictions, including, but not limited to police, fire, emergency management, public health, and public works.

The NCR consists of 24 jurisdictions within two States and the District of Columbia:

- District of Columbia
- Maryland – Town of Bladensburg, City of Bowie, City of College Park, Charles County, City of Frederick, Frederick County, City of Gaithersburg, City of Greenbelt, City of Hyattsville, City of Laurel, Montgomery County, Prince George's County, City of Rockville, and City of Takoma Park.
- Virginia – City of Alexandria, Arlington County, City of Fairfax, Fairfax County, City of Falls Church, Loudoun County, City of Manassas, City of Manassas Park, and Prince William County.

The MWCOG provides staff support for administrative maintenance of mutual aid agreements in the NCR. Additionally, the MWCOG may assist in coordinating initial requests for mutual aid assistance.

The member jurisdictions of the NCR have entered into a number of agreements for assistance during an emergency or public service event, for example:

- **The National Capital Region Mutual Aid Agreement** was entered into pursuant to IRTPA between and among the District of Columbia, the State of Maryland, the Commonwealth of Virginia, and certain local governments of the National Capital Region, that are MWCOG jurisdictions. According to the NCR-MAA, during an emergency or public service event, assistance will be provided according to the procedures established in one or more operational plans developed and agreed to NCR-MAA members. Parties responding outside of their jurisdiction, and their employees actually providing the assistance, will be under the general control and direction of the appropriate official designated

by the jurisdiction requesting aid. This agreement is effective from December 15, 2005 until terminated by all but one of the parties executing the agreement.

- **The Metropolitan Washington Council of Governments Fire and Rescue Mutual Aid Operations Plan** effectuates provisions of the NCR-MAA, Section 5, and ensures the fullest cooperation among fire prevention and suppression and emergency medical services agencies in the NCR. Fire and Rescue Mutual Aid Operations Plan (MAOP) creates and describes relationships and provides general direction and guidance rather than specifying the operations of responding agencies.
- **The National Capital Region Water and Wastewater Mutual Aid Agreement** allows a signatory's authorized official to request mutual aid and assistance from another participating signatory in the event of an emergency, water emergency, or a public service event. They may also request assistance either orally or in writing. Requests for assistance shall be directed to the authorized official of the potential responding signatory. Each signatory must identify one initial authorized official. The procedure for notifying signatories when the authority to act as an authorized individual is given to or withdrawn from an individual is also set forth in the agreement. Nothing in this agreement is intended to interfere with signatory's ability to request assistance or provide assistance under a state emergency management process, either within the state or out-of-state as part of the EMAC process.

4.10.2 Emergency Management Assistance Compact

EMAC provides mutual assistance between the member states to manage any declared emergency or disaster in the affected state(s), including those arising from natural disasters, technological hazards, man-made disasters, civil emergency aspects of resources shortages, community disorders, insurgencies, and enemy attacks. See [D.C. Official Code § 7-2332](#).

EMAC was ratified by the United States Congress in 1996 by [Public Law 104-321](#), making it the first national disaster-relief compact to be signed by the United States Congress since the Civil Defense and Disaster Compact of 1950. [D.C. Official Code § 7-2332](#) provides the Mayor with authority to enter into EMAC. All 50 states, the District, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to enter into EMAC.

EMAC offers assistance during declared states of emergency through the provision of personnel, equipment, and commodities to help disaster relief efforts in other jurisdictions. Once the conditions for providing assistance to a requesting jurisdiction have been set, the terms constitute a legally binding contractual agreement between the jurisdictions, including the responding jurisdiction.



The EMAC legislation helps resolve issues related to liability and costs, and permits reciprocity of credentials, licenses, and certifications. See <http://www.emacweb.org> for more information.

4.11 National Disaster Medical System

When a disaster overwhelms District resources, health officials may request support from the National Disaster Medical System (NDMS). This request is facilitated by the Assistant Secretary for Preparedness and Response (ASPR) Regional Administrators (RAs) and Regional Emergency Coordinators (RECs). The NDMS provides technical assistance and personnel to augment local health and medical system capacity and response capabilities in the event of disasters and emergencies or as part of a national security special event.

The NDMS is comprised of medical, fatality management, veterinary, and para-professionals. NDMS personnel may be deployed several times per year, and must complete training, attend meetings and drills, respond to requests for information, and maintain appropriate licensure and certifications within their discipline. When NDMS personnel are activated as intermittent federal employees and acting under official orders from NDMS, licensure and certification is recognized in all states. Liability protections are also provided under the Uniformed Services Employment and Reemployment Rights Act (USERRA), the Federal Tort Claims Act (FTCA), and Federal Employees' Compensation Act (FECA).



More information about the NDMS, can be found at

<https://www.phe.gov/Preparedness/responders/ndms/Pages/default.aspx>.



See section 11.0 of the Manual for more information on licensing and legal protections for volunteers during an emergency.

ASPR can call on a number of NDMS teams, depending on the situation, needs of the community, and the resources overwhelmed. These teams include:

- **Trauma and Critical Care Teams (TCCTs):** TCCTs provide critical, operative, and emergency care, and advanced trauma life support. TCCTs can provide a deployable advance unit, augmentation to existing medical facilities, and establish a stand-alone field hospital.
- **Disaster Medical Assistance Teams (DMATs):** DMATs can assist hospitals and medical facilities in serving their patients, support medical sites and shelters, provide mass prophylaxis, and stand ready to serve in case of an emergency or during a special event. DMATs are comprised of clinical, non-clinical, and leadership staff.
- **National Veterinary Response Teams (NVRTs):** NVRTs provide expert veterinary care to service animals, including security animals. NVRT members include veterinarians, animal health technicians, epidemiologists, safety specialists, logisticians, communications specialists, and other support personnel.
- **Victim Information Center (VIC) Team:** The VIC team supports local authorities and other NDMS teams in the aftermath of a mass casualty event. The VIC team provides technical assistance and consultation on the collection and management of ante-mortem

data, such as pictures, fingerprints, dental x-rays, and other medical records, to help identify the victims. They can also provide subject matter expertise in mass fatality management and victim information procurement, assist in updating the Victim Identification Program (VIP) database, coordinate the release of remains, and serve as a liaison to the victims' families.

- **Disaster Mortuary Operational Response Teams (DMORTs):** DMORTs are composed of funeral directors, medical examiners, pathologists, forensic anthropologists, fingerprint specialists, forensic odontologists, dental assistants, administrative specialists, and security specialists. While DMORTs work under the delegated jurisdictional authority of the local or state Coroner or Medical Examiner, DMORT personnel work under the overall command and control of the United States Department of Health and Human Services (HHS) Emergency Management Group (EMG) and/or the Incident Response Coordination Team (IRCT).

DMORTs can assist a community by:

- Quickly and accurately identifying victims;
- Supporting local mortuary services;
- Reuniting victims with their loved ones in a dignified, respectful manner;
- Helping families, friends, and communities find closure so that they can move forward and begin to heal;
- Tracking and documenting human remains and personal effects;
- Establishing temporary morgue facilities;
- Assisting in the determination of cause and manner of death;
- Collecting ante-mortem data;
- Collecting medical records, dental records, or DNA of victims from next of kin to assist in victim identification;
- Performing postmortem data collection;
- Providing documentation during field retrieval and morgue operations;
- Performing forensic dental pathology and forensic anthropology methods; and
- Processing and re-interment of disinterred remains preparation.

DMORTs may deploy with a Disaster Portable Morgue Unit (DPMU). A DPMU contains a complete morgue and prepackaged equipment and supplies.



Region III DMORT's primary area of coverage includes Delaware, the District, Maryland, Pennsylvania, Virginia, and West Virginia. As of January 2017, the team has

approximately 86 members representing all disciplines and support personnel. Region III maintains relationships with the medical examiners' offices in each state and the District, and coroners in Pennsylvania. See dmort3.org.

5.0 MEDICAL COUNTERMEASURES

5.1 Summary

In the event of a major disaster or emergency, critical medical supplies will be needed across the District. These items, often referred to as medical countermeasures (MCM), may come from many sources, including District stockpiles, hospital and health system stockpiles, privately owned stockpiles, neighboring jurisdictions through mutual aid, and federal stockpiles. MCM include both pharmaceutical interventions, such as vaccines, antimicrobials, antidotes, and antitoxins, and non-pharmaceutical interventions, such as ventilators, diagnostics, personal protective equipment (PPE), and patient decontamination, that may be used to prevent, mitigate, or treat the adverse health effects of an intentional, accidental or naturally occurring public health emergency. A terrorist attack employing biological or chemical weapons may cause mass casualties that require rapid distribution and dispensing of MCM to minimize morbidity and mortality. Similarly, disease outbreaks and natural disasters may cause serious health impacts for entire populations that require MCM to mitigate impacts. Both federal and District laws authorize or guide the use of MCM, including liability exemptions. In some cases, special United States Food and Drug Administration (FDA) emergency use authorities may need to be utilized in order to use the best MCMs available for response in impacted populations.

5.2 Mayor's Authority

The Mayor has the authority to declare a state of public emergency, [D.C. Official Code § 7-2304](#), and a subsequent state of public health emergency, [D.C. Official Code § 7-2304.01](#). In both of these situations, the Mayor's declaration could implement a wide range of measures designed to respond to and mitigate the emergency, including the deployment of medical countermeasures (MCM). For example, the terms of the declaration could include a temporary overriding of the District law so as to establish a grant of authority to the DC Health Director (or the District's Chief Health Officer or Chief Medical Officer, or a similarly qualified official) to issue one or more "standing medical orders" or "blanket prescriptions" to enable the distribution, dispensing, and administration of prophylactic medications and/or other pharmaceuticals as a means of combating the emergency and protecting potentially exposed individuals.



See section 4.5 of the Manual regarding the mayor's authority to declare emergencies.

5.3 Strategic National Stockpile

The Strategic National Stockpile (SNS), which includes drugs, vaccines, biological products, medical devices, and other supplies, is maintained by the United States Secretary of Health and Human Services (HHS Secretary) to provide for the emergency health security of the U.S. The HHS Secretary may deploy the SNS to respond to an actual or potential public health emergency or to otherwise protect the public health or safety, or as required by the Secretary of the United States Department of Homeland Security (DHS Secretary) to respond to an actual or potential emergency. The federal government established the SNS, which is managed by the Office of the Assistant Secretary for Preparedness and Response (ASPR) within the United States Department

of Health and Human Services (HHS), to augment local supplies of critical medical items. See [42 U.S.C. § 247d-6b](#).



One component included in the SNS is “Push Packs,” which are caches of large quantities of medicines, antidotes, and medical supplies that are responsive to a wide range of threats. Push Packs include MCMs that may be useful in biological attacks (using agents such as anthrax, plague, and tularemia), nuclear attacks, radiological events, and explosive events, as well as natural disasters and other human caused incidents. Another component of the SNS is CHEMPACKS that are prepositioned and stored locally to provide chemoprophylaxis to nerve agents released during a large-scale chemical event. Having these items forward deployed allows for their immediate use in suspected or confirmed victims. This is essential since any delay in treatment could gravely affect patient outcomes.



Section 402: Public Health Emergency Medical Countermeasure Enterprise (PHEMCE) of the [Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019](#) (PAHPIA) codifies the PHEMCE into law. The PHEMCE is designed to inform the direction of research, development, stockpiling, utilization, and procurement of MCMs for the SNS, including considerations for deployment and distribution of MCMs.



Section 403: Strategic National Stockpile of the [PAHPIA](#) requires collaboration between the ASPR Secretary and the Centers for Disease Control and Prevention (CDC) regarding management of the SNS, while reauthorizing the SNS through 2023.



SNS played a significant role during the COVID-19 pandemic. See section 16.4 for further information.

5.4 Chemical, Biological, Radioactive, or Nuclear, or Explosive Event

Human casualties are the highest priority for emergency responders in disasters and emergencies, especially acts of terrorism involving Chemical, Biological, Radioactive, Nuclear, or Explosive (CBRNE) weapons. A terrorist attack may be localized or widespread and multiple CBRNE events may occur simultaneously over a short span of time, or in combination with another hazard. The effects may be immediate (e.g., due to chemical agents) or delayed (e.g., due to biological agents). Persons who are not symptomatic but are known or believed to have been exposed will receive MCM as prophylaxis in accordance with the District’s emergency medical plans.



Persons who experience symptoms resulting from any hazard will be referred to a designated facility for care and/or treatment. For example, during the 2014 Ebola outbreak, there were a

number of hospitals designated nationally as treating facilities, including Children’s National Medical Center, Medstar Washington Hospital Center, and George Washington University Hospital in the District. See <https://dc.gov/release/dc-based-hospitals-among-35-nationally-recognized-treatment-centers-ready-handle-ebola>.

5.5 Personnel Authorized to Dispense Medications During a State of Public Health Emergency

The Mayor has the authority, as part of a public health emergency order, to implement emergency measures regarding the dispensing of medication. [D.C. Official Code § 7-2304.01\(c\)\(4\), \(d\)\(1\), \(d\)\(2\), \(d\)\(4\)](#). The Mayor’s authority in this regard may be delegated to the Chief Public Health Officer/DC Health Director.



For example, the order may include a provision to expand the types of healthcare providers authorized to dispense medications.

5.6 Procurement or Taking of Private Property

The Mayor has the authority, as part of a public health emergency order, to procure property, supplies, and equipment as necessary to respond to the emergency. [D.C. Official Code § 7-2304\(b\)](#).



The District’s procurement laws and regulations provide procedures for emergency procurements when there is an imminent threat to the public health, welfare, property, or safety, or to minimize disruption in District services when an emergency condition exists. See [D.C. Official Code § 2-354.05](#); [27 DCMR § 1702](#).

5.7 Medical Countermeasures Emergency Use Authorities

Under most circumstances, drugs, medical devices, and biologics may only be introduced into interstate commerce if they have been approved, cleared, or licensed by the United States Food and Drug Administration (FDA). In certain situations, the best MCMs available for response are unapproved by the FDA or may need to be used in unapproved ways. The FDA has special authorization to allow for the use of such MCMs in impacted populations during or in anticipation of emergencies. Mechanisms the FDA can use to allow the emergency use of MCMs include the emergency use authorization (EUA) authority and several authorities related to the emergency use of approved MCMs. See <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/mcm-related-counterterrorism-legislation>.



The FDA-issued [Emergency Use Authorization of Medical Products and Related Authorities: Guidance for Industry and Other Stakeholders](#) provides useful information regarding MCM emergency use authorities.

5.7.1 Emergency Use Authorization Authority

Under [section 564](#) of the Federal Food, Drug, and Cosmetic Act (FD&C Act), the FDA may authorize (1) the use of an unapproved medical product, or (2) an unapproved use of an approved medical product, in certain situations through an EUA to make available an MCM for use in an emergency without violating provisions of the FD&C Act. Before the FDA may issue an EUA, the HHS Secretary must declare that circumstances exist justifying the authorization. The HHS EUA declaration is based on one of four types of determinations issued by the HHS Secretary, the DHS Secretary, or the United States Department of Defense Secretary. The FDA also must ensure that certain criteria for issuance are met, such as that the known and potential benefits of the product outweigh its known and potential risks and that there is no adequate, approved, and available alternative to the product.

Each EUA includes specific conditions for the various stakeholders involved (e.g., HHS, state and local stakeholders, and healthcare providers) and fact sheets about the product and its emergency use for healthcare providers and recipients. The FDA has issued [over 60 EUAs](#). Generally, an EUA remains in effect for the duration of the emergency declaration made by the HHS Secretary unless revoked at an earlier date.

5.7.2 Other Medical Countermeasure Emergency Use Authorities (limited to approved medical products)

Emergency activities involving eligible the FDA-approved products without the FDA needing to issue an EUA are also possible through actions under section 564A of the FD&C Act, including the issuance of an emergency dispensing order (EDO), waiver of Current Good Manufacturing Practice (CGMP) requirements, waiver of Risk Evaluation and Mitigation Strategies (REMS) requirements, extension of labeled expiration dating, and/or issuance of emergency use instructions (EUI) for specific MCMs.




These authorities are delegated from HHS to the FDA. However, the EUI authority was delegated from HHS to CDC in 2013. For additional information about the FDA and CDC coordination on the EUI authority, refer to the FDA-CDC [memorandum of understanding](#).


The EDO authority allows the FDA to facilitate the availability and use of eligible, approved MCMs needed during public health emergencies by allowing emergency dispensing of approved MCMs without requiring an individual prescription for each recipient of the MCM. The FDA intends to issue orders to allow emergency dispensing when, based on available information about the MCM, emergency response plans, and operational needs, The FDA concludes that it is reasonable to permit emergency dispensing of eligible FDA-approved products. The FDA may allow emergency dispensing (including mass dispensing at a point of dispensing (POD)) of approved MCMs during an actual Chemical, Biological, Radioactive, or Nuclear (CBRN) emergency, without requiring an individual prescription for each recipient of the MCM, if (1) permitted by state law or (2) in accordance with an order issued by the FDA. EDOs issued by the FDA also may include waivers of CGMP


requirements, such as storage or handling when appropriate to accommodate emergency response needs.


When MCMs are needed during public health emergencies, information about the emergency use of the product is also needed. The EUI authority allows CDC to provide streamlined information (also referred to as fact sheets for recipients of an MCM and for healthcare professionals) about the use of eligible, approved MCMs. Under section 564A(e) of the FD&C Act, CDC may create and issue, and government stakeholders may disseminate, EUI about the FDA-approved conditions of use for such MCMs before or during a CBRN event. EUI are intended to be similar to “fact sheets” that have been authorized in past EUAs, and may be directed to healthcare professionals and authorized dispensers or to recipients of an eligible MCM. The EUI authority offers enhanced flexibility for CDC to prepare and disseminate EUI concerning a disease or condition for which an MCM is FDA-approved, licensed, or cleared without further limitation.

 The FDA and CDC interpret this provision as permitting the creation of EUI that describe how the approved drug may be used, for the disease or condition for which it is approved, but in ways that may deviate from or extend beyond the FDA-approved labeling. When feasible, the FDA and CDC will coordinate issuance of an EDO and EUI for a specific approved MCM together as a “package.” Such packages also may include waivers of certain CGMP requirements (e.g., temporary deviations from the labeled storage conditions) and expiration dating extensions.

Under section 564B of the FD&C Act, government entities and their agents may preposition or stockpile an unapproved medical product intended for emergency use in anticipation of the FDA approval or clearance, or issuance of an EUA to enable them to better prepare for potential rapid deployment during an actual CBRN emergency.

 Currently, there are [EDOs for doxycycline and ciprofloxacin](#) for post-exposure prophylaxis of inhalational anthrax during an anthrax emergency, with accompanying [EUI](#).

 Information about expiration dating extensions by the FDA can be found at <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/expiration-dating-extension>.

 See section 16.4.3 for information regarding how EUA's were used during the COVID-19 pandemic.

5.8 Liability Protection

The Mayor has the authority, as part of a public health emergency order, to appoint healthcare providers as agents of the District, and to specifically exempt healthcare providers from civil liability, except in instances of gross negligence, and solely for the duration of the public health emergency. [D.C. Official Code § 7-2304.01\(d\)\(2\), \(d\)\(3\)](#).

[The Advanced Life Support Act of 1977 \(D.C. Official Code § 7-401\)](#) provides a blanket exemption from civil liability for any person who renders medical care in good faith in an emergency situation on a volunteer basis. This law limits liability for rendering medical care or assistance during any emergency event with or without a public health emergency order. It protects any non-licensed individual rendering emergency care as a Good Samaritan. This law also covers any emergency medical technician (paramedic, intermediate or basic) certified in any state or the District who is providing assistance under the direction of a licensed physician, as well as the licensed physician who is providing the emergency medical instruction as long as the care is provided in good faith and does not constitute gross negligence. During a declared emergency pursuant to [D.C. Official Code § 7-2304](#), this protection is also extended to the employer of the emergency medical technician, provided that the care is rendered in good faith and does not constitute gross negligence.



See section 11.3.1 of the Manual for information regarding liability protections for volunteer health practitioners who provide services under [D.C. Official Code § 7-2361.01 to-2361.12](#).

[The Public Readiness and Emergency Preparedness Act \(PREP Act\) of 2005 Pub. L. No. 109-148; 42 U.S.C. §§ 247d-6d, 247d-6e](#) authorizes the HHS Secretary to issue a declaration (called a “PREP ACT declaration”) that provides immunity (except for willful misconduct) for claims related to administration or use of countermeasures against CBRN agents to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration includes, among other provisions:

- The countermeasures covered by the declaration;
- The category of diseases, health conditions, or health threats for which administration and use of the countermeasures are recommended;
- The effective time period of the declaration;
- The population of individuals receiving the countermeasure;
- Limitations, if any, on the geographic area for which immunity is in effect;
- Limitations, if any, on the means of distribution of the countermeasure; and
- Any additional persons identified by the HHS Secretary as qualified to prescribe, dispense, or administer the countermeasures.

The PREP Act also authorizes a fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of countermeasures covered by the Secretary's declaration.



See section 16.4.7 for information about how the PREP Act was used during the COVID-19 pandemic.



Additional information about the PREP Act and current PREP Act declarations are available at <https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx>.

6.0 OPERATION OF THE COURTS AMID PUBLIC HEALTH THREATS

6.1 Summary

In the event of a public health emergency, such as the widespread outbreak of an infectious disease within a community, the standard procedures of the court may need to be altered to assure the safety of persons participating in judicial proceedings. The court might have to determine whether an individual suspected of being infected with a contagious disease should be permitted to physically appear in the courtroom and, if not, how the proceedings will be conducted to adequately ensure the individual's participation. Other issues might arise, such as the sufficiency of the individual's access to and consultation with counsel, the availability of court judicial and non-judicial personnel not affected by the contagious disease, and the need to relocate to safer and more sanitary premises. A public health emergency could strain the resources of the courts and require innovative solutions that ensure the continued operation of the judicial system while respecting constitutional due process guarantees.



See <https://www.dccourts.gov/coronavirus> for more information about the operation of District court operations during the COVID-19 pandemic.

6.2 Appearance of Individuals Posing a Potential Threat to Public Health

6.2.1 Appearance by Means Other Than in Person

Although isolation and quarantine orders may, under certain circumstances, be issued following *ex parte* hearings, an individual affected by such an order is subsequently entitled to a hearing on the subject within 10 days after the District of Columbia Superior Court (Superior Court) receives the individual's petition. [D.C. Official Code § 7-134\(b\)](#); see also [U.S. Const. amend. V](#). However, an individual who is the subject of an isolation or quarantine order may be physically unable to appear in court due to illness, isolation, or quarantine. In addition, the court may be unwilling to permit an infected or potentially infected individual to appear in person because of a potential health threat to court personnel, counsel, and the attending public (if the hearing is not closed).



An *ex parte* hearing is one that has only one party present, which is an exception to the general rule of court procedure that both parties must be present at any argument before a judge.

In the event an individual is not permitted to attend proceedings in person, the court may wish to consider an alternative procedure. [Super. Ct. Civ. R. 43\(b\)](#) provides that “[f]or good cause in compelling circumstances and with appropriate safeguards, the court may permit testimony in open court by contemporaneous transmission from a different location.” [Superior Court Administrative Order 12-16](#) provides that “court video and web conferencing technology . . . will be made available . . . where witnesses and other parties are physically unavailable to appear in court.”

For misdemeanor prosecutions for criminal violations, under [D.C. Official Code § 7-140, Super. Ct. Crim. R. 43](#), the defendant is required to be present in the court unless, with the defendant’s written consent, the court permits arraignment, plea, trial, and sentencing to occur by video teleconferencing or in the defendant’s absence.

6.3 Closure of Hearings or Sealing of Records

In addition to the question of whether a person who is infected or potentially infected will be physically present in the courtroom, the court may need to decide whether a hearing should be closed to the public. Furthermore, the court may need to decide whether to order that certain records be sealed.

The likely basis for closing a hearing would be to protect the individual’s privacy interest regarding their health condition. The court must weigh the following criteria:

- The party seeking to close the courtroom must advance an overriding interest that is likely to be prejudiced;
- The closure must be no broader than necessary to protect that interest;
- The trial court must consider reasonable alternatives to closing the proceeding; and
- The trial court must make findings adequate to support the closure.

Waller v. Georgia, 467 U.S. 39, 48 (1984); *Morgan v. Foretich*, 521 A.2d 248, 251 (D.C. 1987).

The court is required to evaluate this interest in each case. The individual may waive their privacy interest.

The Superior Court has the authority to seal cases and documents by court order pursuant to [Super. Ct. Civ. R. Rule 5-III](#). However, the public has a presumptive right of access to a broad range of court records in civil cases. See *Mokhiber v. Davis*, 537 A.2d 1100, 1106, 1111 (D.C. 1988) (citing *Nixon v. Warner Communications, Inc.*, 435 U.S. 589, 597 (1978)) which recognizes the public’s general right to access, inspect, and copy public records and documents, including judicial records). The common law presumptive right of access to judicial records is “bolstered when the materials sought will shed light on events of historical or contemporary interest to a wider audience; an issue of greater and wider public importance may create a stronger claim of access than a less important issue.” *Id.* at 1115-16.

A party seeking to seal a judicial record must show specific harms that are substantial enough to outweigh the presumption of openness. *Mokhiber*, 537 A.2d at 1115-16. The Superior Court has discretion to weigh a moving party’s need for secrecy against the public’s right of access. *In re Application of National Broadcasting Co.*, 653 F.2d 609, 613 (D.C. Cir. 1981) (noting “[b]ecause of the difficulties inherent in formulating a broad yet clear rule to govern the variety of situations in which the right of access must be reconciled with legitimate countervailing public or private interests, the decision as to access is one which rests in the sound discretion of the trial court.”).



Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a covered healthcare provider may disclose a person’s protected health information (PHI) in response to a

court order, or in response to a subpoena or other lawful process if the provider receives satisfactory assurances that the party seeking the information has made a reasonable effort to provide notice to the person or seek a protective order from the court. [45 C.F.R. § 164.512\(e\)\(1\)](#). See section 10.4.4 D of the Manual.

6.4 Protection of Court Personnel

In the event of an outbreak of infectious disease in a community, the court may adopt the procedures discussed in section 6.2.1 to ensure that an individual subject to an isolation or quarantine order does not potentially expose court personnel to the disease. In certain circumstances, such as when the outbreak has affected large numbers of persons or the infectious disease is easily transmitted through airborne droplets, the court may need to limit public access to the courtroom. In extreme circumstances, the court itself may need to relocate to a non-affected area to ensure its continued operation.

6.4.1 Relocation of the Court

- A. Relocation of Hearings at Judicial Discretion** – Trials upon the merits must be conducted in open court and so far as convenient in a regular courtroom. [Super. Ct. Civ. R. 77\(b\)](#). However, all other acts or proceedings may be conducted without the attendance of the clerk or other court officials and at any place either within or without the District of Columbia (the District). *Id.* A hearing may be conducted outside the District with the consent of all affected parties. *Id.*
- B. Emergency Authority to Conduct Proceedings Outside District of Columbia** – The Superior Court may hold special sessions outside the District when the chief judge finds that because of emergency conditions, no location within the District is reasonably available where such special sessions could be held. [D.C. Official Code § 11-911\(a\)](#). The Superior Court may transact any business at the special session outside the District which it has the authority to transact at a regular session, except that a criminal trial may not be conducted without the consent of the defendant. [D.C. Official Code § 11-911\(b\)](#).

6.5 Tolling or Delaying of Proceedings

If a natural disaster or other emergency requires the closure of the Superior Court or renders it impracticable for the U.S. or District government or a class of litigants to comply with deadlines imposed by any federal or District law or rule that applies in the Superior Court, the chief judge may enter such orders as may be appropriate to delay, toll, or otherwise grant relief from the time deadlines, except that the writ of habeas corpus may not be suspended. [D.C. Official Code § 11-947\(a\)\(2\)\(A\), \(a\)\(4\)](#). This authority extends to all laws and rules affecting criminal and juvenile proceedings (including, pre-arrest, post-arrest, pretrial, trial, and post-trial procedures) and civil, family, domestic violence, probate, and tax proceedings. [D.C. Official Code § 11-947\(a\)\(2\)\(B\)](#).

If the chief judge of the Superior Court is absent or disabled, this authority may be exercised by the judge designated under [D.C. Official Code § 11-907\(a\)](#) or by the Joint Committee on Judicial Administration. [D.C. Official Code § 11-947\(a\)\(3\)](#).

An order may not toll or extend time deadlines for a period of more than 14 days, unless the chief judge, with the consent of the Joint Committee on Judicial Administration, enters additional orders to further toll or extend such time deadlines. [D.C. Official Code § 11-947\(d\)](#).

6.6 Proceedings Involving Numerous Persons

In the event of an infectious disease outbreak, the Superior Court may be called upon to issue numerous isolation and quarantine orders. Judicial surge capacity may be obtained through several logistical and procedural measures.

6.6.1 Additional Juridical Personnel

A. Additional Judges – Upon presentation of a certificate of necessity by the chief judge of the Superior Court, the chief judge of the District of Columbia Court of Appeals (Court of Appeals) may designate and assign temporarily one or more judges of the Court of Appeals to serve as a judge of the Superior Court. [D.C. Official Code § 11-707\(b\)](#).

B. Use of Magistrate Judges – Magistrate judges may hear civil and criminal proceedings with the consent of the parties involved. [D.C. Official Code § 11-1732\(j\)\(5\)](#).

Magistrate judges may be appointed as masters and may hold trial proceedings and make or recommend findings of fact on issues to be decided by the Superior Court without a jury if appointment is warranted by some exceptional condition. [Super. Ct. Civ. R. 53](#).

6.6.2 Consolidation of Cases

The Superior Court may order consolidation of any or all the matters in issue when the proceedings involve a common question of law or fact. [D.C. Official Code § 7-134\(b\)](#); [Super. Ct. Civ. R. 42\(a\)](#).

7.0 COMMUNICABLE DISEASE REPORTING AND INVESTIGATIONS

7.1 Summary

Mandatory communicable disease reporting assists public health officials in investigating communicable diseases and taking actions to protect the health of the community. Identification and reporting of communicable disease is a collaborative effort among physicians and other healthcare providers, veterinarians, hospitals and other health facilities, laboratories, and the local public health system. Timely reporting of the specific illness or condition, as well as any unusual manifestations of disease, will allow public health officials to determine if further action is necessary to protect public health, such as isolation or quarantine of an individual or group of individuals. Thus, communicable disease reporting and investigation is an integral part of public health emergency law.



Before action is taken, it is critical that officials have a thorough understanding of the disease in question, including issues such as mode of transmission (*e.g.*, airborne or through contact with bodily fluids) and how long the disease incubates in an affected individual before they become contagious (the incubation period). Thus, District epidemiologists should be consulted before action is taken.



Today's global nature of travel and commerce means that disease spreads quickly throughout the world, requiring increased vigilance for emerging and re-emerging infectious diseases. Examples of such diseases include Ebola, Zika, Middle Eastern Respiratory Syndrome (MERS), measles, Severe Acute Respiratory Syndrome (SARS), and Coronavirus Disease 2019 (COVID-19). See section 16.0 of the Manual for more information about emerging and re-emerging diseases.

7.2 Communicable Diseases

A communicable disease is any disease listed as a notifiable disease under [D.C. Official Code § 7-131](#), including any illness due to an infectious agent or its toxic product that is transmitted:

- Directly or indirectly to a well person from an infected person, animal, or ectoparasite (*e.g.*, lice, fleas);
- Through the agency of an intermediate host or vector, or by exposure to chemical or radiological agents within the immediate environment; or
- Occurring as an outbreak of illness or toxic conditions, regardless of causation, in an institution or other identifiable group of people.

[D.C. Official Code § 7-132\(2\)](#).



Chemical and radiological agents and other toxic conditions are included within the definition of a communicable disease. Accordingly, communicable disease reporting in the District is not

limited to traditional infectious diseases, and diseases that have or could result from exposure of individuals to chemical or radiological agents or other toxic conditions must also be reported to the DC Health Director.



As many diseases are transmitted via animals and vectors (e.g., mosquitoes), see section 13.0 of the Manual.

7.3 Communicable Disease Reporting



See Appendix 5.0 for a chart of notifiable diseases and conditions developed by DC Health (last revised March 2018). To ensure that the information is the most current, visit: <https://dchealth.dc.gov/service/infectious-diseases>.



Occasionally the DC Health Division of Epidemiology-Disease Surveillance and Investigation (DE-DSI) will issue health notices providing important information and updates on diseases and issues of public health significance. For the most up to date information regarding communicable diseases, refer to the recent health notices posted at <https://dchealth.dc.gov/page/health-notices>. For example, in February 2019, a [Health Notice](#) was issued for reporting, control, and containment of *Candida auris*.



See <https://dchealth.dc.gov/node/1487006> for COVID-19 reporting requirements.

7.3.1 Notifiable Diseases

A. The following diseases must be reported immediately upon provisional diagnosis or the appearance of suspicious symptoms by submission in writing via an online case report within 24 hours:

- Animal bites;
- Hepatitis A;
- Shiga toxin-producing *Escherichia coli* (STEC);
- Staphylococcal infections in newborns (nosocomial); and
- Vibriosis (non-cholera *Vibrio* species infections).

See [List of Notifiable Diseases and Conditions in the District of Columbia](#).

B. The following diseases must be reported by telephone to DC Health immediately upon provisional diagnosis or the appearance of suspicious symptoms, with written confirmation via an online case report within 24 hours:

- Anthrax (*Bacillus anthracis*);
- Botulism;
- Cholera (*Toxigenic Vibrio cholerae* 01 or 0139);
- Diphtheria;
- Encephalitis, acute arboviral (e.g. Eastern Equine Encephalitis, St. Louis Encephalitis, Western Equine Encephalitis);
- Hantavirus pulmonary syndrome (HPS);
- Hemolytic uremic syndrome;
- Influenza A, novel;
- Influenza-associated mortality (patients less than eighteen (18) years of age);
- Listeriosis;
- Measles (Rubeola);
- Meningitis (*Neisseria meningitidis*);
- Meningococcal disease, invasive;
- Middle East Respiratory Syndrome (MERS);
- Mumps;
- Pertussis (Whooping cough);
- Plague (*Yersinia pestis*);
- Poliovirus infection;
- Rabies (animal or human);
- Rubella (German measles), including congenital rubella syndrome;
- Severe Acute Respiratory Syndrome (SARS);
- Smallpox;
- Tularemia;
- Typhoid fever (*Salmonella typhi*);
- Viral hemorrhagic fevers (Ebola or other);
- Yellow fever;
- An infection or outbreak that may be of public health concern (including healthcare associated and foodborne); and

- An emerging infectious disease or an unusual occurrence of any disease.

See [22B DCMR § 201.1](#) and [List of Notifiable Diseases and Conditions in the District of Columbia](#).



A healthcare associated infection (HAI) is an infection that develops in a patient or resident in a healthcare facility that was not present or incubating at the time of admission. An HAI outbreak is the occurrence of more cases of infections than expected in a given healthcare facility area among a specific group of people over a particular period of time, or when the number of infections in a healthcare facility is higher than the baseline rate for that facility. [22B DCMR § 299.1](#).



A foodborne disease outbreak is an incident in which two or more persons experience a similar illness resulting from ingestion of a common food. [22B DCMR § 299.1](#).

C. The following diseases must be reported to DC Health in writing via an online case report within 24 hours after provisional diagnosis or the appearance of suspicious symptoms:

- Brucellosis;
- Campylobacteriosis;
- Chikungunya;
- Dengue;
- Haemophilus influenza, invasive disease;
- Healthcare-associated infection, cluster or outbreak;
- Lymphogranuloma venerium (LGV, including atypical LGV);
- Meningitis, (aseptic or viral, fungal, and bacterial (other than N. meningitidis));
- Psittacosis (Ornithosis);
- Q Fever;
- Streptococcal infection, invasive (Pneumococcal disease);
- Tetanus; and
- Zika virus disease (including congenital Zika virus infection).

See [22B DCMR § 201.2](#) and [List of Notifiable Diseases and Conditions in the District of Columbia](#).

D. The following diseases must be reported to DC Health in writing via an online case report within 24 hours after provisional diagnosis or the appearance of suspicious symptoms if there are 3 or more cases that occur within a 7-day period in a school or childcare facility:

- Conjunctivitis (Pink Eye) outbreak;
- Gastrointestinal illness outbreak;
- Hand, foot, and mouth disease outbreak;
- Head lice outbreak;
- Impetigo outbreak;
- Pinworm (Enterobiasis) outbreak;
- Ringworm (Tinea) outbreak;
- Scabies outbreak; and
- Streptococcal non-invasive, Group A (Scarlet fever and strep throat) outbreak.

See [22B DCMR § 201.2\(k\)](#) and [List of Notifiable Diseases and Conditions in the District of Columbia](#).

E. The following diseases must be reported to DC Health in writing via an online case report within 48 hours after diagnosis or the appearance of suspicious symptoms:

- Babesiosis;
- Chancroid;
- Chickenpox (morbidity, pediatric mortality);
- Chlamydia trachomatis infection (including PID, perinatal, and trachoma);
- Coccidioidomycosis;
- Cryptosporidiosis;
- Cyclosporiasis;
- Ehrlichiosis;
- Giardiasis;
- Gonococcal infection;
- Granuloma inguinale;
- Hepatitis (acute B, C);

- Human immunodeficiency virus (HIV) infection, and pregnancies in HIV-infected women;
- Kawasaki disease;
- Legionellosis;
- Leptospirosis;
- Lyme Disease (*Borrelia Burgdorferi*);
- Malaria;
- Melioidosis;
- Powassan virus;
- Rickettsiosis, spotted fever (e.g. Rocky Mountain Spotted Fever);
- Salmonellosis;
- Shigellosis;
- Syphilis (all stages congenital);
- Toxic shock syndrome (Staphylococcal, Streptococcal, and other);
- Trichinosis (*Trichinellosis*);
- Tuberculosis;
- Urethritis, atypical;
- Vaccine adverse events; and
- West Nile virus.

See [22B DCMR § 201.3](#) and [List of Notifiable Diseases and Conditions in the District of Columbia](#).



Reporting for acute hepatitis B is currently mandated. However, DC Health is requesting case reports for chronic and perinatal hepatitis B, which will be mandated in forthcoming regulations. Reports are also requested for a pregnancy in a woman positive for hepatitis B or C. See Appendix 5.0 of the Manual.

- F. Acute care, ambulatory, long-term acute care, skilled nursing, and outpatient renal dialysis facilities should report the following conditions to the National Healthcare Safety Network (NHSN) and provide DC Health with access to these data:
- Carbapenem-resistant enterobacteriaceae - LabID event;
 - Catheter-associated urinary tract infections;

- Central line-associated bloodstream infections;
- Clostridium difficile (C. difficile)- LabID event;
- Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia- LabID event; and
- Surgical site infection, abdominal hysterectomy; and
- Surgical site infection, colon surgery.

G. Lead poisoning in children must be reported to the District of Columbia Department of Energy & Environment (DOEE) immediately by telephone or fax if the results are greater than or equal to 10 µg/dL.



As a courtesy, all results greater than or equal to 5 µg/dL should also be reported immediately. Providers must report the case to DOEE by telephone within 72 hours of receiving notification from a laboratory or another provider/facility. Laboratories, including providers who utilize point-of-care testing, are required to report all test results less than 10 µg/dL within 1 week of analysis.

See [List of Notifiable Diseases and Conditions in the District of Columbia](#).

7.3.2 Information to Be Reported

When reporting diseases to the DC Health Director as indicated above, the report must be filed on a form approved by the DC Health Director, and must include the following:

- Information regarding the person submitting the report, including:
 - First and last name;
 - Phone number;
 - Facility name;
 - Facility address;
 - Name of provider who saw patient; and
 - Date report was sent.
- Information regarding the patient, including:
 - First and last name;
 - Date of birth;
 - Sex;
 - Home address;

- Race or ethnicity;
- Telephone number; and
- School or place of occupation.
- Disease, condition, or symptom information, including:
 - Name of suspected or confirmed disease;
 - Date of symptom onset;
 - Date of diagnosis;
 - Supporting laboratory documentation; and
 - Other epidemiologic information the DC Health Director may request.

[22B DCMR § 202.9.](#)



District law requires the use of an approved form in order to report infectious diseases. The most up-to-date forms for reporting various diseases can be found at <https://dchealth.dc.gov/service/infectious-diseases>.



