



NORTH CAROLINA SHERIFFS' ASSOCIATION LAW ENFORCEMENT OFFICERS AND STATE OFFICIALS OF NORTH CAROLINA

President
SHERIFF JOHN W. INGRAM, V
Brunswick County

First Vice President
SHERIFF DAVID A. MAHONEY
Transylvania County

Second Vice President
SHERIFF ED McMAHON
New Hanover County

Third Vice President
SHERIFF CHARLES S. BLACKWOOD
Orange County

Secretary
SHERIFF ALAN C. JONES
Caldwell County

Treasurer
SHERIFF ALAN CLONINGER
Gaston County

Chairman - Executive Committee
SHERIFF JAMES E. CLEMMONS, JR.
Richmond County

Executive Vice President
and General Counsel
EDMOND W. CALDWELL, JR.

EXECUTIVE COMMITTEE MEMBERS (Past Presidents)

SHERIFF STEVE BIZZELL
Johnston County

SHERIFF SAM PAGE
Rockingham County

SHERIFF KEVIN FRYE
Avery County

SHERIFF ASA B. BUCK, III
Carteret County

SHERIFF HUBERT A. PETERKIN
Hoke County

EMAIL TO: All Sheriffs

FROM: Eddie Caldwell
Executive Vice President and General Counsel
North Carolina Sheriffs' Association

SENT: March 12, 2020

SUBJECT: COVID-19 Update

COVID-19, commonly known as the "coronavirus," was identified initially as low-risk to the public by the Centers for Disease Control and Prevention (CDC). However, on Wednesday, February 26, 2020, the CDC changed their stance on coronavirus by indicating it will likely spread in the United States. Because of this development and the March 3, 2020 appearance of the coronavirus in our State, the Association is providing you with some guidance on responding to coronavirus that will assist sheriffs in the coming months.

The CDC believes the situation with the coronavirus is rapidly evolving and their risk assessment could change daily. However, at this point, the CDC has issued Interim Guidance to all first responders, including law enforcement and telecommunicators, to assist when encountering a potential case of the coronavirus. Law enforcement most frequently encounter the public at the point of arrest, on calls, upon admittance to the jail, or via interaction with an inmate who was exposed before being admitted to the jail. Therefore, the CDC recommendations for law enforcement during these scenarios include minimizing contact with the potentially infected person until that person is wearing a facemask, wearing disposable examination gloves, using respiratory protection (N-95 or higher-level respirator), and wearing eye protection. For complete details about the CDC's Interim Guidance for first responders, see the attached "CDC Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPS) for COVID-19 in the United States."

In addition to the above Interim Guidance, there is both federal and State law relating to the quarantine and isolation of persons which could be utilized by federal and State officials during the spread of coronavirus, as explained below.

Under federal law, the United States Secretary of Health and Human Services is authorized to take steps to prevent the spread of communicable disease from foreign countries into the United States and from state to state. The CDC has been



100% Membership

Post Office Box 20049 • Raleigh, N.C. 27619-0049 • Telephone: (919) SHERIFF (743-7433)

Fax: (919) 783-5272 • E-mail: nca@ncsheriffs.net • www.ncsheriffs.org

The North Carolina Sheriffs' Association is a Non-Profit, tax exempt organization recognized by the I.R.S.

delegated the authority to carry out that mission. The CDC is authorized to detain, medically examine, and release persons arriving into the United States and traveling between states who are suspected of carrying these communicable diseases. For example, when a crew member or passenger of an airplane or captain of a ship is symptomatic, the CDC may detain the person(s) at any U.S. port or point of entry into the country to determine the cause of illness. The federal government may call upon state or local officials, such as sheriffs or chiefs of police, to enforce a federal quarantine and may also assist state and local officials in enforcing a state or local quarantine.

Furthermore, G.S. 166A-19.20 gives the Governor the authority to declare a state of emergency, which occurred on Tuesday, March 10, 2020. A copy of the Declaration of a State of Emergency (Declaration) is attached. The Governor's Declaration activates the State Emergency Operations Center to help State and local agencies coordinate coronavirus response efforts from one location. In order to prepare for the potential of coordinated response efforts under the Governor's Declaration, you should consult with your local Emergency Manager who can provide you with up-to-date information on the coordinated efforts of the Emergency Operations Center and any impact this may have on your sheriff's office. Currently, the Declaration does not require your sheriff's office to perform any specific task to assist with coronavirus response efforts.

Pursuant to G.S. 166A-19.30(b)(5), during a state of emergency, the Governor, with a concurrence of the Council of State, can do what is necessary to promote and secure the safety and protection of the citizens of this State. In addition, if the emergency becomes such that local emergency response is insufficient, G.S. 166A-19.30(c) allows the Governor to order state and local agencies and officers to coordinate their efforts and authorizes the Governor to appoint a person to manage that coordination. This occurred in the Governor's March 10 Declaration and Erik A. Hooks, Secretary of the North Carolina Department of Public Safety, has been designated to coordinate the coronavirus response. Pursuant to G.S. 166A-19.30(c)(2), all law enforcement officers involved in the coordinated efforts will be given the same power and authority as a sheriff throughout the territory where the officer is assigned.

G.S. 130A-145(a) also gives State and local health directors the ability to order isolation and quarantine when public health is endangered. Under this statute, isolation or quarantine orders are permitted only: (1) when and for so long as the public health is endangered; (2) when all other reasonable means for correcting the problem have been exhausted; and (3) when no less restrictive alternative exists. There is no statute that sets forth the specific steps a health director must follow in ordering isolation or quarantine—it is not necessary that the order even be in writing. However, orders limiting freedom of movement of persons may not exceed 30 days under G.S. 130A-145(d). Therefore, if a health director wishes to issue a longer order, they must seek an order extending that time period in superior court.

Our General Statutes also give State and local health directors the ability to delegate to law enforcement the authority to assist in enforcing the order to isolate and quarantine. G.S. 130A-6. The failure of a citizen to comply with an isolation or quarantine order is classified as a misdemeanor pursuant to G.S. 130A-25. If you have any questions or concern regarding an order to isolate or quarantine that has been delegated to you for enforcement, we recommend you consult with your legal counsel or county attorney for further guidance.

Next, Title 10A of the North Carolina Administrative Code, 10A NCAC 14J .1001, requires each jail to have a written medical plan in place. The medical plan requires, among other things, a

plan on how to screen inmates for contagious disease upon admission and how to avoid the spread of contagious disease within your jail. Your jail's medical plan is developed in consultation with your local health director or county physician pursuant to G.S. 153A-225. Therefore, we recommend you consult with these officials before a coronavirus incident is reported at your jail to ensure your medical plan adequately addresses the appropriate response to the coronavirus threat. The local health director must assist in putting an appropriate plan in place to address the threat and they should also be your point of contact for agency concerns related to coronavirus.