Notifiable disease reporting requirements can change over time. For the most up-to-date information, please visit DC Health’s website: [Notifiable Diseases and Conditions in DC](#).

7.3.3 Mandated Reporters and Special Reporting Obligations

A. Physicians and Other Healthcare Providers – Physicians and other healthcare providers are required to report communicable disease cases as described above. In addition, physicians and other healthcare providers must report information regarding carriers or contacts to the DC Health Director. [22B DCMR § 202.3](#).

Physicians and other healthcare providers must advise the infected adult or the infected minor’s parent or guardian of the applicable requirements for isolation, quarantine, and restriction of movement. [22B DCMR § 202.4](#).



See section 8.0 of the Manual for more information about isolation, quarantine, and other types of detention.

Physicians who are treating or caring for a person with a communicable disease must immediately report the name, address, and other relevant information to the DC Health Director in the following circumstances:

- When the person is delinquent in treatment;
- When the person violates isolation or quarantine; and
- When there is any change in location of the case (must be reported to the DC Health Director by phone or in writing within 24 hours of the change).

[22B DCMR § 202.10](#), [202.12](#).

In addition to the duty to report the diseases described above, physicians and other licensed healthcare providers must report an HIV/AIDS (Acquired Immune Deficiency Syndrome) diagnosis, as well as a pregnancy in an HIV-infected woman, to the DC Health Director within 48 hours of diagnosis and furnish information the DC Health Director deems necessary to complete a confidential case report. [22B DCMR § 206.2](#). These reports must include the following information:

- Patient's name;
- Address of residence, including city, state, and zip code;
- Sex;
- Race or ethnicity;
- Mode of exposure;
- Place or country of birth;
- Date of birth;
- Date of diagnosis of HIV or AIDS and opportunistic infections;
- Name/telephone number of person making report; and
- Name of entity providing health/medical services.

[22B DCMR § 206.3](#).



Protected health information (PHI) which is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), may be disclosed for public health activities, including disease reporting and surveillance. See section 10.4.4 B of the Manual.

- B. Veterinarians** – Veterinarians are required to report communicable disease cases as described above. In addition, veterinarians must report information regarding carriers or contacts to the DC Health Director. Such reports must include a statement of the instructions provided regarding isolation, quarantine, and restriction of movement. [22B DCMR § 202.1-202.3](#).

Veterinarians must advise the person in charge of the infected animal of the applicable requirements for isolation, quarantine, and restriction of movement. [22B DCMR § 202.4](#).

Veterinarians or other persons who have reason to suspect any of the following must make an immediate report to the DC Health Director by telephone, followed by an immediate written online report to the DC Health Director:

- A dog or other animal is suffering from rabies;
- A dog or other animal has been bitten by or exposed to a dog or other animal suffering with rabies; or
- A person with potential rabies exposure as a result of having been bitten or exposed to a dog or other animal.

[22B DCMR § 203.1](#).

The report made by the veterinarian must include the information listed in section 7.3.2 above, as well as the following information:

- The name, contact information, and place of residence of the person owning or harboring the animal;
- The location of the animal; and
- The dog license number and rabies license number, if any.

[22B DCMR § 203.3](#).



If a report is made to a member of the Metropolitan Police Department (MPD), DC Health Animal Services Animal Care and Control Fields Services Division, or a privately owned veterinary hospital or clinic of any of the foregoing events, such event must be immediately communicated to the DC Health Director, followed immediately by a written report to the DC Health Director.



For more information regarding animal bites and rabies, see section 13.5 of the Manual and the DC Health website: <https://dchealth.dc.gov/node/115012>, <https://dchealth.dc.gov/service/dog-bites>, and <https://dchealth.dc.gov/service/rabies-and-animal-exposures>.

C. Schools – Schools are required to inform the DC Health Director within two hours when any student has contracted the following diseases:

- Measles;
- Meningococcal meningitis;

- Mumps;
- Pertussis;
- Rubella;
- Tuberculosis; or
- Hepatitis A or any other food-borne illness.

[22B DCMR § 209.6.](#)



The specific form for schools to report these infectious diseases can be found at <https://dchealth.dc.gov/node/115022>.

D. Laboratories – A laboratory that tests a communicable disease specimen must report its findings directly to the person who submitted the specimen. In addition, laboratory operators must report positive tests for syphilis to the DC Health Director in writing within 24 hours, including the name and address of the person requesting the test. [22B DCMR § 211.3](#). Laboratory operators must also report HIV positive tests, as well as tests that are indicative of an HIV diagnosis such as CD4 and viral load tests, to the DC Health Director or their designee in writing within 48 hours and include the following information:

- The name of the subject of the test;
- The name and address of the physician or provider requesting the test; and
- The patient’s medical record number.

[22B DCMR § 211.4.](#)

E. Blood Banks – Physicians in charge of blood banks must report positive tests for syphilis to the DC Health Director in writing within 24 hours. Physicians in charge of blood banks must also report HIV positive tests to the DC Health Director in writing within 48 hours. [22B DCMR § 211.8](#).

F. Child Care Facilities – Child care facilities must immediately report to the DC Health Director the presence of an individual who has or is reasonably suspected of having a notifiable communicable disease. [29 DCMR § 322.1](#).

G. Acute Care, Ambulatory, Long-Term Acute Care, Skilled Nursing, and Outpatient Renal Dialysis Facilities – These facilities should report the conditions in 7.3.1 F to the NHSN and provide DC Health with access to these data.

7.4 Communicable Disease Investigations

7.4.1 Disease Investigation Authority

The DC Health Director is responsible for initiating an investigation upon receipt of a report of:

- A case or suspected case of a communicable disease; or
- A communicable disease contact or carrier.

[22B DCMR § 210.1.](#)

7.4.2 Purpose of Investigation

The investigation should determine the source of the infection and determine if the proper management and control measures are in place. [22B DCMR § 210.1.](#)

7.4.3 Extent of Investigation

The DC Health Director may:

- Enter and inspect public or private property in the District. [22B DCMR § 210.2;](#)
- Institute preventive measures to eradicate the vectors and sources of the communicable disease. [22B DCMR § 210.3;](#)
- Order an individual having or suspected of having a communicable disease, or of being a contact or carrier of a communicable disease, to submit to an examination. [22B DCMR § 210.4;](#) and/or
- Order an individual having or suspected of having a communicable disease, or of being a contact or carrier of a communicable disease, to submit specimens of body secretions, excretions, fluids, and discharges for laboratory examination. [22B DCMR § 210.5.](#)

7.5 Reporting Deaths from Communicable Diseases

Physicians are required to immediately notify the DC Health Director by telephone when they issue a certificate of death due to:

- Cholera;
- Anthrax;
- Diphtheria plague (bubonic and pneumonic);
- Smallpox; or
- Louse-borne typhus fever.

[22B DCMR § 214.1.](#)



Special rules apply to the bodies of persons who died from the diseases listed in section 7.5 to prevent the spread of these diseases. [22B DCMR § 214.2 – 214.4](#). See section 12.5.1 Manual.



Under [D.C. Official Code § 5-1405\(b\)\(6\)](#), deaths related to disease that may threaten public health are investigated by the Office of the Chief Medical Examiner (OCME).

8.0 DETENTION OF INDIVIDUALS AND GROUPS OF INDIVIDUALS

8.1 Summary

District law authorizes both the Mayor and DC Health to issue detention orders to individuals and groups of individuals. Typically, however, the Mayor delegates detention authority to DC Health. “Quarantine” refers to the detention of an individual or group of individuals who *may* be affected with communicable disease. “Isolation” can be ordered when an individual or a group of individuals is *known* to be infected with a communicable disease.

Detained individuals are entitled to some procedural due process protections, including notice, a right to a hearing, and, in certain situations, the right to appointed counsel. While in detainment, individuals may be subject to medical examination. The results of the medical examination may be used to either release a non-affected individual or prolong the detainment. Individuals who leave detainment without discharge or impede in the detainment of others may be subject to fines and jail time. Individuals may exercise a religious exemption to the appointed place of detainment or compelled medical treatment.

8.2 Definitions

8.2.1 Quarantine

“Quarantine” separates and restricts the movement of individuals exposed to contagious disease to see if they become sick. See [Quarantine and Isolation](#).

8.2.2 Isolation

“Isolation” separates people affected with a contagious disease from people who are not sick. See [Quarantine and Isolation](#).

8.2.3 Affected with Communicable Disease

“Affected with a communicable disease” is an individual that is:

- Infected with a communicable disease or exposed to a chemical or radiological agent that is capable of infecting others with the same disease or radiological agent if permitted to move freely in the general public; or
- A carrier of or contaminated with an infectious disease or chemical or radiological agent and capable of infecting others with the disease or chemical or radiological agent.

[D.C. Official Code § 7-132\(1\)](#).

8.3 Rulemaking Authority

8.3.1 Authority of the Mayor

The Mayor may promulgate regulations governing isolation, quarantine, and other restrictions of movement. This authority has been delegated to DC Health. DC Health may issue such regulations when necessary to prevent and control the spread of communicable diseases, environmentally or occupationally related diseases, or other

diseases or medical conditions that the DC Health Director has advised should be monitored for epidemiological or other public health reasons. [D.C. Official Code § 7-131\(a\)](#).



Communicable disease is defined in section 7.2 of the manual.

8.3.2 Construction of the Regulations

Regulations to prevent spread of communicable disease are to be constructed liberally to aid public authorities in the protection of public health. [D.C. Official Code § 7-144](#).



Courts give great deference to governmental public health authority when individuals have been deprived of their liberty for a public health purpose. See *Sch. Bd. of Nassau Cty., Fla. v. Arline*, 480 U.S. 273, 288 (1987).

8.4 Ordering an Individual to Submit to Quarantine, Isolation, and/or Medical Treatment

8.4.1 Authority of the Mayor

The Mayor may order an individual to submit to quarantine, isolation, and/or medical treatment (collectively referred to as “detention”). This authority has been delegated to DC Health. DC Health may issue such detention orders when:

- DC Health has probable cause to believe that an individual is affected with or a carrier of a communicable disease; and
- The individual’s presence in the general population is likely to cause death or seriously impair the health of others.

[D.C. Official Code § 7-133 \(a\)](#); see [Jacobson, 197 U.S. 11 \(1905\)](#).



There is no separate legal definition for “probable cause” as it is used in the isolation and quarantine statutes. As articulated by the District of Columbia Court of Appeals (Court of Appeals), the standard in the criminal context is when an officer “has reasonably trustworthy information at the moment of arrest ‘sufficient to warrant a reasonably prudent [person] in believing that the [suspect has] committed or [is] committing an offense.’” *Brown v. United States*, 590 A.2d 1008, 1012 (D.C.1991); see also *Umanzor v. United States*, 803 A.2d 983, 992 (D.C. 2002). In the context of a false imprisonment defense, the Court of Appeals has defined probable cause as “a good faith, reasonable belief in the validity of the arrest and detention.” *DeWitt v. District of Columbia.*, 43 A.3d 291, 295 (D.C. 2012).

8.4.2 Content of Detention Orders

Detention orders for individuals must meet the following requirements:

- The detention order must be in writing;
- The detention order must state where the detention is to take place. The place of detention may either be within the District or outside the District, provided that the place of detention is under the supervision of the District Government; and
- The detention order must be served by the Metropolitan Police Department (MPD) or a designated employee of the District.
 - The server must give a copy of the detention order to the detained individual and explain its contents;
 - The place of detention cannot be a place of imprisonment or jail. *Benton v. Reid*, 231 F.2d 780, 782 (D.C. Cir. 1956);
 - The server must give a copy of the detention order to the person in charge of the place where the individual is detained; and
 - If the place of detention is a residence, the copy of the detention order may be given to “any person of suitable age and discretion.”

[D.C. Official Code § 7-133\(b\)](#), [D.C. Official Code § 7-134\(a\)](#).



See Appendix 1.0 for sample documents related to communicable disease and detention, including DC Health and court orders.



If the detained individual has limited English proficiency or does not speak English, interpretation services should be provided.

8.4.3 Duration of Detention Orders

A detention order expires within 24 hours of issuance; therefore, prompt service of the order and return of service is required. [D.C. Official Code § 7-134\(a\)](#). A District of Columbia Superior Court (Superior Court) judge may extend a detention order if probable cause exists to believe that the detained individual’s presence in the general population is likely to cause death or seriously impair the health of others. [D.C. Official Code § 7-134\(a\)](#).

8.4.4 Challenging Detention Orders

If a Superior Court judge extends a detention order beyond 24 hours, the detained individual may petition for a hearing contesting the detention. [D.C. Official Code § 7-134\(b\)](#).

A hearing on the petition must take place “as soon as practical,” but no later than 10 days after the court receives the petition. At the hearing, the judge will determine if:

- The detained individual is affected with a communicable disease; and, if so,

- Whether the release of the detained individual into the general population would likely cause death or seriously impair the health of others.

[D.C. Official Code § 7-134\(b\).](#)



District law is silent regarding who pays the cost for involuntary quarantine.

8.4.5 Authority of the Director of DC Health

The DC Health Director has authority to issue detention orders under [22B DCMR § 210.8](#). The DC Health Director may issue a removal and detention order pursuant to the Mayor's authority (see [D.C. Official Code §§ 7-131 to-144](#)) when:

- The DC Health Director has probable cause to believe that an individual is affected with or is a carrier of a communicable disease; and
- The DC Health Director has probable cause to believe that the individual is likely to be dangerous to the life or health of any other person because
 - There are improper facilities or the lack of facilities for isolation; or
 - The individual is non-cooperative or careless, including any refusal to submit to examination or refusal to be properly treated or cared for, and is likely to be a danger to public health. [22B DCMR § 210.8](#).

The DC Health Director may order a placard to be posted on the premises occupied by any individual affected with a communicable disease. [22B DCMR § 210.6](#). The placard may not be mutilated, defaced, obliterated, concealed or removed without the authorization of the DC Health Director. [22B DCMR § 210.7](#).



In March 2014, Patient X was diagnosed with active pulmonary tuberculosis (TB) in Champaign-Urbana, Illinois. Champaign-Urbana Public Health District (CUPHD) officials ordered Patient X to remain at home and receive daily visits from a public health nurse for directly observed therapy. Patient X refused to comply with the CUPHD isolation order and continued to shop in public and live with others. Based on Patient X's actions, the CUPHD Administrator decided that a court order was necessary for protection of the public's health. A hearing was held at CUPHD and the court issued an order of isolation, which also included an order to wear a GPS monitoring device. Patient X refused to wear a facemask when in the presence of others, submit sputum samples, and allow a public health nurse to observe him taking his medications. Patient X also removed a quarantine sign from his front door, continued to live with others, and failed to charge the batteries for their GPS electronic monitoring device. Due to Patient X's noncompliance, the Champaign County State's Attorney filed a petition for indirect criminal contempt on April 17, 2014. Patient X was arrested and jailed in neighboring Piatt County, where a negative airflow room was located. In jail, Patient X resumed his TB medications. After 3 negative sputum samples were collected from Patient X, Champaign County filed a Petition for Discharge

from Isolation and Termination of Order of Isolation. The court granted the petition and vacated the order. Patient X was released the next day but the indirect criminal contempt charges remained. Those charges were eventually dropped in September 2014. See [Putting the Law Into Practice: A Comparison of Isolation and Quarantine as Tools to Control Tuberculosis and Ebola](#).



In certain circumstances, such as when the communicable disease is easily transmitted through airborne droplets, the court may require that all attendees at hearings be fitted with N95 respirator masks for their protection.



Quarantined persons may not attend a public funeral service but may, at the discretion of the DC Health Director, be taken to places of burial provided they do not mingle with the non-quarantined persons present. [22B DCMR § 214.6](#).

8.4.6 Religious Exemptions to Detention

Individuals who, on behalf of themselves, their children or their wards, rely in good faith upon spiritual means or prayer to prevent or cure disease cannot be ordered to detainment in a hospital or other medical institution unless no other place for quarantine can be secured. An individual who exercises a religious exemption cannot be compelled to submit to medical treatment. [D.C. Official Code § 7-141](#).



This religious exemption is limited to quarantine in an institutional setting and does not permit an individual to disregard an order to be quarantined at home.

If a court determines that a child is “neglected” and the child’s parent or guardian takes a position clearly beyond the child’s best interest or displays judgment contrary to all competent medical evidence, the court must act in the child’s best interest regardless of any objection of the parent or guardian. See *In re K.I.*, 735 A.2d 448 (D.C. 1999).

8.5 Ordering Groups to Submit to Quarantine, Isolation, and/or Medical Treatment

8.5.1 Authority of the Mayor

The Mayor may order groups of individuals to submit to detention. This authority has been delegated to DC Health. DC Health may order groups of individuals to submit to detention when:

- The DC Health Director has probable cause to believe that the group is affected with a communicable disease; and
- The group’s ability to move freely in the general population is likely to cause death or seriously impair the health of others.

[D.C. Official Code § 7-133\(c\)](#).



“Group” does not refer to specific groups (*i.e.*, racial or ethnic groups, people with similar characteristics).

8.5.2 Content of Group Detention Orders

Detention orders for groups of individuals must comport with the following requirements:

- The group detention order must be in writing;
- The group detention order must state the bounds of the area subject to the order;
- The person or persons executing the group detention order must inform by “reasonable means” all persons within the detention area of the contents of the order;
- The person or persons executing the group detention order must post a copy of the order in a conspicuous place within the detention area; and
- The person or persons executing the group detention order must give a copy of the detention order to the person in charge of the place where the group is detained.
 - If the place of detention is a residence, the copy of the order should be given to “any person of suitable age and discretion.”

[D.C. Official Code §§ 7-133\(c\), 134\(a\)](#).



[D.C. Official Code § 7-133](#) does not expressly reference who is to serve a group detention order. Presumably, a group detention order must be served the same way as an individual detention order (*i.e.*, by the MPD or a designated District employee).

8.5.3 Duration of Group Detention Orders

A group detention order expires within 24 hours of issuance; therefore, prompt service of the order and return of service is required. A Superior Court judge may extend a group detention order if probable cause exists to believe that the group’s presence in the general population is likely to cause death or seriously impair the health of others. [D.C. Official Code § 7-134\(a\)](#).

8.5.4 Challenging a Group Detention Order

If a Superior Court judge extends a group detention order beyond 24 hours, the detained group may petition for a hearing on the detention. [D.C. Official Code § 7-134\(b\)](#).

The hearing must take place “as soon as practical,” but no later than 10 days after the court receives the petition. At the hearing, the judge will determine whether:

- The group is affected with a communicable disease; and
- If the group is affected with a communicable disease, whether the release of the group into the general population is likely to cause death or seriously impair the health of others.

[D.C. Official Code § 7-134\(b\)](#).



The right to object to quarantine on religious grounds is an individual and not a collective right under District law. [D.C. Official Code § 7-141](#).



See Appendix 3.0 for an isolation, quarantine, and treatment flowchart.

8.6 Medical Examination of Detained Individuals

8.6.1 Authority of the Mayor

The Mayor is required to designate medical personnel to medically examine each detained person to determine whether the individual is affected with a communicable disease. [D.C. Official Code § 7-135\(a\)](#). The Mayor has delegated this authority to DC Health.

The results of the medical examination must comport with the following requirements:

- The diagnosis resulting from the medical examination must be in writing;
- The examining physician must sign the diagnosis;
- A copy of the signed diagnosis must be given to the detained individual;
- A copy of the signed diagnosis must be given to the person in charge of the place where the individual is detained (if the place of detention is a residence, the copy of the order should be given to “any person of suitable age and discretion”); and
- A copy of the signed diagnosis must be given to the DC Health Director.

[D.C. Official Code § 7-135](#).



See section 10.4.4 B of the Manual for information regarding when information may be disclosed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for public health activities.

8.6.2 Authority of the Director of DC Health

The DC Health Director may order an individual who has or is suspected of having a communicable disease or being a carrier of a communicable disease to submit to an examination to determine the existence of communicable disease. [22B DCMR § 210.4](#).

The DC Health Director may also order an individual to submit specimens or permit the obtaining of authentic specimens of body secretions, excretions, body fluids, and discharges for laboratory examination. [22B DCMR § 210.5](#).

8.6.3 Refusal to Submit to a Medical Examination

If an individual refuses to submit to medical examination, the DC Health Director may issue a removal and detention order to compel a person who has or is suspected of having a communicable disease or who is or is suspected of being a carrier of communicable disease to submit to an examination to determine the existence of such communicable disease. [22B DCMR § 210.8\(b\)](#).

8.6.4 Diagnosis

An individual who is found not to be affected with a communicable disease must be immediately discharged. [D.C. Official Code § 7-135\(a\)](#).

If an individual is diagnosed as being affected with a communicable disease, the person may be detained for as long as necessary to protect the public health. [D.C. Official Code § 7-135\(b\)](#).

8.6.5 Challenging a Detention Order Based Upon a Medical Diagnosis

An individual detained because of a medical diagnosis may, at any time, petition the Superior Court for a discharge hearing. If the individual cannot afford counsel, counsel will be appointed. [D.C. Official Code § 7-135\(b\)](#).



See Appendix 3.0 for a medical examination flowchart.

8.7 The Role of Physicians in Detentions

If an individual is detained due to suspected communicable disease, a physician must examine such individual, with the diagnosis of the individual made in writing signed by the examining physician. [D.C. Official Code § 7-135\(a\)](#). In addition, the examining physician may be asked to sign an affidavit to support probable cause for detention or extension of a detention order. [D.C. Official Code § 7-134](#), [D.C. Official Code § 7-137](#).




Certain information sharing laws change during emergencies, such as some provisions under HIPAA and the Emergency Medical Treatment and Active Labor Act (EMTALA). See section 10.0 of the Manual for further information regarding HIPAA and section 4.4 for further information regarding EMTALA.

8.7.1 Care of Detained Individuals

The management of any detained infected person must be in accordance with good medical and public health practices. [22B DCMR § 202.7](#). Meeting the requirements of [Chapter 22-B2 of the DCMR](#) and complying with the recommendations of the latest edition of “Control of Communicable Disease,” published by the American Public Health

Association is prima facie evidence of good medical and public health practices. [22B DCMR § 202.8](#).

The physician or other person in charge of the detention must advise each adult infected person and each parent, guardian, or person in charge of an infected person of the applicable requirements of the isolation, quarantine, and other restriction of movement. [22B DCMR § 202.4](#).


 [22B DCMR § 202.4](#) refers to “infected” persons and parents, guardians, or persons in charge of “infected” persons only and not to those suspected of being infected with a communicable disease. Since the remainder of the provision references quarantine, it is reasonable to assume that the requirements of [22B DCMR § 202.4](#) extend to those suspected of being infected as well.

8.7.2 Duty of Detained Individuals

An infected individual, contact or carrier or the parent, guardian, or person in charge of such individual, must comply with the instructions given by the physician or other person responsible for the control of a case of communicable disease. [22B DCMR § 210.9-210.10](#).

8.7.3 Reporting Requirements

The physician or person in charge of a detained individual must report the case to the DC Health Director within the time required and manner prescribed for notifiable disease reporting. [22B DCMR § 202.1-202.2](#).

 Section 7.3 of the Manual provides a list of notifiable disease and reporting requirements. Appendix 5.0 provides a chart of notifiable diseases and conditions developed by DC Health (last revised March 2018).

In addition, the physician or person in charge of a detained individual must submit detailed instructions concerning the detention in their report to DC Health. Alternatively, the report may contain a statement that instructions were given in accordance with [Chapter 22-B2 of the DCMR](#) and the latest edition of “Control of Communicable Disease,” published by the American Public Health Association. [22B DCMR § 202.2](#).

The physician treating or caring for a person with a communicable disease must report immediately the name, address, and other relevant information to the DC Health Director if:

- An individual violates his or her isolation or quarantine;
- An individual is delinquent in treatment; or
- There is a change of location of the patient.

[22B DCMR § 202.10.](#)

8.8 Use of Warrants in Detentions

8.8.1 Authority

The Superior Court may issue a warrant for the arrest of an individual who is believed, upon probable cause, to be affected with or a carrier of any communicable disease. [D.C. Official Code § 7-137\(a\)](#). The warrant is directed to the Chief of Police and can only be served by the Chief or an officer or member of the MPD. [D.C. Official Code § 7-137\(a\),\(c\)](#).

8.8.2 Contents of the Warrant

The warrant must be supported by an affidavit or affidavits setting forth the grounds for the application. [D.C. Official Code § 7-137\(b\)](#). The Superior Court is responsible for maintaining and keeping records of all warrants issued and returned. [D.C. Official Code § 7-137\(f\)](#).

8.8.3 Powers if Admittance is Refused

If refused admittance, an officer may break open any door or window of a house, any part of a house, or “anything therein” to execute the warrant. [D.C. Official Code § 7-137\(d\)](#).



Although [D.C. Official Code § 7-137\(d\)](#) speaks specifically to “house,” presumably, an officer has the authority to open any door or window of any building or place to execute the warrant.

8.8.4 Expiration of the Warrant

The warrant must be returned to the court within 10 days or it becomes void. [D.C. Official Code § 7-137\(e\)](#).

8.8.5 Discharge

If an individual is detained under the authority of a warrant, the individual may not be discharged until after being medically examined by a physician and determined not to be affected by a communicable disease. [D.C. Official Code § 7-135](#).

8.9 Inspection of Property for the Purpose of Detention or Investigation

8.9.1 Authority of the Mayor

The Mayor, without fee or hindrance, may enter, examine and inspect all vessels, premises, grounds, structures, buildings, and every part thereof in the District, for purposes of preventing the spread of communicable diseases. Owners, agents, representatives, lessees, and occupants of these places must give officers or employees of the Mayor free access. [D.C. Official Code § 7-138](#).

8.9.2 Authority of the DC Health Director

The DC Health Director may enter and inspect any public or private property in the District to investigate a case or suspected case of a communicable disease. [22B DCMR § 210.2](#).



The authority to inspect property is not limited to detention. See sections 9.0 and 13.0 of the Manual for further instances where inspection of property is permitted.

8.10 Sanctions

8.10.1 The Venue

An individual may be prosecuted in the Superior Court for leaving detention without discharge, [D.C. Official Code § 7-136](#), hindering access for the inspection of property, [D.C. Official Code § 7-138](#), or interfering with persons performing duties associated with detention or investigation, [D.C. Official Code § 7-139](#). [D.C. Official Code § 7-140](#).

8.10.2 Conditions Imposed by the Court

The Superior Court may impose conditions upon a person found guilty of violating [D.C. Official Code § 7-136](#), [D.C. Official Code § 7-138](#), or [D.C. Official Code § 7-139](#). Such conditions may include submission to medical examination, diagnosis, and treatment by proper public health and welfare authorities or by any licensed physician approved by the court, and such other terms and conditions as the court may deem best for the protection of the community and the punishment, control, and rehabilitation of the defendant. As long as the defendant complies with such conditions to the satisfaction of the court, the court may suspend the imposition or execution of the sentence. At or before the expiration of such period, the court can choose to vacate or execute the sentence. [D.C. Official Code § 7-140](#).

8.10.3 Penalties

Violation of one of these statutes is a misdemeanor punishable by a fine not exceeding \$5,000, imprisonment for not more than 90 days, or both. Violation of any rule and regulation issued under [Title 7, chapter 1, subsection II](#) is a misdemeanor punishable by a fine not exceeding \$1,000, imprisonment for not more than 30 days, or both. [D.C. Official Code § 7-140](#).

8.11 Habeas Corpus

In addition to, or as an alternative to, the hearing provided under [D.C. Official Code § 7-135](#), a detained individual may file a habeas corpus petition to end his or her commitment, confinement, detainer, or restraint. [D.C. Official Code § 16-1901](#).



[D.C. Official Code § 7-135](#) states that counsel must be provided if the person detained cannot afford counsel. [D.C. Official Code § 16-1901](#) is silent regarding the appointment of counsel.

8.11.1 Parties

A writ of habeas corpus may be brought by a detained individual or on behalf of a detained individual. [D.C. Official Code § 16-1901\(a\)](#).

8.11.2 Venue

Petitions for writs directed to federal officers and employees must be filed in the United States District Court for the District of Columbia. [D.C. Official Code § 16-1901 \(b\)](#). Petitions for writs directed to any other person must be filed in the Superior Court. [D.C. Official Code § 16-1901\(c\)](#).

8.11.3 Proof

The facts in the habeas corpus petition must make a prima facie case. [D.C. Official Code § 16-1901\(a\)](#); *United States v. Tuck*, 194 U.S. 161, 170 (1904); *Bennett v. Ridley*, 633 A.2d 824, 826 (D.C. 1993). It is sufficient to present an allegation and supporting facts that, if proven, would entitle the petitioner to relief. *Price v. Johnston*, 334 U.S. 266, 292 (1948); *Bennett*, 633 A.2d at 826.



[D.C. Official Code Title 16, chapter 19](#) outlines the habeas corpus process and requirements in the District.

9.0 INSPECTIONS, SEIZURES, AND DESTRUCTION OF PROPERTY

9.1 Summary

The Mayor has broad authority to enter private property for the purposes of examining the premises to prevent the spread of communicable disease as well as investigate habitability and sanitary conditions. Constitutional principles found in the Fourth, Fifth, and Fourteenth Amendments must be followed. When public health concerns are being addressed, particularly in emergency situations, however, constitutional restraints are less stringent. The Mayor and the Mayor's agents may take reasonable actions to investigate, examine, search, seize, abate, or destroy private property that may harm the public's health, with just compensation concerns addressed after the need for such actions has ended. Preventing foodborne illness outbreaks through inspections and other regulating actions is a significant public health function performed by DC Health.



"The Fourteenth Amendment provides that '[n]o State shall ... deny to any person within its jurisdiction the equal protection of the laws.' By its own terms, this amendment applies solely to the states, and not to the District. See [Bolling v. Sharpe, 347 U.S. 497, 74 S.Ct. 693, 98 L.Ed. 884 \(1954\)](#). However, 'it is unquestioned that equal protection principles are embodied in the Due Process Clause of the Fifth Amendment, which does apply' to the District. *Hessey v. Burden*, 615 A.2d 562, 567 n. 6 (D.C.1992)." *Dean v. United States*, 938 A.2d 751, 759 (D.C. 2007).

9.2 Constitutional Considerations

9.2.1 The Fourth Amendment: Searches and Seizures

[The Fourth Amendment](#) limits the government's ability to conduct searches and seizures. A "search" occurs when government action infringes upon an expectation of privacy that society recognizes as reasonable. *United States v. Jacobson*, 466 U.S. 109, 113 (1984). A "seizure" of an individual occurs when government action meaningfully interferes with an individual's freedom of movement. [Skinner v. Railway Labor Executives' Assn., 489 U.S. 602, 616 \(1989\)](#). The duration of the interference is not relevant. *Id.* A seizure of property occurs when government action meaningfully interferes with an individual's possessory interest in that property. *United States v. Jacobson*, 466 U.S. at 113.

In general, governmental searches and seizures conducted without consent are considered to be unreasonable unless authorized by a valid search warrant. [Camara v. Municipal Court, 387 U.S. 523, 528-529 \(1967\)](#). A warrant must be based on probable cause and issued by a neutral magistrate. [Maryland v. Pringle, 540 U.S. 366, 369 \(2003\)](#). Probable cause exists when there are reasonable grounds for the belief of guilt that are particularized with respect to the person, place, or items searched or seized. *Id.*

The court determines whether a search is permissible "by assessing, on the one hand, the degree to which it intrudes upon an individual's privacy and, on the other, the degree to which it is needed for the promotion of legitimate governmental interests." *United States v. Knights*, 534 U.S. 112, 118-119 (2001) (quoting *Wyoming v. Houghton*, 526 U.S. 295,

300 (1999)); see also [New Jersey v. T.L.O., 469 U.S. 325, 337 \(1985\)](#). Thus, privacy expectations are balanced against governmental interests.

Administrative searches of private property, such as health and safety inspections, fall under the Fourth Amendment's protection against unreasonable searches and seizures, as well as its requirement that warrants not be issued unless there is probable cause. [Camara v. Municipal Court, 387 U.S. at 534 \(1967\)](#). Administrative warrants, however, may be based on a "modified probable cause" standard that 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. *Marshall v. Barlow's, Inc.*, 436 U.S. 307, 312 (1978); *Michigan v. Tyler*, 436 U.S. 499, 506 (1978). See, e.g., [D.C. Official Code § 42-3131.02\(b\)](#).

There is also a "special needs exception" to the Fourth Amendment's warrant requirement that may be applicable to public health emergency issues when "special needs, beyond the normal need for law enforcement, make the warrant and probable cause requirement impracticable." [Board of Education v. Earls, 536 U.S. 822, 829 \(2002\)](#). When applying this exception, the court must balance the individual's privacy expectations against governmental interests, with consideration of relevant context-specific factors. These factors include:

- The nature of the privacy interest affected by the government action;
- The character of the government intrusion on the individual's privacy interest; and
- The nature and immediacy of concerns giving rise to government action and the efficacy of the action in addressing those concerns. [Board of Education v. Earls, 536 U.S. at 830-38.](#)

The government's interests must be substantial if the individual's privacy interests are high. A substantial government interest may include "exigent conditions" where the government seeks to discover "latent or hidden conditions" or to "prevent the development of hazardous conditions," [Board of Education v. Earls, 536 U.S. at 828-29](#), or strives to "protect or preserve life." [Mincey v. Arizona, 437 U.S. 385, 392-93 \(1978\)](#). The seriousness of the threat and the need for immediate governmental action are considerations when determining whether a warrantless search or seizure in the context of communicable diseases and other health hazards is warranted. [Camara v. Municipal Court, 387 U.S. at 539.](#)



There is extensive case law related to the government's ability to conduct searches and seizures under the Fourth Amendment and a full discussion is beyond the scope of this Manual.

9.2.2 Fifth Amendment: Just Compensation

Under the [Fifth Amendment](#) of the United States Constitution, "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.” This provision, referred to as the “Taking Clause”, is applied to state action under the [Fourteenth Amendment](#). In general, the government must pay “just compensation” for private property taken for public use. To trigger the just compensation requirement, there must first be a government “taking.” Where there is a legitimate exercise of the police power supported by a substantial government interest, the test is whether the owner has been deprived of property rights. [Lucas v. South Carolina Coastal Council, 505 U.S. 1003, 1051 \(1992\)](#).

However, when the taking is made to address a public health hazard related to the property, there is no deprivation of property rights because all property is held under the implied obligation that its use will not injure the community. *Keystone Bituminous Coal Assoc. v. DeBenedictis*, 480 U.S. 470, 491-92 (1987). Thus, as the United States Supreme Court has stated, “[s]ince no individual has a right to use his property so as to create a nuisance or otherwise harm others, the State has not taken anything when it asserts its power to enjoin the nuisance-like activity.” *Id.* at 491.



Whether just compensation is required when property that is not itself a hazard is used in a public health emergency, such as when property is commandeered to use as a shelter for flood victims or a triage center, or when a business is required to alter or reduce its hours, is dependent upon the circumstances. Under District law, the Mayor has broad powers over private property when an emergency has been declared. See section 4.0 of the Manual.



There is extensive case law related to just compensation under the Fifth and Fourteenth Amendments and a full discussion is beyond the scope of this Manual.

9.3 Public Nuisance

A “public nuisance” is an unreasonable interference with a right common to the general public. Public nuisances include those that interfere with public health, such as harboring diseased animals. Restatement (Second), Torts, § 821B.

When a public nuisance is identified, the Mayor may remove it in the public streets, roads, alleys, highways, and other places. [D.C. Official Code § 5-101.03 \(6\)](#).

9.4 Sanitary Regulations

9.4.1 Access to Prevent the Spread of Communicable Diseases

The Mayor may enter, examine, and inspect all vessels, premises, grounds, structures, and buildings at no cost and with no interference in order to prevent the spread of communicable disease. [D.C. Official Code § 7-138](#). The owner, his agent, or representative, any lessee or occupant, and any person having care or management of any vessel, premises, grounds, structure, and building must allow such access. Non-

compliance with this provision is a misdemeanor punishable by a fine up to \$5,000, imprisonment for 90 days, or both. [D.C. Official Code § 7-140](#).



Under the Mayor's authority to declare a public health emergency, the Mayor has the power to destroy or remove property that is contaminated by a matter or substance that makes it harmful to life and health, leading to imminent danger to persons or property. [D.C. Official Code § 7-2304\(b\)\(5\)](#). See section 4.5.1 E of the Manual.



An administrative search warrant may be issued by a District of Columbia Superior Court (Superior Court) judge authorizing the administrative inspection and search of any property or premises, private, commercial, or public, if there is probable cause to believe that: (1) the property is subject to one or more statutes relating to public health, safety, or welfare; (2) entry to such property has been denied to officials authorized to enforce the relevant statutes or regulations, unless special circumstances exist so that prior denial of entry is not required; and (3) reasonable grounds exist for the administrative search and inspection. [Super. Ct. Civ. R. 204\(b\)](#). See, e.g., [D.C. Official Code § 42-3131.02\(b\)](#).

9.4.2 Inspection of Insanitary Buildings

The Mayor or the Mayor's designated agent is authorized to investigate and examine the habitability and sanitary condition of all buildings in the District and may condemn buildings that are in such insanitary condition as to endanger the health or lives of the occupants of such buildings or those living nearby. The Mayor is also authorized to cause all buildings to be habitable and sanitary or to be demolished and removed. [D.C. Official Code § 6-901\(a\)](#).



Buildings that are under the exclusive jurisdiction of the U.S. government cannot be investigated under this section.

- A. "Uninhabitable" is being in an unlivable condition due to deterioration and infestation, improper maintenance, decaying structures, insufficient light or ventilation, inadequate plumbing, defective electrical system, or general filthy conditions that may cause health and safety concerns for the public, or that is a fire hazard or nuisance. [D.C. Official Code § 6-901\(b\)](#).
- B. The Mayor and those acting under their authority may peaceably enter into and upon all lands and buildings in the District between the hours of 8:00 am and 5:00 pm for the purpose of inspecting the habitability and sanitary conditions. [D.C. Official Code § 6-901\(a\)](#).

9.4.3 Unsafe Structures

If any building or part of a building, staging, or other structure, or anything attached to or connected to any building or other structure is reported as unsafe from any cause, the

Mayor may examine the structure or excavation. If the Mayor determines that the condition of the structure or excavation is an imminent threat to public safety requiring immediate emergency measures, the Mayor may enter the premises without notice or delay to take action to secure the structure or excavation. [D.C. Official Code § 6-801](#).



Special rules apply to buildings and structures that are historic landmarks or that are located in historic districts, and consultation with the State Historic Preservation Officer is necessary before action can be taken under [D.C. Official Code § 6-801](#) or [D.C. Official Code § 6-901\(a\)](#). More information regarding historic preservation issues can be found at: <https://planning.dc.gov/>. See [Mayor's Order 2011-120 \(July 18, 2011\)](#).

9.4.4 Condemnation of Buildings

During disaster recovery, it may be necessary to condemn damaged buildings. The Board of Condemnation of Insanitary Buildings, appointed by the Mayor, is responsible for issuing orders of condemnation that require correction of the conditions or the demolition of any buildings. [D.C. Official Code § 6-902\(a\)\(1\)](#).



For example, in November 2016, Hurricane Matthew caused the condemnation of numerous buildings in North Carolina, including a school. In addition, at least 12 homes were condemned after an April 1, 2017 tornado touched down in Virginia Beach, Virginia.

Condemnation procedures are outlined in [D.C. Official Code § 6-903](#) with review of condemnation orders and appeals found at [D.C. Official Code §§ 6-913, 6-914](#). In emergencies when many buildings need to be condemned, it may be necessary to waive these steps via a declaration of public emergency issued by the Mayor.



See section 4.5 of the Manual regarding the Mayor's authority to declare emergencies.



See Appendix 3.0 for an inspection and condemnation flowchart.

9.5 Food Establishment Inspections

9.5.1 Food Establishment Defined

A full listing of what constitutes a “food establishment” can be found at [25-A DCMR § 9901](#).