We are also attaching two additional documents containing helpful information regarding coronavirus and further explanation of North Carolina communicable disease law and protocol, which was prepared by the UNC School of Government. These publications may also be accessed on the internet at the following: <https://www.sog.unc.edu/resources/microsites/north-carolina-public-health-law/covid-19-coronavirus>. Finally, more valuable information from the UNC School of Government on the coronavirus can be found here: <https://canons.sog.unc.edu/resources-for-reliable-information-on-coronavirus-in-north-carolina/>.

Finally, the International Association of Chiefs of Police (IACP) has issued a General Fact Sheet and guidelines for Staying Healthy as a Police Officer, which I also attach to this email. The IACP has also prepared guidance on Organizational Readiness that can be accessed on the internet at the following: <https://www.theiacp.org/resources/document/organizational-readiness-considerations-for-preparing-your-agency-for-covid-19#.XmklcypJXFE.email>.

We will continue to update sheriffs on the coronavirus threat as appropriate, based upon the prevalence of coronavirus in this State, as the weeks progress. If you have any questions or need any additional information, please contact Matthew Boyatt, NCSA Deputy General Counsel, at (919) 459-6467 or mboyatt@ncsheriffs.net.

Thanks....Eddie C.



Edmond W. (Eddie) Caldwell, Jr.
Executive Vice President and General Counsel
North Carolina Sheriffs' Association, Inc.
Post Office Box 20049
Raleigh, North Carolina 27619-0049
Telephone: (919) 459-1052 Fax: (919) 783-5272
Email: ecaldwell@ncsheriffs.net Webpage: www.ncsheriffs.org

North Carolina Sheriffs' Association
Proudly Serving the Sheriffs and Citizens of North Carolina since 1922

Coronavirus Disease 2019 (COVID-19)



On February 11, 2020 the World Health Organization announced an official name for the disease that is causing the current outbreak of coronavirus disease, COVID-19. CDC will be updating our website and other CDC materials to reflect the updated name.

Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States

This guidance applies to all first responders, including law enforcement, fire services, emergency medical services, and emergency management officials, who anticipate close contact with persons with confirmed or possible COVID-19 in the course of their work.

Background

Emergency medical services (EMS) play a vital role in responding to requests for assistance, triaging patients, and providing emergency medical treatment and transport for ill persons. However, unlike patient care in the controlled environment of a healthcare facility, care and transports by EMS present unique challenges because of the nature of the setting, enclosed space during transport, frequent need for rapid medical decision-making, interventions with limited information, and a varying range of patient acuity and jurisdictional healthcare resources.

When preparing for and responding to patients with confirmed or possible coronavirus disease 2019 (COVID-19), close coordination and effective communications are important among 911 Public Safety Answering Points (PSAPs)—commonly known as 911 call centers, the EMS system, healthcare facilities, and the public health system. Each PSAP and EMS system should seek the involvement of an EMS medical director to provide appropriate medical oversight. For the purposes of this guidance, “EMS clinician” means prehospital EMS and medical first responders. When COVID-19 is suspected in a patient needing emergency transport, prehospital care providers and healthcare facilities should be notified in advance that they may be caring for, transporting, or receiving a patient who may have COVID-19 infection.

Updated information about COVID-19 may be accessed at <https://www.cdc.gov/coronavirus/2019-ncov/index.html>. Infection prevention and control recommendations can be found here: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>. Additional information for healthcare personnel can be found at <https://www.cdc.gov/coronavirus/2019-nCoV/guidance-hcp.html>.

Case Definition for COVID-19

CDC’s most current case definition for a person under investigation (PUI) for COVID-19 may be accessed at <https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>.

Recommendations for 911 PSAPs

Municipalities and local EMS authorities should coordinate with state and local public health, PSAPs, and other emergency call centers to determine need for modified caller queries about COVID-19, outlined below.

Development of these modified caller queries should be closely coordinated with an EMS medical director and informed by local, state, and federal public health authorities, including the city or county health department(s), state health department(s), and CDC.

Modified Caller Queries

PSAPs or Emergency Medical Dispatch (EMD) centers (as appropriate) should question callers and determine the possibility that this call concerns a person who may have signs or symptoms and risk factors for COVID-19. The query process should never supersede the provision of pre-arrival instructions to the caller when immediate lifesaving interventions (e.g., CPR or the Heimlich maneuver) are indicated. Patients in the United States who meet the appropriate criteria should be evaluated and transported as a PUI. Information on COVID-19 will be updated as the public health response proceeds. PSAPs and medical directors can access CDC's PUI definitions [here](#).

Information on a possible PUI should be communicated immediately to EMS clinicians before arrival on scene in order to allow use of appropriate personal protective equipment (PPE). PSAPs should utilize medical dispatch procedures that are coordinated with their EMS medical director and with the local or state public health department.

PSAPs and EMS units that respond to ill travelers at US international airports or other ports of entry to the United States (maritime ports or border crossings) should be in contact with the CDC quarantine station of jurisdiction for the port of entry (see: [CDC Quarantine Station Contact List](#)) for planning guidance. They should notify the quarantine station when responding to that location if a communicable disease is suspected in a traveler. CDC has provided job aids for this purpose to EMS units operating routinely at US ports of entry. The PSAP or EMS unit can also call CDC's Emergency Operations Center at (770) 488-7100 to be connected with the appropriate CDC quarantine station.

Recommendations for EMS Clinicians and Medical First Responders

EMS clinician practices should be based on the most up-to-date COVID-19 clinical recommendations and information from appropriate public health authorities and EMS medical direction.

State and local EMS authorities may direct EMS clinicians to modify their practices as described below.

Patient assessment

- If PSAP call takers advise that the patient is suspected of having COVID-19, EMS clinicians should put on appropriate PPE before entering the scene. EMS clinicians should consider the signs, symptoms, and risk factors of COVID-19 (<https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html>).
- If information about potential for COVID-19 has not been provided by the PSAP, EMS clinicians should exercise appropriate precautions when responding to any patient with signs or symptoms of a respiratory infection. Initial assessment should begin from a distance of at least 6 feet from the patient, if possible. Patient contact should be minimized to the extent possible until a facemask is on the patient. If COVID-19 is suspected, all PPE as described below should be used. If COVID-19 is not suspected, EMS clinicians should follow standard procedures and use appropriate PPE for evaluating a patient with a potential respiratory infection.
- A facemask should be worn by the patient for source control. If a nasal cannula is in place, a facemask should be worn over the nasal cannula. Alternatively, an oxygen mask can be used if clinically indicated. If the patient requires intubation, see below for additional precautions for aerosol-generating procedures.
- During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.