A food establishment does not include the following:

- An establishment that offers only prepackaged foods that are not potentially hazardous due to the need for time or temperature control for safety;

- A produce stand that only offers whole, uncut, fresh fruits and vegetables;
- A food processing plant, including one that is located on the premises of a food establishment;
- A kitchen in a private home where only food that is not potentially hazardous due to the need for time or temperature control for safety, is prepared for sale or served at any function such as a religious or charitable organization's bake sale where the consumer is informed by a clearly visible placard that the food is prepared in a kitchen that is not subject to regulation or inspection by DC Health;
- An area where food that is prepared in a kitchen in a private home where only food that is not potentially hazardous due to the need for time or temperature control for safety, is sold or offered for human consumption;
- A kitchen in a private home, including a child development home; a community residential home; or a bed and breakfast operation that prepares and offers food to guests if the home is owner occupied, the number of available guest bedrooms does not exceed three, breakfast is the only meal offered, the number of guests served does not exceed nine, and the consumer is informed by statements contained in published ads, mailed brochures, and placards posted at the registration area that the food is prepared in a kitchen that is not regulated and inspected by DC Health;
- A private home that receives catering or home-delivered food;
- A private club, or a church, which serves occasional meals at not more than 24 events during a 12-month period; and
- Restaurants of the United States Congress.

[25-A DCMR § 9901.](#)

9.5.2 Right to Enter and Inspect a Food Establishment

After DC Health representatives present official credentials and provide notice of the intent to conduct an inspection in accordance with the District Food Code, [25-A DCMR § 100 et seq.](#) (Food Code) the person in charge of the food establishment must allow access to DC Health during regular hours of operation to: (1) determine if the food establishment is in compliance with the Food Code; (2) examine and sample the food; (3) obtain information, and examine records related to the food purchased, received, or used by the food establishment. [25-A DCMR § 4402.1](#)

If access is denied to DC Health, a DC Health representative will inform the person in charge that: (1) access is required under the license obtained under the Food Code; (2) access is a condition of a continued food establishment license; (3) if access is denied, an inspection order allowing access may be obtained; and (4) DC Health is making a final request for access. [25-A DCMR § 4402.2.](#)



While foodborne illness outbreaks are not likely to result in a declared emergency, they still have the potential to sicken large numbers of people, triggering the need for action from DC Health. Thus, the right to inspect food establishments is critical to protect the public's health.

9.5.3 Imminent Health Hazard

An “imminent health hazard,” is a significant threat or danger to when there is sufficient evidence that a product, practice, circumstance, or event requires immediate correction or cessation of operations to prevent injury because of the number of potential injuries, and the nature, severity, and duration of the anticipated injury. [25-A DCMR § 9901.1](#). If an imminent health hazard is identified, a food establishment must immediately discontinue operations and notify DC Health. [25-A DCMR § 4408](#).



Violations of the Food Code come with a range of penalties, including embargo orders, revocation or suspension of license, condemnation order, civil fines, fees, and penalties, and criminal fines and penalties (including imprisonment). [25-A DCMR Chapter 47](#). Judicial review in accordance with the District of Columbia Administrative Procedures Act is available to persons subject to a final order or decision by the DC Health. [25-A DCMR § 4900.1](#).

9.5.4 Prevention of Foodborne Disease Transmission by Food Employees

DC Health will take the following actions when it has probable cause to believe that a food employee: (1) has transmitted a disease; (2) may be infected with a disease in a communicable form that is transmissible through food; (3) may be a carrier of an infectious agent that causes a disease that is transmissible through food; or (4) is affected with a boil, an infected wound, or acute respiratory infection:

- Secure a confidential medical history of the food employee suspected of transmitting disease or making other investigations as deemed appropriate; and
- Require appropriate medical examinations, including collection of specimens for laboratory analysis, of a suspected food employee.

[25-A DCMR § 4500.1](#).

Based on the investigation findings, DC Health may issue an order to the suspected food employee taking one or more of the following control measures:

- Restricting the food employee's service to the food establishment;
- Excluding the food employee from the food establishment; or
- Closing the food establishment by summarily suspending a license to operate in accordance with the Food Code.

[25-A DCMR § 4501.1.](#)

The order or restriction or exclusion may be issued without prior warning, notice of a hearing, or a hearing if the order: (1) states the reasons for the restriction or exclusion that is ordered; (2) states the evidence that must be provided by the suspected food employee or licensee in order to demonstrate that the reasons for the restriction or exclusion are eliminated; (3) states that the suspected food employee or licensee may request a hearing by submitting a timely request as provided in the Food Code; and (4) provides the name and address of the DC Health representative to whom the hearing request may be made.

[25-A DCMR 4502.1.](#)

10.0 PRIVACY AND CONFIDENTIALITY OF PATIENT RECORDS

10.1 Summary

The information contained in medical records and confidential reporting is highly protected under federal and District law, as well as by the United States Constitution.

However, both federal and District law provide exceptions that allow disclosure to public health officials without an individual's consent. In general, the Health Insurance Portability and Accountability Act of 1966 (HIPAA) specifically allows disclosure of protected health information (PHI), without the patient's written authorization for statistical or public health purposes or when essential to safeguard the health and safety of others. In addition, healthcare providers must provide patients with access to their medical records within a reasonable time after a written request is made.



The District of Columbia Mental Health Information Act of 1978, [D.C. Official Code § 7-1201.01 et seq.](#), which regulates the privacy of mental health information, is a complex law that is beyond the scope of this Manual.

10.2 Constitutional Right to Privacy

There is no express right to privacy in the United States Constitution. The courts, however, have recognized a constitutional right to privacy, which includes an “individual interest in avoiding disclosure of personal matters.” [Whalen v. Roe, 429 U.S. 589, 599-600 \(1977\)](#). See, e.g., *United States v. D.C.*, 44 F. Supp. 2d 53, 60–61 (D.C. 1999). When such a protected individual interest exists, a court will balance the individual's privacy right against the governmental interest in disclosure. *Whalen*, 429 U.S., at 602-604.



When courts rule on issues related to patient privacy related to public health emergencies, generally, the community's interest in addressing the public health emergency is likely to outweigh the individual's privacy interest.

10.3 District of Columbia Law

10.3.1 Access to Patient Records Maintained by Healthcare Providers

- A. Obligation to Provide Access to Medical Records** – Healthcare providers are required to provide access to individuals, upon written request, to patient medical records within a reasonable time. The request may be made by the patient or a person authorized to have access to the patient's record under a healthcare power of attorney. [D.C. Official Code § 3-1210.11\(a\)](#).
- B. Time Within Which Medical Records Must be Provided** – Physicians must provide, to a patient or the patient's representative, a copy of the patient's medical record within 30 days of the request from the patient or the patient's representative for the records. [17 DCMR § 4612.2](#).

C. Access to Medical Records in HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) Cases – Any entity providing health or medical services must make medical records and histories available to the DC Health Director to facilitate an investigation into a report regarding an HIV infection, potential AIDS case, or pregnancy in an HIV-infected woman. [22B DCMR § 206.4](#).

10.3.2 Use and Disclosure of Communicable Disease Reporting Information

A. Use of Communicable Disease Reporting Information – The DC Health Director may use the records generated in relation to a case of a disease or medical condition reported under [D.C. Official Code §§ 7-131 to -144](#) for statistical or public health purposes only. [D.C. Official Code § 7-131\(b\)\(1\)](#).



See section 7.0 of the Manual for more information regarding communicable disease reporting.

B. Disclosure of Identifying Information – Identifying information contained in records generated in relation to a disease or medical condition reported under [D.C. Official Code §§ 7-131 to -144](#) may be disclosed only when essential to safeguard the physical health of others. No person may disclose information from those records unless:

- The person reported gives written permission prior to disclosure; or
- A court finds, using a clear and convincing evidence standard and after providing the person reported with an opportunity to contest the disclosure, that disclosure:
 - Is essential to safeguard the physical health of others; or
 - Would provide evidence that relates to the guilt or innocence of an individual in a criminal prosecution.

[D.C. Official Code § 7-131\(b\)\(1\)](#).

C. Exceptions – The restrictions set forth above do not apply to the use and disclosure of identifying information pursuant to [D.C. Official Code § 4-1301.01 to -1371.14](#) (child abuse and neglect, Family Division proceedings) or [D.C. Official Code §§ 16-2301 to -2399](#) (delinquency, neglect, or need of supervision, Family Division proceedings). [D.C. Official Code § 7-131\(b\)\(2\)](#).

D. Penalties for Violation – Willfully disclosing, receiving, using, or permitting the use of information in violation of [D.C. Official Code § 7-131\(b\)](#) is a misdemeanor, punishable by a fine up to \$5,000, imprisonment up to 90 days, or both. [D.C. Official Code § 7-140](#).



It is important to note that many additional laws and regulations govern privacy of health information related to specific diseases and persons, including but not limited to,

sexually transmitted diseases and HIV. See [22B DCMR § 205.8](#), [206.5](#); see also [D.C. Official Code § 7-1605](#) (Hepatitis B), [22B DCMR § 207.9](#), [209.5](#) (student health information).

10.3.3 Use and Disclosure of Health and Human Services Information

A. Definitions –

- “Health and human services information” is any information that relates to:
 - The past, present, or future physical or mental health of an individual or family;
 - The provision of healthcare or human services, including benefits or supports, to an individual or family; or
 - The past, present, or future payment for the provision of healthcare or human services to an individual or family.
- “Service provider” is an entity that provides health or human services to District residents pursuant to a contract, grant, or other similar agreement with an agency.
- “Use” is the sharing, employment, application, utilization, examination, or analysis of health and human services information.
- “Human services” are programs, assistance, supports or benefits of any kind to improve quality of life or to meet the social, physical health, housing, and mental health needs of an individual.
- “Individually identifiable information” has the same meaning as it does under the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

[D.C. Official Code § 7-241](#).

B. Use and Disclosure of Health and Human Services Information – Without prior consent from the identified individual to whom the information pertains, an agency or service provider may use and shall disclose to another agency or service provider health and human services information referencing or relating to the identified individual for certain purposes, such as establishing eligibility for benefits, coordinating treatment, and performing examinations and inspections. [D.C. Official Code § 7-242\(a\)](#).

C. Accordance with the Health Insurance Portability and Accountability Act – Any uses or disclosures by an agency or service provider of individually identifiable health information must be in accordance with HIPAA. [D.C. Official Code § 7-242\(c\)](#).



See section 10.4 of the Manual for more information regarding HIPAA.

- D. Minimum Necessary** – The agency or service provider using or disclosing health and human services information must follow the “minimum necessary” principle described in HIPAA and disclose the minimum amount of information necessary to achieve the purpose of the use or disclosure. [D.C. Official Code § 7-242\(d\)](#).
- E. Written Request** – A service provider wishing to receive health and human services information must make a written request to an agency or service provider that describes the information sought and purpose for the information. [D.C. Official Code § 7-244\(a\)](#).
- F. Civil Penalties** – If an individual negligently uses or discloses health and human services information in violation of [D.C. Official Code §§ 7-241 to -248](#), they may be fined \$500 per violation. [D.C. Official Code § 7-245\(a\)](#). If an individual willfully uses or discloses health and human services information in violation of [D.C. Official Code §§ 7-241 to -248](#), they may be fined \$1000 per violation. [D.C. Official Code § 7-245\(b\)](#).
- G. Criminal Penalties** – If an individual knowingly obtains, uses, or discloses health and human services information in violation of [D.C. Official Code §§ 7-241 to -248](#) or any other District law, they are guilty of a misdemeanor and may be fined up to \$2,500, imprisoned up to 60 days, or both. However, if the offense was committed through deception or theft, the fine is increased to up to \$5,000, imprisonment up to 180 days, or both. [D.C. Official Code § 7-246](#).

10.3.4 Freedom of Information Act

- A. Right of Access to Public Records** – Under the District’s Freedom of Information Act, [D.C. Official Code §§ 2-531 to -540](#) (D.C. FOIA), individuals are entitled to full and complete information about government affairs and the official acts of public officials and employees of the District. Thus, individuals have the right to inspect and copy any public record of a public body unless an exception exists that exempts certain information from disclosure.
- B. Personal Information** – Information of a personal nature where public disclosure of such information would constitute a clear and unwarranted invasion of personal privacy is exempted from disclosure under D.C. FOIA. [D.C. Official Code § 2-534\(a\)\(2\)](#).
- C. Information Exempted from Disclosure by Another Statute** – Certain types of information are protected from disclosure under District law. Such information will be exempt from disclosure under D.C. FOIA, provided the District law either:
- Requires that the information be withheld from the public with no discretion regarding disclosure;
 - Establishes criteria for withholding; or
 - Refers to particular types of matters to be withheld.

[D.C. Official Code § 2-534\(a\)\(6\)](#).

D. Response Plans – District response plans, including public emergency response plans, and specific vulnerability assessments that are intended to prevent or mitigate acts of terrorism, are exempt from disclosure under D.C. FOIA. [D.C. Official Code § 2-534\(a\)\(10\)](#).



During a communicable disease outbreak or other public health emergency, public agencies may receive requests for information related to the outbreak or emergency. Whether such information must be disclosed under D.C. FOIA depends upon the type of information to be disclosed. Information may be exempt from disclosure because it would be an invasion of privacy. Communicable disease reporting information that identifies individuals is protected under [D.C. Official Code § 7-131](#) and may not be disclosed under D.C. FOIA. However, non-identifying or de-identified information is not protected and must be disclosed. See section 7.3 of the Manual for more details regarding use and disclosure of communicable disease reporting information.

10.4 Federal Law



See <https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html> for information regarding how patient health information could be used and disclosed during the COVID 19 pandemic.

10.4.1 Health Insurance Portability and Accountability Act of 1996

[HIPAA Pub. L. No. 104-191, 110 Stat. 1938 \(1996\)](#) protects the privacy and security of protected health information (PHI) unless otherwise provided for in the implementing regulations.

10.4.2 Health Information Technology for Economic and Clinical Health Act

[The Health Information Technology for Economic and Clinical Health Act \(HITECH Act\) Pub. L. No. 111-5, 123 Stat. 115 \(2009\)](#) was enacted as part of the American Recovery and Reinvestment Act of 2009 to promote the adoption and meaningful use of health information technology. The HITECH Act also increased the scope of privacy and security protections available under HIPAA, broadened the potential legal liability for non-compliance, and provided for increased penalties for violations under HIPAA.

10.4.3 Health Insurance Portability and Accountability Act Privacy Rule

The Federal Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) were adopted in 2002 to implement HIPAA. The Privacy Rule, contained in [45 C.F.R. §§ 160.101-552](#), [164.102-106](#), and [164.500-534](#), provides that a covered entity and its business associates may not use or disclose PHI except as permitted or required by the Privacy Rule.

A. Covered Entities – The Privacy Rule applies to three types of entities: health plans, healthcare clearinghouses, and healthcare providers who transmit health information electronically in connection with certain transactions. These entities are referred to as “covered entities.” [45 C.F.R. §160.103](#).

B. Business Associates – A business associate is a person or entity that creates, receives, maintains, or transmits PHI to perform certain functions or activities on behalf of a covered entity. Under the Privacy Rule, covered entities are allowed to disclose PHI to business associates to create and receive PHI on behalf of the covered entity, subject to the terms of a business associate agreement between the parties. The HITECH Act makes business associates directly liable for violations of the Privacy Rule. [45 C.F.R. § 160.103](#).

C. Protected Health Information – PHI is “individually identifiable health information” that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or media. [45 C.F.R. §160.103](#).

Individually identifiable health information is health information that identifies the individual or could reasonably be used to identify the individual. *Id.*

D. Disclosure – The release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information. [45 CFR § 160.103](#).



Genetic information is considered to be “health information” under HIPAA and will be protected if falls within the definition of PHI.

10.4.4 Disclosures Permitted by the Health Insurance Portability and Accountability Act

A. Disclosures Required By Law – A covered entity may use or disclose PHI to the extent that such use or disclosure is required by law. In addition, the use or disclosure must comply with and be limited to the relevant requirements of the law. [45 C.F.R. §164.512\(a\)](#).

B. Disclosures for Public Health Activities – A covered entity may disclose PHI for public health activities and purposes to:

- A public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including:
 - The reporting of disease, injury, and death; and
 - The conducting public health surveillance, public health investigations, and public health interventions.
- An official of a foreign government agency acting in collaboration with a public health authority, at the direction of a public health authority;

- A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
- An individual subject to the jurisdiction of the United States Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety, or effectiveness of such FDA-regulated product or activity;
- An individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such individual as necessary in the conduct of a public health intervention or investigation; and
- An employer, about an individual who is a member of the workforce of the employer, under specific circumstances.

[45 C.F.R. §164.512\(b\)\(1\).](#)

C. Disclosures to Avert a Threat to Health and Safety – A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose PHI, if the covered entity, in good faith, believes the use or disclosure is:

- Necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public; and
- To individuals reasonably able to prevent or lessen the threat, including the target of the threat.

[45 C.F.R. §164.512\(j\)\(1\)\(i\)\(A\)-\(B\).](#)



The Privacy Rule specifically allows disclosure of PHI, without the patient's written authorization, to public officials and organizations for reasons related to a public health emergency (e.g., disease reporting, public health surveillance).

D. Disclosures for Judicial and Administrative Proceedings – A covered entity may disclose PHI in connection with a judicial or administrative proceeding under the following circumstances:

- In response to a court order or the order of an administrative tribunal, provided that only the PHI requested by the order is disclosed; or
- In response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if:
 - The covered entity receives satisfactory assurances from the party seeking the information that it has made reasonable efforts to ensure

that the individual who is the subject of the PHI has been given notice of the request; or

- The covered entity receives satisfactory assurances from the party seeking the information that it has made reasonable efforts to secure a qualified protective order that:
 - Is in the form of an order from a court, administrative tribunal, or a stipulation by the parties to the proceeding;
 - Prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which the PHI was requested;
 - Requires that the PHI and all copies be returned to the covered entity or destroyed at the end of the proceeding; or
 - The covered entity itself makes reasonable efforts to seek a protective order or to provide notice to the individual.

[45 C.F.R. § 164.512 \(e\)\(1\)](#).



The Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) developed a guide to assist first responders in understanding HIPAA during a disaster, including what protected health information can be disclosed and under what circumstances. See <https://files.asprtracie.hhs.gov/documents/aspr-tracie-hipaa-emergency-fact-sheet.pdf>.



The minimum necessary standard, a key protection of the Privacy Rule, is derived from confidentiality codes and practices in common use today. It is based on sound current practice that PHI should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information. The Privacy Rule's requirements for minimum necessary are designed to be sufficiently flexible to accommodate the various circumstances of any covered entity. See <https://www.hhs.gov/hipaa/for-professionals/faq/minimum-necessary/index.html>.

10.4.5 Family Educational Rights and Privacy Act

[The Family Educational Rights and Privacy Act](#) (FERPA) protects the privacy of student education records, giving parents or eligible students more control of their education records, as well as prohibiting educational institutions from disclosing personally identifiable information in education records without written consent.



See www.cdc.gov/phlp/docs/hipaa-ferpa-infographic-508.pdf for a comparison of HIPAA and FERPA.

11.0 SCOPE OF PRACTICE, VOLUNTEER HEALTH PRACTITIONERS, AND CRISIS STANDARDS OF CARE

11.1 Summary

In the event of a public health emergency, there may be disruptions in governmental operations and infrastructure as well as in the clinical healthcare system. At the same time, there may be a surge of patients and individuals in the community who require services. It is critical that the District take steps to address a medical surge. Such steps may include modifying scopes of practice for health professionals, using volunteer health practitioners, and switching to crisis standards of care. Another way to address medical surge is through the use of mobile medical clinics that may be deployed in the areas of the District that are most in need.

11.2 Scope of Practice

In general, scope of practice refers to the range of services that licensed practitioners are authorized to perform. In the District, scopes of practice are defined by the Health Occupations Boards. [D.C. Official Code § 3-1201.01](#). During disasters and emergencies, the Mayor may determine that it is necessary to modify the scope of practice for health professionals to meet increased demand for services. In that case, the Mayor may issue a Mayor's Order enlarging the permitted activities practitioners may perform or expanding the types of practitioners that are authorized to perform certain activities (e.g., a physician assistant may be permitted to provide certain services without the supervision of a physician).



Model Mayor's Orders prepared before disasters or emergencies strike will ensure that the necessary providers' scopes of practice are modified so that response to medical surge is adequate.

11.3 Licensure Portability and Volunteer Health Practitioners

The portability of healthcare practitioners' licenses may become an issue during and after a disaster or emergency if there is a surge in the number of individuals who require medical care. Licensure portability is addressed in the Emergency Management Assistance Compact (EMAC), in which the District is a participant. [D.C. Official Code § 7-2332](#).

The EMAC provides for interstate recognition of licenses held by professionals responding to disasters and emergencies. However, its provisions related to licensure and portability have been interpreted to apply to state government employees only, with no application to private sector workers. See [Portability of Licensure and the Nation's Health](#). EMAC also addressed liability issues.



See section 4.10.1 of the Manual for more information regarding EMAC.

The [Uniform Emergency Volunteer Health Practitioners Act](#) (UEVHPA) is model legislation developed in 2006 by the Uniform Law Commission in response to criticisms made after Hurricane

Katrina regarding healthcare practitioner licensure under EMAC. The District adopted sections of the UEVHPA in 2010. [D.C. Official Code §§ 7-2361.01 to - 2361.12](#).

While an emergency declaration is in effect, a volunteer health practitioner registered with a registration system that complies with [D.C. Official Code § 7-2361.04](#) and who is licensed and in good standing in the state where the practitioner's registration is based may practice in the District as if the practitioner was licensed in the District. [D.C. Official Code § 7-2361.05\(a\)](#). A volunteer health practitioner, however, may not provide services outside of the practitioner's scope of practice, even if permissible under District law. "Scope of practice" is defined as the extent of the authorization to provide health or veterinary services, including any conditions imposed, granted to the practitioner by the relevant licensing authority. [D.C. Official Code § 7-2361.01\(14\)](#).

"Volunteer health practitioner" is defined as a health practitioner who provides health or veterinary services, with or without compensation for those services, including an employee of the federal government. Practitioners who receive compensation pursuant to a preexisting employment relationship with a host entity or affiliate that requires the practitioner to provide health services in the District are not considered volunteer health practitioners unless the practitioner is employed by a disaster relief organization while an emergency declaration is in effect. [D.C. Official Code § 7-2361.01\(17\)](#).



Nothing in [D.C. Official Code §§ 7-2361.01 to -2361.12](#) precludes a health facility from waiving or modifying its credentialing and privileging standards if an emergency declaration is in effect. [D.C. Official Code § 7-2361.06\(a\)](#).



The Mayor can declare a public health emergency if there is the occurrence of other emergency events that create an acute and immediate need for volunteer health practitioners. See section 4.5.2 of the Manual.



Section 207: Improving All-Hazards Preparedness and Response by Public Health Emergency Volunteers of the [Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019](#) (PAHPIA) encourages states to both raise awareness of opportunities for public health professionals to provide medical services during emergencies and to structure their licensure programs so as to allow those professionals to provide care across state lines during an emergency.




Section 208: Clarifying State Liability Law for Volunteer Healthcare Professionals of the [PAHPIA](#) clarifies that, under certain circumstances, voluntary medical professionals who are providing out of state care in a state that has declared a state of emergency will be subject to the liability laws of the state in which the service was provided.


11.3.1 Provision of Services During Declared Emergencies

During a declared emergency, the Mayor may issue an order that limits, restricts, or otherwise regulates:

- The duration of practice by volunteer health practitioners;
- The geographical areas in which volunteer health practitioners may practice;
- The types of volunteer health practitioners who may practice; and
- Any other matter necessary to coordinate effectively the provision of health or veterinary services during the emergency.

[D.C. Official Code § 7-2361.03\(a\)](#).

 Volunteer health practitioners who provide health or veterinary services under [D.C. Official Code §§ 7-2361.01 to -2361.12](#) are not liable for damages for acts or omissions in providing those services. [D.C. Official Code § 7-2361.10\(a\)](#). This liability limitation does not apply to willful misconduct or wanton, grossly negligent, reckless, or criminal conduct; an intentional tort; breach of contract; a claim asserted by a host entity or by an entity located in the District or another state which employs or uses the services of the practitioner; or an act or omission relating to the operation of a motor vehicle, a vessel, an aircraft, or other vehicle. [D.C. Official Code § 7-2361.10\(c\)](#). Moreover, in authorizing health services under [D.C. Official Code §§ 7-2361.01 to -2361.12](#), the District has no liability for the act or omission of a volunteer health practitioner. [D.C. Official Code § 7-2361.10\(e\)](#).

 See section 5.8 of the Manual for additional information regarding liability protection.

11.3.2 Medical Reserve Corps

The Medical Reserve Corps (MRC) is a national network of volunteers, organized locally to improve the health and safety of the community. MRC units engage volunteers to strengthen public health, improve emergency response capabilities, and build community resiliency.

DC Health has established the District of Columbia Medical Reserve Corps (D.C. MRC), a cadre of trained and qualified volunteers, to supplement public health and medical resources during emergencies and other times of community need, and to enhance the District's capability. D.C. MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Non-medical volunteers include interpreters, chaplains, office workers, legal advisors, and others to fill key support positions.

The D.C. MRC is primarily designed to assist and supplement the existing emergency medical response and public health systems in emergencies and does not replace existing emergency medical response systems or their resources. Volunteers may be requested

to support large-scale, complex emergencies involving multiple jurisdictions and interagency operations, or smaller incidents involving a single jurisdiction or agency. D.C. MRC volunteers are required to register in DC Health database, [The District of Columbia \(DC\) Medical Reserve Corps | doh](#).



The [Emergency Law Inventory](#) (ELI), a tool developed by the University of Pittsburgh Graduate School of Public Health Center for Public Health Practice, provides summaries and full text of laws impacting volunteers who prepare for and respond to disasters.

11.4 Crisis Standards of Care

The standard of care generally refers to the duty owed by healthcare practitioners to their patients. Crisis standards of care (CSC) are defined by the Institute of Medicine (IOM) as a “substantial change in usual healthcare operations and the level of care it is possible to deliver ... justified by specific circumstances and ... formally declared by a state government in recognition that crisis operations will be in effect for a sustained period.” See [Guidance for Establishing Standards of Care for Use in Disaster Situations: A Letter Report](#). A formal declaration that CSC are in operation enables specific legal/regulatory powers and protections for healthcare providers working to treat as many patients as possible with limited resources.

11.4.1 Institute of Medicine Guidance

The IOM has issued various guidance documents related to crisis standards of care since 2009, including:

- [Guidance for Establishing Standards of Care for Use in Disaster Situations: A Letter Report \(2009\)](#). Washington, DC: The National Academies Press.
- [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response \(2012\)](#). Washington, DC: The National Academies Press.
- [Crisis Standards of Care: A Toolkit of Indicators and Triggers \(2013\)](#). Washington, DC: The National Academies Press.

Through these various guidance documents, the IOM identifies surge capacity issues across a continuum of care that are based on demand for healthcare services and the availability of resources. Moving along the continuum of care from conventional care to CSC enables health practitioners to treat more patients with limited resources.



CSC does not authorize the provision of substandard care. Instead, the standard of care becomes what a “reasonable” practitioner would do given the limited resources available.

The switch to CSC may be prompted by different events, such as loss of essential services (e.g., electricity, water, parts of the supply chain) or disruption to health system

infrastructure. Shortages of certain healthcare practitioners and/or shortages of medications and other supplies may also initiate the switch to CSC.



There is no official mechanism for a shift to CSC under District law. A public health emergency order issued by the Mayor under [D.C. Official Code § 7-2304.01\(a\)](#) would address provisions of law that would need to change in the event a shift to CSC is necessary. Such action is taken on a case-by-case basis.

12.0 MASS FATALITY INCIDENT AND MASS FATALITY MANAGEMENT

12.1 Summary

In accordance with [Emergency Support Function \(ESF\) #8](#), Public Health and Medical Services, the Office of the Chief Medical Examiner (OCME) was designated by the Mayor as the lead agency for the District’s mass fatality management and mass fatality incident response through a statutory amendment in 2017. Under the [District Response Plan](#) (DRP), OCME coordinates all mass fatality efforts, including investigating, establishing a temporary morgue(s), coordinating transportation of remains, performing postmortem examinations and identifications, securing evidence, certifying cause and manner of death, and releasing remains. The OCME also coordinates with District area hospitals for examination and storage or release of remains and deputize hospital physicians pursuant to [D.C. Official Code § 5-1404](#) to allow in-house hospital examinations on behalf of the Chief Medical Examiner (CME).

12.2 Definitions

12.2.1 Mass Fatality Incident

“Mass fatality incident” is a situation resulting in more human remains to be investigated, recovered, and examined than can be managed using routine District resources, or any other exceptional circumstance that results in the inability to process human remains under routine conditions. Chief Medical Examiner Amendment Act of 2017 ([D.C. Law 13-172](#), as added Dec. 13, 2017, [D.C. Law 22-33](#)).

12.2.2 Mass Fatality Management

“Mass fatality management” is the training of, and cooperation among, governmental and nongovernmental agencies, organizations, associations, and other entities to ensure the following after a mass fatality incident: 1) the proper recovery, handling, identification, transportation, tracking, storage, and certification of cause and manner of death of victims; and 2) the facilitation of access to mental and behavioral health services to family members, responders, and survivors. Chief Medical Examiner Amendment Act of 2017 ([D.C. Law 13-172](#), as added Dec. 13, 2017, [D.C. Law 22-33](#)).

12.3 Mass Fatality Incident Management

12.3.1 Conditions that Exceed Routine Office of the Chief Medical Examiner Operations

The following conditions trigger OCME mass fatality incident operations:

- The issuance of a public health emergency executive order by the Mayor. [D.C. Official Code § 7-2304.01](#).
- The issuance of a public emergency executive order by the Mayor. [D.C. Official Code § 7-2304](#).

- A situation resulting in more human remains to be investigated, recovered, and examined than can be managed using District resources that may include:
 - Any confirmed incident associated with five or more fatalities tied to a single event;
 - Any confirmed incident with the potential for mass fatalities (*i.e.*, five or more deaths), such as a mass casualty incident; or
 - Multiple, simultaneous incidents that produce any number of fatalities, and have the potential to be man-made, coordinated or terror-related, such as complex coordinated attacks (CCAs).
- Anticipated events such as:
 - Impending or predicted natural disasters; and
 - National security special events (NSSEs), or any large gatherings greater than 100,000 persons.
- Credible knowledge of a perceived threat as determined by law enforcement, the District of Columbia Homeland Security and Emergency Management Agency (HSEMA), DC Health or any entity with authority to issue threat alerts to the District government.
- Events that exceed OCME's routine operational capacity, which includes:
 - Greater than 20 fatalities in a single day;
 - Pandemic-related or highly infectious deaths;
 - Remains contaminated with any hazardous material or exposed to a Chemical, Biological, Radioactive, Nuclear, or Explosive (CBRNE) agent;
 - A single event that produces multiple highly fragmented remains; and
 - Protracted and/or complex fatality scenarios (*e.g.*, building collapse, water recovery).



OCME has a number of resources to support its role in mass fatality incident management, including National Capital Region (NCR) assets, a Medical Examiner Transport Team (METT) that has a fleet capable of recovery and removal of decedent remains; and a Memorandum of Agreement with the Defense Health Agency, National Museum of Health and Medicine, for forensic anthropological consultation services, training, and collaboration on medical education activities.



See section 4.5 of the Manual regarding the Mayor’s authority to declare emergencies and section 4.7.1 regarding NSSEs.

12.3.2 Identification of Victims

When there is a mass fatality incident, the OCME may stand up the OCME Disaster Victim Identification (DVI) Service to provide accurate and timely identification of victims for the rapid return of decedents to their legal next of kin.

In mass fatality incidents, normal identification protocols through visual identification may not be possible or desirable. Therefore, alternate means of identification may be used, including scientific (e.g., fingerprints, radiograph comparison, DNA); and circumstantial (e.g., tattoos, scars, and clothing). Depending on the nature of the incident, OCME may request family who believe their next of kin is a victim of a mass fatality incident to complete the OCME “DNA Evidence Collection Consent Form” for collection of a DNA sample to test to aid identification of the victims.



See Appendix 6.0 for an example of this form.

Victim identification will also inform the order of priority for the release of remains to control decedent disposition and any District notification obligations in the event of mandatory mass burial, mass cremation, or other executive directive that affects the disposition of the decedent’s remains. [D.C. Official Code § 3-413](#).

12.3.3 Subpoena Authority

The OCME has broad subpoena authority with respect to confidential medical records and relevant information from physicians, hospitals, nursing home, residential care facilities and other healthcare providers as they deem necessary for investigating deaths. [D.C. Official Code § 5-1407](#). Use of this subpoena authority, in connection with a death investigation, may be used to help identify victims in a mass fatality incident.



The identification of the victim may also impact the court when determining standing, resolving disputes, and any civil considerations resulting from the District’s action that affects the decedent’s remains and next-of-kin rights.

12.4 Professional Licensure and Mass Fatality Incidents

The OCME staff includes board certified forensic pathologists who determine cause and manner of death. In mass fatality incidents, the OCME may utilize non-staff physicians to assist with these functions. [D.C. Official Code § 5-1410](#).

There may be a need to waive licensure requirements for the following individuals:

- Physicians;

- Funeral directors; and
- First responders.



See sections 11.2 and 11.3 of the Manual for information regarding scope of practice, licensure portability, and volunteer health practitioners.

12.5 Decedent Disposition and Storage

The District has locations to accommodate burial of human remains; however, due to space limitations and locations, such sites may not be suitable for mass burial of infected or contagious remains. The District currently has no crematorium; therefore, all human remains to be cremated must be transported out of state.



In the event decedent remains require direct transport outside of the District (e.g., in cases of Ebola or other infectious diseases), or for other purposes, licensure requirements for non-District licensed funeral directors may need to be modified or waived to effectuate out-of-state transfers of human remains. See section 11.2 of the Manual. Under District law, the provision of funeral, cremation, cemetery, or other mortuary services by an individual who is authorized to provide such services under [Chapter 23C of Title 7](#) is not prohibited while an emergency declaration is in effect. [D.C. Official Code § 3-411\(h\)](#).



During the West African Ebola epidemic in 2014, DC Health determined that, in the event of a death in the District in which Ebola may be the cause or suspected cause, the OCME would assume all control and management of disposition of the involved human remains. It was decided that all human remains of Ebola patients would be promptly cremated. All funeral directors were notified of this protocol. A plan was adopted, the Interim Draft Concept of Operations for the Management of Decedents with Confirmed or Suspected Viral Hemorrhagic Fever (ConOps Plan), that was consistent with [CDC Guidance for Safe Handling of Human Remains of Ebola Patients in U.S. Hospitals and Mortuaries](#).

12.5.1 Special Rules Regarding Decedent Disposition When Death Caused by Certain Diseases

Special rules apply in cases of death from the following diseases:

- Cholera;
- Anthrax;
- Diphtheria;
- Plague (bubonic and pneumonic);
- Smallpox; or

- Louse-borne typhus fever.

When death is caused by one of the diseases listed above, the physician issuing the certificate of death must give immediate notice by telephone of the death to the DC Health Director. [22B DCMR § 214.1](#). Certain steps must be taken with the body of a person who died from one of the diseases listed above. In addition, the body of a person who died from one of the diseases listed above may not be moved from the place of death except after issuance of a permit by the DC Health Director. [22B DCMR §214.2](#).

A public funeral service for a person who has died of any of the diseases listed above must not be held in the presence of the body unless the body has been embalmed and placed in a hermetically sealed casket.



See section 7.5 of the Manual regarding special reporting requirements for deaths from these diseases.

12.6 Mutual Aid Agreements

The District may enter into Mutual Aid Agreements with neighboring jurisdictions in the NCR for cremation and/or mass burial in the event of a mass fatality incident. These agreements are authorized through Emergency Management Assistance Compact (EMAC) and various Mayor's Orders, including:

- [Mayor's Order 97-42](#)
- [Mayor's Order 2009-123](#)
- [Mayor's Order 2012-234](#)
- [Mayor's Order 2014-059](#)



During the West African Ebola epidemic in 2014, Maryland's Board of Morticians and Funeral Directors and Maryland's Secretary of Health and Mental Hygiene's Office agreed that it was acceptable to transport any infected decedents from the District to Maryland for the purposes of cremation. Transportation plans in that incident included details for postmortem preparation of the infectious remains.



See section 4.10.2 for more information about EMAC.



If a mass fatality incident overwhelms District resources, aid can be requested via the National Disaster Medical System (NDMS). See section 4.11 of the Manual.

13.0 ANIMAL CARE AND CONTROL

13.1 Summary

Vectors are animals or organisms like mosquitoes or ticks that are capable of transmitting disease to humans or animals. District law prohibits certain activities and conditions that increase the risk of vector-borne disease, thereby creating a public health nuisance. The Mayor has authority to order the abatement of such nuisance activities.

There are many issues related to the care and control of animals during disasters and emergencies. Federal and District law provide protection for pets and service animals during disasters and emergencies. The District has created an emergency preparedness plan for the protection, sheltering, and evacuation of domestic animals following passage of the federal Pets Evacuation and Transportation Standards Act.

13.2 Vector-Borne Infectious Disease Control

13.2.1 Definitions

- A “vector” is any animal or organism capable of transmitting the causative agent of human or animal disease or capable of producing human discomfort or injury, including mosquitoes, flies, mites, ticks, or other arthropods. [D.C. Official Code § 8-2131.01\(6\)](#).
- A “public health nuisance” is any property, including water, that supports the development, attraction, or harborage of vectors; any property that has a vessel, container, or other structure holding water that provides a breeding place for vectors; or any activity that supports the development, attraction, or harborage of vectors, or that facilitates the introduction or spread of vectors. [D.C. Official Code § 8-2131.01\(5\)](#).
- “Abate” is to eliminate a public health nuisance, or to reduce the degree or intensity of a public health nuisance. [D.C. Official Code § 8-2131.01\(1\)](#).

13.2.2 Prohibited Activities – Tires

Tires play a prominent role in the breeding and harboring of vectors such as mosquitoes; therefore, the following activities are prohibited:

- Causing or allowing the open dumping of tires;
- Causing or allowing the open burning of tires;
- Causing or allowing the storing of any tire unless the owner or operator of the property where the tire is stored takes measures to store the tire indoors or, if the tire is stored outdoors, to prevent the accumulation of water in the tire by covering or altering the tire; and
- Causing or allowing the tire to be used in playground equipment unless the tire is altered to prevent the accumulation of water.

[D.C. Official Code § 8-2131.02\(a\)](#).

13.2.3 Prohibited Activities – Standing Water

Standing water leads to the breeding and harboring of vectors, such as mosquitoes, which may use natural and artificial water-holding containers (e.g., tree holes, used tires, plastic containers, clogged gutters) to lay their eggs.



For example, female mosquitoes prefer to lay eggs in water that collects or is stored in manmade containers. After hatching, larvae grow and develop into pupae and subsequently into terrestrial, flying adult mosquitos.

Therefore, the following measures must be taken in relation to standing water to prevent such breeding and harboring:

- Performing routine checks around property to ensure there is no standing water collected;
- Draining or replacing water frequently enough to prevent vector breeding;
- Keeping swimming pools and other open waters used for bathing or swimming sufficiently chlorinated to prevent vector larvae from hatching;
- Covering water-bearing containers with covers or fine netting to prevent access by vectors; or
- Applying larvicide to the standing water.

[D.C. Official Code § 8-2131.02\(b\)](#).

13.2.4 Mayoral Authority to Inspect

The Mayor may inspect occupied or vacant property to investigate an allegation of a public health nuisance. Such allegation may come from the Mayor’s own information or observation, or the information or observation of another individual. The inspection must be conducted during reasonable times and in a reasonable manner. If the owner or occupant of the property denies access for such inspection, the Mayor may petition a court of competent jurisdiction for a search warrant. If the Mayor determines that a public health nuisance exists after the inspection, the Mayor may order the owner or occupant to take appropriate action to abate the nuisance in accordance with [D.C. Official Code § 8-2131.05](#).



If vectors are present in their developmental stage on a property, or in a vessel, container, or other structure on a property, such presence constitutes prima facie evidence of a public health nuisance. [D.C. Official Code § 8-2131.04](#).

13.2.5 Abatement of a Public Health Nuisance

Upon determination by the Mayor that a public health nuisance exists, the Mayor will issue a notice of violation to the individual alleged to have created the public health nuisance or

to the owner or occupant of the property. Upon receipt of such notice, the individual must abate the public health nuisance within the time specified in the notice. The Mayor may grant additional time to abate upon request from the responsible party and a good faith showing that the person has made an effort to abate the public health nuisance and that a longer time for abatement is necessary. [D.C. Official Code § 8-2131.05](#).