Recommended Personal Protective Equipment (PPE)

- EMS clinicians who will directly care for a patient with possible COVID-19 infection or who will be in the compartment with the patient should follow Standard, Contact, and Airborne Precautions, including the use of eye protection. Recommended PPE includes:
 - A single pair of disposable patient examination gloves. Change gloves if they become torn or heavily contaminated,
 - Disposable isolation gown,
 - Respiratory protection (i.e., N-95 or higher-level respirator), and

- Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).
- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
 - If the transport vehicle does not have an isolated driver's compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene. A respirator should continue to be used during transport.
- All personnel should avoid touching their face while working.
- On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures.
- Other required aspects of Standard Precautions (e.g., injection safety, hand hygiene) are not emphasized in this document but can be found in the guideline titled *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

Precautions for Aerosol-Generating Procedures

- If possible, consult with medical control before performing aerosol-generating procedures for specific guidance.
- In addition to the PPE described above, EMS clinicians should exercise caution if an aerosol-generating procedure (e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous positive airway pressure (CPAP), bi-phasic positive airway pressure (biPAP), or resuscitation involving emergency intubation or cardiopulmonary resuscitation (CPR) is necessary.
 - BVMs, and other ventilatory equipment, should be equipped with HEPA filtration to filter expired air.
 - EMS organizations should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
- If possible, the rear doors of the transport vehicle should be opened and the HVAC system should be activated during aerosol-generating procedures. This should be done away from pedestrian traffic.

EMS Transport of a PUI or Patient with Confirmed COVID-19 to a Healthcare Facility (including interfacility transport)

If a patient with an exposure history and signs and symptoms suggestive of COVID-19 requires transport to a healthcare facility for further evaluation and management (subject to EMS medical direction), the following actions should occur during transport:

- EMS clinicians should notify the receiving healthcare facility that the patient has an exposure history and signs and symptoms suggestive of COVID-19 so that appropriate infection control precautions may be taken prior to patient arrival.
- Keep the patient separated from other people as much as possible.
- Family members and other contacts of patients with possible COVID-19 should not ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask.
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
 - Close the door/window between these compartments before bringing the patient on board.
 - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
 - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
 - Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle. Such a unit can be used to increase the number of air changes per hour (ACH) (<https://www.cdc.gov/niosh/hhe/reports/pdfs/1995-0031-2601.pdf>).
- If a vehicle without an isolated driver compartment and ventilation must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting. This will create a negative pressure gradient in the patient area.

- Follow routine procedures for a transfer of the patient to the receiving healthcare facility (e.g., wheel the patient directly into an Airborne Infection Isolation Room).

Documentation of patient care

- Documentation of patient care should be done after EMS clinicians have completed transport, removed their PPE, and performed hand hygiene.
 - Any written documentation should match the verbal communication given to the emergency department providers at the time patient care was transferred.
- EMS documentation should include a listing of EMS clinicians and public safety providers involved in the response and level of contact with the patient (for example, no contact with patient, provided direct patient care). This documentation may need to be shared with local public health authorities.

Cleaning EMS Transport Vehicles after Transporting a PUI or Patient with Confirmed COVID-19

The following are general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a PUI:

- After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air changes to remove potentially infectious particles.
 - The time to complete transfer of the patient to the receiving facility and complete all documentation should provide sufficient air changes.
- When cleaning the vehicle, EMS clinicians should wear a disposable gown and gloves. A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 (the virus that causes COVID-19) in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2. These products can be identified by the following claim:
 - “[Product name] has demonstrated effectiveness against viruses similar to SARS-CoV-2 on hard non-porous surfaces. Therefore, this product can be used against SARS-CoV-2 when used in accordance with the directions for use against [name of supporting virus] on hard, non-porous surfaces.”
 - This claim or a similar claim, will be made only through the following communications outlets: technical literature distributed exclusively to health care facilities, physicians, nurses and public health officials, “1-800” consumer information services, social media sites and company websites (non-label related). Specific claims for “SARS-CoV-2” will not appear on the product or master label.
 - See additional information about EPA-approved [emerging viral pathogens claims](#) .
- If there are no available EPA-registered products that have an approved emerging viral pathogen claim, products with label claims against human coronaviruses should be used according to label instructions.
- Clean and disinfect the vehicle in accordance with standard operating procedures. All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant in accordance with the product label.
- Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
- Follow standard operating procedures for the containment and disposal of used PPE and regulated medical waste.

- Follow standard operating procedures for containing and laundering used linen. Avoid shaking the linen.

Follow-up and/or Reporting Measures by EMS Clinicians After Caring for a PUI or Patient with Confirmed COVID-19

EMS clinicians should be aware of the follow-up and/or reporting measures they should take after caring for a PUI or patient with confirmed COVID-19:

- State or local public health authorities should be notified about the patient so appropriate follow-up monitoring can occur.
- EMS agencies should develop policies for assessing exposure risk and management of EMS personnel potentially exposed to SARS-CoV-2 in coordination with state or local public health authorities. Decisions for monitoring, excluding from work, or other public health actions for HCP with potential exposure to SARS-CoV-2 should be made in consultation with state or local public health authorities. Refer to the Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) for additional information.
- EMS agencies should develop sick-leave policies for EMS personnel that are nonpunitive, flexible, and consistent with public health guidance. Ensure all EMS personnel, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick-leave policies.
- EMS personnel who have been exposed to a patient with suspected or confirmed COVID-19 should notify their chain of command to ensure appropriate follow-up.
 - Any unprotected exposure (e.g., not wearing recommended PPE) should be reported to occupational health services, a supervisor, or a designated infection control officer for evaluation.
 - EMS clinicians should be alert for fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat). If symptoms develop, they should self-isolate and notify occupational health services and/or their public health authority to arrange for appropriate evaluation.

EMS Employer Responsibilities

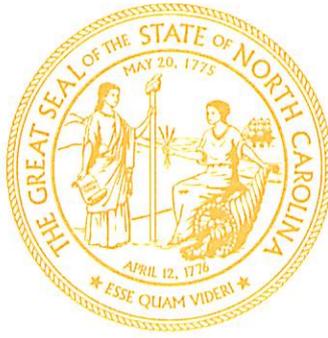
The responsibilities described in this section are not specific for the care and transport of PUIs or patients with confirmed COVID-19. However, this interim guidance presents an opportunity to assess current practices and verify that training and procedures are up-to-date.