13.2.6 Notice of Existence of a Public Health Nuisance

Notice to the owner, occupant, or any other responsible individual may be served: (1) by delivery by prepaid mail, return receipt requested to the owner or occupant of the property; or (2) by public posting of the notice in a conspicuous place on the property where the public health nuisance exists. The notice must contain the following:

- The location, date, and time that the public health nuisance took place or that the Mayor investigated the public health nuisance;
- The nature of the public health nuisance;
- The time, no later than 10 days, within which the public health nuisance must be abated;
- The specific corrective actions the owner or occupant will take to abate the public health nuisance with a referral to DC Health's Regulation and Licensing Administration (HRLA) to provide assistance with the abatement efforts of the public health nuisance; and
- A statement that failure to abate the public health nuisance constitutes a violation of [D.C. Official Code § 8-2131](#) *et seq.*

[D.C. Official Code § 8-2131.05\(a\)](#).

13.2.7 Corrective Actions by Mayor to Abate a Public Health Nuisance

Subject to the availability of funds, the Mayor may take action to abate health hazards that are the result of vectors. Such action may include cleanup, abatement, and preventive measures; however, the District must take action to protect human health when one or more of the following conditions exist:

- The action is required to protect public space;
- No person can be found who is the owner of the property in question, and is capable of implementing the required corrective action within 30 days of the posting of the notice on the property, or a shorter period if the Mayor determines that action must be taken to protect human health;
- A situation exists that requires immediate action by the Mayor to protect human health; and/or
- The responsible party has failed or refused to comply within 30 days of a Mayoral order for compliance.

[D.C. Official Code § 8-2131.06\(a\)](#).

13.2.8 Costs Recoverable for Corrective or Enforcement Action

The District may recover costs incurred when taking corrective or enforcement action to abate development, attraction, and harborage of vectors from all parties found to be liable by the Mayor. Such liability is joint and several. In addition, the Mayor may assess any reasonable costs for correcting the condition and any related expenses as a tax against the property, carry the tax on the regular tax rolls, and collect the tax in the same manner as real estate taxes are collected. [D.C. Official Code § 8-2131.06\(b\)](#).

13.2.9 Penalties and Adjudication

A violation of the vector-borne infectious disease control laws, [D.C. Official Code § 8-2131.01](#) *et seq.*, constitutes a civil infraction under the [Department of Consumer and Regulatory Affairs Civil Infractions Act](#). Civil fines, penalties, and fees can be imposed pursuant to the Civil Infractions Act. Adjudication of any infraction is pursuant the Civil Infractions Act as well. See [Bernstein Management v. DC Rental Housing Commission, 92 A.2d 190 \(D.C. 2008\)](#).

13.3 Rodent Abatement

13.3.1 Definitions

- “Rodent abatement” is removal of rodent infestations by eliminating or rodent-proofing food sources, eliminating rodent nesting areas, rodent-proofing building entry ways, and poisoning or trapping existing rodent populations. [D.C. Official Code § 8-2103.01](#).
- “Harborage” is rodent infestation or providing food or nesting areas for rodents that can be identified by the presence of burrows, droppings, tracks, runways, gnawing, urine stains, odor, live or dead rodents, nests, or rodent-gnawed food. [D.C. Official Code § 8-2103.01](#).

13.3.2 Rodent Harborage Prohibited

It is unlawful for any individual to cause or permit the accumulation of debris on public or private property or cause or permit weeds or grass to grow to a height of more than eight inches. Rodent abatement must occur within 14 days of notice of a violation from the Mayor. If abatement does not occur, the individual who fails to abate the condition may be subject to arrest and penalties, including a misdemeanor conviction and a fine not to exceed \$10,000 per incident and/or imprisonment not to exceed 90 days. [D.C. Official Code § 8-2103.05](#).

13.4 Annual Mosquito Control and Abatement Plan

Annually, DC Health must develop and submit to the Council of the District of Columbia (D.C. Council) a mosquito-abatement plan, delineated by ward, for the next fiscal year to prevent and abate the infestation of mosquitoes. The plan, at a minimum, must include:

- A determination of the wards in greatest need of mosquito abatement;

- A plan of action to eliminate the habitats of immature mosquitoes and control immature and adult mosquitoes;
- A plan to ensure that eradication measures do not injure pets or wildlife; and
- Delineation of the costs associated with the entire plan.

[D.C. Official Code § 8-2141.01.](#)

13.5 Rabies and Animal Bites

If the DC Health Director has reason to believe that a dog or other animal: (1) is rabid; (2) has been bitten by a suspected rabid animal; or (3) has bitten a person or exposed a person to rabies, the DC Health Director has the authority to take action to quarantine or humanely euthanize the affected animal, and order rabies post-exposure prophylaxis for the affected person. [22-B DCMR § 203.](#)



For more information on animal bite reporting requirements, see section 7.3.3 of the Manual.

13.6 Pets and Service Animals during Disasters and Emergencies

13.6.1 Federal Pets Evacuation and Transportation Standards Act

The federal [Pets Evacuation and Transportation Standards Act](#) (PETS Act) was passed in 2006 in the wake of the devastation wrought by Hurricane Katrina. It is estimated that 250,000 animals died in the aftermath of Katrina. Many pet owners and individuals with service animals refused evacuation orders or rescued animals they were forced to abandon. The PETS Act directs the Federal Emergency Management Agency (FEMA) administrator to develop emergency preparedness plans that include animals, as well as ensure the adequacy of state and local emergency plans. The FEMA administrator may make financial contributions for animal emergency preparedness purposes, including emergency shelter facilities to accommodate individuals with household pets and service animals. Moreover, FEMA is authorized to provide rescue, care, shelter, and essential needs for individuals with household pets and service animals, and to the household pets and service animals themselves following a major disaster or emergency. [42 U.S.C. § 5196.](#)

FEMA has defined “household pet” as a domesticated animal, such as a dog, cat, bird, rabbit, rodent, or turtle that is traditionally kept in the home for pleasure rather than commercial purposes, that can travel in commercial carriers and be housed in temporary facilities. Household pets do not include reptiles (except turtles), amphibians, fish, insects/arachnids, farm animals (including horses), and animals kept for racing purposes. [FEMA 2017 Public Assistance Program and Policy Guide.](#)

FEMA defines “service animal” as any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to

intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items. *Id.*

13.6.2 District of Columbia Animal Emergency Preparedness Plan

In response to the PETS Act, the D.C. Council passed a law that required the Mayor to establish an emergency preparedness plan for the protection, sheltering, and evacuation of domestic and service animals during and following a major disaster or emergency. [D.C. Official Code § 8-1861.01](#).

DC Health added an “Animal Response and Protection Annex” to the [District Response Plan](#) (DRP) that provides guidance and coordination of local resources and mutual aid agreements in response to animal care needs before, during, and after a significant natural or man-made event. In addition, Metropolitan Washington Council of Governments (MWCOC) created a “Companion Animal Evacuation and Sheltering Model Plan Template” to be used as a resource for emergency managers and animal care partners in the National Capital Region (NCR) for planning the effective evacuation, sheltering, and safe return of companion animals to their place of origin.

14.0 AT-RISK POPULATIONS

14.1 Summary

During and after disasters, special attention is needed for at-risk individuals. Such at-risk individuals may include children, older adults, pregnant women, and individuals with disabilities. Specific issues that may arise relate to transportation, communication, access to medical care and supplies, and power-dependent equipment. Many resources are available to address these issues from the federal and District governments, as well as nonprofit organizations. The Americans with Disabilities Act's broad anti-discrimination provisions extend to emergency preparedness, response, and recovery efforts.



The homeless are another population at risk who should be considered during emergency preparedness, response, and recovery. There are a number of resources related to the needs of people who are homeless during and after disasters, including:

- [Disaster Response for Homeless Individuals and Families: A Trauma-Informed Approach](#)
- [Disaster Preparedness, Response, and Recovery and Homelessness](#)
- [Disaster Planning, Response, and Recovery for Organizations Serving People Experiencing Homelessness](#)
- [Disaster Preparedness, Response, and Recovery Resources](#)



Three back-to-back hurricanes – Harvey, Irma, and Maria – affected more than 28 million people in 2017. Hurricane survivors aged 65 and older and those with disabilities faced particular challenges evacuating to safe shelter, accessing medicine, and obtaining recovery assistance. In June 2018, the Federal Emergency Management Agency (FEMA) began implementing a new approach to assist individuals with disabilities. The Government Accountability Office (GAO) was asked to review disaster assistance for individuals who are older or have disabilities. In May 2019, the GAO issued a [report](#) that examines: (1) challenges FEMA's partners reported in providing disaster assistance to individuals who are older or have disabilities; (2) challenges faced by these individuals in accessing FEMA's disaster assistance programs and actions FEMA has taken to address such challenges; and (3) the extent to which FEMA has implemented its new approach to disability integration. The GAO analyzed FEMA data and reviewed relevant federal laws, agency policy, and federal frameworks. The GAO also interviewed state, territorial, local, and nonprofit officials in Florida, Puerto Rico, Texas, and the U.S. Virgin Islands; FEMA officials at headquarters, in regional offices, and deployed to disaster sites; and officials at relevant nonprofit organizations. The GAO made seven recommendations to FEMA, including that it establish new registration questions, objectives for its new disability integration approach, and a training plan for FEMA staff. This report highlights the special needs faced by at-risk individuals.

14.2 Definitions

14.2.1 At-Risk Individuals

“At-risk individuals” are children, pregnant women, older adults and other individuals who have access or functional needs in the event of a public health emergency, as determined by the United States Secretary of Health and Human Services (HHS Secretary). [42 USC § 300hh-1\(b\)\(4\)\(B\)](#).

14.2.2 Access Based Needs

“Access based needs” require that resources are accessible to all individuals, such as social services, accommodations, information, transportation, medications to maintain health, etc. See www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx.

14.2.3 Function Based Needs

“Function based needs” are restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency. See www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx.

14.2.4 Individual with a Disability

“Individual with a disability” is a person who has a physical or mental impairment that substantially limits one or more major life activities. This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability. The Americans with Disabilities Act (ADA) also makes it unlawful to discriminate against a person based on that person’s association with a person with a disability. [42 USC § 12102](#).



Section 303 of the [Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019](#) (PAHPIA) clarifies the definition of the term “at-risk individual” across the PAHPIA framework while encouraging the director of at-risk individuals to incorporate data regarding public health risks to those individuals into the existing situational awareness and biosurveillance network at the Centers for Disease Control and Prevention (CDC).



[Rx Open](#) is a resource that helps patients find nearby open pharmacies in areas impacted by disaster. Combining multiple data feeds from the pharmaceutical industry, RX Open displays the precise location on Google Maps of open pharmacies, closed pharmacies, and those whose status is unknown.

14.3 Older Adults

Older adults, particularly those over age 65, can be vulnerable during and after disasters. Older adults are more likely to have multiple chronic health conditions, limited mobility, declining vision and hearing, and physical and cognitive deficits that can negatively impact their ability to prepare for, respond to, and recover from a disaster event. Moreover, older adults may be socially isolated,

often living alone. As such, it is critical to consider this population in emergency preparedness planning and response.



There are a number of resources that address the needs of older adults during and after disasters, including:

- [Emergency Preparedness for Older Adults, including COVID-19](#)
- [Disaster Preparedness for Seniors by Seniors](#)
- [Ready.gov](#)
- [Seniors \(Ready DC\)](#)
- [How to Prepare for Emergencies - Seniors](#)
- [How the Elderly Can Prepare for Storms](#)
- [Emergency Preparedness](#)
- [Older Adults and Disasters How to Be Prepared and Assist Others](#)



Section 305 of [PAHPIA](#) authorizes a National Advisory Committee on Seniors and Disasters.

14.3.1 Age-Friendly DC

Age-Friendly DC is an initiative of the District to coordinate community members and public agencies to make the District an easier place to grow older. There are three pillars under the [Age-Friendly DC 2023 Strategic Plan](#), with each pillar having several domains: (1) Built Environment, (2) Changing Attitudes About Growing Older, and (3) Lifelong Health and Security. Emergency Preparedness and Resilience is a domain that falls within the third pillar, with a vision of “[a] city that ensures the readiness, immediate safety and resiliency of all residents and communities before, during and after an emergency.”

Under the [Age-Friendly DC 2023 Strategic Plan](#), the District will work to continue to provide uniform trainings regarding preparedness, mass care, emergency response, access and functional needs, behavioral health, CPR/first aid and resilience. In addition, the District will strive to create and assist community supported, neighborhood networks across the city that are accessible to all income levels.



Older adults were disproportionately affected by Hurricane Katrina, with half of the deaths from adults over age 75. See [Hurricane Katrina deaths, Louisiana, 2005](#). Hurricane Sandy had a similar impact on seniors, as 31 of the 44 New Yorkers who died due to the storm were over age 55. See <https://www.carecentrix.com/blog/caring-elderly-natural-disasters>.

In the District, in 2018, a 74-year old man was trapped for five days in his apartment before being rescued after a fire at a senior housing complex. He emerged unhurt. District officials blamed the building management company for providing an inaccurate report that all residents were safe, which led to fire officials suspending further searches of the building. See https://www.washingtonpost.com/local/public-safety/man-pulled-alive-from-rubble-of-dc-senior-complex-destroyed-in-fire/2018/09/24/59af9fa2-c00a-11e8-9005-5104e9616c21_story.html?noredirect=on. This dramatic event emphasizes the vulnerability older adults face during disasters and emergencies.

14.3.2 HHS emPOWER

Established in 2013 by the United States Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR), [emPOWER](#) assists public health officials/authorities, aging agencies, volunteer organizations, emergency managers, hospitals, first responders, electric companies, and community members in identifying at-risk individuals in their community (e.g., state, territory, county, or zip code) who are dependent on electricity to power in-home medical and assistive equipment, as well as rely on at home healthcare services. The purpose of emPOWER is to help communities easily anticipate, plan for, prepare for, and respond to the needs of at-risk individuals during incidents, emergencies, and disasters.

In such instances, a resulting prolonged large-scale electrical outage may become a life-threatening situation to the over 2.5 million Medicare beneficiaries who rely on electricity-dependent medical and assistive equipment (e.g., ventilators, oxygen concentrators, enteral feeding machines, intravenous pumps, suction pumps, at-home dialysis machines, electric wheelchairs and scooters, and electric beds) and home healthcare services (e.g., dialysis, oxygen tank services, and home health visits). Serving at-risk individuals poses a challenge to the health care and emergency response systems during and after a disaster. Some at-risk individuals may decide to shelter in place due to limited mobility or access to transportation, potentially putting their lives at risk. Requests for access to power for medical devices or care for issues related to an electrical outage may strain health department, health care facility, and human service organization resources.

Table 1. HHS emPOWER Community Tools

| Tool | Description | Use |
|--|--|--|
| HHS emPOWER Map and REST Service Components in Cycle: Preparedness, Response, Recovery, Mitigation | A public, interactive map that displays the total number of at-risk electricity-dependent Medicare beneficiaries in a geographic area, down to the zip code. The emPOWER Map displays three types of data: (1) Medicare claims data; (2) Severe weather and natural hazards; and (3) Geographic information system basemaps. A Representational State Transfer | Acquiring population-level situational awareness; conducting emergency planning activities; developing emergency response systems, processes, and triggers; planning |

| | | |
|---|---|--|
| <p>Access: Public</p> | <p>Service, provided via ASPR's GeoHEALTH platform, allows users to consume the same map data layer in their own geographic information system. The Medicare claims data are updated on a monthly basis. The weather and natural hazard data from National Oceanic and Atmospheric Administration/United States Geological Survey is updated in real or near-real time (usually hourly or daily).</p> | <p>for life-saving outreach.</p> |
| <p>HHS emPOWER Emergency Planning De-Identified Dataset</p> <p>Components in Cycle: Preparedness Response, Recovery, Mitigation</p> <p>Access: Public Health Authorities</p> | <p>A tool that provides the monthly total number of Medicare claims for selecting electricity-dependent medical equipment and healthcare services in a geographic area, down to the zip code. The dataset provides de-identified Medicare billing information for each type of durable medical equipment and dialysis, oxygen tank, and home healthcare service in use.</p> | <p>Acquiring population-level situational awareness; conducting emergency planning activities; developing emergency response systems, processes, and triggers; identifying planning factors; identifying resources for emergency scenarios; and planning for life-saving outreach; cannot be used to identify individuals.</p> |
| <p>HHS emPOWER Emergency Response Outreach Individual Dataset</p> <p>Components in Cycle: Response, Recovery</p> <p>Access: Authorized Public Health Authorities upon approved official disclosure request</p> | <p>A secure and restricted tool that can be officially requested by a public health authority to support lifesaving assistance and outreach public health activities in the event of an incident, emergency, or disaster. It contains limited individual-level beneficiary information and healthcare provider information.</p> | <p>Activating emergency plans; deploying response assets and resources; activating emergency communications networks; conducting life-saving outreach; prior to, during, and after a public health emergency.</p> |

Information adapted from the HHS emPOWER Fact Sheet available at <https://empowermap.hhs.gov/>.

The HHS emPOWER tools and data can be used by communities to:

- Ensure their preparedness efforts are inclusive, addressing the needs of all residents;

- Develop and enhance emergency systems, plans, and processes to support community-based at-risk populations;
- Support data driven decision-making regarding potential shelter and evacuation assistance needs, response asset and resource allocation, and power restoration prioritization;
- Rapidly identify, locate, and voluntarily evacuate at-risk individuals; and
- Help ensure continuity of care by reconnecting at-risk individuals with their healthcare providers.

14.4 Individuals with Disabilities

The needs of individuals with disabilities should be considered during and after emergencies with respect to accessible transportation, power-dependent equipment and assistive technology, access to medical care and supplies, communication, and emergency sheltering.



Other District agencies should be consulted with respect to these needs, including the Mayor’s Office of Disability Rights (ODR), the District’s Homeland Security and Emergency Management Agency (HSEMA), the Emergency Transportation Working Group, Sheltering and Power Outage Working Group, High Rise Evacuation Working Group, Public Communications Working Group, and Post Emergency Canvassing Operation Working Group.



Section 305 of [PAHPIA](#) authorizes a National Advisory Committee on Individuals with Disabilities in Disasters through 2023.

14.4.1 Americans with Disabilities Act

The [ADA](#) provides broad nondiscrimination protection for individuals with disabilities in public services, employment, and public accommodations and services operated by private entities. [42 U.S.C. § 12101](#) et seq. Although the ADA does not include specific provisions related to disasters and emergencies, its far-reaching nondiscrimination provisions have been extended to emergency preparedness, response, and recovery efforts. Thus, state and local governments are required to comply with Title II of the ADA in the emergency-and-disaster-related programs, services, and activities they provide. [42 U.S.C. § 12132](#). Under Title II of the ADA, emergency programs, services, activities, and facilities must be accessible to people with disabilities. [28 C.F.R. §§ 35.149-35.151](#), and may not use eligibility criteria that screen out people with disabilities. [28 C.F.R. § 35.130\(b\)\(8\)](#).

Accordingly, under Title II of the ADA, state and local governments must ensure that their communications, including emergency communications, are fully accessible to people with disabilities. This includes live and recorded announcements made by local governments including Mayors and Governors’ offices.

The ADA also requires that individuals with service animals (under the ADA) and assistance animals (under the Fair Housing Act) not be discriminated against with regard to emergency shelters. Such individuals may not be asked to remove the animal from shelter premises unless the animal is out of control and poses a direct threat to others. A “service animal” is defined in Title II of the ADA as any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The tasks performed may vary and may include pulling a wheelchair, retrieving dropped items, alerting a person to a sound, reminding a person to take medication, or pressing an elevator button. [28 C.F.R. § 35.104](#). Other species of animals besides dogs, regardless of training, are not considered “service animals” under Title II of the ADA.

In addition to the ADA, the Fair Housing Act allows for assistance animals to be admitted with their handlers when emergency shelters are opened. Assistance animals are dogs, cats, and/or other domesticated animals that are not necessarily trained to perform work or tasks, but whose presence alleviates a disability-related symptom or need.

See [Service Animals and Assistance Animals in Housing and HUD-Funded Programs](#).



Numerous Department of Justice and other federal agency technical assistance and resources to help state and local governments ensure that their emergency preparedness, response, and management programs are accessible to individuals with disabilities are available at https://www.ada.gov/emerg_prep.html.



Several successful lawsuits have been filed by disability rights advocates regarding the failure of jurisdictions to plan for the needs of individuals with *disabilities when preparing for emergencies and disasters, thereby violating the ADA*. See, e.g., *Brooklyn Ctr. for Independence of the Disabled et al. v. Bloomberg*; *Communities Actively Living Indep. and Free et al. v. City of Los Angeles*. In May 2019, the District reached an historic, amicable settlement with the plaintiffs in *United Spinal Ass’n et al v. District of Columbia*, in which the District emphasized its recommitment to inclusive emergency response planning for individuals with disabilities and others with access and functional needs.



There is extensive case law related to liability under the ADA and other ADA-related topics; a full discussion is beyond the scope of this Manual.

14.4.2 Accessible Transportation

Accessible vehicles available throughout the District that can transport both individuals and their equipment including wheelchairs, walkers, and other equipment must be documented and tracked so that accessible transportation options are available.

14.4.3 Accessible Emergency Communications

During an emergency, it is critical that individuals who are deaf or hard of hearing receive important information that may be broadcast by traditional information channels. Therefore, the District should ensure that qualified translators and interpreters are available to provide this critical information and that pertinent information be available in various formats.

- **Auxiliary Aids and Services at Post Disaster Sites:** The District must have processes and procedures to offer auxiliary aids and other services at all post-disaster sites where services are available to the public. In addition to qualified sign language interpreters, other examples of auxiliary aids and services are: note-takers, computer-aided transcription services, written materials, assistive listening devices, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons videotext displays, or other effective methods of making aurally delivered materials available to individuals who are deaf and hard of hearing. See [ADA.gov](https://www.ada.gov/).
- **Emergency Communications:** Emergency communications should be available, to the extent possible, in alternative formats including electronic, braille, and large print formats. In the event that these formats are not available, staff working during an emergency must be able to provide information and explain information directly to an individual who needs it including directional orientation and explanation of a setting and material.
- **Alternatives:** If provision of a particular auxiliary aid or service would result in a fundamental alteration in the nature of the goods, services, facilities, privileges, advantages, or accommodations being offered or is an undue burden, *i.e.*, significant difficulty or expense, the District must provide an alternative auxiliary aid or service, if one exists, that would not result in an alteration or such burden but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the goods, services, facilities, privileges, advantages, or accommodations offered by the District. See [ADA.gov](https://www.ada.gov/).



The National Association of the Deaf has a Position Statement on Accessible Emergency Management for Deaf and Hard of Hearing People, available at <https://www.nad.org/about-us/position-statements/position-statement-on-accessible-emergency-management-for-deaf-and-hard-of-hearing-people/>.

14.4.4 Power Outage

Power-dependent medical equipment such as breathing apparatuses, power wheelchairs, communication devices, etc., must have access to power strips and available backup

generators. Priority of coolers or refrigerators should be given to individuals who have medication that must be stored in a cool environment.



HHS emPOWER, discussed in section 14.3.2 of the Manual, may be a valuable resource during power outages.

14.4.5 Emergency Sheltering

The District recognizes the importance of providing certain supplies and equipment in emergency shelters that are necessary to accommodate individuals with disabilities. Therefore, whenever a District-owned building is open to the public as an accessible emergency shelter, the District will make the best efforts to ensure that:

- The facility can provide backup power and charging stations, which shall be available for use by individuals with disabilities who require power as an accommodation;
- The facility has the capacity to store medication requiring refrigeration; and
- Shelter staff members at the facility have access to sufficient quantities of reserve supplies for basic hygiene, mobility and personal maintenance purposes, such that individuals with disabilities can maintain the well-being and independence while accessing emergency shelter services. [United Spinal, et. al., v. District of Columbia, et. al. Settlement Agreement \(May 2, 2019\)](#).
- The facility has access to temporary wall dividers and privacy screens to be used for privacy as well as to reduce sensory stimulation.

In the event that individuals with disabilities arrive at emergency shelters that are full or unable to support their needs, the District will make the best efforts to provide accessible transportation to an alternate shelter site that is the least restrictive, integrated site able to accommodate them. [United Spinal, et. al., v. District of Columbia, et. al. Settlement Agreement \(May 2, 2019\)](#).

14.5 Children

There are approximately 69 million children under the age of 18 in the U.S., comprising nearly 25% of the entire U.S. population. See <https://www.fema.gov/children-and-disasters>. Children have unique needs during and after disasters; therefore, it is essential that children are considered in emergency preparedness and planning.



There are a number of resources that address children's needs during and after disasters, including:

- [Topic Collection: Pediatric/Children](#)
- [Pediatric Disaster Preparedness and Response Topical Collection](#)

- [Welcome to Ready Kids!](#)
- [Caring for Children in a Disaster](#)

14.5.1 District of Columbia Family Assistance Center Plan

In the event of a mass fatality incident, the District will establish a Family Assistance Center (FAC) in a pre-designated location to provide emergency assistance to victims and families and to serve as a hub for information collection, sharing and human services regarding the missing or deceased in a public health emergency. This is a multi-agency operation coordinated by the D.C. Department of Human Services and supported by other District agencies, including DC Health, and volunteers. The FAC can support the collection of antemortem information from family and friends of the deceased and missing in order to reunite them, whether living or deceased. Once reunification takes place, the FAC may also coordinate and support psychological first aid and other mental health services as needed for the grieving family and friends of the deceased.

The [FAC Plan](#) serves as an appendix to the DC Health Public Health Fatality Management Plan.



See section 12.0 of the Manual for more information about mass fatality incidents.

14.5.2 National Advisory Committee on Children and Disasters

The National Advisory Council on Children and Disasters (NACCD) was established to provide advice and consultation to the HHS Secretary and ASPR on issues related to the medical and public health needs of children as they relate to disasters. [42 U.S.C. § 300hh-10a](#). To fulfill this mission, the NACCD will:

- Provide advice and consultation with respect to the activities carried out pursuant to section 2814 of the Public Health Service (PHS) Act as applicable and appropriate. [42 U.S.C. § 300hh-16](#);
- Evaluate and provide input with respect to the medical and public needs of children as they relate to preparation for, response to, and recovery from all-hazards emergencies;
- Provide advice and consultation with respect to state emergency preparedness and response activities for children, including related drills and exercises pursuant to the preparedness goals under section 2802(b) of the PHS Act. [42 U.S.C. § 300hh-1](#); and
- Provide advice and recommendations to the HHS Secretary with respect to children and the medical and public health grants and cooperative agreements as applicable to preparedness and response activities authorized under Titles III and XXVIII of the PHS Act. [42 U.S.C. § 241](#) *et seq.*



Section 305 of [PAHPIA](#) reauthorizes the National Advisory Committee on Children and Disasters through 2023. Section 304 codifies and continues the work of the Children's Preparedness Unit at CDC to ensure the needs of children are taken into consideration when preparing for and responding to public health emergencies.

14.5.3 Family Reunification

There is a strong likelihood that children will be away from their families and caregivers at the time of an emergency or disaster event, as every weekday in the U.S., roughly 67 million children spend time either in school or a child care facility. In addition, children who were initially with their family or caregiver may become separated during a disaster event. It is critical to reunite these vulnerable children with their families as quickly as possible to avoid additional trauma and/or possible abuse. Family reunification is the process of ensuring that children return to the care of their parent(s) and family as quickly as possible after an emergency. Family reunification may prove challenging in the immediate aftermath of a disaster. Thus, hospitals and other healthcare facilities, as well as schools, day care centers, and similar institutions, should plan for family reunification. See <https://www.cdc.gov/childrenindisasters/reunification.html>.



During Hurricanes Katrina and Rita, more than 5000 children were separated from their families, with some ending up in different states. In the aftermath of these devastating hurricanes, numerous changes were made to improve family reunification, including the passage of the Post-Katrina Emergency Management Reform Act of 2006 (PKEMRA). [Public Law No. 109-295](#). Among other things, PKEMRA mandated the creation of the National Emergency Child Locator Center (NECLC) within the National Center for Missing and Exploited Children (NCMEC) to facilitate the identification and reunification of displaced children with their families. The Unaccompanied Minor Registry (UMR), administered by the NCMEC, was created to gather and share information, and provide technical assistance to local law enforcement and assist in the reunification of displaced children with their families.



The National Commission on Children and Disasters was established by the [Kids in Disasters Well-being, Safety, and Health Act of 2007](#) and charged with identifying gaps in the U.S.' disaster planning, preparedness, response, and recovery for children. The Commission submitted its [final report](#) to the President and Congress in October 2010. Through the Commission, various federal agencies, including Federal Emergency Management Agency (FEMA), United States Department of Health and Human Services (HHS), the United States Department of Justice (DOJ) and United States Department of Education have closely collaborated to address the disaster needs of children.

15.0 CENTERS FOR MEDICARE AND MEDICAID SERVICES EMERGENCY PREPAREDNESS RULE

15.1 Summary

In 2016, the Centers for Medicare and Medicaid Services (CMS) published a [Final Rule](#) entitled “Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers” (CMS Emergency Preparedness Rule), which established national emergency preparedness requirements for participating providers and certified suppliers (hereinafter referred to as facilities) to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. The regulation became effective on November 16, 2016, with compliance required on November 15, 2017. Thus, healthcare systems must be involved in emergency preparedness, response, and recovery activities.

The CMS Emergency Preparedness Rule applies to 17 categories of Medicare and Medicaid providers and suppliers as Conditions of Participation and Conditions for Coverage for CMS. Providers and suppliers must meet four mandated core elements: (1) risk assessment and emergency plan; (2) policies and procedures; (3) communication plan; and (4) training and testing. In addition, the CMS Emergency Preparedness Rule includes specific requirements that vary based on provider or supplier type.

15.2 National Emergency Preparedness Requirements

The Centers for Medicare and Medicaid Services (CMS) promulgated the “Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers” Final Rule ([CMS Emergency Preparedness Rule](#)), to establish national emergency preparedness requirements for facilities to plan adequately for disasters and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. These national requirements are designed to assist facilities with adequately preparing to meet the needs of patients, clients, residents, and participants during disasters and emergencies, and also provide consistent requirements across types of facilities.

The goals of the CMS Emergency Preparedness Rule are to:

- Safeguard human resources, maintain business continuity, and protect physical resources;
- Establish consistent emergency preparedness requirements across facilities; and
- Establish a more coordinated response to natural and man-made disasters.



A number of resources are available to assist facilities with complying with the CMS Emergency Preparedness Rule, including <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html> and <https://asprtracie.hhs.gov/cmsrule>.



On September 20, 2018, CMS issued a [proposed rule](#) to revise the applicable conditions of participation for facilities and conditions for coverage as part of its efforts to reduce regulatory burden in accordance with [Executive Order 13771 “Reducing Regulation and Controlling Regulatory Costs”](#) (January 30, 2017). Significant changes to the CMS Emergency Preparedness Rule were proposed, including changing the required updates and training to be every two years rather than annually. Specific changes by facility type were also proposed. The proposed changes are designed to “simplify the emergency preparedness requirements, eliminate duplicative requirements, and/or reduce the frequency with which providers and suppliers would need to perform certain required activities.”

15.3 Applicable Facilities

The CMS Emergency Preparedness Rule applies to [17 categories](#) of Medicare and Medicaid facilities. Eight are inpatient facilities:

- Hospitals
- Critical access hospitals
- Religious nonmedical healthcare institutions
- Psychiatric residential treatment facilities
- Long-term care facilities
- Intermediate care facilities for individuals with intellectual disabilities
- Hospices
- Transplant centers

Ten facilities are outpatient facilities:

- Ambulatory surgical centers
- Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- End-stage renal disease facilities
- Rural health clinics and federally qualified health centers
- Home health agencies
- Hospices (hospices are also considered inpatient facilities so are listed twice)
- Organ procurement organizations

- Programs of all-inclusive care for the elderly

Table 2. Affected Provider and Supplier Types (updated January 24, 2018)

| Inpatient | | Outpatient | |
|---|----------------------|---|----------------------|
| Facility Type | Final Rule Reference | Facility Type | Final Rule Reference |
| Critical Access Hospitals | Section II. N | Ambulatory Surgical Centers | Section II. E |
| Hospices | Section II. F | Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services | Section II. O |
| Hospitals | Section II. C | Community Mental Health Centers | Section II. P |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities | Section II. D | Comprehensive Outpatient Rehabilitation Facilities | Section II. M |
| Long Term Care | Section II. J | End-Stage Renal Disease Facilities | Section II. S |
| Psychiatric Residential Treatment Facilities | Section II. G | Home Health Agencies | Section II. L |
| Religious Nonmedical Healthcare Institutions | Section II. D | Hospices | Section II. F |
| Transplant Centers | Section II. I | Organ Procurement Organizations | Section II. Q |
| | | Programs of All Inclusive Care for the Elderly | Section II. H |
| | | Rural Health Clinics and Federally Qualified Health Centers | Section II. R |

Table reproduced from [CMS and Disasters: Resources at Your Fingertips \(hhs.gov\)](#)

Each facility has its own set of emergency preparedness regulations incorporated into its Conditions of Participation (CoP) and Conditions for Coverage (CfC).



CMS develops CoPs and CfCs that healthcare organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of Medicare and Medicaid beneficiaries. More information about CoPs and CfCs can be found at <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html?redirect=/CFCsAndCoPs>.

15.4 Four Mandated Elements

The CMS Emergency Preparedness Rule includes [four mandated core elements](#), with specific requirements that vary based on type of facility:

- Risk assessment and emergency planning;
- Policies and procedures;
- Communications plan; and
- Training and testing.



Specific requirements for each type of facility are beyond the scope of the Manual. CMS created a table that provides an overview of the CMS Emergency Preparedness Rule by provider type, which can be found at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/EP-Rule-Table-Provider-Type.pdf>.

15.4.1 Risk Assessment and Emergency Plan

Each facility must develop an emergency plan based upon a facility and community-based risk assessment using an “all-hazards” approach that provides an integrated system for emergency planning focused on capacities and capabilities. The emergency plan should be reviewed and updated at least annually. The risk assessment should include:

- Hazards likely in geographic area;
- Care-related emergencies;
- Equipment and power failures;
- Interruption in communications, including cyber-attacks;
- Loss of all or a portion of facility; and
- Loss of all or a portion of supplies.

See, e.g., [CMS Core Emergency Preparedness Rule Elements](#).

15.4.2 Policies and Procedures

Each facility must develop and implement policies and procedures based upon the emergency plan and risk assessment that are reviewed and updated at least annually. Policies and procedures must comply with federal and state laws and address a range of issues, which may include subsistence needs, evacuation plans, sheltering in place, and tracking patients and staff during an emergency.

See, e.g., [CMS Core Emergency Preparedness Rule Elements](#).

15.4.3 Communication Plan

Each facility must develop and maintain an emergency preparedness communication plan that complies with federal, state, and local laws and provides a system to contact staff,

including patients' physicians and other necessary persons. Patient care must be coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management systems to protect patient health and safety in the event of a disaster. The communication plan should be reviewed and updated annually.

See, e.g., [CMS Core Emergency Preparedness Rule Elements](#).

15.4.4 Training and Testing

Each facility must develop and maintain training and testing programs, including initial training in policies and procedures, which comply with federal, state, and local laws. Facility staff must demonstrate knowledge of emergency procedures and be provided with training at least annually. Facilities must conduct drills and exercises to test the emergency plan or participate in an actual incident that tests the plan. The training and testing program should be reviewed and updated annually. See, e.g., [CMS Core Emergency Preparedness Rule Elements](#).

15.5 Enforcement and Penalties for Non-Compliance

State survey agencies are responsible for evaluating compliance with the CMS Emergency Preparedness Rule. If a facility is found to be non-compliant with these requirements, state survey agencies will follow the same process regarding noncompliance as with any other CoP and CfC. Non-compliance with CMS Emergency Preparedness Rule requirements may lead to termination of the facility's participation agreement with CMS. See <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf>. These surveys are initiated in conjunction with regularly scheduled survey cycles.

15.6 Section 1135 Waivers and the CMS Emergency Preparedness Rule

Under [section 1135](#) of the Social Security Act (SSA), the United States Secretary of Health and Human Services (HHS Secretary) may temporarily waive or modify certain federal requirements to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in SSA programs in the emergency area and during the emergency time (absent any determination of fraud or abuse).

Under the CMS Emergency Preparedness Rule, inpatient facilities are required to have policies and procedures in place to address the facility's role in a section 1135 waiver in the provision of care and treatment at an alternate care site identified by emergency management officials. See, e.g., [42 C.F.R. § 482.15\(b\)\(8\)](#).



Additional information regarding section 1135 waivers, including required elements, can be found at section 4.3 of the Manual and <https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx>.

16.0 EMERGING AND RE-EMERGING INFECTIOUS DISEASES

16.1 Summary

Infectious diseases have posed threats to communities for centuries, including the appearance of new infectious disease threats. Diseases that were once major threats, but had declined in prevalence, are re-emerging as significant concerns. Despite advances in technology to prevent, detect, and treat infectious diseases, the ease of global travel and interconnectedness across continents adds new dimensions to disease control. Coronavirus Disease 2019 (COVID-19), Ebola Virus Disease (EVD), and measles are three examples of infectious diseases of concern in the modern era, although other diseases such as chikungunya, pertussis, avian influenza, and polio are also concerning. Disease reporting and surveillance are vitally important to prevent outbreaks of emerging and re-emerging disease.

16.2 Definitions

16.2.1 Emerging Infectious Diseases

Emerging infectious diseases are diseases that have not occurred in humans before, have occurred previously but affected only small numbers of people in isolated places, or have occurred throughout human history but have only recently been recognized as distinct diseases due to an infectious agent. See [National Institutes of Health Understanding Emerging and Re-emerging Infectious Diseases](#). Examples of emerging diseases include Coronavirus Disease 2019 (COVID-19), Ebola Virus Disease (EVD), avian influenza, chikungunya, Zika, severe acute respiratory syndrome (SARS), and Middle East respiratory syndrome (MERS).



Disease reporting, surveillance, and contact tracing are key components to preventing, detecting, and treating emerging and re-emerging diseases. It may be necessary to detain individuals to prevent the spread of disease or declare public health emergencies, and mass fatalities may occur. See sections 4.0, 7.0, 8.0, 12.0, and 17.0 of the Manual for more information about these critical topics.



There are certain restrictions related to travel within, and entry into, the U.S. with respect to particular diseases. See sections 17.5, 17.6, and 17.7 of the Manual for more information.

16.2.2 Re-emerging Infectious Diseases

Re-emerging infectious diseases are diseases that once were major health problems globally or in a particular country, but then declined dramatically, and are again becoming health problems for a significant proportion of the population. See [National Institutes of Health Understanding Emerging and Re-emerging Infectious Diseases](#). Examples of re-emerging diseases include measles and tuberculosis.



Due to the complex and dynamic nature of many infectious diseases, the distinction between “emerging” and “re-emerging” can be difficult to determine, which can lead to different classifications by infectious disease experts. See [Emerging Infectious Diseases: Threats to Human Health and Global Stability](#).

16.3 Factors Influencing Emergence and Re-emergence

The World Health Organization (WHO) warned in a [2007 report](#) that infectious diseases are emerging at an unprecedented rate. Since the 1970s, approximately 40 infectious diseases have been discovered, including COVID-19, SARS, MERS, EVD, avian and swine influenza, and Zika. As the world becomes more interconnected through globalization and increased travel over longer distances, the potential for novel diseases to emerge or old diseases to re-emerge increases dramatically. In addition, increased population density exacerbates this concern.

Many factors are associated with the emergence of new infectious diseases or the re-emergence of an old one. Such factors include:

- The evolution of pathogens over time;
- Change in human migration;
- Population growth and expansion into new geographic areas;
- Climate change;
- Wars and conflict;
- Antimicrobial resistance;
- Decline in vaccination coverage;
- Destruction of the environment;
- Increased contact with wild animals;
- Increased travel;
- Weak health systems;
- Delayed emergency response; and
- Inadequate public health infrastructure.

See [Baylor College of Medicine Emerging infectious Diseases](#).



As the nation’s capital, the District is a hub of international travel and often hosts international summits, conferences, and meetings; thus, emerging and re-emerging diseases are of particular concern to the District.