- EMS units should have infection control policies and procedures in place, including describing a recommended sequence for safely donning and doffing PPE.
- Provide all EMS clinicians with job- or task-specific education and training on preventing transmission of infectious agents, including refresher training.
- Ensure that EMS clinicians are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.
- Ensure EMS clinicians are medically cleared, trained, and fit tested for respiratory protection device use (e.g., N95 filtering facepiece respirators), or medically cleared and trained in the use of an alternative respiratory protection device (e.g., Powered Air-Purifying Respirator, PAPR) whenever respirators are required. OSHA has a number of respiratory training videos [\[1\]](#).
- EMS units should have an adequate supply of PPE.
- Ensure an adequate supply of or access to EPA-registered hospital grade disinfectants (see above for more information) for adequate decontamination of EMS transport vehicles and their contents.
- Ensure that EMS clinicians and biohazard cleaners contracted by the EMS employer tasked to the decontamination process are educated, trained, and have practiced the process according to the manufacturer's recommendations or the EMS agency's standard operating procedures.

Additional Resources

The EMS Infectious Disease Playbook, published by the Office of the Assistant Secretary for Preparedness and Response's Technical Resources, Assistance Center, Information Exchange (TRACIE) is a resource available to planners at <https://www.ems.gov/pdf/ASPR-EMS-Infectious-Disease-Playbook-June-2017.pdf>   .

Page last reviewed: February 15, 2020



State of North Carolina

ROY COOPER
GOVERNOR

MARCH 10, 2020

EXECUTIVE ORDER NO. 116

DECLARATION OF A STATE OF EMERGENCY TO COORDINATE RESPONSE AND PROTECTIVE ACTIONS TO PREVENT THE SPREAD OF COVID-19

WHEREAS, COVID-19 is a respiratory disease that can result in serious illness or death by the SARS-CoV-2 virus, which is a new strain of coronavirus previously unidentified in humans and which can spread from person to person; and

WHEREAS, the World Health Organization declared COVID-19 a Public Health Emergency of International Concern on January 30, 2020; and

WHEREAS, the Centers for Disease Control and Prevention (“CDC”) has warned of the high public health threat posed by COVID-19 globally and in the United States and has deemed it necessary to prohibit or restrict travel to areas designated by the CDC; and

WHEREAS, on January 31, 2020, the United States Department of Health and Human Services Secretary declared a public health emergency in the United States for COVID-19 under Section 319 of the Public Health Service Act; and

WHEREAS, the North Carolina Department of Health and Human Services (“NCDHHS”) confirmed multiple cases of COVID-19 in North Carolina as of March 10, 2020; and

WHEREAS, NCDHHS has organized a Public Health Incident Management Team to manage the public health impacts of COVID-19 in this state; and

WHEREAS, health insurance companies have begun to waive the costs for COVID-19 testing and are encouraged to continue to ensure ease of access to health care for diagnostics and treatment without regard to the issue of cost or a patient’s ability to pay; and

WHEREAS, first responders and health care professionals remain integral to ensuring the state is best situated to respond to and mitigate the threat posed by COVID-19 and such first responders and health care professionals should have the availability of all necessary personal protective equipment and continue to follow all necessary response protocols; and

WHEREAS, N.C. Gen. Stat. §§ 166A-19.10 and 166A-19.20 authorize the undersigned to declare a state of emergency and exercise the powers and duties set forth therein to direct and aid in response to, recovery from, and mitigation against emergencies; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.30(b)(3), the undersigned, with the concurrence of the Council of State, may regulate and control the flow of vehicular traffic and the congregation of persons in public places or buildings; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.30(b)(4), the undersigned, with the concurrence of the Council of State, may waive a provision of any regulation or ordinance of a state agency which restricts the immediate relief of human suffering; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.30(b)(5), the undersigned, with the concurrence of the Council of State, may perform and exercise other such functions, powers and duties as are necessary to promote and secure the safety and protection of the civilian population; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.10(b)(7), the undersigned has authority to requisition state property and state resources to utilize state services, equipment, supplies and facilities in response to a state of emergency; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.70, the undersigned may declare that the health, safety, or economic well-being of persons or property requires that the maximum hours of service for drivers prescribed by N.C. Gen. Stat. § 20-381 and similar rules should be waived for essentials, as defined in N.C. Gen. Stat. § 166A-19.70(f)(3), for assisting in the restoration of utility services; and

WHEREAS, pursuant to N.C. Gen. Stat. § 166A-19.70(g), upon the recommendation of the North Carolina Commissioner of Agriculture and the existence of an imminent threat of severe economic loss of livestock, poultry or crops ready to be harvested, the Governor shall direct the North Carolina Department of Public Safety (“DPS”) to temporarily suspend weighing vehicles used to transport livestock, poultry or crops to include timber ready to be harvested; and

WHEREAS, 49 C.F.R. § 390.23 allows the governor of a state to suspend the rules and regulations under 49 C.F.R. §§ 390-399 for up to thirty (30) days if the governor determines that an emergency condition exists; and

WHEREAS, the undersigned, in consultation with the Secretary of NCDHHS, has determined it is necessary and appropriate to act to ensure that COVID-19 remains controlled and that residents and visitors in North Carolina remain safe and secure; and

WHEREAS, the undersigned has sought and obtained concurrence from the Council of State consistent with the Governor’s emergency powers authority in N.C. Gen. Stat. § 166A-19.30.

NOW, THEREFORE, by the authority vested in me as Governor by the Constitution and the laws of the State of North Carolina, **IT IS ORDERED**:

Section 1. State of Emergency

I hereby declare a State of Emergency, as defined in N.C. Gen. Stat. §§ 166A-19.3(6) and 166A-19.3(19) for the State of North Carolina based on the public health emergency posed by COVID-19.

The emergency area, as defined in N.C. Gen. Stat. §§ 166A-19.3(7) and 166A-19.20(b) is the State of North Carolina (the “Emergency Area”).

Section 2. Application

All state and local government entities and agencies are ordered to cooperate in the implementation of the provisions of this declaration and the provisions of the North Carolina Emergency Operations Plan (the “Plan”).

Section 3. Delegation of Authority

I delegate to Erik A. Hooks, the Secretary of the North Carolina Department of Public Safety (“DPS”), or his designee, the power and authority granted to and required of me by Article 1A of Chapter 166A of the North Carolina General Statutes for the purpose of implementing the Plan and deploying the State Emergency Response Team to take the appropriate actions necessary to promote and secure the safety and protection of the populace in North Carolina.

Secretary Hooks, or his designee, shall implement the Plan in coordination with the Secretary of the Department of Health and Human Services, Dr. Mandy Cohen, and the State Health Director, Dr. Elizabeth Tilson.

Section 4. Exercise of Powers

Further, Secretary Hooks, as Chief Coordinating Officer for the State of North Carolina, shall exercise the powers prescribed in N.C. Gen. Stat. §§ 143B-602 and 166A-19.11.

Section 5. Maximum Hours of Service

In order to ensure adequacy and location of supplies and resources to respond to COVID-19, DPS, in conjunction with the North Carolina Department of Transportation (“DOT”), shall waive the maximum hours of service for drivers prescribed by DPS pursuant to N.C. Gen. Stat. § 20-381, if the driver is transporting medical supplies and other equipment in support of the Plan or other efforts to address the public health threat posed by COVID-19, through the duration of the State of Emergency or until further notice.

Section 6. Height and Weight Restrictions

DPS, in conjunction with DOT, shall waive certain size and weight restrictions and penalties arising under N.C. Gen. Stat. §§ 20-116, 20-118, and 20-119, certain registration requirements and penalties arising under N.C. Gen. Stat. §§ 105-449.45, 105-449.47, and 105-449.49 for vehicles throughout the Emergency Area involved in transporting medical supplies and other equipment in support of the Plan or other efforts to address the public health threat posed by COVID-19. Furthermore, pursuant to N.C. Gen. Stat. § 20-118.1, DPS shall temporarily suspend weighing vehicles throughout the Emergency Area used to transport medical supplies and other equipment in support of the Plan or other efforts to address the public health threat posed by COVID-19. Furthermore, pursuant to N.C. Gen. Stat. § 20-118.1, DPS shall temporarily suspend weighing vehicles used to transport livestock, poultry, or crops to include timber ready to be harvested and feed to livestock and poultry in the Emergency Area.

Section 7. Unwaived Size and Weight Restrictions

- I. Notwithstanding the waivers set forth above in Section 6, size and weight restrictions and penalties have not been waived under the following conditions:
 - a. When the vehicle weight exceeds the maximum gross weight criteria established by the manufacturer (GVWR) or 90,000 pounds gross weight, whichever is less.
 - b. When the tandem axle weight exceeds 42,000 pounds and the single axle weight exceeds 22,000 pounds.
 - c. When a vehicle and vehicle combination exceed twelve (12) feet in width and the total overall vehicle combination's length exceeds seventy-five (75) feet from bumper to bumper.
 - d. Vehicles and vehicle combinations subject to exemptions or permits by authority of this Executive Order shall not be exempt from the requirement of having (i) a yellow banner on the front and rear that is seven (7) feet long and eighteen (18) inches wide and bears the legend “Oversized Load” in ten (10) inch black letters, 1.5 inches wide and (ii) red flags measuring eighteen (18) inches square on all sides at the widest point of the load. When operating between sunset and sunrise, a certified escort shall be required for loads exceeding eight (8) feet 6 inches in width.
- II. Vehicles subject to this Executive Order shall adhere to the following conditions:
 - a. The size and weight exemption for vehicles will be allowed on all DOT designated routes, except those routes designated as light traffic roads under N.C. Gen. Stat. § 20-118. This Order shall not be in effect on bridges posted pursuant to N.C. Gen. Stat. § 136-72.
 - b. The waiver of regulations under Title 49 of the Code of Federal Regulations (“Federal Motor Carrier Safety Regulations”) does not apply to the Commercial Drivers’ License and Insurance Requirements. This waiver shall be in effect for thirty (30) days or the duration of the emergency, whichever is less.
 - c. Upon request by law enforcement officers, exempted vehicles must produce documentation sufficient to establish that their loads are limited to medical supplies and other equipment to be used in support of the Plan or other efforts to address the public health threat posed by COVID-19.
- III. The North Carolina State Highway Patrol shall enforce the conditions set forth in Sections 5 through 8 of this Executive Order in a manner that does not endanger North Carolina motorists.

Section 8. Additional Transportation Waivers

Vehicles subject to this Executive Order shall be exempt from the following registration requirements:

- a. The requirement to obtain a temporary trip permit and pay the associated \$50.00 fee listed in N.C. Gen. Stat. § 105-449.49.
- b. The requirement of filing a quarterly fuel tax return as the exemption in N.C. Gen. Stat. § 105-449.45(b)(1) applies.
- c. The registration requirements under N.C. Gen. Stat. § 20-382.1 concerning intrastate for hire authority and N.C. Gen. Stat. § 20-382 concerning interstate for-hire authority; however, vehicles shall maintain insurance as required as required by law.
- d. Non-participants in North Carolina's International Registration Plan and International Fuel Tax Agreement will be permitted to enter North Carolina in accordance with the exemptions identified by this Executive Order.

Section 9. Consumer Protection

Pursuant to N.C. Gen. Stat. § 166A-19.23, this declaration triggers the prohibition against excessive pricing as provided in N.C. Gen. Stat. §§ 75-37 and 75-38.

I further hereby encourage the North Carolina Attorney General to use all resources available to monitor reports of abusive trade practices towards consumers and make readily available opportunities to report price gouging as well as unfair and deceptive trade practice under Chapter 75 of the North Carolina General Statutes to the public.

Section 10. Task Force

I hereby memorialize the establishment of the Governor's Novel Coronavirus Task Force on COVID-19 ("Task Force"). The Director of Emergency Management and the State Health Director shall continue to serve as co-chairs of the Task Force. The Task Force shall continue to work with state, local, and federal partners in responding to challenges posed by COVID-19.

Section 11. State Employee Policy Guidance

- a. I hereby authorize hiring of temporary employees and contractors to support NCDHHS and local health departments in responding to the threats posed by COVID-19.
- b. I hereby authorize the State Health Director to monitor areas of concentration of COVID-19 and make recommendations regarding travel restrictions for travel of state employees conducting state business. Agencies shall have the authority to cancel, restrict or postpone travel of state employees as needed to protect the wellbeing of others. Agencies are urged to cancel travel to restricted areas (as defined by the Division of Public Health of NCDHHS and the CDC). Exceptions to travel restrictions may be needed based on the unique circumstances or job duties of state employees.