16.4 Coronavirus Disease 2019

As the new decade began, a novel coronavirus spread around the globe, originating in Wuhan, China. Extraordinary public health measures were employed by governments across the world, including stay-at-home orders and closure of schools and non-essential businesses; still, by May 8, 2020, nearly 4 million cases were reported by global authorities, with approximately 276,000 deaths worldwide. As of September 2023, there were more than 760,000,000 confirmed cases, including 6,000,000 Coronavirus-related deaths worldwide. The COVID-19 pandemic offers a prime illustration of the importance of all facets of preparedness.

16.4.1 Transmission

Coronaviruses are a large family of viruses, some causing illness in people and others circulating among animals, including camels, cats, and bats. Rarely, animal coronaviruses can spread to people. SARS-CoV-2, the virus that causes COVID-19, is the seventh coronavirus known to infect humans. Three (SARS-CoV, MERS-CoV and SARS-CoV-2) can cause severe respiratory illness and be fatal; the other four produce mild, cold-like symptoms. SARS-CoV-2 likely originated in an animal and spread to humans, with bats currently thought to be the most likely reservoir host of the progenitor virus. See [The proximal origin of SARS-CoV-2](#).

COVID-19 is spread person to person, between people who are in close contact with one another (within about 6 feet). It is transmitted through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the primary mode of transmission, as coronaviruses on surfaces and objects naturally die within hours to days. Warmer temperatures and exposure to sunlight may reduce the time the virus survives on surfaces and objects. Emerging science suggests that aerosolized virus may also be transmissible, although this route of infection requires further study. See [Aerodynamic analysis of SARS-CoV-2 in two Wuhan hospitals](#); [Reopening Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes](#).

COVID-19 spreads easily and sustainably in the community in affected areas. Community spread means people have been infected with the virus in a geographic area, including some who are not sure how or where they became infected. COVID-19 spreads more easily than influenza but is less contagious than measles. See [Centers for Disease Control and Prevention How COVID-19 Spreads](#).

16.4.2 Symptoms

The incubation period of COVID-19 is 2-14 days, with the median time of 4-5 days from exposure to onset of symptoms. Individuals with COVID-19 report a wide range of symptoms. The most prevalent symptoms are cough and shortness of breath or difficulty breathing. People also report a combination of the following: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, and loss of taste or smell. Other less common symptoms that have been reported include gastrointestinal symptoms like

nausea, vomiting, or diarrhea. Reported illnesses have ranged from people with no or mild symptoms to people being severely ill with pneumonia and other complications. People are thought to be most contagious when they are most symptomatic (*i.e.*, the sickest), although there have been reports of transmission before an infected person has symptoms and by infected individuals with no symptoms. See [Centers for Disease Control and Prevention Symptoms of Coronavirus; Centers for Disease Control and Prevention Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease.](#)

16.4.3 Testing and Contact Tracing

The FDA has issued several testing options for the population to make an informed decision on their needs related to SARS-CoV-2, first through the emergency use authorization (EUA) process and then with full FDA approval. There are two types of tests: molecular and antibody. The molecular tests, such as polymerase chain reaction (PCR), are nucleic acid amplification tests that detect the genetic material of the virus. Molecular tests analyze the virus in respiratory samples typically collected from the nose or throat with a special swab. They determine whether an individual is currently infected and can be used to directly diagnose COVID-19.

Antibody tests are serology tests to detect the body's immune response to the infection; they do not detect the actual virus but rather antibodies in the blood with which the body is fighting the infection. However, antibodies may not be detected in the early days of an infection, causing the test to be a false negative. Antibody tests can also give a false positive if a person has antibodies from a previous infection by a different coronavirus. Therefore, antibody tests cannot be used in isolation to diagnose COVID-19. See [United States Food and Drug Administration Medical Devices Including Tests for COVID-19; Centers for Disease Control and Prevention Testing for COVID-19.](#)

The FDA has also authorized at-home OTC (over-the-counter) COVID-19 diagnostic tests self-testing at home or in other locations. The kit requires one to collect their own sample, perform the test, and read the result themselves without the need to send a sample to a laboratory. Most authorized at-home OTC COVID-19 tests are antigen tests, and there are also a few of authorized at-home OTC COVID-19 molecular tests. It is recommended that after using a COVID-19 antigen diagnostic test, one should repeat testing following a negative result, whether one have symptoms or not, to reduce one's risk of a false negative test result. See [At-Home OTC COVID-19 Diagnostic Tests.](#)

Contact tracing is a core disease control measure utilized by health departments in any outbreak investigation. After defining a "case" based on what is known about the disease, infected individuals are interviewed to determine all individuals with whom they had contact during the period in which they were likely to have been infectious. Public health officials then educate all potentially exposed persons about their risk of infection (without revealing the personal information of the initially infected person), what they should do to separate themselves from others who are not exposed, how to monitor themselves for illness, and the possibility that they could spread the infection to others even if they themselves do not feel ill. Contact tracing was significantly expanded during the COVID-

19 pandemic and continues to be critical to containing COVID-19 and other infectious diseases in the District.

16.4.4 Treatment and Vaccines

There are a number of FDA-approved drugs now available to treat COVID-19. There are treatments for those who have been hospitalized by COVID-19 and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO); other treatments are available for those who have mild-to-moderate COVID-19 and are at high risk for progression to severe COVID 19, including hospitalization or death. See [Coronavirus \(COVID-19\) | Drugs](#).

As of September 2023, there are 3 vaccines that have been approved by the FDA: Pfizer-BioNTech and Moderna COVID-19 vaccines, which are mRNA vaccines, and the Novavax COVID-19 vaccine, which is a protein subunit vaccine. J&J/Janssen COVID-19 vaccine, a viral vector vaccine, was originally offered during the pandemic, but has now expired and is no longer available for use in the United States. People who are up to date on their vaccines have lower risk of severe illness, hospitalization and death from COVID-19 than people who are unvaccinated or who have not completed the doses recommended for them by CDC. See [Overview of COVID-19 Vaccines](#).



COVID-19 vaccine mandates were issued at various levels of government and were challenged in court. The U.S. Supreme Court issued rulings on the issue of federal vaccine mandate authority. In [National Federation of Independent Business v. Department of Labor, Occupational Safety and Health Administration](#), the court stayed the enforcement of a rule issued by the Occupational Safety and Health Administration (OSHA) that imposed a vaccine or test mandate for employees in companies with more than 100 workers. In [Biden v. Missouri](#), the Supreme Court allowed the Department of Health and Human Services (DHSS) to require the COVID-19 vaccine for all staff in healthcare facilities that participate in Medicare and Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) withdrew the COVID-19 health care staff vaccination requirement June 2023. See [Policy and Regulatory Changes to the Omnibus COVID-19 Health Care Staff Vaccination Requirements](#).



State and local vaccine mandates, a longstanding exercise of public health authority, face an uncertain legal future after recent Supreme Court opinions. See, e.g., [Tandon v. Newsom](#) and [Roman Catholic Diocese of Brooklyn v. Andrew Cuomo](#). See also [Vaccine Mandates—A Old Public Health Tool Faces New Challenges](#).



All 50 states and the District allow medical exemptions for school vaccine mandates; nearly all allow religious exemptions. See [State Vaccination Requirements](#) and [States with Religious and Philosophical Exemptions from School Immunization Requirements](#).

Among the 50 states and the District of Columbia, the District was the only one to enforce a school COVID-19 vaccine mandate. See [States Address School Vaccine Mandates](#). However, [D.C. Official Code §38-502.01](#) was repealed by emergency legislation that will expire on October 29, 2023.



On September 11, 2023, the FDA announced the approval and authorization for emergency use for new COVID-19 vaccine booster shots that were formulated to more closely target currently circulating variants and to provide better protection against serious consequences of COVID-19, including hospitalization and death. See [FDA Takes Action on Update mRNA COVID-19 Vaccines to Better Protect Against Currently Circulating Variants](#).

16.4.5 Prevention

The best way to prevent becoming infected with COVID-19 is to avoid being exposed to the virus. CDC recommends actions individuals should take to protect themselves and others. Self-protection includes activities such as regular handwashing, use of hand sanitizer containing at least 60 percent alcohol, avoiding touching one's eyes, nose, or mouth with unwashed hands, and avoiding close contact with others (*i.e.*, social distancing). Actions that individuals can take to protect others include staying home when sick (except to seek medical care), covering coughs and sneezes, mask usage when around others, especially in public spaces, and regular cleaning and disinfection of surfaces. See [Centers for Disease Control and Prevention Prevent Getting Sick](#).

16.4.6 2019-2023 COVID-19 Outbreak: Global Response

On December 31, 2019, the World Health Organization (WHO) was informed of a pneumonia of unknown cause, detected in the city of Wuhan in Hubei province, China, appearing to originate from the Huanan Seafood Market. On January 7, 2020, Chinese authorities identified the causative agent to be a novel coronavirus, one not previously identified as causing disease in humans, which was named SARS-CoV-2. China recorded its first death from SARS-CoV-2 on January 11, 2020. The first case outside of China was confirmed on January 13, 2020, in Thailand. WHO declared a Public Health Emergency of International Concern (PHEIC) on January 30, 2020.

One million COVID-19 cases were reported around the world by April 2, 2020; the global death toll surpassed 100,000 on April 10, 2020. By April 15, 2020, the global number of COVID-19 cases surpassed two million. On April 22, 2020, the U.S. reported the highest single-day death toll for any country, more than 2,600.

On January 22, 2021, COVAX, the global initiative to ensure rapid and equitable access to COVID-19 vaccines for all countries, announced the signing of an advance purchase agreement for up to 40 million doses of the Pfizer-BioNTech vaccine.

In 2022, the WHO continued its efforts to combat COVID-19 and [declared that the end of the pandemic was in sight](#). As of September 13, 2023, there were 770,563,467 confirmed COVID-19 cases reported to WHO. As of September 5, 2023, 13,500,135,157 vaccine doses have been administered. See [WHO Coronavirus \(COVID-19\) Dashboard](#).

See [World Health Organization Coronavirus disease \(COVID-19\) Pandemic](#); [Centers for Disease Control and Prevention Coronavirus \(COVID-19\)](#); [Johns Hopkins University & Medicine Coronavirus Resource Center](#); [New York Times: End of Federal COVID-19 Public Health Emergency \(PHE\) Declaration](#).



[Timeline: WHO's COVID-19 Response](#) provides a detailed look at WHO's COVID-19 response

16.4.7 2020-2023 COVID-19 Outbreak: Federal Response

On January 31, 2020, United States Secretary of Health and Human Services (HHS Secretary) Azar declared that a [public health emergency](#) under section 319 of the [Public Health Service Act](#) existed nationwide since January 27, 2020 due to COVID-19. The declaration of public health emergency was [renewed](#) 11 times by May 9, 2023.

President Trump declared dual emergencies, effective March 1, 2020, on March 13, 2020 under the [National Emergencies Act](#) (NEA) and section 501(b) [the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988](#) (Stafford Act), which allows the federal government to declare an emergency without a governor's request. See [Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease \(COVID-19\) Outbreak](#).

All 50 states, the District of Columbia, and four territories were approved for major disaster declarations to assist with additional needs identified under the nationwide emergency declaration for COVID-19. See [Federal Emergency Management Agency COVID-19 Disaster Declarations](#).

On March 10, 2020, HHS Secretary Azar issued a [declaration](#) under the [Public Readiness and Emergency Preparedness Act](#) (PREP Act) to provide liability immunity for activities related to medical countermeasures against COVID-19. This declaration was [amended 11 times](#), most recently on May 9, 2023.

On January 6, 2021, HHS and CDC announced plans to provide \$22 billion in funding for states, localities, and territories to support expanded COVID-19 testing and vaccine distribution. The Biden Administration reversed the Trump Administration's attempt to withdraw from WHO and joined the COVID-19 Vaccine Global Access Facility "COVAX", a program aimed at vaccinating people in low- and middle-income countries against COVID-19. By late 2021, with the Delta and Omicron variants emerging and proving to be more transmissible than the original disease, the CDC and FDA expand COVID-19 booster recommendations to include everyone 16 years and older.

May 11, 2023 marked the end of the federal COVID-19 PHE declaration. Over 6,300,000 hospitalizations due to COVID-19, including 1,140,278 deaths, have been reported to the CDC as of September 2023.



See section 4.2 for more information about federal declarations and section 5.8 for more information about the PREP Act.



See section 4.3 for more information about section 1135 waivers and [Section 1135 Waivers and COVID-19: An Overview](#) for more information regarding section 1135 waivers during the COVID-19 pandemic.



See section 5.7 for more information about Emergency Use Authorizations (EUAs) and [Coronavirus \(COVID-19\) EUA Information](#) for more information about EUAs during the COVID-19 pandemic.



See [Medicaid Emergency Authority Tracker: Approved State Actions to address COVID-19](#) for more information regarding approved Medicaid emergency authorities to address the COVID-19 pandemic.

Congress passed several significant pieces of legislation in response to the COVID-19 pandemic. Key bills are summarized below.

Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

[The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#), which passed with near unanimous support in both the House and Senate, was signed on March 6, 2020. The bill provided \$8.3 billion in emergency funding for federal agencies to respond to the coronavirus outbreak, both domestically and globally.



See [The U.S. Response to Coronavirus: Summary of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#) for more information.

Families First Coronavirus Response Act

[The Families First Coronavirus Response Act](#) (FFCRA) was signed on March 18, 2020. This Act addressed the domestic outbreak, including paid sick leave, insurance coverage of coronavirus testing, nutrition assistance, and unemployment benefits.



See [The Families First Coronavirus Response Act: Summary of Key Provisions](#) for a summary of key provisions of the FFCRA.

Coronavirus Aid, Relief, and Economic Security Act

The [Coronavirus Aid, Relief, and Economic Security Act \(CARES Act\)](#), which was signed on March 27, 2020, provided \$2.2 trillion in economic stimulus funds relief to individuals and businesses suffering losses from the COVID-19 pandemic.



See [The Coronavirus Aid, Relief, and Economic Security Act: Summary of Key Health Provisions](#) for a summary of key health provisions of the CARES Act.

The CARES Act created a new category of covered countermeasures eligible for liability immunity under the PREP Act: respiratory protective devices approved by the National Institute for Occupational Safety and Health (NIOSH) that the HHS Secretary determines to be a priority for use during a declared public health emergency. See section 5.8 of the Manual for more information about the PREP Act.

Paycheck Protection Program and Health Care Enhancement Act

[The Paycheck Protection Program and Health Care Enhancement Act](#) was signed on April 24, 2020. This Act provided \$484 billion in additional funding to replenish and supplement key programs under the CARES Act, including the Paycheck Protection Program (PPP), small business disaster loans and grants, hospitals and healthcare providers, and testing.



See [The Paycheck Protection Program and Health Care Enhancement Act: Summary of Key Health Provisions](#) for a summary of key health provisions of this act



Fraud relating to the coronavirus played a major role during the pandemic where scammers would persuade people seeking resources online to provide their personal information and take part in COVID-19 vaccine fraud schemes. These exploitations of the coronavirus created numerous civil and criminal lawsuits that are still ongoing today. See [Coronavirus Response](#) for more information on the response to these fraud schemes.

16.4.8 Closure of Services

The closure of businesses and organizations, including houses of worship and sporting venues, in the beginning of the pandemic raised many concerns.

Each state imposed social distancing orders differently and as a result, approached religious rights during a public health emergency differently. Many cases challenging the closure of houses of worship or limiting attendance at such locations cite the Free Exercise Clause included in the First Amendment. See [Free Exercise Clause](#).

The District of Columbia attempted to set a limit on attendance at houses of worship in December of 2020, but the ruling was ultimately struck down in March of 2021 through [Roman Catholic Archbishop of Washington v. Muriel Bowser](#).

Social distancing orders and the closure of non-essential businesses and organizations, which includes sporting venues, varied by state as well concerning length of closure and strictness as well. Mayor Bowser of Washington D.C. ordered the closure of non-essential businesses March of 2020, including businesses like theaters, auditoriums, and other places of large gatherings. Specific categories of businesses and organizations were allowed to resume operation, some with a limited capacity, on May 21, 2021, but large entertainment venues were allowed to resume full operation at a later date of June 11, 2021. See [Mayor Bowser Orders Closure of Non-Essential Businesses](#) and [Modified Measures for Spring/Summer 2021 of Washington](#).



See [Judicial Review of Public Health Powers Since the Start of the COVID-19 Pandemic](#) and [Banning Religious Assemblies to Stop the Spread of COVID-19](#) for more information about litigation related to closures.

16.4.9 Equity Concerns Raised by the COVID-19 Pandemic

The COVID-19 pandemic shined a spotlight on existing health inequities in the United States. African Americans, Latinx, and tribal communities were disproportionately impacted by both the disease and its accompanying economic devastation. Individuals experiencing homelessness had no home in which to shelter or access to sanitation facilities to wash their hands. Older adults and individuals with disabilities became concerned that policies regarding the allocation of scarce resources (e.g., ventilators and intensive care unit beds) would result in scoring systems that would put them at lower priority to receive such resources. Individuals from Asia and Asian Americans experienced increased racism and stigmatization for being responsible for the “Chinese virus.” See [COVID-19 Disparities](#).

The environments of nursing homes, residential facilities, and correctional facilities led to significant outbreaks of COVID-19, putting older adults, individuals with disabilities, and incarcerated persons, at risk. Families who relied on schools to provide their children with food were faced with sudden food insecurity, as were those who relied on federal nutrition assistance programs. Households lacking technology created a digital divide limiting information, education, and other resources that could've been beneficial during isolation.



For more information about equity issues and the COVID-19 pandemic, see the following:

[State Policies May Send People with Disabilities to the Back of the Line for Ventilators](#)

[Ten Equity Implications of the Coronavirus COVID-19 Outbreak in the United States](#)

[American Medical Association COVID-19 health equity resources](#)

[Centers for Disease Control and Prevention Interim Guidance for Homeless Service Providers to Plan and Respond to Coronavirus Disease 2019\(COVID-19\)](#)

[COVID-19 and Health Equity Resources](#)

[HHS-OIG's Oversight of COVID-19 Response and Recovery](#)

[DC Health Equity Summit 2021 Summary](#)



See section 14.0 of the Manual for more information regarding at-risk populations.

16.5 Ebola

The Ebola virus causes an acute, serious illness that is often fatal if left untreated. EVD was first discovered in 1976 in two consecutive outbreaks in different parts of Central Africa. The first one occurred near the Ebola River in what is now the Democratic Republic of the Congo (DRC), giving the virus its name. See [Centers for Disease Control and Prevention Ebola \(Ebola Virus Disease\) History of Ebola Virus Disease](#). Since that time, periodic outbreaks have occurred in several African countries. The 2014-2016 outbreak in West Africa was the largest and most complex outbreak, with more cases and deaths in this outbreak than all others combined spread across several countries. See [World Health Organization Ebola Virus Disease](#). In 2018, the DRC declared its ninth and tenth outbreaks of EVD, the latter of which is still ongoing. See [European Medicines Agency Ebola](#). This is considered to be the second largest Ebola outbreak.



DC Health has an Ebola information page: <https://dchealth.dc.gov/page/ebola-information>.

16.5.1 Transmission

The natural wildlife host of Ebola virus has not been definitely identified but African fruit bats may be the reservoir. The virus is introduced into the human population through close contact with the blood, secretions, organs, or other bodily fluids of infected animals like chimpanzees, monkeys, gorillas, and fruit bats. EVD is then spread from human to human

via direct contact with the blood, secretions, organs, or other bodily fluids of infected individuals, and with surfaces and materials contaminated with these fluids like bedding or clothing.

Healthcare workers who have close contact with patients with suspected or confirmed EVD have frequently become infected when infection control precautions are inadequate and PPE is not available. EVD may also be transmitted through traditional burial ceremonies that involve direct contact with the deceased individual. Pregnant women infected with EVD may transmit the virus via breastmilk or pregnancy-related fluids and tissue. EVD transmission may occur from semen from a man who recovered from EVD, but has not been shown to be transmitted through vaginal fluids from a woman.

See [Overview, Control Strategies, and Lessons Learned in the Centers for Disease Control and Prevention \(CDC\) Response to the 2014-2016 Ebola Epidemic](#).

16.5.2 Symptoms

The incubation period of EVD is 2-21 days; symptoms usually appear within 8-10 days after exposure. First symptoms include the sudden onset of fever, fatigue, muscle pain, headache, and sore throat; these symptoms are similar to other infectious diseases such as malaria and Lassa fever, making diagnosis difficult. Initial symptoms are followed by vomiting, diarrhea, rash, and in some cases, both internal and external bleeding. In severe cases, multi-organ dysfunction such as kidney and liver failure can develop. An infected person becomes contagious once symptoms appear.

See [Overview, Control Strategies, and Lessons Learned in the CDC Response to the 2014-2016 Ebola Epidemic](#).

16.5.3 Treatment and Vaccines

Currently, there are no anti-viral drugs approved by the FDA. Two of the four investigational treatments utilized in the 2018 DRC outbreak that demonstrated higher survival rates, regenerin (REGN-EB3) and mAb114, are currently being used to treat confirmed cases of EVD. See [Centers for Disease Control and Prevention Ebola \(Ebola Virus Disease\)](#). Symptomatic treatment, early supportive care with intravenous hydration and supplemental oxygen, and treatment of co-infections improve the likelihood of survival.

On November 11, 2019, a vaccine, [Ervebo](#) (Ebola Zaire Vaccine [rVSV Δ G-ZEBOV-GP, live]) was granted EU-wide conditional marketing authorization, following a recommendation by the European Medicines Agency (EMA). See [European Medicines Agency Ebola](#). On November 19, 2019, WHO prequalified Ervebo, fast-tracking its licensing, access, and rollout in countries at highest risk. See [WHO prequalifies Ebola vaccine, paving the way for its use in high-risk countries](#). On December 19, 2019, Ervebo became the first FDA-approved vaccine for the prevention of EVD. Prior to licensure, it was used during the 2018 outbreak in the DRC as an investigational vaccine under the FDA's [Expanded Access Program](#) to protect persons at highest risk of the Ebola outbreak under a "ring vaccination" strategy that continues today. This strategy tracks the epidemic,

recruiting individuals at increased risk of infection due to their connection to a patient confirmed with EVD. See [World Health Organization Uganda's groundwork in preparedness bodes well for stopping Ebola's spread within its borders](#).

16.5.4 2014-2016 Ebola Virus Disease Outbreak: West Africa

The first reported cases in the 2014-2016 Ebola outbreak in West Africa were reported to WHO on March 23, 2014 in the forested rural region of southeastern Guinea bordering Liberia and Sierra Leone. The lack of public health infrastructure, including the absence of adequate surveillance capabilities, impeded a rapid and effective response in the affected countries. The outbreak spread to urban areas and exploded into an epidemic, overwhelming the isolation, laboratory testing, and treatment capacities of the three countries. The epidemic was further exacerbated by poor infection control in healthcare facilities as well as the high mobility and intermixing of populations. By late summer 2014, EVD had reached the densely populated capitals of all three countries. On August 8, 2014, WHO [declared](#) the situation a PHEIC.

CDC Emergency Operations Center (EOC) was activated from July 9, 2014 until March 31, 2016. CDC's response was the agency's largest emergency response in its history. Approximately 4,000 CDC staff directly participated in the response, with 1,897 deployed in Guinea, Sierra Leone, Liberia, and other African countries affected to provide surveillance, contact tracing, data management, laboratory testing, and health education.

Airport screenings were required for travelers leaving West Africa to prevent the spread of EVD to other countries. CDC trained over 24,000 healthcare workers in West Africa on infection prevention and control. By the end of 2015, laboratory capacity was expanded in Guinea, Sierra Leone, and Liberia, to 24 laboratories able to test for EVD. See [Overview, Control Strategies, and Lessons Learned in the CDC Response to the 2014-2016 Ebola Epidemic](#).

WHO lifted the PHEIC status for the West Africa Ebola crisis on March 29, 2016. During the outbreak 28,616 cases of EVD and 11,310 deaths were reported in Guinea, Sierra Leone, and Liberia. See [2014-2016 Ebola Outbreak in West Africa](#).

16.5.5 2014-2016 Ebola Virus Disease Outbreak: United States

During the 2014-2016 Ebola outbreak, 11 individuals were treated for EVD in the U.S. On September 30, 2014, CDC confirmed the first travel-associated case of EVD diagnosed in the U.S. in a patient who traveled from West Africa to Dallas, Texas. The patient died on October 8, 2014. Two nurses who provided care for the patient became infected with EVD, were hospitalized, and recovered. A fourth case was confirmed in a healthcare worker who volunteered in Guinea and returned to NYC in October 2014; the individual was hospitalized there and recovered. An additional seven individuals with EVD symptoms were transported by charter aircraft from West Africa for treatment at U.S. hospitals; six of these patients recovered. See, e.g., [2014-2016 Ebola Outbreak in West Africa](#).



After her return to the U.S. after caring for EVD patients in West Africa, nurse Kaci Hickox was asked by Maine public health officials to quarantine herself in her home for the 21-day EVD incubation period, receive direct active monitoring from a public health nurse, and restrict her movements to avoid contact with others. While Hickox agreed to participate in direct active monitoring, she refused to self-quarantine or restrict her movements absent the onset of symptoms. Under Maine law, Maine public health officials are required to request court intervention to effectuate their detention order, which will be issued if the court finds by clear and convincing evidence that a public health threat exists. See [ME Rev Stat Ann tit 22, § 805](#) and [ME Rev Stat Ann tit 22, § 812](#). Maine public health officials filed such a petition. A Maine court ruled that while Hickox was required to comply with direct active monitoring and other steps, the state had not shown by clear and convincing evidence that restricting Hickox's movements was necessary to protect public health, as Hickox did not have EVD symptoms and was therefore not infectious. See [Mayhew v. Hickox, No. CV-2014-36 \(Me Dist Ct, Fort Kent, October 31, 2014\)](#).

16.5.6 2018-2019 Ebola Virus Disease Outbreak: Democratic Republic of the Congo

A new outbreak of EVD was declared by the Ministry of Health of the DRC in North Kivu Province on August 1, 2018. As of May 3, 2020, 3,462 EVD cases and 2,243 deaths were reported, with an overall case fatality ratio of 65%. See [World Health Organization Ebola virus disease – DRC](#). Four EVD cases were reported in Uganda in June 2019, three in June and one in August. All four patients had recently traveled to the DRC and died from EVD. In response, the Ugandan Health Ministry registered 108 of their contacts for follow-up. There have been no reports of non-travel related cases of EVD in Uganda. See [U.S. Food and Drug Administration First FDA-approved vaccine for the prevention of Ebola virus disease, marking a critical milestone in public health preparedness and response](#).

On July 17, 2019, WHO [declared](#) that the EVD outbreak in the DRC was a PHEIC. The declaration followed a meeting of the International Health Regulations Emergency Committee for EVD in the DRC. The Committee cited recent developments in the outbreak in making its recommendation, including the first confirmed case in Goma, a city of almost two million people on the border with Rwanda, and the gateway to the rest of DRC and the world.

16.5.7 Centers for Disease Control and Prevention Guidance for United States Hospitals

To facilitate a coordinated response to a suspected or confirmed case of EVD in the U.S., in 2014 CDC issued the [Interim Guidance for U.S. Hospital Preparedness for Patients Under Investigation \(PUIs\) or with Confirmed EVD: A Framework for a Tiered Approach](#). Under this framework, state and local health officials, in consultation with hospital officials, urgent/emergency care settings, and emergency medical services providers in each state were advised to develop a concept of operations plan that described a networked approach to the evaluation, care, and testing of PUIs and the transfer and treatment of

patients with confirmed EVD. To create a coordinated, networked approach, state and local health officials, in collaboration with hospital executives, designated acute healthcare facilities to serve in one of three roles:

- Frontline healthcare facilities;
- Ebola assessment hospitals; and
- Ebola treatment centers.

While states were not required to adopt a three-tiered approach, CDC strongly encouraged all states to identify Ebola assessment hospitals that could effectively manage PUIs until the diagnosis of EVD was confirmed or ruled out. This was especially important in states where there was not expected to be an Ebola treatment center. As of July 2012, 55 hospitals in 17 states and D.C. had established Ebola treatment centers. See [Centers for Disease Control and Prevention Overview, Control Strategies, and Lessons Learned in the CDC Response to the 2014–2016 Ebola Epidemic](#).

CDC also worked with the United State Department of Homeland Security, United State Customs and Border Control, and health departments to institute a process for screening and monitoring travelers returning from West African countries with EVD outbreaks. After being screened at one of five designated airports, these returning travelers were monitored by their state or local health department for Ebola symptoms over the 21-day incubation period. From October 2014 through December 2015, roughly 29,000 individuals were monitored. See [Centers for Disease Control and Prevention Overview, Control Strategies, and Lessons Learned in the CDC Response to the 2014–2016 Ebola Epidemic](#).



Although CDC has stopped issuing EVD guidance, current information is available at <https://www.cdc.gov/vhf/ebola/index.html>.

16.5.8 Interstate Transportation

An infectious substance is regulated as a hazardous material under the United States Department of Transportation's (U.S. DOT) [Hazardous Materials Regulations](#) (HMR). The HMR apply to any material U.S. DOT determines is capable of posing an unreasonable risk to health, safety, and property when transported in commerce. An infectious substance must conform to all applicable HMR requirements when being transported.

Solid materials contaminated with the Ebola virus are classified as Category A infectious substances according to the HMR and may only be transported in two scenarios:

- In full compliance with classification and packaging requirements of the HMR; or
- Under the terms of a special permit.



See <https://www.phmsa.dot.gov/transporting-infectious-substances/transporting-infectious-substances-overview> for U.S. DOT guidance on transporting infectious substances.



A patient died of Ebola in Texas in 2014. Six truckloads of Ebola-contaminated waste were removed from his apartment after his death. The U.S. DOT granted an emergency special permit authorizing a waste removal company to transport this Ebola-contaminated waste for autoclaving or incineration. The waste was incinerated in Texas, with the ashes to be transported out-of-state to Louisiana to be buried in a landfill. Louisiana took legal action to prevent the ashes from entering the state and was ultimately successful.

16.6 Measles

Measles is a serious, and sometimes fatal disease caused by a virus in the paramyxovirus family. It is typically transmitted through direct contact and through airborne droplets. The virus infects the respiratory tract, then spreads throughout the body. Measles is not spread by animals. Before the introduction of measles vaccine in 1963 and widespread uptake in vaccinations, major epidemics occurred approximately every 2–3 years, causing an estimated 2.6 million deaths each year. More than 140,000 people died from measles worldwide in 2018, mostly children under the age of 5 years, despite the availability of a safe and effective vaccine. See [World Health Organization Measles](#).



On March 26, 2019, the DC Health Division of Epidemiology-Disease Surveillance and Investigation (DE-DSI) issued a [health notice](#) for District of Columbia Healthcare Providers regarding guidance on measles testing and control measures. DC Health urges healthcare providers to maintain an increased index of suspicion for measles in patients with clinically compatible symptoms, and ensure that all patients are up to date on measles, mumps, rubella (MMR) vaccine, including before international travel.

16.6.1 Transmission

Measles is a highly contagious virus that lives in the nose and throat mucus of an infected person. It can spread to others through coughing and sneezing. The measles virus can live for up to two hours in an airspace where the infected person coughed or sneezed. Measles is so contagious that if one person is infected, up to 90% of the people close to that person who are not immune will also become infected. Infected people can spread measles to others four days before the rash appears and remain contagious for four days after the rash presents. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Transmission](#).

16.6.2 Symptoms

Measles symptoms include high fever, cough, runny nose, and red, watery eyes. Symptoms appear 7-14 days after exposure. Measles rash appears 3-5 days after the first symptoms appear. The rash usually begins as flat red spots that appear on the face at the hairline and spread downward to the neck, trunk, arms, legs, and feet. Small raised bumps may also appear on top of the flat red spots. The spots may become joined together as they spread from the head to the rest of the body. When the rash appears, a person's fever may spike to more than 104° Fahrenheit. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Signs and Symptoms](#).

16.6.3 Complications and Vaccines

Common complications from measles include otitis media, bronchopneumonia, laryngotracheobronchitis, and diarrhea. Even in previously healthy children, measles may cause serious illness requiring hospitalization.

- One of every 1,000 measles cases will develop acute encephalitis, which often results in permanent brain damage.
- One to three of every 1,000 children who become infected with measles will die from respiratory and neurologic complications.
- Subacute sclerosing panencephalitis is a rare but fatal degenerative disease of the central nervous system characterized by behavioral and intellectual deterioration and seizures that generally develops 7 to 10 years after measles infection.

People at high risk for severe illness and complications from measles include:

- Infants and children under 5 years old;
- Adults over 20 years old;
- Pregnant women; and
- People with compromised immune systems, such as from leukemia and HIV /Acquired Immune Deficiency Syndrome (AIDS) infection.

See [Centers for Disease Control and Prevention Measles \(Rubeola\) for Healthcare Professionals](#).

Measles can be prevented with an MMR vaccine. The vaccine protects against three diseases: measles, mumps, and rubella. MMR vaccine is given later than some other childhood vaccines because antibodies transferred from the mother to the baby may provide some protection from disease and make the MMR vaccine less effective until about 1 year of age. Two doses of MMR vaccine are 97% effective at preventing measles; one dose is approximately 93% effective. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Vaccine for Measles](#).

16.6.4 Measles History in the United States

In 1912, measles became a nationally notifiable disease in the U.S. Before the vaccine was available, nearly all children got measles by the time they were 15 years of age. The measles vaccination program started in 1963; prior to this, an estimated 3 to 4 million people got measles each year in the U.S. Approximately 500,000 cases were reported each year to CDC; of these, 400 to 500 people died, 48,000 were hospitalized, and 1,000 developed encephalitis (inflammation of the brain) from measles. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Vaccine for Measles](#).

In 1978, CDC sought to eliminate measles in the U.S. by 1982. Although this goal was not met, by 1981, the number of reported measles cases was 80% fewer than the previous year. A 1989 measles outbreak among vaccinated school-aged children prompted the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) to recommend a second dose of MMR vaccine for all children. Following widespread implementation of this recommendation and improvements in first-dose MMR vaccine coverage, reported measles cases declined even more. Measles was declared eliminated (absence of continuous disease transmission for greater than 12 months) from the U.S. in 2000. See [Centers for Disease Control and Prevention Measles \(Rubeola\) History of Measles](#).

16.6.5 Cases and Outbreaks

As vaccination rates began decreasing in the U.S., cases and outbreaks of measles became more frequent. In addition, travelers bring measles into the U.S. from countries where the disease still occurs or where outbreaks are occurring. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Questions About Measles](#). In 2014, Disneyland California experienced an outbreak during which at least 131 California residents, as well as residents from six other states, Mexico, and Canada, were infected with measles. See [California Department of Public Health Immunization Branch Measles](#).

The U.S. experienced a significant measles outbreak in 2019: 2019, 1,282 individual cases of measles were confirmed in 31 states, the greatest number of cases reported in the U.S. since measles was declared eliminated in 2000. In 2020, as of April 5, 12 cases in seven jurisdictions have been reported. See [Centers for Disease Control and Prevention Measles \(Rubeola\) Cases and Outbreaks](#).

- A. Washington State** – On January 25, 2019, Washington State Governor Jay Inslee [declared a state of emergency](#) for all counties in the state due to measles outbreaks. At the time of the declaration, there were 25 confirmed measles cases in Clark County and one confirmed case in King County. Another outbreak began on May 9 in three Puget Sound counties. As of July 16, 2019, there were a total of 85 confirmed measles cases in the state. See [Washington State Department of Health Measles 2019](#).
- B. New York City** – A significant measles outbreak began in NYC in late 2018 centered in regions with a large Orthodox Jewish population. On April 9, 2019, the NYC Health Commissioner [declared a public health emergency](#) and ordered every adult and child who lives, works or resides in certain zip codes in NYC to be vaccinated. On April 17,

2019, the NYC Board of Health voted unanimously to adopt a resolution supporting the Commissioner's order and the vaccination requirement. People who are immune to measles or have a medical condition that prevents them from receiving the vaccine are exempt. Noncompliant individuals can be fined \$1,000. As of July 15, 2019, 31,299 doses of the MMR vaccine have been administered to people who are under 19 years old in these areas. From September 2018 to July 15, 2019, there have been 623 confirmed measles cases in NYC. See [NYC Health Measles](#).

Parents of unvaccinated children challenged the NYC order, claiming it was disproportionate to the circumstances and failed to use the least restrictive means to control measles while protecting individual autonomy, informed consent, and free exercise of religion. The order was [upheld](#) by a New York state court on April 18, 2019, which held that the petitioners had not offered a demonstrably better, safer, or more efficient alternative to support their argument that the mandatory vaccination fails the "least restrictive means" standard. The court dismissed religious objections because the petitioners did not offer affidavits of a religious official or other doctrinal documentation to support their claim of religious exemption. Finally, with respect to informed consent, the issue was inappropriately raised in the context of a measles outbreak: "A fireman need not obtain the informed consent of the owner before extinguishing a house fire. Vaccination is known to extinguish the fire of contagion." See [C.F. v New York City Dept. of Health and Mental Hygiene, 2019 NY Slip Op 31047\(U\) \(April 18, 2019\)](#).

- C. Rockland County, New York** – On March 26, 2019, Rockland County, a suburb outside of NYC, [declared a state of emergency](#) due to a measles outbreak. As part of the declaration, unvaccinated individuals under the age of 18 were prohibited from being in public places, including restaurants, civic centers, houses of worship, shopping malls and schools. At the time of the declaration, there were more than 150 confirmed cases of measles in the county, the majority of whom had not received the MMR vaccine. See [Rockland County Measles Information](#).

Parents of unvaccinated children sued Rockland County, arguing that the county executive overstepped his powers because the current measles outbreak did not qualify as an emergency. On April 5, 2019, a New York State court [ruled](#) that the number of measles cases did not rise to an epidemic or constitute a disaster, thereby not meeting the requirements of Executive Law section 24.



The judge who upheld NYC's mandatory vaccination order disagreed with the judge who overturned the Rockland County public health emergency/quarantine order on the basis of the definition of the word "epidemic." While the Rockland County judge looked at the percentage of the overall population affected to determine whether there is an epidemic, the judge in the NYC case stated that the appropriate measure is the sudden percentage rise in infection experience by the subject population. "If one were to wait till a significant percentage of overall population were infected, disaster would

inevitably ensue.” See [C.F. v New York City Dept. of Health and Mental Hygiene, 2019 NY Slip Op 31047\(U\) \(April 18, 2019\)](#).

After an appellate panel upheld judge’s order, the Rockland County Department of Health (RCDOH) Commissioner [issued](#) a Communicable Disease & Exposure Exclusion Order, which has three components:

1. Any person diagnosed with the measles or exposed to a person diagnosed with the measles as evidenced by laboratory evidence or a measles tracing investigation conducted by RCDOH must be excluded from indoor and outdoor places of public assembly located in Rockland County for a period of up to 21 days.
2. The individual is prohibited from going to or being present at any place of public assembly for any period of time with exceptions for medical care, emergency situations and court appointments.
3. Individuals are required to cooperate with RCDOH public health authorities by providing information regarding details of one's illness, exposures and contacts.

Failure to comply can result in a \$2,000 fine per violation per day.

16.7 Monkey Pox (Mpox)

Also known as Mpox or MPX, monkey pox is a viral disease caused by the monkey pox virus. It was discovered in Denmark in 1958 in monkeys kept for research. The first reported human case of Mpox was a nine-month-old boy in the Democratic Republic of the Congo (DRC, 1970). Mpox can spread from person to person or occasionally from animals to people. Following eradication of smallpox in 1980 and the end of smallpox vaccination worldwide, Mpox steadily emerged in central, east and west Africa. The natural reservoir of the virus is unknown – various small mammals such as squirrels and monkeys are susceptible. See [Mpox \(monkeypox\)](#).

In May 2022, an unprecedented global outbreak of Mpox was detected. Cases in the United States increased rapidly, peaking in August 2022. This outbreak of Mpox is still ongoing and is different from past outbreaks because it is primarily spread through sexual contact. CDC lab experts have found at least two variants of Mpox virus circulating in this outbreak. Both variants share common ancestors with strains present in Nigeria since 2017. It is likely that there were at least two separate events where the Mpox virus spread from animals to people in Nigeria, and then began to spread person-to-person through close contact. Cases prior to 2022 were related to travel and exposure to animals imported from Africa



The outbreak has raised concern for health equity, specifically with LGBTQ individuals. The message that there is an increased risk of disease transmission through sexual interaction between gay or bisexual men may stigmatize an already marginalized group and harm public health efforts. See [As Monkeypox Spreads Know the Difference Between Warning and](#)

[Stigmatizing People](#). In addition, the name itself raised concerns related to racism and led it its renaming. See [MPX Mpox? The Struggle to Replace 'Monkeypox' with a Name that Isn't Racist](#).