Section 12. Public Health Surveillance and Control Measures

Notwithstanding the public health authorities in place under Chapter 130A of the North Carolina General Statutes, I hereby order the State Health Director to work with local health directors to implement public health surveillance and control measures where appropriate for individuals who have been diagnosed with or are at risk of contracting COVID-19 in order to control or mitigate spread of the disease. I hereby order the State Health Director to utilize all authorities under N.C. Gen. Stat. Chapter 130A to obtain information and records necessary to prevent, control, or investigate COVID-19.

Section 13. Laboratory Testing

I hereby order the State Health Director to work with the State Laboratory of Public Health to maximize the availability of laboratory testing for COVID-19.

I further encourage private laboratories and universities to take all reasonable steps to expand COVID-19 testing capacity.

Section 14. Right of Entry and Disinfection for Local Health Departments and NCDHHS Secretary

With the concurrence of the Council of State and notwithstanding the public health authorities in place under Chapter 130A of the North Carolina General Statutes, I hereby grant local health departments, the Secretary of NCDHHS, and Division of Public Health employees serving the Secretary of NCDHHS' agents, and on her direction, a right of entry into public places for the purposes of assisting with or investigating potential COVID-19 cases or exposure and requiring cleaning and disinfecting measures to help control transmission of COVID-19.

Section 15. Cleaning of Regulated Facilities

With the concurrence of the Council of State, I hereby waive restrictions related to the type of product or chemical concentration used to control COVID-19 at facilities whose sanitation is regulated by NCDHHS, if conducted and handled in a safe manner and approved by the local health department in consultation with the Division of Public Health of NCDHHS. The State Health Director may issue additional orders or regulations consistent with the state's Public Health Law to regulate the sanitation of public facilities regulated by NCDHHS or local health departments.

Section 16. Out of State Health Care Licensure and Additional Testing Resources

With the concurrence of the Council of State, I hereby temporarily waive North Carolina licensure requirements for health care and behavioral health care personnel who are licensed in another state, territory, or the District of Columbia to provide health care services within the Emergency Area.

With the concurrence of the Council of State, and in the interest of alleviating immediate human suffering, nothing in Subchapters 32B, 32M, or 32S of Article 21 of the North Carolina Administrative Code shall be interpreted to prevent physicians, nurse practitioners, and physician assistants from issuing a standing order for qualified agents or employees who are working under the direct supervision of a physician, physician assistant or nurse practitioner to collect throat or nasopharyngeal swab specimens from individuals suspected of suffering from a COVID-19 infection, for purposes of testing.

Section 17. Federal Support

I further direct Secretary Hooks, or his designee, to seek assistance from any and all agencies of the United States Government as may be needed to address the emergency and seek reimbursement for costs incurred by the state in responding to this emergency.

Section 18. Local County Public Health Aid Funding Formula

With the concurrence of the Council of State, I hereby grant the Secretary of NCDHHS, or her designee, the authority to waive the formula requirements of 15A NCAC 18A .2901 and adjust aid-to-county funding, if a local health department's resources are diverted in response to COVID-19.

Section 19. Access to State Funds

I hereby order access to the State Emergency Response and Disaster Relief Fund to the extent necessary to cover costs associated with responding to this State of Emergency as provided in N.C. Gen. Stat. § 166A-19.42, including but not limited to the substance of this Executive Order.

Section 20. Purchase and Contract Regulation Waivers

With the concurrence of the Council of State, I hereby temporarily waive Sections .0301 through .0317 of Chapter 5B in Title 1 in the North Carolina Administrative Code to the extent necessary to permit NCDHHS, DPS, and local governmental entities to enter into contracts to secure resources and equipment needed to respond to COVID-19.

In addition to the provisions in Section 11, I further order all components of state government to expedite and prioritize the leasing of real property, including but not limited to, laboratories and health care facilities in order to provide the state with the resources needed to address COVID-19.

Section 21. Cost Sharing Reduction

Pursuant to N.C. Gen. Stat. § 166A-19.30(a)(1), I hereby direct NCDHHS and the North Carolina Department of Insurance to immediately work with health insurance plans operating in the state to identify any burdens for testing for COVID-19 as well as access to prescription drugs and telehealth services, as needed, in order to reduce cost-sharing (including, but not limited to, co-pays, deductibles, or coinsurance) to zero for all medically necessary screening and testing for COVID-19.

Section 22. Clinical Coverage Policy

With the concurrence of the Council of State, and in order to provide the immediate relief of human suffering, I hereby temporarily waive the regulatory requirements and suspend the enforcement of the statutory requirements under N.C. Gen. Stat. § 108A-54.2 for modifications of Medicaid Clinical Coverage Policy.

I order the NCDHHS, Division of Health Benefits to create coverage policies necessary for Medicaid and Health Choice Beneficiaries to receive medically necessary services for testing and treatment of COVID-19 and to create coverage policies or modify existing policies that will allow beneficiaries to continue to receive necessary services without disruption during the State of Emergency.

Section 23. Inapplicability of Section 166A-19.30(c)

This Executive Order does not prohibit or restrict lawfully possessed firearms or ammunition or impose any limitation on the consumption, transportation, sale or purchase of alcoholic beverages as provided in N.C. Gen. Stat. § 166A-19.30(c).

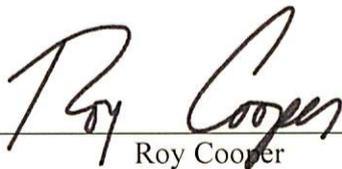
Section 24. Distribution

I hereby order that this Executive Order be: (1) distributed to the news media and other organizations calculated to bring its contents to the attention of the general public; (2) promptly filed with the Secretary of DPS, the Secretary of State, and the superior court clerks in the counties to which it applies, unless the circumstances of the State of Emergency would prevent or impede such filing; and (3) distributed to others as necessary to ensure proper implementation of this Executive Order.

Section 25. Effective Date

This Executive Order is effective immediately and shall remain in effect until rescinded.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed the Great Seal of the State of North Carolina at the Capitol in the City of Raleigh, this 10th day of March in the year of our Lord two thousand and twenty.



Roy Cooper
Governor

ATTEST:



Elaine F. Marshall
Secretary of State





Coates' Canons Blog: Resources for Reliable Information on Coronavirus in North Carolina

By Jill Moore

Article: <https://canons.sog.unc.edu/resources-for-reliable-information-on-coronavirus-in-north-carolina/>

This entry was posted on March 05, 2020 and is filed under Communicable Diseases, Public Health

The first case of COVID-19 in North Carolina was announced on March 3, in a press conference that can be viewed here. A press release from the N.C. Department of Health and Human Services is available here.