16.7.1 Transmission

Person-to-person transmission of Mpox can occur through direct contact with infectious skin or other lesions such as in the mouth or on genitals; this includes contact which is

- face-to-face (talking or breathing)
- skin-to-skin (touching or vaginal/anal sex)
- mouth-to-mouth (kissing)
- mouth-to-skin contact (oral sex or kissing the skin)
- respiratory droplets or short-range aerosols from prolonged close contact

The virus enters the body through broken skin, mucosal surfaces (e g oral, pharyngeal, ocular, genital, anorectal), or via the respiratory tract. Mpox can spread to other members of the household and to sex partners. People with multiple sexual partners are at higher risk.

In the current Mpox outbreak, the virus is spreading primarily through sexual contact; however, infections have occurred through other exposures, including non-sexual contact with infectious lesions and from contaminated instruments in clinic settings. See [How It Spreads | Mpox](#).



CDC will continue to monitor the [latest information](#) about [how Mpox spreads](#).

16.7.2 Symptoms

Common symptoms of Mpox are a skin rash or mucosal lesions which can last 2–4 weeks accompanied by fever, headache, muscle aches, back pain, low energy, and swollen lymph nodes. During this time, a person does not have symptoms and may feel fine. The rash will go through several stages, including scabs, before healing and can initially look like pimples or blisters that may be painful or itchy.

A person with Mpox can spread it to others from the time symptoms start until the rash has fully healed and a fresh layer of skin has formed. As of February 2023, new data show that some people can spread Mpox to others from one to four days before their symptoms appear. It's not clear how many people this has affected during the current outbreak. There is currently no evidence showing that people who never develop symptoms have spread the virus to someone else.

16.7.3 Treatment and Vaccines

Tecovirimat (also known as TPOXX or ST-246) is FDA-approved for the treatment of human smallpox disease caused by variola virus in adults and children. TPOXX®, the brand name for the antiviral drug tecovirimat, is approved by the United States Food and

Drug Administration (FDA) for the treatment of smallpox in adults and children. Both smallpox and Mpox are orthopoxviruses, and tecovirimat (TPOXX®) targets a specific protein that is present in these viruses. As there are currently no FDA-approved treatments for human Mpox infection, the Centers for Disease Control and Prevention (CDC) recommends that tecovirimat (TPOXX®) can also be used for patients with Mpox who have severe disease or who are at risk for developing severe disease. TPOXX® is not available from local pharmacies or hospitals. It is held in the Strategic National Stockpile (SNS), which is a repository of drugs, vaccines, and medical supplies maintained by the federal government for distribution during public health emergencies. Because it is held in the SNS, TPOXX® is typically obtained from the CDC or state health departments. Doctors must complete special documentation forms before, during, and after patients are administered TPOXX® for treatment of Mpox. After completion, the forms are returned to the CDC.

There is only one vaccination authorized by the FDA to protect against the Mpox virus, JYNNEOS, which is also approved for the prevention of smallpox disease. JYNNEOS is a live virus vaccine that contains Modified Vaccinia Ankara-Bavarian Nordic (MVA-BN), a weakened, non-replicating orthopoxvirus. JYNNEOS may be safely used in significantly immunocompromised individuals who may not be indicated or recommended to receive certain live vaccines.

JYNNEOS is approved for use in individuals 18 years of age and older who are determined to be at high risk for smallpox or Mpox infection. The JYNNEOS vaccine can be given in two ways: subcutaneously or intradermally. The same vaccine is used for both types of administration, but intradermal administration uses a smaller dose (one-fifth of what is needed for subcutaneous administration). The vaccine is given as a two-dose series, 4 weeks apart. JYNNEOS was originally developed for use in the event of a smallpox bioterrorist attack in certain populations (e.g., immunocompromised individuals) as an alternative to ACAM2000. ACAM2000 is an FDA-approved, live replicating vaccinia virus vaccine for the prevention of smallpox disease. It is associated with certain serious adverse reactions that have not been observed with JYNNEOS. See [Key Facts About Vaccines to Prevent Monkeypox Disease](#).



There are health equity concerns related to access to the Mpox vaccine. See, e.g., [National Data Show Continuing Disparities in Monkeypox \(MPX\) Cases and Vaccinations Among Black and Hispanic People](#) and [ASPR/CDC Mpox Vaccination Operational Planning Guide – HHS Mpox Vaccination Program](#).

16.7.4 2022-2023 Outbreak

Since early May 2022, cases of Mpox have been reported from countries where the disease is not endemic and continue to be reported in several endemic countries. Most confirmed cases with travel history reported travel to countries in Europe and North America, rather than West or Central Africa where the Mpox virus is endemic. This is the first time that many Mpox cases and clusters have been reported concurrently in non-endemic and endemic countries in widely disparate geographical areas.

Most reported cases so far have been identified through sexual health or other health services in primary or secondary health-care facilities and have involved mainly, but not exclusively, men who have sex with men. See [2022-2023 Outbreak Cases and Data](#) and [Mpox \(monkeypox\) outbreak](#).

16.8 Other Emerging and Re-emerging Diseases

The diseases discussed above are just some of the many emerging and re-emerging diseases of concern. Other infectious diseases of concern include whooping cough, polio, chikungunya, and avian influenza. Most of these diseases are reportable under District law.



See section 7.0 and Appendix 5.0 of the Manual for more information about notifiable diseases.



CDC developed [A CDC Framework for Preventing Infectious Diseases: Sustaining the Essentials and Innovating for the Future](#) (CDC's ID Framework) to provide a roadmap for improving the U.S.'s ability to prevent known infectious diseases and to recognize and control rare, highly dangerous, and newly emerging threats through a strengthened, adaptable, and multi-purpose U.S. public health system. While the primary purpose of CDC's ID Framework is to guide CDC's infectious disease activities, the document also seeks to advance collective action to prevent and control infectious diseases, recognizing the realities of the current fiscal climate and our changing public health and healthcare environments.

17.0 FEDERAL CONTROL OF COMMUNICABLE DISEASES

17.1 Summary

Under section 361 of the Public Health Service Act ([42 U.S.C. § 264](#)), the United States Secretary of Health and Human Services (HHS Secretary) is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the U.S. and between states. This authority has been delegated to the Centers for Disease Control and Prevention (CDC). CDC is authorized to detain, medically examine, and release individuals coming into the U.S. and traveling between states who are suspected of carrying certain communicable diseases. CDC and United States Department of Homeland Security (DHS) have developed a public health Do Not Board (DNB) list and Public Health Boarder Lookout (Lookout) to prevent individuals with certain communicable diseases from entering, leaving, or traveling within the U.S. CDC has also issued criteria for requesting federal travel restrictions for public health purposes.



CDC has published a [Questions and Answers about the Final Rule for Control of Communicable Diseases: Interstate \(Domestic\) and Foreign Quarantine](#).

17.2 Federal Authority

The United States Secretary of Health and Human Services (HHS Secretary) is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the U.S. and between states under section 361 of the Public Health Service Act ([42 U.S.C. § 264](#)). This authority has been delegated to the Centers for Disease Control and Prevention (CDC). CDC updated its regulations regarding control of interstate and foreign communicable disease in 2017. Under 42 Code of Federal Regulations parts [70](#) and [71](#), CDC is authorized to detain, medically examine, and release persons arriving into the U.S. and traveling between states who are suspected of carrying certain communicable diseases. Under this authority, CDC routinely monitors individuals in the U.S. for signs or symptoms of communicable diseases. If a quarantinable disease is suspected or identified, CDC may issue a federal isolation or quarantine order. An individual may be conditionally released from quarantine if they comply with medical monitoring and surveillance. See [Legal Authorities for Isolation and Quarantine](#).



CDC exercised its isolation and quarantine authority in 2020 during the novel coronavirus pandemic. See [COVID-19: Current Travel Restrictions and Quarantine Measures](#); [Covid-19 — The Law and Limits of Quarantine](#).

17.3 Interstate Quarantine

17.3.1 Definitions

- “Quarantinable communicable disease” is one of the diseases listed in an Executive Order and is currently limited to cholera, diphtheria, infectious tuberculosis (TB), plague, smallpox, yellow fever, and viral hemorrhagic fevers (such as Marburg, Ebola Virus Disease (EVD), Lassa fever, and Crimean-Congo), severe acute respiratory

syndromes (SARS), and influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic). [42 C.F.R. § 70.1](#), [Executive Order 13295 \(April 4, 2003\)](#), as amended by [Executive Order 13375 \(April 1, 2005\)](#) and [Executive Order 13674 \(July 31, 2014\)](#).

- “Reasonably believed to be infected” is specific articulable facts upon which a public health officer could reasonably draw the inference that an individual has been exposed, either directly or indirectly, to the infectious agent that causes a quarantinable communicable disease and that as a consequence of the exposure, the individual is or may be harboring in the body the infectious agent of that quarantinable communicable disease. [42 C.F.R. § 70.1](#).
- “Qualifying stage” is (1) the communicable stage of a quarantinable communicable disease, or (2) the precommunicable stage of the quarantinable communicable disease, but only if the quarantinable communicable disease would be likely to cause a “public health emergency” if transmitted to other individuals. [42 C.F.R. § 70.1](#).
- “Precommunicable stage” is the stage beginning upon an individual's earliest opportunity for exposure to an infectious agent and ending upon the individual entering or reentering the communicable stage of the disease or, if the individual does not enter the communicable stage, the latest date at which the individual could reasonably be expected to have the potential to enter or reenter the communicable stage. [42 C.F.R. § 70.1](#).
- “Public health emergency” is:
 - (1) Any communicable disease event as determined by the CDC Director with either documented or significant potential for regional, national, or international communicable disease spread or that is highly likely to cause death or serious illness if not properly controlled; or
 - (2) Any communicable disease event described in a Department of Health and Human Services (HHS) public health emergency declaration pursuant to the Public Health Service (PHS) Act; or
 - (3) Any communicable disease event World Health Organization (WHO) is notified about that may constitute a Public Health Emergency of International Concern (PHEIC); or
 - (4) Any communicable disease event WHO determines to be a PHEIC; or
 - (5) Any communicable disease event for which WHO issues temporary or standing recommendations for preventing or detecting the occurrence or reoccurrence of the communicable disease.

[42 C.F.R. § 70.1](#).
- “Non-invasive” is procedures conducted by an authorized public health worker (*i.e.*, an individual with education and training in the field of public health) or another individual

with suitable public health training, and includes the visual examination of the ear, nose, and mouth; temperature assessments using an ear, oral, cutaneous, or noncontact thermometer, or thermal imaging; and other procedures not involving the puncture or incision of the skin or insertion of an instrument or foreign material into the body or a body cavity excluding the ear, nose, and mouth. [42 C.F.R. § 70.1](#).

- “Conditional release” is the temporary supervision by a public health official or designee of an individual or group who may have been exposed to a quarantinable communicable disease to determine the risk of disease spread, including public health supervision through in-person visits, telephone, or through electronic or Internet-based monitoring. [42 C.F.R. § 70.1](#).
- “Medical examination” is the assessment of an individual by an authorized and licensed health worker to determine the individual's health status and potential public health risk to others and may include the taking of a medical history, a physical examination, and collection of human biological samples for laboratory testing as may be needed to diagnose or confirm the presence or extent of infection with a quarantinable communicable disease. [42 C.F.R. § 70.1](#).



See section 8.2 of the Manual for quarantine and isolation definitions.

17.3.2 Apprehension and Detention of Person with Quarantinable Communicable Disease

The CDC Director may authorize a person's apprehension, medical examination, quarantine, isolation, or conditional release when the person is reasonably believed to be infected with a quarantinable communicable disease in a qualifying stage and is:

- Engaging or about to engage in interstate travel; or
- A probable source of infection to others who may be engaging in interstate travel.

[42 C.F.R. 70.6\(a\)](#).

Individuals who have been apprehended or held in quarantine or isolation must be provided with adequate food and water, appropriate accommodation, appropriate medical treatment, and means of necessary communication. [42 C.F.R. 70.6\(b\)](#).



[Some legal scholars](#) have criticized the “reasonable belief” standard provided in [42 C.F.R. § 70.6\(a\)](#) for federal quarantine authority, arguing that it provides the federal government with too much enforcement discretion. They point to the Supreme Court's decision in *Foucha v. Louisiana*, 504 U.S. 71 (1992), where the court explained that involuntary commitment does not violate the constitutional rights of people with mental illnesses when there is sufficient evidence to conclude that they have a mental illness and present a danger to themselves or others, as providing the proper standard: government officials should have to prove that the person has a quarantinable communicable disease

and presents a risk of harm to public health in order to avoid potential constitutional due process violations.

17.3.3 Measures in the Event of Inadequate Local Control

If the CDC Director determines that the measures taken by state or territorial health authorities are not sufficient to prevent the spread of communicable diseases to other states or territories, the CDC Director may take measures to prevent the spread of such diseases as deemed reasonably necessary, including inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of animals or articles believed to be sources of infection. [42 C.F.R. § 70.2](#).

17.3.4 Public Health Prevention Measures to Detect Communicable Disease

The CDC Director may conduct public health prevention measures at U.S. airports, seaports, railway stations, bus terminals, and other locations where individuals may gather to engage in interstate travel, through non-invasive procedures deemed appropriate by the CDC Director to detect the presence of communicable diseases. [42 C.F.R. § 70.10\(a\)](#). The CDC Director may require individuals to provide contact information such as addresses, telephone numbers, email addresses, and other contact information, information regarding their intended destination, health status, known or possible exposure history, and travel history. [42 C.F.R. § 70.10\(b\)](#).

17.3.5 Medical Examinations

The CDC Director may require an individual to undergo a medical examination as part of a federal order for quarantine, isolation, or conditional release for a quarantinable communicable disease. [42 C.F.R. § 70.12\(a\)](#). As part of the federal order, the individual must be advised that the medical examination, which must be promptly arranged, will be conducted by an authorized and licensed health worker, and with prior informed consent. [42 C.F.R. § 70.12\(b\)](#).

As part of the medical examination, the individual may be required to provide information and undergo such testing as may be reasonably necessary to diagnose or confirm the presence or extent of infection with a quarantinable communicable disease. [42 C.F.R. § 70.12\(c\)](#). Individuals reasonably believed to be infected based on the medical examination results may be isolated. If such results are inconclusive or unavailable, individuals may be quarantined or conditionally released in accordance with [42 C.F.R. part 70](#). [42 C.F.R. § 70.12\(d\)](#).



At CDC's sole discretion and subject to the availability of appropriations, the CDC Director may authorize payment for the care and treatment of individuals subject to medical examination, quarantine, isolation, or conditional release. [42 C.F.R. § 70.13\(a\)-\(b\)](#).

17.3.6 Requirements Related to Federal Orders for Quarantine, Isolation, or Conditional Release

A federal order authorizing quarantine, isolation, or conditional release must be in writing, signed by the CDC Director and contain the following:

- The identity of the individual or group subject to the order;
- The location of the isolation or quarantine or, in the case of conditional release, the entity to and means by which the individual must report for public health supervision;
- An explanation of the factual basis underlying the CDC Director's reasonable belief that the individual is in the qualifying stages of a quarantinable communicable disease;
- An explanation of the factual basis underlying the CDC Director's reasonable belief that the individual is moving or about to move from one state into another or constitutes a probable source of infection to others who may be moving from one state into another;
- An explanation that the federal order will be reassessed no later than 72 hours after it has been served, as well as an explanation of such medical review, including the right to request a medical review, present witnesses and testimony at the medical review, be represented at the medical review by either an advocate (e.g., an attorney, family member, or physician) at the individual's own expense, or, if indigent, have representatives appointed at the government's expense;
- An explanation of the criminal penalties for violating a federal order of quarantine, isolation, or conditional release; and
- An explanation that if a medical examination is required as part of the federal order, the examination will be conducted by an authorized and licensed health worker, and with the individual's prior informed consent.

[42 C.F.R. § 70.14\(a\)](#).


A federal order authorizing quarantine, isolation, or conditional release must be served on the individual no later than 72 hours after the individual has been apprehended, except that the federal order may be published or posted in a conspicuous location if the federal order is applicable to a group and individual service would be impractical. [42 C.F.R. § 70.14\(b\)](#). Translation or interpretation services must be arranged by the CDC Director as needed. [42 C.F.R. § 70.14\(c\)](#).


17.3.7 Mandatory Reassessment of Federal Orders for Quarantine, Isolation, or Conditional Release


No later than 72 hours after service of the federal order, the CDC Director must reassess the need to continue the quarantine, isolation, or conditional release of an individual. [42 C.F.R. § 70.15\(a\)](#). As part of the reassessment, CDC must:


- Review all records considered in issuing the federal order, including travel records, records evidencing exposure or infection with a quarantinable communicable disease, as well as any relevant new information; and
- Consider and make a determination regarding whether less restrictive alternatives would adequately serve to protect public health.

[42 C.F.R. § 70.15\(b\)](#).

 Upon a request by an individual under federal quarantine, isolation, or conditional release, the CDC Director must arrange for a medical review as soon as practicable. Such request may only occur after the CDC Director's mandatory reassessment under [42 C.F.R. § 70.15](#) and following service of a federal order continuing or modifying the quarantine, isolation, or conditional release. The purpose of the medical review is to determine whether the CDC Director has a reasonable belief that the individual is infected with a quarantinable communicable disease in a qualifying stage. [42 C.F.R. § 70.16\(a\)-\(c\)](#). The medical reviewer is a physician, nurse practitioner, or similar medical professional qualified in the treatment and diagnosis of disease who is appointed by the HHS Secretary or the CDC Director provided that the employee differs from the CDC official who issued the federal order for isolation, quarantine, or conditional release. [42 C.F.R. § 70.1](#).

 [42 C.F.R. part 70](#) does not specify penalties for violations. However, the PHS Act provides penalties for persons who violate regulations promulgated under [42 U.S.C. § 264](#). Such penalties are a fine of not more than \$1,000 or imprisonment for not more than one year, or both. [42 U.S.C. § 271\(a\)](#).

 Nothing in [42 C.F.R. § 70.14](#) affects the constitutional or statutory rights of individuals to receive judicial review of their federal detention. [42 C.F.R. § 70.14\(d\)](#).

 See Appendix 3.0 for a federal public health orders and interstate travel flowchart.

17.4 Foreign Quarantine

17.4.1 Definitions

- “Quarantinable communicable disease” is one of the diseases listed in an Executive Order and currently limited to cholera, diphtheria, infectious TB, plague, smallpox, yellow fever, and viral hemorrhagic fevers (such as Marburg, EVD, Lassa fever, and Crimean-Congo), severe acute respiratory syndromes, and influenza caused by novel or re-emergent influenza viruses that are causing or have the potential to cause a pandemic). [42 C.F.R. § 71.1](#), [Executive Order 13295 \(April 4, 2003\)](#), as amended by [Executive Order 13375 \(April 1, 2005\)](#) and [Executive Order 13674 \(July 31, 2014\)](#).
- “Non-invasive” is procedures conducted by an authorized public health worker or another individual with suitable public health training and includes the visual examination of the ear, nose, and mouth; temperature assessments using an ear, oral, cutaneous, or noncontact thermometer, or thermal imaging; and other procedures not involving the puncture or incision of the skin or insertion of an instrument or foreign material into the body or a body cavity excluding the ear, nose, and mouth. [42 C.F.R. § 71.1](#).
- “Conditional release” is surveillance as defined under [42 CFR part 71](#) and includes public health supervision through in-person visits by a health official or designee, telephone, or through any electronic or internet-based means as determined by the CDC Director. [42 C.F.R. § 71.1](#).
- “Surveillance” is the temporary supervision by a public health official or designee of an individual or group, who may have been exposed to a quarantinable communicable disease, to determine the risk of disease spread. [42 C.F.R. § 71.1](#).

17.4.2 Public Health Prevention Measures to Detect Communicable Disease

The CDC Director may conduct public health prevention measures at U.S. ports of entry or other locations through non-invasive measures to detect the potential presence of communicable diseases. [42 C.F.R. § 71.20\(a\)](#). The CDC Director may require individuals to provide contact information such as addresses, telephone numbers, email addresses, and other contact information, as well as information regarding their intended destination, health status, known or possible exposure history, and travel history. [42 C.F.R. § 71.20\(b\)](#).

17.4.3 Detention of Persons with Quarantinable Communicable Disease

If the CDC Director has reason to believe that any arriving person is infected with or has been exposed to a quarantinable communicable diseases, such person may be isolated, quarantined, or placed under surveillance. [42 C.F.R. § 71.32\(a\)](#).

Individuals who have been apprehended or held in quarantine or isolation must be provided with adequate food and water, appropriate accommodation, appropriate medical treatment, and means of necessary communication. [42 C.F.R. § 71.33\(a\)](#).

17.4.4 Medical Examinations

The CDC Director may require that an individual arriving in the U.S. undergo a medical examination as part of a federal order for quarantine, isolation, or conditional release. [42 C.F.R. § 71.36\(a\)](#). As part of the medical examination, the individual may be required to provide information and undergo testing reasonably necessary to diagnose or confirm the presence, absence, or extent of infection with a quarantinable communicable disease. [42 C.F.R. § 71.36\(c\)](#). Individuals reasonably believed to be infected, based on the medical examination results, may be isolated; if such results are inconclusive or unavailable, individuals may be quarantined or conditionally released. [42 C.F.R. § 71.36\(d\)](#).



At CDC's sole discretion and subject to the availability of appropriations, the CDC Director may authorize payment for the care and treatment of individuals subject to medical examination, quarantine, isolation, or conditional release. [42 C.F.R. § 71.30\(a\)-\(b\)](#).

17.4.5 Requirements Related to Federal Orders for Quarantine, Isolation, or Conditional Release

A federal order authorizing quarantine, isolation, or conditional release must be in writing, signed by the CDC Director and contain the following:

- The identity of the individual or group subject to the order;
- The location of the isolation or quarantine or, in the case of conditional release, the entity to and means by which the individual must report for public health supervision;
- An explanation of the factual basis underlying the CDC Director's reasonable belief that the individual is in the qualifying stages of a quarantinable communicable disease;
- An explanation of the factual basis underlying the CDC Director's reasonable belief that the individual is moving or about to move from one state into another or constitutes a probable source of infection to others who may be moving from one state into another;
- An explanation that the federal order will be reassessed no later than 72 hours after it has been served, as well as an explanation of such medical review, including the right to request a medical review, present witnesses and testimony at the medical review, be represented at the medical review by either an advocate (e.g., an attorney, family member, or physician) at the individual's own expense, or, if indigent, have representatives appointed at the government's expense;
- An explanation of the criminal penalties for violating a federal order of quarantine, isolation, or conditional release; and

- An explanation that if a medical examination is required as part of the federal order that the examination will be conducted by an authorized and licensed health worker, and with the individual's prior informed consent.

[42 C.F.R. § 71.37\(a\)](#).

A federal order authorizing quarantine, isolation, or conditional release must be served on the individual no later than 72 hours after the individual has been apprehended, except that the federal order may be published or posted in a conspicuous location if the federal order is applicable to a group and individual service would be impractical. [42 C.F.R. § 71.37\(b\)](#). Translation or interpretation services will be arranged by the CDC Director as needed. [42 C.F.R. § 71.37\(c\)](#).

17.4.6 Mandatory Reassessment of Federal Orders for Quarantine, Isolation, or Conditional Release

No later than 72 hours after service of the federal order, the CDC Director must reassess the need to continue the quarantine, isolation, or conditional release of an individual. [42 C.F.R. § 71.38\(a\)](#). As part of the reassessment, CDC must:

- Review all records considered in issuing the federal order, including travel records, records evidencing exposure or infection with a quarantinable communicable disease, as well as any relevant new information; and
- Consider and make a determination regarding whether less restrictive alternatives would adequately serve to protect public health. [42 C.F.R. § 71.38\(b\)-\(c\)](#).



Upon a request by an individual under federal quarantine, isolation, or conditional release, the CDC Director must arrange for a medical review as soon as practicable. Such request may only occur after the CDC Director's mandatory reassessment under [42 C.F.R. § 71.38](#) and following service of a federal order continuing or modifying the quarantine, isolation, or conditional release. The purpose of the medical review is to determine whether the CDC Director has a reasonable belief that the individual is infected with a quarantinable communicable disease in a qualifying stage. [42 C.F.R. § 71.39\(a\)-\(c\)](#). The medical reviewer is a physician, nurse practitioner, or similar medical professional qualified in the treatment and diagnosis of disease who is appointed by the HHS Secretary or the CDC Director and may include a HHS or CDC employee provided that the employee differs from the CDC official who issued the federal order for isolation, quarantine, or conditional release. [42 C.F.R. § 71.1](#).



Individuals in violation of [42 C.F.R. part 71](#) are subject to a fine of no more than \$100,000 if the violation does not result in a death or one year in jail, or both. If the violation results in a death, the person is subject to a fine of no more than \$250,000 or one year in jail, or both. [42 C.F.R. § 71.2](#).



See Appendix 3.0 for a federal public health orders and foreign travel flowchart.

17.5 Public Health Do Not Board List

In June 2007, CDC and the United States Department of Homeland Security (DHS) developed a public health Do Not Board (DNB) list to prevent commercial air travel by individuals with certain communicable diseases of public health concern (e.g., TB, measles) arriving into, departing from, or traveling within the U.S. See [Federal Air Travel Restrictions for Public Health Purposes --- United States, June 2007--May 2008](#). The public health DNB list is administered by DHS based on CDC's requests and is intended to supplement state and/or local public health measures to prevent individuals who are infectious, or reasonably believed to have been exposed to a communicable disease, from boarding commercial aircraft. [80 Fed. Reg. 16400](#) (March 27, 2015). The communicable disease for which the DNB list may be used are those diseases that would pose a public health threat to travelers if the infected individual was permitted to board a flight. While a state or local health department is usually the initiator of such requests, other agencies, such as the United States Department of State, or foreign public health authorities may also make a request.

Once an individual is placed on the DNB list, airlines are instructed not to issue the individual a boarding pass for any commercial domestic flight or for any commercial international flight arriving into or departing from the U.S. If an individual is able to board regardless of placement on a DNB list, CDC staff are notified upon detection by DHS to facilitate public health intervention. An individual is typically removed from the DNB List upon receipt by CDC of the treating physician's or public health authority's statement or other medical documentation that the individual is no longer infectious, or that the period the individual is at risk of becoming infectious without developing symptoms has lapsed. [80 Fed. Reg. 16400 \(March 27, 2015\)](#).



The public health DNB list does not apply to other forms of transportation, such as buses and trains. See [Federal and State Quarantine and Isolation Authority](#).



See section 17.7 of the Manual for criteria for requesting federal travel restrictions for public health purposes.

17.6 Public Health Border Lookout

The Public Health Border Lookout (Lookout) was also developed by CDC and DHS to ensure that any person placed on the DNB list is found if they try to enter or leave the U.S. through any port of entry. Individuals included on the DNB list are assigned a Lookout record. If an individual on the DNB list tries to enter or depart the U.S. through a port of entry, CDC is notified by U.S. Customs and Border Protection. CDC then notifies state and local public health authorities that a person on the Lookout list has been detected so that a thorough public health inquiry and evaluation can be conducted and appropriate actions taken to protect public health if necessary,

including quarantine, isolation, and treatment. See <https://www.cdc.gov/quarantine/do-not-board-faq.html>.



An [analysis](#) of requests for travel restrictions from May 22, 2007 to December 31, 2015 revealed that 396 individuals were placed on the DNB list/Lookout during that time period; the majority were for suspected or confirmed cases of pulmonary TB.

17.7 Criteria for Requesting Federal Travel Restrictions for Public Health Purposes

CDC [initially published criteria](#) for consideration when making requests to DHS to include an individual on the DNB list and associated Lookout record in 2008. Updated criteria were published in 2015 in the wake of the 2014 Ebola outbreak. [80 Fed. Reg. 16400 \(March 27, 2015\)](#).

For an individual to be added to the DNB list, an individual must be known or believed to be infectious with, or at risk for, a serious communicable disease that poses a public health threat to others during travel. In addition, the individual must satisfy one of the following criteria:

- Not be aware of their diagnosis, have been told of their diagnosis and is non-compliant with public health recommendations, or be unable to locate;
- Be at risk of traveling on a commercial flight or of traveling internationally by any means; or
- Need to be placed on the DNB list and Lookout to effectively respond to outbreaks of communicable disease or other conditions of public health concern. [80 Fed. Reg. 16400 \(March 27, 2015\)](#).



CDC published an FAQ related to the DNB list and Lookout. See <https://www.cdc.gov/quarantine/do-not-board-faq.html>. It also published questions and answers related to the updated criteria for adding an individual to the DNB list. See https://www.cdc.gov/quarantine/criteria-for-recommending-federal-travel-restrictions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fquarantine%2Fqas-frn-travel-restriction.html.



Diplomatic privileges and immunities are not intended to benefit individuals but to ensure the efficient and effective performance of their official missions on behalf of their governments. Although diplomatic law dictates certain immunities apply to members of diplomatic missions, the U.S. still has a duty to protect its populace and police authorities may intervene to the extent necessary to prevent the commission of a crime or in instances where public safety is in imminent danger. Immunities are intended to benefit the mission of the foreign government or international organization; therefore, an individual does not “own” his or her immunity and it may be waived, in whole or in part, by the mission member’s government. Additionally, the Department of State may request a waiver of immunity in such cases in which the prosecutor advises that they would prosecute but for immunity. To learn more about diplomatic immunity and specific privileges for

the various categories of diplomatic mission personnel, visit https://www.state.gov/wp-content/uploads/2019/07/2018-DipConImm_v5_Web.pdf.

APPENDIX 1.0 SAMPLE DOCUMENTS RELATED TO COMMUNICABLE DISEASE AND DETENTION

1. Detention Order
2. Seal Cover for Motion
3. Motion to Continue Detention
4. Affidavit in Support of Motion to Continue Detention
5. Clinical Summary – TB Case
6. Court Order – TB Case

DETENTION ORDER

D.C. DEPARTMENT OF HEALTH
PREVENTIVE HEALTH SERVICES
COMMUNICABLE DISEASE REMOVAL AND DETENTION ORDER

TO: THE CHIEF OF POLICE, METROPOLITAN POLICE DEPARTMENT

DATE:

ORDER:

I, [NAME], Director of D.C. Department of Health, have probable cause to believe that [INSERT INITIALS] of [ADDRESS] is infected with tuberculosis and is likely to be dangerous to the lives or health of other persons and that by reason of non-cooperation with treatment the public health is likely to be endangered.

Therefore, I, [NAME], Director of D.C. Department of Health, acting in accord with my belief, as stated above, by the authority of the provisions of law contained in the District of Columbia Official Code § 7-131 *et seq.* (2012 Repl.), and according to the regulations promulgated by the Commissioners of the District of Columbia under those provisions of law (22 DCMR 22-200 *et seq.*), order that you cause [INITIALS], of [ADDRESS], an [RACE & SEX], [NUMBER] years of age, weighing approximately [NUMBER] pounds and standing [HEIGHT] tall, to be taken into custody and removed to United Medical Center and deliver them together with the original of this order, into the custody of Dr. [NAME] to be detained in the hospital under the provisions of the laws and regulations referred to herein.

[Signed]

Director
D.C. Department of Health

SEAL COVER FOR MOTION

**IN THE SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Special Proceedings Branch
Criminal Division**

| | |
|---|---|
| DISTRICT OF COLUMBIA [UNDER SEAL] v. [UNDER SEAL], | SP No. Judge in Chambers |
|---|---|

**DISTRICT OF COLUMBIA’S MOTION TO CONTINUE
DETENTION ORDER OF THE D.C. DEPARTMENT OF HEALTH
PURSUANT TO D.C. OFFICIAL CODE § 7-134**

[FILED UNDER SEAL]

MOTION TO CONTINUE DETENTION

**SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Special Proceedings
Criminal Division**

DISTRICT OF COLUMBIA

v.

[INITIALS],

SP No.

Judge in Chambers

**DISTRICT OF COLUMBIA’S MOTION TO CONTINUE DETENTION ORDER OF
D.C. DEPARTMENT OF HEALTH PURSUANT TO D.C. OFFICIAL CODE § 7-134**

The District of Columbia, by and through its attorneys, the Office of the Attorney General for the District of Columbia, respectfully moves to continue the Detention Order issued by the Director of D.C. Department of Health pursuant to D.C. Official Code § 7-134 (2012 Repl.), directing the taking into custody of [INITIALS], a [DESCRIPTION FROM D.C. DEPARTMENT OF HEALTH ORDER], residing at [ADDRESS], and their removal to and detention in [MEDICAL FACILITY].

In support of its Motion, pursuant to D.C. Official Code § 7-134 (2012 Repl.), the District respectfully refers the Court to the accompanying Affidavit of [NAME], M.D., Chief Medical Officer, [DIVISION], D.C. Department of Health. The District has probable cause to believe that [INITIALS] is affected with, and is a carrier of, a communicable disease, [NAME OF DISEASE], and that their release into the general population is likely to cause death or seriously impair the health of other persons, and that by reason of their non-cooperation or carelessness, the public health is likely to be endangered, all as set forth in the attached Affidavit and accompanying documents.

Wherefore, the District respectfully requests that this Court grant the District’s Motion to Continue the Detention Order issued by the Director of D.C. Department of Health in the above-

captioned lawsuit for the reasons set forth in the accompanying affidavit. A proposed order is attached.

Respectfully submitted,
[ATTORNEY GENERAL NAME]
Attorney General for the District of Columbia

[DEPUTY ATTORNEY GENERAL NAME]
Deputy Attorney General
Public Interest Division

[Signed]

[NAME OF CHIEF]
Chief, Civil Enforcement Section

[Signed]

[ASSISTANT ATTORNEY GENERAL NAME]
Assistant Attorney General
Bar Number [number]
[address]
Washington, D.C. 20001
[phone]; [fax] (desktop fax)
Email: [email]

MEMORANDUM OF POINTS AND AUTHORITIES

1. D.C. Official Code § 7-131 (2012 Repl.).
2. D.C. Official Code § 7-132 (2012 Repl.).
3. D.C. Official Code § 7-133 (2012 Repl.).
4. D.C. Official Code § 7-134 (2012 Repl.).
5. 22 DCMR 201.
6. 22 DCMR 210.
7. D.C. Official Code § 7-140 (2012 Repl.).
8. D.C. Official Code § 7-144 (2012 Repl.).

AFFIDAVIT IN SUPPORT OF MOTION TO CONTINUE DETENTION

**SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Special Proceedings Branch
Criminal Division**

| | |
|--|---|
| DISTRICT OF COLUMBIA v. [INITIALS], | SP No. Judge in Chambers |
|--|---|

**AFFIDAVIT IN SUPPORT OF MOTION TO CONTINUE ORDER OF
D.C. DEPARTMENT OF HEALTH IN THE CASE OF [INITIALS]**

I, [NAME], M.D. Chief Medical Officer, Area C Chest Clinic, Division of Tuberculosis Control, D.C. Department of Health, having first been duly sworn, upon oath, depose and say that:

1) I have probable cause to believe that [INITIALS], a [DESCRIPTION FROM D.C. DEPARTMENT OF HEALTH ORDER], residing at [ADDRESS], is affected with and is a carrier of a communicable disease, [DISEASE], and is likely to be dangerous to the lives and health of other persons by reason of their non-cooperation or carelessness, thereby endangering the public health;

2) The detention of [INITIALS] was ordered by the Director of D.C. Department of Health on [DATE], all as set forth in the Communicable Disease Removal and Detention Order, Order Number [XXX-XX], which is attached hereto and made a part of this Affidavit along with my Clinical Summary of [INITIALS].

[Signed]

[NAME], M.D.
CHIEF MEDICAL OFFICER

SUBSCRIBED AND SWORN TO
BEFORE ME THIS _____ DAY OF [MONTH], [YEAR]

NOTARY PUBLIC

My Commission Expires:

CLINICAL SUMMARY – TB CASE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
D.C. DEPARTMENT OF HEALTH



Office of the Senior Deputy Director
HIV/AIDS Administration

TB Control Program
CLINICAL SUMMARY

DATE:

PATIENT: [INITIALS]
DOB:
ADDRESS:
DIAGNOSIS: Pulmonary/Pleural Tuberculosis

[INITIALS] is a [AGE, RACE, SEX DESCRIPTION] who was diagnosed with pleural tuberculosis On [DATE] and pulmonary tuberculosis on [DATE] at [MEDICAL FACILITY]. The chest x-ray showed large loculated pleural effusion, CT scan of chest showed large loculated pleural effusion on right side with mediastinal adenopathy. Although the sputum sample taken on [DATE] was negative for acid fast bacillus (AFB) on smear, the subsequent culture from that sample grew Mycobacterium tuberculosis on culture about 7 weeks later.

I saw [INITIALS] for first time at the [MEDICAL FACILITY] on [DATE]. They were subsequently admitted to [MEDICAL FACILITY] on [DATE] and 4 anti-tuberculosis medications were started after obtaining sputum for acid fast bacilli (AFB). [INITIALS] refused medications or partial medications several times while in the hospital. Three sputum smears for AFB came back negative and patient was discharged from [MEDICAL FACILITY] on anti-tuberculosis meds on [DATE]. Subsequently, the sputum smear that was negative on [DATE] grew mycobacterium tuberculosis on culture about 7 weeks later.

Upon discharge, anti-tuberculosis medications were continued as directly observed therapy (DOT) by District TB Control. The patient is currently on INH 300 mg po qd, Rifampin 600 mg po qd and Pyridoxine 50 mg po qd. According to records, patient missed 3 hemodialysis treatments in [DATE] and 3 hemodialysis treatments on [DATE].

In review of their DOT, they were relatively compliant on [DATE] (missed 3 doses) and [DATE] (missed 2 doses) but missed more doses on [DATE] (missed 6 doses) and [DATE] (missed 10 doses). Patient is also noncompliant with their TB clinic follow-up visits. Patient missed their meds at times by not being available for DOT by TB control staff and, at times, by refusing to take the anti-tuberculosis medications when presented them by TB control staff at their home.

Despite repeated phone calls and site visits by multiple members of TB control, including myself and [NAME] (TBI Supervisor), to explain risk of noncompliance (up to and including detention) with treatment to them and to the community at large, they continued to be non-adherent with their meds.

Even though the sputum smear was negative last time it was taken on [DATE], subsequently the sputum culture came back positive on [DATE], and [INITIALS] is at risk of reactivation due to their non-adherence with treatment which can make them contagious to others. [INITIALS] is also at risk for developing multiple drug resistant TB due to their noncompliance. [INITIALS] is a carrier of a communicable disease (tuberculosis) and is likely to be dangerous to lives and health of other persons by reason of their non-cooperation or carelessness thereby endangering the public health.

In summary, [INITIALS] has active pulmonary tuberculosis whose sputum culture from [DATE] indicates active tuberculosis. Despite repeatedly explaining risk of non-adherence with treatment to themselves and the public [INITIALS] continues to be uncooperative with treatment and follow-up. [INITIALS] can become potentially infectious due to non-adherence with treatment and is a public health risk. At this time, I recommend removal from public domain and admittance to [MEDICAL FACILITY] until laboratory tests can confirm that [INITIALS] is non-infectious and not a public health risk because of non-compliance with treatment regimen.

[Signed]

[NAME]
Medical Director
Division of Tuberculosis Control

COURT ORDER – TB CASE

**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
Special Proceedings Branch
Criminal Division**

| | |
|--|---|
| DISTRICT OF COLUMBIA v. [INITIALS], | SP No. Judge in Chambers |
|--|---|

ORDER

This matter came before the Court on [DATE], for a hearing before the Honorable Judge [NAME], Judge in Chambers, pursuant to D.C. Official Code § 7-135 (2012 Repl.), in the presence of, [NAME], Assistant Attorney General for the District of Columbia, [NAME], Esquire, Counsel for [INITIALS] and [INITIALS], present by telephone. Testimony was taken from [NAME], M.D., Medical Director, D. C. Tuberculosis (TB) Control Program, D.C. Department of Health, [NAME], TB Program Manager, D.C. Department of Health, and [INITIALS].