Based on the patient's recent travel history, public health officials believe that the case was acquired outside of North Carolina. At the time of this writing, there are no other known cases in the state, but it is certainly possible that additional cases could be discovered. Public health officials have been preparing for the possibility of cases in our state since the outbreak was first reported in late 2019, and have developed essential information and resources for North Carolina local governments and the public.

For the latest developments in the outbreak, local governments and members of the public are encouraged to monitor reliable sources of information, especially the two primary sites for public health information about COVID-19 in North Carolina and the U.S.:

- N.C. Department of Health & Human Services, Coronavirus Disease 2019 (COVID-19) Response in North Carolina
- Centers for Disease Control & Prevention, Coronavirus Disease 2019 (COVID-19)

Local health departments have access to more detailed information and specific guidance from the N.C. Division of Public Health's Communicable Disease Branch. This information is frequently updated, so department staff should take care to ensure they have access to the most recent versions.

Local health departments that identify suspected cases must immediately notify the state Communicable Disease Branch. This is required by NC disease reporting laws, as I explained in an earlier post. It also provides an opportunity to assure that the local health department has the most current information and guidance, as well as assistance in applying up-to-date guidance appropriately.

The School of Government is compiling resources about North Carolina communicable disease law and the COVID-19 outbreak on its North Carolina Public Health Law microsite. This direct link will take you to those resources. Because I have been receiving a number of questions about North Carolina isolation and quarantine law, the resources include free access to a 2017 book chapter that I wrote on that subject—click here for North Carolina Communicable Disease Law Chapter 6, Isolation and Quarantine Law. The chapter provides an overview of state law but is not specific to the current outbreak. (For more information about the book, or to order, click here.)

It is essential for local health departments and their attorneys to work closely with the state Communicable Disease Branch if they are considering isolation or quarantine for COVID-19. The Branch can assist a department and its attorney with assuring that the criteria for such measures has been met, and can provide template orders.

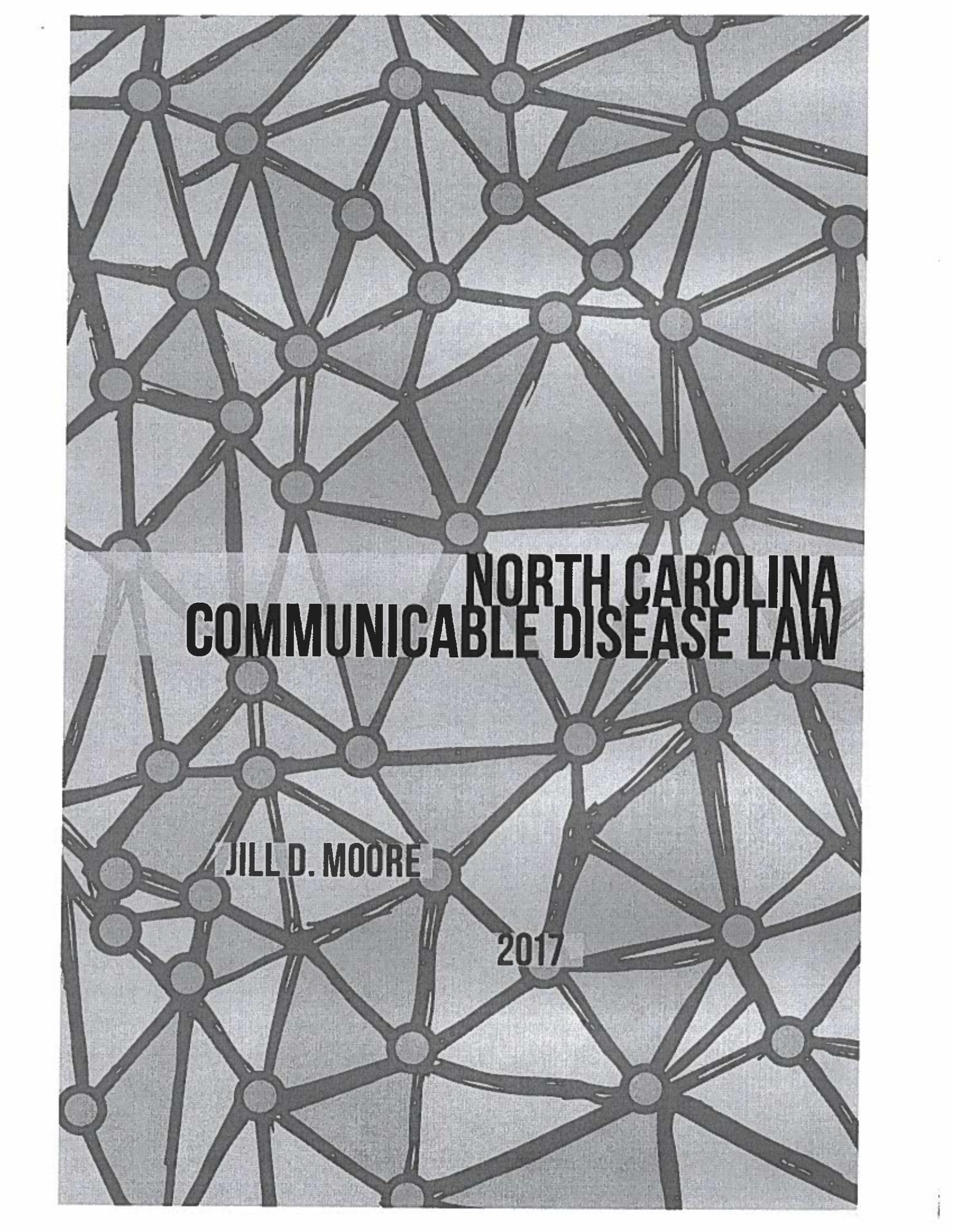
Local government officials and the public should expect information about the outbreak to change over time as the situation develops, and are encouraged to periodically check these resources for updates.

Links

- www.unctv.org/watch/live-stream/eoc/#coronavirus
- www.ncdhhs.gov/news/press-releases/north-carolina-identifies-first-case-covid-19



-
- www.ncdhhs.gov/divisions/public-health/coronavirus-disease-2019-covid-19-response-north-carolina
 - www.cdc.gov/coronavirus/2019-ncov/index.html
 - www.sog.unc.edu/resources/microsites/north-carolina-public-health-law
 - www.sog.unc.edu/resources/microsites/north-carolina-public-health-law/nc-legal-resources-coronavirus-disease-2019-covid-19
 - www.sog.unc.edu/resources/microsites/north-carolina-public-health-law/covid-19-coronavirus
 - www.sog.unc.edu/publications/books/north-carolina-communicable-disease-law



NORTH CAROLINA COMMUNICABLE DISEASE LAW

JILL D. MOORE

2017

The School of Government at the University of North Carolina at Chapel Hill works to improve the lives of North Carolinians by engaging in practical scholarship that helps public officials and citizens understand and improve state and local government. Established in 1931 as the Institute of Government, the School provides educational, advisory, and research services for state and local governments. The School of Government is also home to a nationally ranked Master of Public Administration program, the North Carolina Judicial College, and specialized centers focused on community and economic development, information technology, and environmental finance.