Upon consideration of the evidence and the record herein, this Court this _____ day of [DATE], hereby **FINDS:**

That the District of Columbia met its burden of proof, pursuant to D.C. Official Code § 7-134 (2012 Repl.), to show that releasing [INITIALS] into the general population is likely to cause death or seriously impair the health of others for the following reasons:

1. [INITIALS] progressed from pleural tuberculosis, diagnosed by sputum culture taken on [DATE], to pulmonary tuberculosis, diagnosed by sputum culture taken on [DATE];
2. [INITIALS] demonstrated increasing non-compliance, from [DATE] through [DATE], by not taking their medicine under Direct Observation Therapy (DOT) from Monday through Friday, as required by the applicable standard of care for the treatment of pulmonary tuberculosis;
3. [INITIALS] failed to attend monthly appointments at the D.C. Department of Health TB clinic, and provide monthly sputum for testing, which would monitor the effectiveness of their medical treatment; and

4. On [DATE], a CT scan of [INITIALS's] lungs revealed "large loculated hemothorax in the right lower chest . . . compressive atelectasis of the right lower and middle lobes, and multiple small nodules in the left lung more likely to be infectious in etiology than metastatic," according to the Medical Director of the TB Control Program, which have developed since [DATE].

THEREFORE, it is hereby,

ORDERED: That the TUBERCULOSIS ISOLATION ORDER NUMBER XXXX-XX, dated [DATE], issued by the Director of D.C. Department of Health against [INITIALS] be continued in force and effect that [INITIALS] continue to be **DETAINED** in isolation and quarantine at [MEDICAL FACILITY], or in an appropriate setting as determined by the Director of D.C. Department of Health, at United Medical Center, despite their testimony today that they would remain voluntarily, until the results of [INITIALS's] [DATE] or [DATE] sputum culture are found to be negative. It is hereby,

FURTHER ORDERED: That this Order is valid until further Order of the Court. A hearing is scheduled for the [DATE], at _____ a.m./ p.m., in Room _____ located at the Superior Court of the District of Columbia, 500 Indiana Avenue, N.W., Washington, D.C. 20001, before Judge _____. It is hereby,

FURTHER ORDERED: That [INITIALS] may contact the Court's ADA Compliance Officer at (202) 879-1770 (voice), (202) 879-1802 (fax), 711 DC Relay, or ADACoordinator@dcsc.gov for any appropriate and available accommodation.

[NAME]
Superior Court Judge

Copies to:

[NAME]
Assistant Attorney General
Office of the Attorney General for the District of Columbia
441 Fourth Street, N.W., Suite 630 South
Washington, D.C. 20001

[Other attorneys]

APPENDIX 2.0 SAMPLE MAYOR'S ORDERS

1. Public Emergency Declaration
2. Public Emergency Declaration Rescission
3. Public Health Emergency Declaration
4. Public Health Emergency Declaration Rescission

PUBLIC EMERGENCY DECLARATION

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order

[MONTH DAY, YEAR]

SUBJECT: DECLARATION OF PUBLIC EMERGENCY

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422 of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, approved December 24, 1973, 87 Stat. 790, Pub. Law 93-198, D.C. Official Code § 1-204 (2006 Repl.), the District of Columbia Public Emergency Act of 1980, effective March 5, 1981, D.C. Law 3-149, D.C. Official Code § 7-2301 *et seq.* (2001) ("Public Emergency Act"), and section 903(c) of the Omnibus Anti-Terrorism Act of 2002, effective October 17, 2002, D.C. Law 14-194, D.C. Official Code § 7-2304.01 (2006 Supp.) ("Anti-Terrorism Act"), it is hereby ORDERED that:

- 1) A state of a public emergency is hereby declared in the District of Columbia effective immediately and continuing until midnight, _____. [EFFECTIVE NO MORE THAN 15 CALENDAR DAYS, UNLESS THE COUNCIL BY EMERGENCY ACT EXTENDS THE EFFECT FOR UP TO AN ADDITIONAL 15 CALENDAR DAYS]. The Chief Financial Officer of the District of Columbia and employees of the Office of the Chief Financial Officer are authorized to approve the disbursement of all appropriations necessary to carry out this order.
- 2) The Director of the Homeland Security and Emergency Management Agency is authorized to implement those provisions of the District of Columbia Emergency Response Plan, as approved by the Mayor, that are necessary to carry out this order.
- 3) All agencies, departments, instrumentalities, and other organizational entities of the District of Columbia government ("the Agencies") shall coordinate their operations under the direction of the Mayor, City Administrator, and Chief of Staff in order to carry out this Order.
- 4) The Agencies shall coordinate their operation in implementing the following measures to protect persons and property in the District of Columbia [AMONG OTHER THINGS, DISTRICT OF COLUMBIA LAW PERMITS THE MAYOR, IN THE EVENT OF A DECLARED EMERGENCY, TO: EXPEND APPROPRIATE FUNDS TO ADDRESS THE EMERGENCY; IMPLEMENT THE DISTRICT EMERGENCY OPERATION PLANS WITHOUT REGARD TO ESTABLISHED OPERATIONAL PROCEDURES; PROCURE SUPPLIES AND EQUIPMENT, INSTITUTE TRAINING PROGRAMS AND PUBLIC INFORMATION PROGRAMS, AND TAKE ALL PREPARATORY STEPS, IN ADVANCE OF AN ACTUAL DISASTER; REQUEST PRE-DISASTER ASSISTANCE FROM THE FEDERAL GOVERNMENT; AND PREVENT OR REDUCE HARMFUL CONSEQUENCES OF DISASTER]:

- 5) The Agencies are ordered to coordinate in evacuating persons in the following areas of the District of Columbia:

_____.

Persons in these designated evacuation areas of the District of Columbia shall be evacuated to the locations designated in the District of Columbia Emergency Response Plan, or to the following shelters within the District or outside the District (with the approval of the Governor of the receiving State):

_____.

The Agencies shall coordinate to receive, shelter, maintain, and care for evacuees at these locations.

This Order to evacuate shall not apply to any personnel or activity of the federal government absent the consent of the President of the United States or his designee; provided that upon agreement between the federal and District of Columbia governments, any prearranged evacuation plan shall constitute such consent.

- 6) The Potomac Electric Power Company (“PEPCO”), any other providers or carriers of electricity, and their parent companies and subsidiaries are hereby ordered to [EITHER suspend, by shutting off, disconnecting, or otherwise temporarily terminating, the provision of electricity to the following areas of the District of Columbia OR continue without interruption the provision of electricity to the following areas of the District of Columbia]:

_____.

The Washington Gas Company, any other providers or carriers of natural gas, and their parent companies and subsidiaries are hereby ordered to [EITHER suspend, by shutting off, disconnecting, or otherwise temporarily terminating, the provision of natural gas to the following areas of the District of Columbia OR continue without interruption the provision of natural gas to the following areas of the District of Columbia]:

_____.

The following utilities, their parent companies, and their subsidiaries are hereby ordered to [EITHER suspend, by shutting off, disconnecting, or otherwise temporarily terminating, the provision of _____ to the following areas of the District of Columbia OR continue without interruption the provision of _____ to the following areas of the District of Columbia]:

_____.

The Agencies are ordered to coordinate to ensure that this paragraph is carried out.

- 7) The Agencies are ordered to coordinate to destroy any property, real or personal, that is contaminated by any matter or substance that renders it deleterious to life or health and poses immediate or imminent danger to persons or property.

The Agencies are ordered to coordinate to prohibit persons from contacting or approaching such property in a manner that could endanger their lives or health, or the lives or health of others.

The Agencies are ordered to remove from, or relocate within, the District any such contaminated personal property that is not destroyed, so as to avoid immediate or imminent danger to persons or other property.

The property subject to this order includes, but is not limited to, the following [SPECIFY THE PROPERTY, ITS LOCATION, AND THE ACTION TO BE TAKEN]

_____.

- 8) The Agencies are ordered to coordinate to [control, restrict, allocate, regulate] the [use, production, distribution] of food, fuel, clothing, and the following other commodities, materials, goods, services, and resources, and to seize critical goods or resources from private owners, as required by the District of Columbia Emergency Response Plan, any federal emergency response plan, or as determined by the Mayor:
- _____.

The Agencies are ordered to coordinate to implement the following regulations pertaining to the use, sale, production, and distribution of food, fuel, clothing, and other commodities, materials, goods, services, and resources, as required by the District of Columbia Emergency Response Plan, any federal emergency response plan, or as determined by the Mayor: [IF POSSIBLE, PHYSICALLY ATTACH REGULATIONS]

_____.

The sale, dispensing, use, and transportation of alcoholic beverages are prohibited [in the District OR in the following areas of the District]:

_____.

The sale, dispensing, use, and transportation of firearms, explosives, and flammables materials and liquids are prohibited [in the District OR in the following areas of the District]:

_____.

- 9) The Agencies are ordered to coordinate to impose a curfew on [DESCRIBE PERSONS AFFECTED, AREAS FOR WHICH THE CURFEW APPLIES, AND TIMES WHEN THE CURFEW IS IN EFFECT]:
- _____.

- 10) All [pedestrian and/or vehicular traffic], except essential emergency vehicles and personnel, shall be [prohibited OR regulated] in the following areas [DESCRIBE AREAS AFFECTED AND NATURE AND SCOPE OF REGULATION/PROHIBITION]:
- _____.

- 11) The occupancy and use of buildings in the following areas is [prohibited OR regulated in the following manner]: [DESCRIBE THE AREAS, AS WELL AS THE NATURE AND SCOPE OF THE REGULATION/PROHIBITION]:
- _____.

- 12) The following persons or entities in the District of Columbia are ordered to alter the hours during which they conduct business or similar activities at premises established and maintained for such activities [DESCRIBE PERSONS/ENTITIES AFFECTED AND THE NATURE OF THE ALTERATION]:

_____.

13) The following public emergency services units are hereby established:

_____.

14) The following units of the following Agencies are hereby expanded, as indicated:

_____.

15) The following persons shall be detained because there is probable cause to believe that they are affected with a communicable disease and that their presence in the general population is likely to cause death or seriously impair the health of others [NAME PERSONS OR DESCRIBE DISCRETE GROUPS OF PERSONS AFFECTED]:

_____.

16) All employees of the Agencies shall comply with the operational directions of the Mayor, City Administrator, and Chief of Staff, or their designees.

17) As soon as practicable, this Order shall be published in the *District of Columbia Register* and shall be posted in such public places in the District of Columbia as regulations require.

18) It is hereby requested of all publishers of daily newspapers of general circulation in the District of Columbia that this Order be published therein as soon as practicable.

19) District of Columbia government funds shall be committed as follows in order to alleviate the damage, loss, hardship, and suffering resulting from the current emergency:

_____.

20) The measures enumerated in this Order are necessary to relieve the public emergency. In addition to executing the specific measures enumerated in this Order, I may invoke all of my lawful authority as Mayor in order to prevent or reduce the harmful consequences of the condition that engendered the emergency.

21) Pursuant to section 8 of the Public Emergency Act of 1980, D.C. Official Code § 7-2307, any person who violates any provision of this Order shall be subject to a fine of \$1,000 for each violation.

22) This Order supersedes any and all other laws, regulations, and reorganization plans to the contrary to the extent permitted by section 422 of the Home Rule Act and by the Public Emergency Act.

23) This order shall take effect immediately.

Signed this _____ day of _____, 20_____.

[MAYOR NAME]
MAYOR

ATTEST: _____
[SECRETARY OF THE DISTRICT OF COLUMBIA NAME]
SECRETARY OF THE DISTRICT OF COLUMBIA

PUBLIC EMERGENCY DECLARATION RESCISSION

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order

[MONTH DAY, YEAR]

SUBJECT: RESCISSION OF DECLARATION OF PUBLIC EMERGENCY

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422 of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, approved December 24, 1973, 87 Stat. 790, Pub. Law 93-198, D.C. Official Code § 1-204 (2006 Repl.) and the District of Columbia Public Emergency Act of 1980, effective March 5, 1981, D.C. Law 3-149, D.C. Official Code § 7-2301 *et seq.* (2001) ("Public Emergency Act"), it is hereby ORDERED that:

- 1) Mayor's Order No. _____, dated _____ is hereby rescinded.
- 2) This order shall take effect immediately.

Signed this ____ day of _____, 20____.

[MAYOR NAME]
MAYOR

ATTEST: _____
[SECRETARY OF THE DISTRICT OF COLUMBIA NAME]
SECRETARY OF THE DISTRICT OF COLUMBIA

PUBLIC HEALTH EMERGENCY DECLARATION

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order

[MONTH DAY, YEAR]

SUBJECT: DECLARATION OF PUBLIC HEALTH EMERGENCY

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422 of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, approved December 24, 1973, 87 Stat. 790, Pub. Law 93-198, D.C. Official Code § 1-204 (2006 Repl.), the District of Columbia Public Emergency Act of 1980, effective March 5, 1981, D.C. Law 3-149, D.C. Official Code § 7-2301 *et seq.* (2001) ("Public Emergency Act"), section 903(c) of the Omnibus Anti-Terrorism Act of 2002, effective October 17, 2002, D.C. Law 14-194, D.C. Official Code § 7-2304.01 (2006 Supp.) ("Anti-Terrorism Act"), and Mayor's Order [NUMBER AND DATE OF MAYOR'S ORDER DECLARING A PUBLIC EMERGENCY] it is hereby ORDERED that:

- 1) A state of a public health emergency is hereby declared in [the District of Columbia OR SPECIFY WHICH GEOGRAPHIC AREAS WITHIN THE DISTRICT ARE SUBJECT TO THE EMERGENCY] effective immediately and continuing until midnight, _____. [EFFECTIVE NO MORE THAN 15 CALENDAR DAYS, UNLESS THE COUNCIL BY EMERGENCY ACT EXTENDS THE EFFECT FOR UP TO AN ADDITIONAL 15 CALENDAR DAYS]. The Chief Financial Officer of the District of Columbia and employees of the Office of the Chief Financial Officer are authorized to approve the disbursement of all appropriations necessary to carry out this order.
- 2) The declaration of a public health emergency is based on the Mayor's reasonable belief that there is an imminent hazard or actual occurrence of [SELECT ONE OR MORE OF THE FOLLOWING: (1) A LARGE NUMBER OF DEATHS IN THE DISTRICT OF COLUMBIA; (2) A LARGE NUMBER OF SERIOUS OR LONG-TERM HUMAN HEALTH DISABILITIES IN THE DISTRICT OF COLUMBIA; (3) WIDESPREAD EXPOSURE TO AN INFECTIOUS OR TOXIC AGENT THAT POSES A SIGNIFICANT RISK OF SUBSTANTIAL FUTURE HARM TO A LARGE NUMBER OF PEOPLE IN THE DISTRICT OF COLUMBIA; OR (4) USE, DISSEMINATION, OR DETONATION OF A WEAPON OF MASS DESTRUCTION, AS DEFINED BY SECTION 102 OF THE ANTI-TERRORISM ACT, D.C. OFFICIAL CODE § 22-3152(12) (2006 SUPP.)].
- 3) The conditions which have created the emergency are [DESCRIBE THE CAUSE, NATURE, EXTENT, AND SEVERITY OF THE PUBLIC HEALTH EMERGENCY]:
_____.

- 4) All agencies, departments, instrumentalities, and other organizational entities of the District of Columbia government (“the Agencies”) shall coordinate their operations under the direction of the Mayor, City Administrator, and Chief of Staff in order to carry out this Order.
- 5) The Agencies shall coordinate their operation in implementing the following measures to relieve the public health emergency:
_____.
- 6) The Mayor may take, or authorize the Agencies to take, the following steps to ensure that the conduct and management of the affairs and property of licensed healthcare providers in the District of Columbia are such that they will reasonably assist and will not unreasonably detract from the ability of the District of Columbia government to respond successfully to and control the public health emergency in accordance with the provisions of the District of Columbia Emergency Response Plan:
_____.
- 7) The Mayor or his designees may appoint licensed healthcare providers, either from the District of Columbia or from other jurisdictions, as temporary agents of the District of Columbia, provided that such appointments are in effect solely for the duration of the public health emergency, in effect solely for the purpose of assisting the District of Columbia in implementing the provisions of the District of Columbia Emergency Response Plan and the Omnibus Anti-Terrorism Act of 2002, and without compensation.
- 8) The Mayor or his designees may exempt licensed healthcare providers, either from the District of Columbia or from other jurisdictions, from civil liability for damages for any actions taken within the scope of the provider’s employment or voluntary service to implement the provisions of the District of Columbia Emergency Response Plan, except in instances of gross negligence, and solely for the duration of the public health emergency.
- 9) The Mayor or his designees may waive any licensing requirements, permits, or fees otherwise required by District of Columbia law to allow healthcare providers from other jurisdictions appointed as temporary agents to respond to the public health emergency, provided that the appointed temporary agents are licensed in their home jurisdictions in their fields of expertise.
- 10) As soon as practicable, this Order shall be published in the District of Columbia Register and shall be posted in such public places in the District of Columbia as regulations require.
- 11) It is hereby requested of all publishers of daily newspapers of general circulation in the District of Columbia that this Order be published therein as soon as practicable.
- 12) The measures enumerated in this Order are necessary to relieve the public emergency. In addition to executing the specific measures enumerated in this Order, I may invoke all of my lawful authority as Mayor in order to prevent or reduce the harmful consequences of the condition that engendered the emergency.
- 13) Pursuant to section 8 of the Public Emergency Act of 1980, D.C. Official Code § 7-2307, any person who violates any provision of this Order shall be subject to a fine of \$1,000 for each violation.

14) This Order supersedes any and all other laws, regulations, and reorganization plans to the contrary to the extent permitted by section 422 of the Home Rule Act and by the Public Emergency Act.

15) This order shall take effect immediately.

Signed this _____ day of _____, 20____.

[MAYOR NAME]
MAYOR

ATTEST: _____
[SECRETARY OF THE DISTRICT OF COLUMBIA NAME]
SECRETARY OF THE DISTRICT OF COLUMBIA

PUBLIC HEALTH EMERGENCY DECLARATION RESCISSION

GOVERNMENT OF THE DISTRICT OF COLUMBIA

ADMINISTRATIVE ISSUANCE SYSTEM

Mayor's Order

[MONTH DAY, YEAR]

SUBJECT: RESCISSION OF DECLARATION OF PUBLIC HEALTH EMERGENCY

ORIGINATING AGENCY: Office of the Mayor

By virtue of the authority vested in me as Mayor of the District of Columbia by section 422 of the District of Columbia Home Rule Act ("Home Rule Act"), as amended, approved December 24, 1973, 87 Stat. 790, Pub. Law 93-198, D.C. Official Code § 1-204 (2006 Repl.), the District of Columbia Public Emergency Act of 1980, effective March 5, 1981, D.C. Law 3-149, D.C. Official Code § 7-2301 *et seq.* (2001) ("Public Emergency Act"), section 903(c) of the Omnibus Anti-Terrorism Act of 2002, effective October 17, 2002, D.C. Law 14-194, D.C. Official Code § 7-2304.01 (2006 Supp.) ("Anti-Terrorism Act"), it is hereby ORDERED that:

- 1) Mayor's Order No. _____, dated _____ is hereby rescinded.

- 2) This order shall take effect immediately.

Signed this _____ day of _____, 20_____.

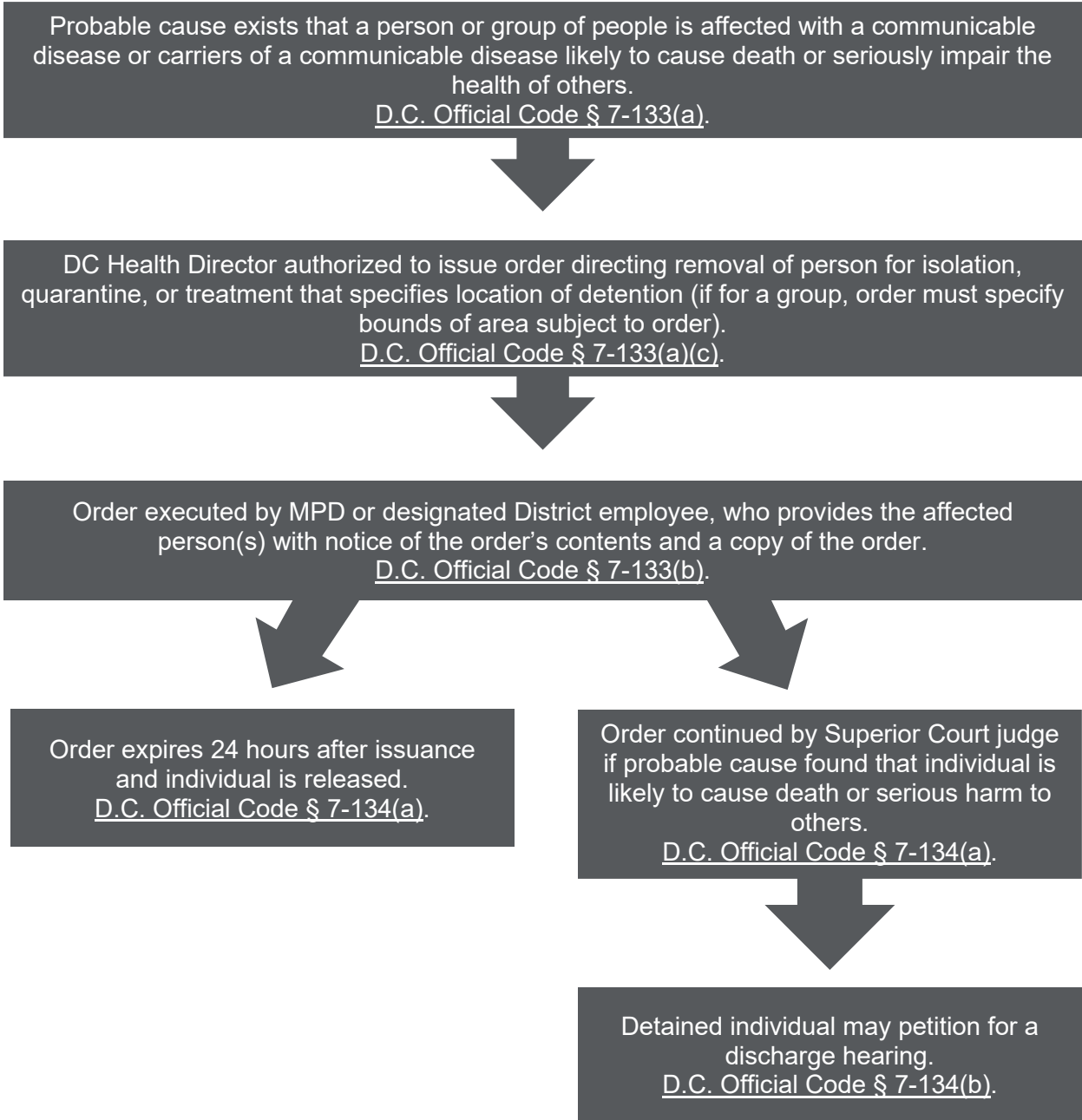
[MAYOR NAME]
MAYOR

ATTEST: _____
[SECRETARY OF THE DISTRICT OF COLUMBIA NAME]
SECRETARY OF THE DISTRICT OF COLUMBIA

APPENDIX 3.0 FLOWCHARTS

1. Isolation, Quarantine, and Treatment
2. Medical Examination
3. Declaration of a Public Emergency
4. Declaration of a Public Health Emergency
5. Inspection and Condemnation
6. Federal Public Health Orders and Interstate Travel, Part 70
7. Federal Public Health Orders and Foreign Travel, Part 71

ISOLATION, QUARANTINE, AND TREATMENT



MEDICAL EXAMINATION

Individual is detained under D.C. Official Code § 7-131 and 22B DCMR § 210.8.

DC Health orders examination by appropriate medical personnel (22B DCMR § 210.4) or submission of specimens by individual to determine whether individual is affected with a communicable disease (22B DCMR § 210.5).

If individual refuses to submit to medical examination, DC Health Director may issue a Removal and Detention Order.
22B DCMR § 210.8.

Exam diagnosis must be signed in writing by examining physician and copy given to detained person and person in charge of location where individual is detained.
D.C. Official Code § 7-135(a).

Individual must be immediately discharged if found not to be affected by communicable disease.
D.C. Official Code § 7-135(a).

Individual may be detained for as long as necessary to protect public health if found to be affected by communicable disease.
D.C. Official Code § 7-135(b).

Individual may petition Superior Court at any time for a discharge hearing.
D.C. Official Code § 7-135(b).

Counsel will be appointed if individual cannot afford counsel.
D.C. Official Code § 7-135(b).

DECLARATION OF PUBLIC EMERGENCY

Mayor Issues Emergency Executive Order Declaring Public Emergency

Standard: reasonable apprehension of existence of public emergency and need for immediate preservation of public peace, health, safety, and welfare.

D.C. Official Code § 7-2304(a).



Contents of Order

- 1) Nature, extent and severity of emergency
- 2) Measures needed to relieve emergency
- 3) Specific requirements of order and to whom order applies
- 4) Duration of order

D.C. Official Code § 7-2304(a).



Publication of Order

Order must be published in D.C. Register, two general circulation daily newspapers, and posted in public places as soon as practicable given the nature of the emergency.

D.C. Official Code § 7-2306(d).



Powers Given To Mayor

- Expend funds • Implement response plans without regard to normal procedures • Evacuate people • Disconnect utilities • Destroy or remove property • Control and allocate resources • Institute curfews • Alter business hours • Expand governmental units • Procure supplies and personnel • Request federal disaster assistance • Prevent harmful consequences of disaster
- Detain persons affected with a communicable disease if probable cause that they are a danger to public health

D.C. Official Code § 7-2304(b)



Duration and Extension of Order

Lasts 15 days and may be extended for 15 additional days upon approval of D.C. Council

D.C. Official Code § 7-2306

DECLARATION OF PUBLIC HEALTH EMERGENCY

Mayor Issues Emergency Executive Order Declaring Public Health Emergency AFTER Declaration of a Public Emergency

Standard: reasonable cause to believe there is imminent hazard or actual occurrence of large number of deaths, large number of serious or long-term health disabilities, widespread exposure to infectious or toxic agent, use or detonation of a weapon of mass destruction, or other emergency events that create an acute and immediate need for volunteer health practitioners.

D.C. Official Code § 7-2304.01(a).



Contents of Order

- 1) Existence, nature, extent and severity of public health emergency
- 2) Geographic area subject to declaration
- 3) Conditions that brought about public health emergency, if known
- 4) Measures needed to relieve public health emergency
- 5) Specific requirements of order and to whom the order applies
- 6) Duration of order

D.C. Official Code § 7-2304.01(c).



Publication of Order

Order must be published in D.C. Register, two general circulation daily newspapers, and posted in public places as soon as practicable given the nature of the public health emergency.

D.C. Official Code § 7-2306(d).



Powers Given To Mayor

Mayor may appoint healthcare providers who become temporary agents of the District for duration of public health emergency and perform without compensation, without liability (except gross negligence), and without regard to licensure, permits and fees otherwise required under District law.

D.C. Official Code § 7-2304.01(d).

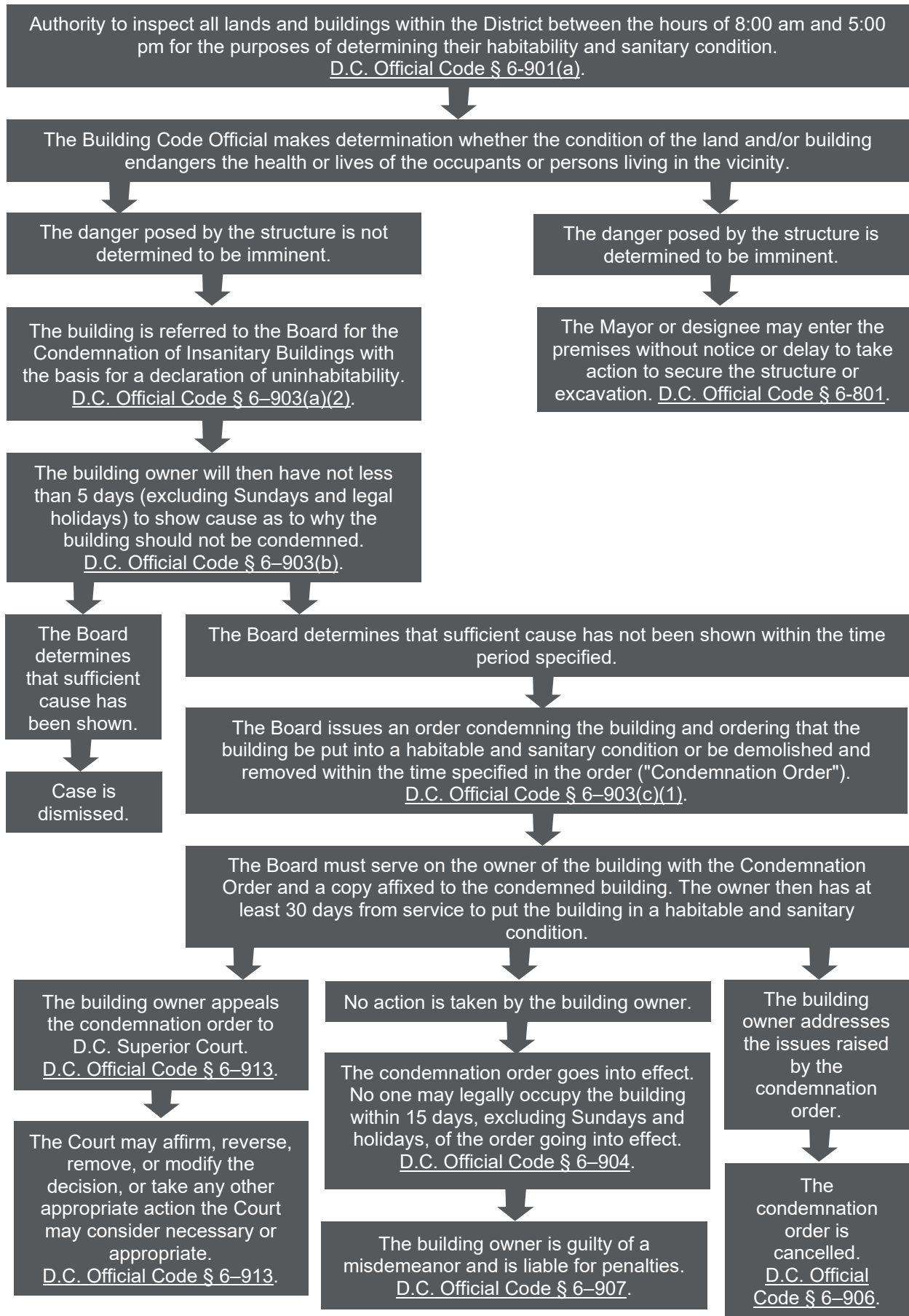


Duration and Extension of Order

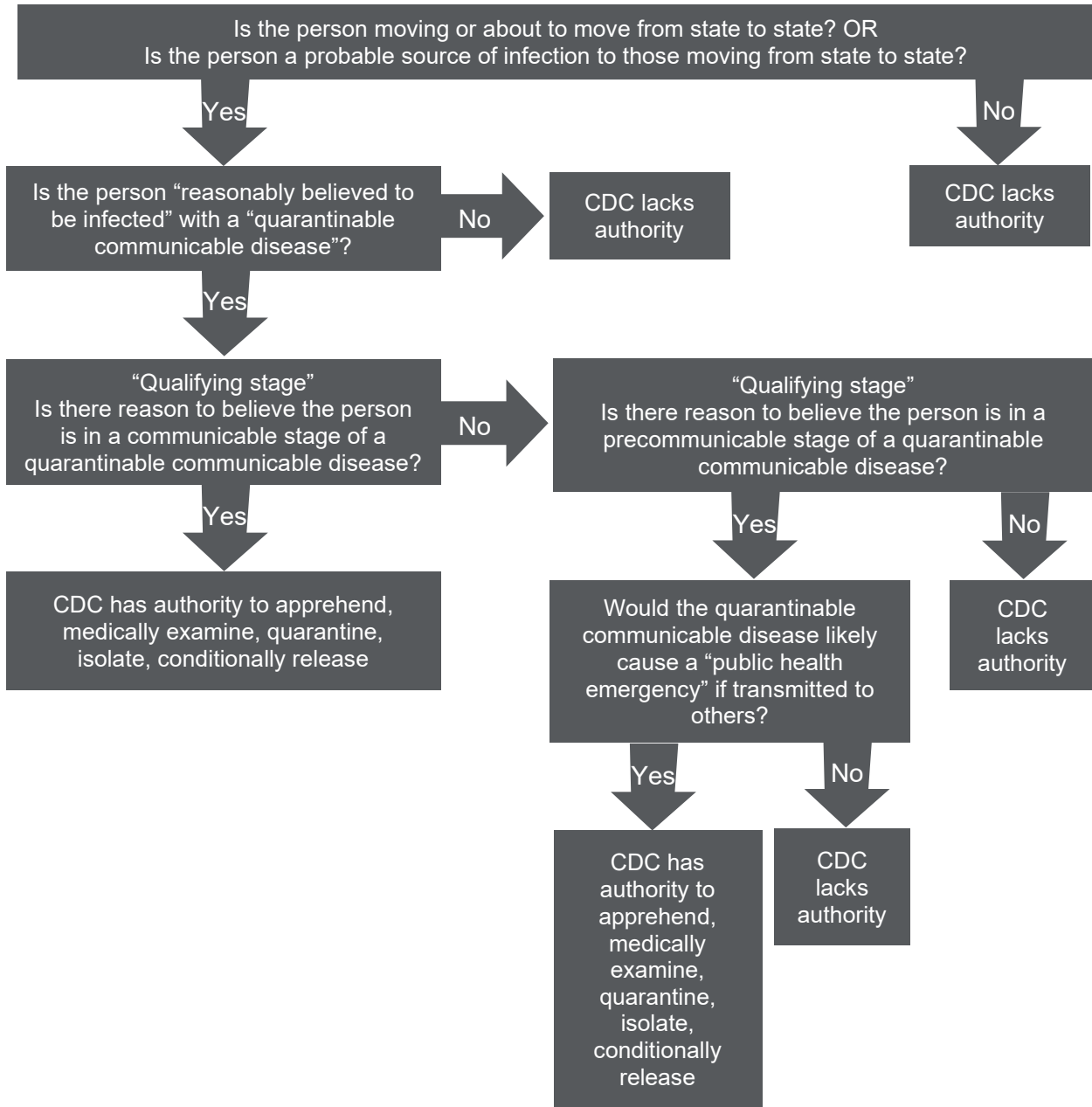
Lasts 15 days and may be extended for 15 additional days upon approval of D.C. Council.

D.C. Official Code § 7-2306.

INSPECTION AND CONDEMNATION

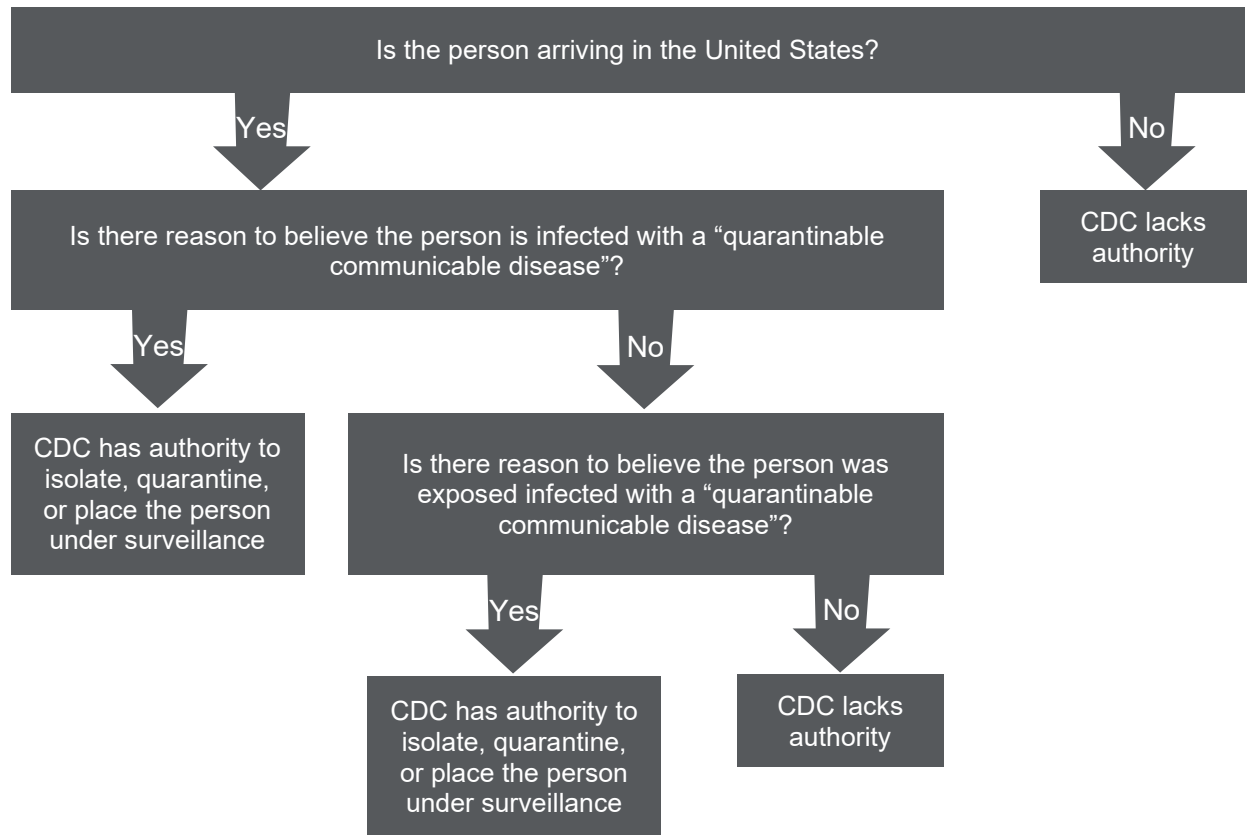


FEDERAL PUBLIC HEALTH ORDERS AND INTERSTATE TRAVEL, PART 70



Adapted from a chart developed in March 2017 by Andy Baker-White, Senior Director, State Health Policy, Association of State and Territorial Health Officials.

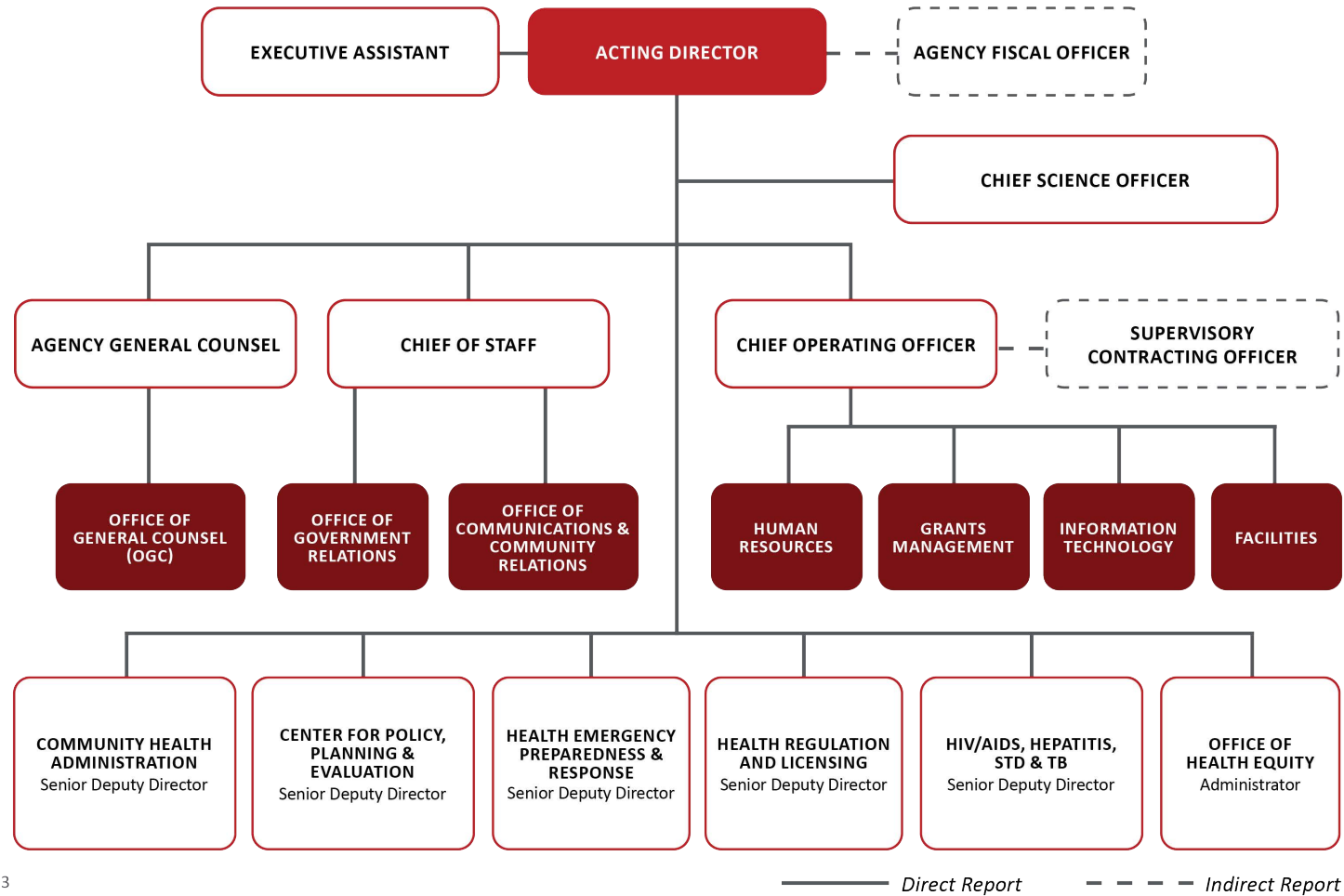
FEDERAL PUBLIC HEALTH ORDERS AND FOREIGN TRAVEL, PART 71



Adapted from a chart developed in March 2017 by Andy Baker-White, Senior Director, State Health Policy, Association of State and Territorial Health Officials.

APPENDIX 4.0 DC HEALTH ORGANIZATIONAL CHART

DC HEALTH ORGANIZATION STRUCTURE



APPENDIX 5.0 ALPHABETICAL LISTING OF NOTIFIABLE DISEASES



Notifiable Diseases and Conditions in the District of Columbia

| Disease/Condition | Code | Disease/Condition | Code |
|---|-----------------|--|-----------------|
| An emerging infectious disease or an unusual occurrence of any disease | I* | Encephalitis, acute arboviral (e.g. Eastern Equine, St. Louis, Western Equine) | I* |
| An infection or outbreak (e.g. healthcare-associated and foodborne) that may be of public health concern | I* | Gastrointestinal illness outbreak - school/child care facility-associated | 24 [±] |
| Animal bites | I | Giardiasis | 48 |
| Anthrax (<i>Bacillus anthracis</i>) | I* | Gonococcal infection | 48 |
| Babesiosis | 48 | Granuloma inguinale | 48 |
| Botulism | I* | <i>Haemophilus influenzae</i> , invasive disease | 24 |
| Brucellosis | 24 | Hand, foot, and mouth disease outbreak - school/child care facility-associated | 24 [±] |
| Campylobacteriosis | 24 | Hantavirus pulmonary syndrome (HPS) | I* |
| Carbapenem-resistant enterobacteriaceae (CRE) - LabID event | NHSN | Head lice outbreak - school/child care facility-associated | 24 [±] |
| Catheter-associated urinary tract infections (CAUTIs) | NHSN | Hemolytic uremic syndrome | I* |
| Central line-associated bloodstream infections (CLABSIs) | NHSN | Healthcare-associated infection (cluster or outbreak) | 24 |
| Chancroid | 48 | Hepatitis (B,C) #- pregnancy in a woman positive for hepatitis B or C also requested | 48 |
| Chickenpox (morbidity, pediatric mortality) | 48 | Hepatitis A | I |
| Chikungunya | 24 | Human immunodeficiency virus (HIV) infection and pregnancies in HIV-infected women | 48 |
| <i>Chlamydia trachomatis</i> infection (including PID, perinatal, and trachoma) | 48 | Impetigo outbreak - school/child care facility-associated | 24 [±] |
| Cholera (Toxigenic <i>Vibrio cholerae</i> 01 or 0139) | I* | Influenza A (novel subtype only) | I* |
| Clostridium difficile (<i>C. difficile</i>) - LabID event | NHSN | Influenza-associated mortality (patients <18 years of age) | I* |
| Coccidioidomycosis | 48 | Kawasaki disease | 48 |
| Conjunctivitis (Pink Eye) outbreak - school/child care facility-associated | 24 [±] | Lead poisoning in children | L |
| Cryptosporidiosis | 48 | Legionellosis | 48 |
| Cyclosporiasis | 48 | Leptospirosis | 48 |
| Dengue | 24 | Listeriosis | I* |
| Diphtheria | I* | Lyme Disease (<i>Borrelia burgdorferi</i>) | 48 |
| Ehrlichiosis | 48 | | |

Visit our website for details on how to report these diseases and conditions online: <http://dchealth.dc.gov/service/infectious-diseases>

| Codes | |
|--------------|--|
| NHSN | Acute care, ambulatory, long-term acute care, skilled nursing, and outpatient renal dialysis facilities should report these conditions to the National Healthcare Safety Network (NHSN) and provide DC DOH with access to these data. Definitions of these infections are provided in the most current edition of the NHSN manual (http://www.cdc.gov/nhsn/). |
| I | Must be reported immediately upon provisional diagnosis or the appearance of suspicious symptoms by submission of a case report within 24 hours. |
| I* | Must be reported immediately by telephone (see detailed guidance documents) upon provisional diagnosis or the appearance of suspicious symptoms, and confirmed by submission of a case report within 24 hours. For epidemiological support to address an urgent/emergent public health issue outside of business hours (weekdays, 8:15am-4:45pm), call 1-844-493-2652. |
| L | Must be reported to the DC Department of Energy & Environment (DOEE) immediately by telephone (202) 654-6002 or fax (202) 535-2607 if results are ≥10 µg/dL. As a courtesy, all results ≥ 5 µg/dL should also be reported immediately. Providers must report the case to DOEE by telephone within 72 hours of receiving notification from a laboratory or another provider/facility. Laboratories, including providers who utilize point-of-care testing, are required to report all test results <10 µg/dL within 1 week of analysis. |
| 24 | Must be reported within 24 hours after provisional diagnosis or the appearance of suspicious symptoms |
| 48 | Must be reported within 48 hours after provisional diagnosis or the appearance of suspicious symptoms |
| [±] | Only required to be reported by school/child care facilities when there are ≥ 3 cases that occur in the facility within a 7-day period |
| # | Acute hepatitis B is currently mandated. However, case reports for chronic and perinatal hepatitis B are requested and will be mandated in forthcoming regulations. |

| Disease/Condition | Code | Disease/Condition | Code |
|---|-----------------|---|-----------------|
| Lymphogranuloma venereum (LGV, including atypical LGV) | 24 | Shigellosis | 48 |
| Malaria | 48 | Smallpox | I* |
| Measles (Rubeola) | I* | Staphylococcal infections in newborns (nosocomial) | I |
| Melioidosis | 48 | Streptococcal infection, invasive (Pneumococcal disease) | 24 |
| Meningitis (<i>Neisseria meningitidis</i>) | I* | Streptococcal non-invasive, Group A (Scarlet fever and strep throat) outbreak - school/child care facility-associated | 24 [±] |
| Meningitis (aseptic or viral, fungal, and bacterial other than <i>N. meningitidis</i>) | 24 | Surgical site infection (SSI): Abdominal hysterectomy | NHSN |
| Meningococcal disease, invasive | I* | Surgical site infection (SSI): Colon surgery | NHSN |
| Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia - LabID event | NHSN | Syphilis (all stages, congenital) | 48 |
| Middle East Respiratory Syndrome (MERS) | I* | Tetanus | 24 |
| Mumps | I* | Toxic shock syndrome (Staphylococcal, Streptococcal, and other) | 48 |
| Pertussis (Whooping cough) | I* | Trichinosis (Trichinellosis) | 48 |
| Pinworm (Enterobiasis) outbreak - school/child care facility-associated | 24 [±] | Tuberculosis | 48 |
| Plague (<i>Yersinia pestis</i>) | I* | Tularemia | I* |
| Poliovirus infection | I* | Typhoid fever (<i>Salmonella typhi</i>) | I* |
| Powassan virus | 48 | Urethritis, atypical | 48 |
| Psittacosis (Ornithosis) | 24 | Vaccine adverse events | 48 |
| Q Fever | 24 | Vibriosis (non-cholera <i>Vibrio</i> species infections) | I |
| Rabies (animal or human) | I* | Viral hemorrhagic fevers (Ebola or other) | I* |
| Rickettsiosis, spotted fever (e.g. Rocky Mountain Spotted Fever) | 48 | West Nile virus | 48 |
| Ringworm (Tinea) outbreak - school/child care facility-associated | 24 [±] | Yellow fever | I* |
| Rubella, including congenital rubella syndrome | I* | Zika virus disease (including congenital Zika virus infection) | 24 |
| Salmonellosis | 48 | | |
| Scabies outbreak - school/child care facility-associated | 24 [±] | | |
| Severe Acute Respiratory Syndrome (SARS) | I* | | |
| Shiga toxin-producing <i>Escherichia coli</i> (STEC) | I | | |

Visit our website for details on how to report these diseases and conditions online: <http://dchealth.dc.gov/service/infectious-diseases>

| Codes | |
|-------------|--|
| NHSN | Acute care, ambulatory, long-term acute care, skilled nursing, and outpatient renal dialysis facilities should report these conditions to the National Healthcare Safety Network (NHSN) and provide DC DOH with access to these data. Definitions of these infections are provided in the most current edition of the NHSN manual (http://www.cdc.gov/nhsn/). |
| I | Must be reported immediately upon provisional diagnosis or the appearance of suspicious symptoms by submission of a case report within 24 hours. |
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| L | Must be reported to the DC Department of Energy & Environment (DOEE) immediately by telephone (202) 654-6002 or fax (202) 535-2607 if results are ≥10 µg/dL. As a courtesy, all results ≥ 5 µg/dL should also be reported immediately. Providers must report the case to DOEE by telephone within 72 hours of receiving notification from a laboratory or another provider/facility. Laboratories, including providers who utilize point-of-care testing, are required to report all test results <10 µg/dL within 1 week of analysis. |
| 24 | Must be reported within 24 hours after provisional diagnosis or the appearance of suspicious symptoms |
| 48 | Must be reported within 48 hours after provisional diagnosis or the appearance of suspicious symptoms |
| ± | Only required to be reported by school/child care facilities when there are ≥ 3 cases that occur in the facility within a 7-day period |
| # | Acute hepatitis B is currently mandated. However, case reports for chronic and perinatal hepatitis B are requested and will be mandated in forthcoming regulations. |

For a print version of this document visit:

<https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Notifiable%20Diseases%20and%20Conditions%20in%20DC%20v20180327.pdf>

APPENDIX 6.0 DNA EVIDENCE COLLECTION CONSENT FORM



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF MEDICAL EXAMINER
401 E Street, SW Washington, D.C. 20024

DNA EVIDENCE COLLECTION CONSENT FORM

Donor Subject:

Name: _____
Last First Middle Initial

Relationship to Decedent: _____

Race/Ethnicity of Donor: _____ Race/Ethnicity of Decedent: _____

Donor History:

Have you:

Ever had a bone marrow transplant? No Yes: Date _____

Had a blood transfusion within the last 90 days? No Yes

To be completed by person collecting the sample: (note: please take 2 buccal swabs)

Type of Sample: Buccal Swabs x2 DNA Card Other: _____

Collection Facility: OCME Other: _____

Name of Person Collecting Sample: _____ Date: _____

Signature of Person Collecting Sample: _____

I HEREBY AUTHORIZE THE OFFICE OF THE CHIEF MEDICAL EXAMINER, WASHINGTON D.C., TO PERFORM DNA TESTING ON THE SAMPLE(S) OBTAINED FROM ME. I VERIFY THAT THE ABOVE IDENTIFICATION AND INFORMATION IS TRUE AND CORRECT.

Signature of Donor Subject
(or guardian if under 18)

Date

Revision Date 6/16/2016

APPENDIX 7.0 COMMONLY USED ACRONYMS AND ABBREVIATIONS

| | |
|--|---|
| AAFP | American Academy of Family Physicians |
| AAP | American Academy of Pediatrics |
| ACIP | Advisory Committee on Immunization Practices |
| ACS | District's Alternate Care Site |
| ADA | Americans with Disabilities Act |
| AIDS | Acquired Immune Deficiency Syndrome |
| ASPR | Assistant Secretary for Preparedness and Response |
| ASSLA | District Accrued Sick and Safe Leave Act |
| CARES Act | Coronavirus Aid, Relief, and Economic Security Act |
| CBRN | Chemical, Biological, Radioactive, or Nuclear Event |
| CBRNE | Chemical, Biological, Radioactive, Nuclear, or Explosive Event |
| CCAs | Complex Coordinated Attacks |
| CCTV | Closed-Circuit Television |
| CDC | Centers for Disease Control and Prevention |
| CDC's ID Framework | Centers for Disease Control and Prevention Framework for Preventing Infectious Diseases |
| CGMP | Current Good Manufacturing Practice |
| CfC | Conditions for Coverage |
| CHIP | Children's Health Insurance Program |
| CISA | United States Department of Homeland Security's Cybersecurity and Infrastructure Security Agency |
| CME | Chief Medical Examiner |
| CMS | Centers for Medicare and Medicaid Services |
| CMS Emergency Preparedness Rule | Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers |
| CMT | Consequence Management Team |
| CON | Certificate of Need |
| CoP | Conditions of Participation |
| Court of Appeals | District of Columbia Court of Appeals |
| COVID-19 | Coronavirus Disease 2019, caused by the virus SARS-CoV-2 |
| CSC | Crisis Standards of Care |
| D.C. | District of Columbia |
| D.C. Council | The Council of the District of Columbia |
| D.C. FOIA | District of Columbia Freedom of Information Act |
| D.C. HIE | District of Columbia Health Information Exchange |
| D.C. MRC | District of Columbia Medical Reserve Corps |
| DC Health-HMC | DC Health, Health and Medical Coalition |
| DE-DSI | Division of Epidemiology-Disease Surveillance and Investigation |
| DHS | United States Department of Homeland Security |

| | |
|----------------------|--|
| DHS Secretary | Secretary of the United States Department of Homeland Security |
| District | District of Columbia |
| DNB | Do Not Board |
| DOJ | United States Department of Justice |
| DOL | United States Department of Labor |
| DOEE | District of Columbia Department of Energy & Environment |
| DRC | Democratic Republic of the Congo |
| DRP | District Response Plan |
| DVI | Disaster Victim Identification |
| EDO | Emergency Dispensing Order |
| EMA | European Medicines Agency |
| EMAC | Emergency Management Assistance Compact |
| EMS | Emergency Medical Services |
| EMTALA | Emergency Medical Treatment and Active Labor Act |
| EOC | District of Columbia's Emergency Operations Center |
| EPA | United States Environmental Protection Agency |
| EPC | Mayor's Emergency Preparedness Council |
| ESF | Emergency Support Function |
| EUA | Emergency Use Authorization |
| EUI | Emergency Use Instructions |
| EVD | Ebola Virus Disease |
| FAC | Family Assistance Center |
| FD&C Act | Federal Food, Drug, and Cosmetic Act |
| FDA | United States Food and Drug Administration |
| FEMA | Federal Emergency Management Agency |
| FFCRA | Families First Coronavirus Response Act |
| Food Code | District Food Code, 25-A DCMR § 100 <i>et seq.</i> |
| GAO | Government Accountability Office |
| HAI | Healthcare associated infection |
| HEPRA | District of Columbia Health Emergency Preparedness and Response Administration |
| HHS | United States Department of Health and Human Services |
| HHS OCR | United States Department of Health and Human Services Office for Civil Rights |
| HHS OGC | Office of the General Counsel of United States Department of Health and Human Services |
| HHS Secretary | United States Secretary of Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act |
| HITECH Act | Health Information Technology for Economic and Clinical Health Act |
| HIV | Human Immunodeficiency Virus |
| HMR | Hazardous Materials Regulations |
| HRLA | Health Regulation and Licensing Administration |

| | |
|---------------------|---|
| HSEMA | District of Columbia Homeland Security and Emergency Management Agency |
| IOM | Institute of Medicine |
| IRTPA | Intelligence Reform and Terrorism Prevention Act of 2004, Public Law 108-458 , as amended by Senate Report 110-237, S. 1245 |
| Lookout | The Public Health Boarder Lookout |
| Mayor | Mayor of the District of Columbia |
| MCM | Medical Countermeasures |
| MERS | Middle Eastern Respiratory Syndrome, caused by the virus MERS-CoV |
| MMR | Measles, Mumps, Rubella |
| MPD | Metropolitan Police Department |
| MPOX | Monkeypox |
| MRC | Medical Reserve Corps |
| MWCOG | Metropolitan Washington Council of Governments |
| NCR | National Capital Region |
| NCREPC | National Capital Region Emergency Preparedness Council |
| NDMS | National Disaster Medical System |
| NEA | National Emergencies Act |
| NIH | National Institutes of Health |
| NIOSH | National Institute for Occupational Safety and Health |
| NSSE | National Special Security Event |
| NYC | New York City |
| OAG | Office of the Attorney General |
| OCME | Office of the Chief Medical Examiner |
| ODR | Mayor's Office of Disability Rights |
| PAHPIA | Pandemic and All-Hazards Preparedness and Advancing Innovation Act of 2019 |
| PETS Act | Pets Evacuation and Transportation Standards Act |
| PHEIC | Public Health Emergency of International Concern |
| PHEMCE | Public Health Emergency Medical Countermeasure Enterprise |
| PHI | Protected Health Information |
| PHL | Public Health Laboratories |
| PHS | Public Health Service |
| POD | Point of Dispensing |
| PPE | Personal Protective Equipment |
| PPP | Paycheck Protection Program |
| PREP Act | The Public Readiness and Emergency Preparedness Act of 2005 |
| Privacy Rule | Federal Standards for Privacy of Individually Identifiable Health Information |
| PUI | Patients Under Investigation |
| RCDOH | Rockland County Department of Health |
| RECP | Regional Emergency Coordination Plan |

| | |
|-----------------------|---|
| RECs | Regional Emergency Coordinators |
| REMS | Risk Evaluation and Mitigation Strategies |
| RESF | Regional Emergency Support Function |
| SARS | Severe Acute Respiratory Syndrome, caused by the virus SARS-CoV |
| SNAP | Supplemental Nutrition Assistance Program |
| SNS | Strategic National Stockpile |
| SSA | Social Security Act |
| Stafford Act | The Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 |
| Superior Court | Superior Court of the District of Columbia |
| TB | Tuberculosis |
| The Manual | District of Columbia Public Health Emergency Law Manual |
| TRACIE | Technical Resources, Assistance Center, and Information Exchange |
| U.S. | United States |
| U.S. DOT | United States Department of Transportation |
| UEVHPA | Uniform Emergency Volunteer Health Practitioners Act |
| USDA | United States Department of Agriculture |
| WHO | World Health Organization |

APPENDIX 8.0 GLOSSARY OF TERMS

*Terms defined in the manual are not included in the glossary of terms.

| A | |
|-------------------------------------|---|
| Acute | Of rapid onset, brief. An acute condition may, but need not necessarily, be severe. Stedman's Medical Dictionary (28th edition, 2006) |
| Administrative Warrants | A warrant issued by a judge on the application of an administrative agency. Administrative agencies with enforcement power often seek administrative warrants to check for contraband or other evidence of non-compliance with the law. Cornell Law School |
| Affidavit | A voluntarily sworn declaration of written facts. Affidavits are commonly used to present evidence in court. See, e.g. <i>Edenfield v. Fane</i> , 507 U.S. 761 (1993). Cornell Law Library |
| All-Hazards | Natural, technological, or human-caused incidents that warrant action to protect life, property, environment, and public health or safety, and to minimize disruptions of school activities. The Federal Emergency Management Agency |
| Ambulatory Surgical Facility | Any facility, other than a hospital or maternity center but including an office-based facility, at which there are performed outpatient surgical and related procedures that have been classified in accordance with § 44-504(h) due to their complexity or the degree of patient risk. D.C. Official Code § 44-501 |
| Antibody | A protein found in the blood that is produced in response to foreign substances (e.g. bacteria or viruses) invading the body. Antibodies protect the body from disease by binding to these organisms and destroying them. Centers for Disease Control and Prevention |
| B | |
| Biological Attack | The deliberate release of germs or other biological substances that can cause sickness. The Centers for Medicare & Medicaid Services |
| Biological Product | A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings. 42 U.S. Code § 262 |
| C | |
| Carrier | A person or animal harboring in his or her or its body the specific infectious agent of a communicable disease without manifest |

symptoms and being a potential source or reservoir of infection for man. [22-B DCMR § 299](#)

Chemical, Biological, Radioactive, Nuclear, or Explosive

Threat agents, radiological materials, and explosives that are dangerous, non-traditional warfare agents. These chemical agents are not used or created for industrial or manufacturing purposes and are therefore only illicit in nature. Together, they comprise the bulk of what is traditionally known as weapons of mass destruction. [DC District Response Plan](#)

Clear and Convincing Evidence

The standard of clear and convincing evidence requires a degree of persuasion much higher than mere preponderance of evidence but still somewhat less than beyond a reasonable doubt. Clear and convincing evidence is evidence that should produce in the mind of the trier of fact a firm belief or conviction as to the facts sought to be established. *Bums v. U.S.*, 880 A.2d 258, 261 fn. 2 (D.C. 2005); *Brown v. The George Washington Univ.*, 802 A.2d 382, 386 n. 6 (D.C. 2002) (describing the standard in a failure-to-promote case); *Henson v. District of Columbia Dept. of Consumer and Regulatory Affairs*, 560 A.2d 543, 545 (D.C. 1989)

Communicable

Capable of being transmitted from one organism or person to another. [Stedman's Medical Dictionary \(28th edition, 2006\)](#)

Complex Coordinated Attack

Also known as a Complex Coordinated Terrorist Attack, is a violent assault or series of assaults by one or more individuals or groups using one or more types of weapons with the intent to inflict harm on large numbers of people. While these type of attacks often result from various motives including terrorist ideology, the continued proliferation of CCAs overseas and domestically demonstrates that CCAs remain a concern for the conceivable future. [The Cybersecurity and Infrastructure Security Agency](#)

Compulsory Treatment

Medical or psychiatric treatment which is ordered or required by courts or the government. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

Consequence Management

Measures to protect public health and safety, restore essential government services, and provide emergency relief to governments, businesses, and individuals affected by the consequences of terrorism. [The Federal Emergency Management Agency](#)

Contact

Any person or animal that has associated with a person or animal infected by a communicable disease, or with an object contaminated by the infectious agent of a communicable disease, in a manner that would provide the person or animal the opportunity of acquiring the disease. [22-B DCMR § 299](#)

Contagious

Capable of being transmitted from one person to another by contact or close proximity. [Centers for Disease Control and Prevention](#)

Contamination The undesirable deposition of a chemical, biological, or radiological material on the surface of structures, areas, objects, or people. [The Federal Emergency Management Agency](#)

D

Decontamination The elimination of poisonous or otherwise harmful agents, such as chemicals or radioactive materials, from a person or object. [Stedman's Medical Dictionary \(27th edition, 2000\)](#)

Device An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:

- (A) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them,
- (B) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or
- (C) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. The term "device" does not include software functions excluded pursuant to section 360j(o) of this title.

[21 U.S. Code § 321](#)

Directly Observed Therapy Visual monitoring of an individual's ingestion of medications by a healthcare worker to ensure compliance in difficult or long-term regimens, such as in oral treatment for tuberculosis. [Stedman's Medical Dictionary \(28th edition, 2006\)](#)

Disease An interruption, cessation, or disorder of a body, system, or organ structure or function; a departure from a state of health. [Stedman's Medical Dictionary \(28th edition, 2006\)](#)

Drug

- (A) Articles recognized in the official United State Pharmacopoeia, official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them;
- (B) Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;
- (C) Articles (other than food) intended to affect the structure or any function of the body of man or other animals; and
- (D) Articles intended for use as a component of any article specified in clause (A), (B), or (C).

[21 U.S. Code § 321](#)

E

| | |
|---|--|
| <i>Ectoparasite</i> | A classification of animals that includes those with hard, segmented bodies and jointed appendages, such as insects. Ectoparasites are usually arthropods which parasitize the skin. Centers for Disease Control and Prevention |
| <i>Effectiveness</i> | The extent to which a treatment achieves its intended purpose in an average clinical environment. Stedman's Medical Dictionary (28th edition, 2006) |
| <i>Efficacy</i> | The extent to which a treatment achieves its intended purpose under ideal circumstances. Stedman's Medical Dictionary (28th edition, 2006) |
| <i>Emergency</i> | An unexpected serious occurrence which usually requires immediate attention. 22-B DCMR § 3299 |
| <i>Emergency Declaration</i> | There are two types of emergency declarations: public emergency declarations and public health emergency declarations. A public emergency involves situations arising from disasters, catastrophes, or other emergency circumstances, including floods, earthquakes, fires, and serious civil disorders, that threaten the health, safety, or welfare of individuals in the District. A public health emergency is an emergency that involves a large number of deaths and/or serious human health disabilities in the District, widespread exposure to an infectious or toxic agent, use, dissemination, or detonation of a weapon of mass destruction, or another type of emergency event that requires the use of volunteer health practitioners. A public health emergency may not be declared unless a public emergency is also declared. See section 4.5 of the Manual |
| <i>Emergency Operations Center</i> | The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., federal, state, regional, county, city, tribal), or by some combination thereof. District of Columbia District Response Plan |
| <i>Emergency Support Function</i> | A grouping of government and certain private-sector capabilities into an organizational structure to provide the support, resources, program implementation, and services that are most likely to be needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help survivors and communities return to normal. District of Columbia District Response Plan |
| <i>Enforcement Action</i> | A criminal prosecution, an action seeking an injunction, a seizure action, a civil monetary proceeding based on willful misconduct, a |

mandatory recall of a product because voluntary recall was refused, a proceeding to compel repair or replacement of a product, a termination of an exemption under section 505(i) or 520(g) of the Federal Food, Drug, and Cosmetic Act, a debarment proceeding, an investigator disqualification proceeding where an investigator is an employee or agent of the manufacturer, a revocation, based on willful misconduct, of an authorization under section 564 of such Act, or a suspension or withdrawal, based on willful misconduct, of an approval or clearance under chapter V of such Act or of a licensure under section 351 of this Act. [Public Law 109-148](#)

Epidemic

An increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. [Centers for Disease Control and Prevention](#)

Epidemiology

The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems. [Stedman's Medical Dictionary \(28th edition, 2006\)](#)

Exemption

Immunity, exception, or freedom from the liability, duty, or other requirements

[Cornell Law School](#)

Ex Parte Hearings

Latin for 'from one party.' In civil procedure, ex parte is used to refer to motions for orders that can be granted without waiting for a response from the other side. Generally, these are orders that are only in place until further hearings can be held, such as a temporary restraining order.

Typically, a court will be hesitant to make an ex parte motion. This is because the Fifth Amendment and the Fourteenth Amendment guarantee a right to due process, and ex parte motions--due to their exclusion of one party--risk violating the excluded party's right to due process.

[Cornell Law School](#)

Exposure

In communicable disease control, contact with a source of a disease agent that leads to transmission of the agent to a new host. Exposure can also occur through contact with a substance by swallowing, breathing, or touching the skin or eyes. Exposure may be short-term (acute exposure), of intermediate duration, or long-term (chronic exposure). [Oxford Dictionary of Public Health \(second edition, 2018\)](#) and [Agency for Toxic Substances and Disease Registry](#)

F

Family Reunification The process of ensuring that children return to the care of their parent(s) and family as quickly as possible after an emergency. [Centers for Disease Control and Prevention](#)

G

Good Faith A term that generally describes honest dealing. Depending on the exact setting, good faith may require an honest belief or purpose, faithful performance of duties, observance of fair dealing standards, or an absence of fraudulent intent. [Cornell Law School](#)

Gross Negligence A lack of care that demonstrates reckless disregard for the safety or lives of others, which is so great it appears to be a conscious violation of other people's rights to safety. It is more than simple inadvertence, and can affect the amount of damages. [Cornell Law School](#)

H

Habeas Corpus Latin for "that you have the body." In the U.S. system, federal courts can use the writ of habeas corpus to determine if a state's detention of a prisoner is valid. A writ of habeas corpus is used to bring a prisoner or other detainee (e.g., institutionalized mental patient) before the court to determine if the person's imprisonment or detention is lawful. See, e.g. *Knowles v. Mirzayance* 556 U.S. 111 (2009), *Felker v. Turpin* 518 U.S. 1051 (1996), and *McCleskey v. Zant* 499 U.S. 467 (1991). [Cornell Law School](#)

Healthcare Provider Any person or entity who provides healthcare services, including hospitals, medical clinics and officers, special care facilities, medical laboratories, physicians, pharmacists, dentists, physician assistants, nurse practitioners, registered and other nurses, paramedics, emergency medical or laboratory technicians, and ambulance and emergency medical workers. [D.C. Official Code § 7-2301](#)

Home Care Agency An agency, organization, or distinct part thereof, other than a hospice, that directly provides skilled nursing services and at least one other therapeutic service to an individual, in his or her home or in a community residence facility, who is sick or who has a disability. [D.C. Official Code § 44-501](#)

Hospice An agency, organization, facility, or distinct part thereof, primarily engaged in providing a program of in-home, outpatient, or inpatient medical, nursing, counseling, bereavement, and other palliative and supportive services to terminally ill individuals and their families. [D.C. Official Code § 44-501](#)

| | |
|-----------------|---|
| Hospital | A facility that provides 24-hour inpatient care, including diagnostic, therapeutic, and other health-related services, for a variety of physical or mental conditions, and may in addition provide outpatient services, particularly emergency care. D.C. Official Code § 44-501 |
| Host | A person, animal, or population group that harbors a disease agent, such as a pathogenic microorganism. In many diseases, the host is the human who harbors the disease agent, but some disease agents have complex life cycles involving an intermediate host as well as a definitive host in which the disease is manifest. Oxford Dictionary of Public Health (second edition, 2018) |

I

| | |
|-----------------------------|---|
| Immunity | Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected. Centers for Disease Control and Prevention |
| Incubation Period | The period of time between a disease agent's entry into an organism and the organism's initial display of disease symptoms. During the incubation period, the disease is developing. Incubation periods are disease-specific and may range from hours to weeks. Stedman's Medical Dictionary (28th edition, 2006) |
| Infection Control | Prevents or stops the spread of infections in healthcare settings. This site includes an overview of how infections spread, ways to prevent the spread of infections, and more detailed recommendations by type of healthcare setting. Centers for Disease Control and Prevention |
| Infectious Agent | A disease-causing organism (e.g. prion, virus, bacterium, fungus, or parasite). 22-B DCMR § 299 |
| Infectious Disease | A disease caused by a communicable agent. 22-B DCMR § 2099 |
| Infectious Substance | Department of Transportation rule revises the definition of an infectious substance to a two-category system adopted by the World Health Organization: Category A is for high-risk infectious substances and Category B is for all other infectious substances. A Category A infectious substance is one that is transported in a form capable of causing permanent disability or life-threatening or fatal disease to otherwise healthy humans or animals when exposure to it occurs. An exposure occurs when an infectious substance is released outside of its protective packaging, resulting in physical contact with humans or animals. Examples are the Ebola, Junin, and Nipah viruses. These substances are assigned the identification number of UN 2814 or UN 2900, as appropriate. A Category B infectious substance is one that does not meet the criteria for inclusion in Category A. A Category B infectious substance is not in a form generally capable of causing permanent disability or life-threatening or fatal disease to humans or animals when exposure to it occurs. Specimens previously termed "diagnostic" and "clinical" |

belong to Category B substances. [Centers for Disease Control and Prevention](#)

Inpatient

The provision of healthcare services over a period of twenty-four (24) consecutive hours or longer. [22-B DCMR § 4099](#)

L

Loss

Any type of loss, including:

- (A) Death;
- (B) Physical, mental, or emotional injury, illness, disability, or condition;
- (C) Fear of physical, mental, or emotional injury, illness, disability, or condition, including any need for medical monitoring; and
- (D) Loss of or damage to property, including business interruption loss.

[42 U.S. Code § 247d–6d](#)

M

Medical Countermeasures

FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, or a naturally occurring emerging disease. [The Food and Drug Administration](#)

Medical Exemption

Certification that a required immunization is or may be detrimental to a person's health and therefore the person is not required to receive the specified immunization. [G.S. §130A-156](#)

Morbidity

Sickness, the state or condition or being unwell. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

Mortality

Death. Usually the cause (a specific disease, a condition, or an injury) is stated. [The Agency for Toxic Substances and Disease Registry](#)

N

National Security Special Event

An event of national significance as determined by the Secretary of Homeland Security. These national or international events, occurrences, contests, activities, or meetings, which, by virtue of their profile or status, represent a significant target, and therefore warrant additional preparation, planning, and mitigation efforts. The USSS, FBI, and FEMA are the Federal agencies with lead responsibilities for NSSEs; other Federal agencies, including DoD,

may provide support to the NSSE if authorized by law. [U.S. Government Publishing Office](#)

Non-Pharmaceutical Interventions

Actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic influenza (flu). [Centers for Disease Control and Prevention](#)

Notifiable Disease

A disease “that, by statutory requirements, must be reported to the public health or veterinary authorities when the diagnosis is made because of its importance to human or animal health.” [Stedman’s Medical Dictionary \(28th edition, 2006\)](#)

O

Opportunistic Infection

An infection that occurs because the pathogenic organism(s) causing it to have an opportunity to invade a susceptible host, usually when the host’s immune system has been compromised by HIV infection, the use of immunosuppressive medication or radiation, or other factors, such as debility associated with advanced old age. Common opportunistic infections include mycoses such as *Candida albicans* and organisms such as *Pneumocystis carinii*. Latent tuberculosis can be reactivated by opportunistic infection. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

Outbreak

The occurrence of an illness of public health importance, when the occurrence is in unusual numbers or under unusual circumstances. [22-B DCMR § 299](#)

Outpatient

The provision of healthcare services over less than twenty-four (24) consecutive hours. [22-B DCMR § 4099](#)

P

Pandemic

An occurrence of a disease affecting the population of an extensive geographic area. [Stedman’s Medical Dictionary \(28th edition, 2006\)](#)

Personal Protective Equipment

A main source of protection for emergency and recovery workers. Depending on the type of emergency which may include flooding, hurricanes, fire, electricity, structural collapse, falls, terrorism, earthquakes, tornadoes, extreme temperatures, diseases, among others. It is necessary to protect emergency response and recovery workers from physical, chemical and biological hazards. Routes of exposure include inhalation, dermal contact, ingestion or contact through mucous membranes. Therefore, main protective equipment includes respirators, eye protection, hearing protection and protective clothing. Depending on the hazard, the recommendations on the use of PPE change. Some examples of PPE may include

Gas masks, gloves, overalls, boots, and goggles. [Centers for Disease Control and Prevention](#)

Police Power

The authority conferred on public health officials by laws and local regulations to take action to protect the health of the public. It includes the power to detain persons diagnosed with contagious diseases that endanger others and has in the past included the authority to enter and search premises to seize persons who have or are in contact with certain contagious diseases. Overzealous use of police powers in the early 20th century, to search homes and seize healthy child contacts of cases of diphtheria, typhoid, or poliomyelitis, received unfavorable publicity that sometimes gave public health authorities an unsavory reputation. Police Power is seldom invoked today but has been used occasionally to restrain irresponsible promiscuous individuals with diagnosed HIV disease. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

Prima facie

Latin for "at first sight." May be used as an adjective meaning "sufficient to establish a fact or raise a presumption unless disproved or rebutted." An example of this would be to use the term "prima facie evidence." [Cornell Law Library](#)

Prophylaxis

The preventive management of disease in individuals and populations. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

Protocol

A written procedural approach to a specific problem or condition. [IOM Guidance document](#)

Public Health Law

The study of the legal powers and duties of the state . . . to ensure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and of the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice. [Public Health Law \(third edition, 2016\)](#)

R

Recovery

A phase after a disaster event in which actions are no longer addressing life-safety related issues. The development, coordination, and execution of service- and site-restoration plans for affected communities and the reconstitution of government operations and services through individual, private sector, nongovernmental, and public assistance programs that identify needs and define resources; provide housing and promote restoration; address long-term care and treatment of affected persons; implement additional measures for community restoration; incorporate mitigation measures and techniques, as feasible; evaluate the incident to identify lessons learned; and develop

initiatives to mitigate the effects of future incidents. [District of Columbia District Response Plan](#)

Religious Exemption

Certification that an individual's religious beliefs are contrary to the immunization requirements and therefore allowing the individual to attend an educational institution or facility without presenting a certificate of immunization. [G.S. §130A-157](#)

Reservoir

The living or non-living material an infectious agent depends on for its survival. The infectious agent multiplies and/or develops in or on the reservoir. [Stedman's Medical Dictionary \(28th edition, 2006\)](#)

Risk

The likelihood that an adverse health effect will occur within a population as a result of a hazard in a food. [25A DCMR § 9901](#)

S

Serology

Measurement of antibodies, and other immunological properties, in the blood serum. [Centers for Disease Control and Prevention](#)

Special Event

A significant domestic or internal event, occurrence, contest, activity, or meeting that, by virtue of its profile and/or status, represents an attractive target for a terrorist attack. [32 C.F.R. § 183.3](#)

Strategic National Stockpile

The nation's largest supply of potentially life-saving pharmaceuticals and medical supplies for use in a public health emergency severe enough to cause local supplies to run out.

When state, local, tribal, and territorial responders request federal assistance to support their response efforts, the stockpile ensures that the right medicines and supplies get to those who need them most during an emergency. Organized for scalable response to a variety of public health threats, this repository contains enough supplies to respond to multiple large-scale emergencies simultaneously.

[The Office of the Assistant Secretary for Preparedness and Response](#)

Surge Capacity

The accommodation by the health system to a transient sudden rise in demand for healthcare following an incident with real or perceived adverse health effects. As neither the risk of surge nor the size of surge can be estimated, neither can surge capacity be estimated. The proper approach to surge is surge management planning rather than surge capacity planning. [The Centers for Medicare & Medicaid Services](#)

Surveillance

A type of observational study that involves continuous monitoring of disease occurrence within a population. [Stedman's Medical Dictionary \(27th edition, 2000\)](#)

T

Terrorism

The National Strategy for Homeland Security characterizes terrorism as any premeditated, unlawful act dangerous to human life or public welfare that is intended to intimidate or coerce civilian populations or governments. This description captures the core concepts shared by the various definitions of terrorism contained in the U.S. Code, each crafted to achieve a legal standard of specificity and clarity. This description covers kidnappings; hijackings; shootings; conventional bombings; attacks involving chemical, biological, radiological, or nuclear weapons; cyber-attacks; and any number of other forms of malicious violence. Terrorists can be U.S. citizens or foreigners, acting in concert with others, on their own, or on behalf of a hostile state. [The Federal Emergency Management Agency](#)

Toxin

A harmful or poisonous substance that is formed during the metabolism and growth of certain microorganisms and some plant and animal species. [Stedman's Medical Dictionary \(27th edition, 2000\)](#)

Transmission

The conveyance of disease from one organism to another. [Stedman's Medical Dictionary \(27th edition, 2000\)](#)

V

Vector-Borne Disease

A large and miscellaneous class of diseases that are transmitted to humans by vectors, predominantly insects. They include mosquito-borne diseases caused by viruses, bacteria, protozoa, and helminths; diseases spread by blackflies and other biting and blood-sucking flies, ticks, lice, fleas, etc.; and diseases in which the intermediate hosts are fish, freshwater snails, and mammals. [Oxford Dictionary of Public Health \(second edition, 2018\)](#)

W

Willful Misconduct

In general- Except as the meaning of such term is further restricted pursuant to paragraph (2), the term “willful misconduct” shall, for purposes of subsection (d), denote an act or omission that is taken:

- (A) intentionally to achieve a wrongful purpose;
- (B) knowingly without legal or factual justification; and

(C) in disregard of a known or obvious risk that is so great as to make it highly probable that the harm will outweigh the benefit. [42 U.S.C. § 247d-6b](#)