As the largest university-based local government training, advisory, and research organization in the United States, the School of Government offers up to 200 courses, webinars, and specialized conferences for more than 12,000 public officials each year. In addition, faculty members annually publish approximately 50 books, manuals, reports, articles, bulletins, and other print and online content related to state and local government. The School also produces the *Daily Bulletin Online* each day the General Assembly is in session, reporting on activities for members of the legislature and others who need to follow the course of legislation.

Operating support for the School of Government's programs and activities comes from many sources, including state appropriations, local government membership dues, private contributions, publication sales, course fees, and service contracts.

Visit sog.unc.edu or call 919.966.5381 for more information on the School's courses, publications, programs, and services.

Michael R. Smith, DEAN

Thomas H. Thornburg, SENIOR ASSOCIATE DEAN

Frayda S. Bluestein, ASSOCIATE DEAN FOR FACULTY DEVELOPMENT

Johnny Bursleson, ASSOCIATE DEAN FOR DEVELOPMENT

Michael Vollmer, ASSOCIATE DEAN FOR ADMINISTRATION

Linda H. Weiner, ASSOCIATE DEAN FOR OPERATIONS

Janet Holston, DIRECTOR OF STRATEGY AND INNOVATION

FACULTY

Whitney Afonso

Trey Allen

Gregory S. Allison

David N. Ammons

Ann M. Anderson

Maureen Berner

Mark F. Botts

Anita R. Brown-Graham

Peg Carlson

Leisha DeHart-Davis

Shea Riggsbee Denning

Sara DePasquale

James C. Drennan

Richard D. Ducker

Robert L. Farb

Norma Houston

Cheryl Daniels Howell

Jeffrey A. Hughes

Willow S. Jacobson

Robert P. Joyce

Diane M. Juffras

Dona G. Lewandowski

Adam Lovelady

James M. Markham

Christopher B. McLaughlin

Kara A. Millonzi

Jill D. Moore

Jonathan Q. Morgan

Ricardo S. Morse

C. Tyler Mulligan

Kimberly L. Nelson

David W. Owens

LaToya B. Powell

William C. Rivenbark

Dale J. Roenigk

John Rubin

Jessica Smith

Meredith Smith

Carl W. Stenberg III

John B. Stephens

Charles Szypszak

Shannon H. Tufts

Vaughn Mamlin Upshaw

Aimee N. Wall

Jeffrey B. Welty

Richard B. Whisnart

© 2017

School of Government

The University of North Carolina at Chapel Hill

Use of this publication for commercial purposes or without acknowledgment of its source is prohibited. Reproducing, distributing, or otherwise making available to a non-purchaser the entire publication, or a substantial portion of it, without express permission, is prohibited.

Printed in the United States of America

21 20 19 18 17 1 2 3 4 5

ISBN 978-1-56011-879-4

♻️ This publication is printed on permanent, acid-free paper in compliance with the North Carolina General Statutes.

♻️ Printed on recycled paper

Contents

Preface / vii

Part 1

Overview of the Main Components of North Carolina Communicable Disease Law / 1

Chapter 1

Introduction / 3

Defining “Communicable Disease” and “Communicable Condition” / 5

Role of the Public Health System in Communicable Disease Control / 6

Roles of State Officials and Agencies / 6

Roles of Local Officials and Agencies / 7

Role of Federal Officials and Agencies / 8

Chapter 2

Detecting Communicable Disease in the Population / 9

Communicable Disease Reporting in North Carolina / 10

Routine Communicable Disease Reporting / 10

Non-Routine Reporting: Temporary Orders to Report / 14

Immunity from Liability for Reporters / 16

Special Categories of Reports / 16

Health Care–Associated Infections / 16

Reports Related to Nuclear, Biological, or Chemical Terrorism / 17

Population Surveillance / 20

Chapter 3

Controlling the Spread of Disease / 23

Investigating Cases and Outbreaks / 23

Access to Information for Investigations / 24

Contact Tracing and Partner Notification / 25

- Communicable Disease Control Measures / 26**
 - Identifying the Required Communicable Disease Control Measures / 27
 - Control Measures for Emerging Illnesses / 27
 - Isolation and Quarantine / 29
- Communicable Disease Outbreaks Caused by Terrorism / 29**

Chapter 4

Enforcement: Remedies for Communicable Disease Law Violations / 31

- Criminal Enforcement: Misdemeanor / 31**
 - Initiating a Misdemeanor Charge / 32
 - Trial and Sentencing / 35
 - Special Considerations for Arrest and Detention / 36
- Civil Enforcement: Injunction / 37**
 - Procedure for Using This Remedy / 37
 - Using This Remedy for Communicable Disease Law Violations / 39

Chapter 5

Communicable Disease and Confidentiality Law / 41

- The HIPAA Privacy Rule and the State Communicable Disease Confidentiality Law / 42**
 - Overview and Comparison of the Two Laws / 42
 - Overview of Relevant Provisions of the HIPAA Privacy Rule / 43
 - Overview of the State Communicable Disease Confidentiality Law / 44
 - Disclosure of Information That Is Not Identifiable / 47
- Obtaining Communicable Disease Information for Public Health Purposes / 47**
 - Obtaining Information through Communicable Disease Reports / 47
 - Obtaining Information Relevant to a Case or an Outbreak Investigation / 48
- Public Health Officials' Obligation to Maintain the Confidentiality of Communicable Disease Information / 49**
 - HIPAA and Communicable Disease Information Held by Public Health Agencies / 49
 - State Communicable Disease Confidentiality Law and Public Health Activities / 50
- Disclosing Information about Communicable Disease to the Public / 51**
 - Public Disclosure with the Individual's Written Authorization / 51
 - Public Disclosure When the Information Is Necessary to Protect the Public Health and the Disclosure Is Made in Accordance with the North Carolina Communicable Disease Control Rules / 52
 - Public Disclosure When the Information That Is Released Is for Statistical Purposes Only and Cannot Be Used to Identify an Individual / 53

Part 2

Special Topics in North Carolina Communicable Disease Law / 55

Chapter 6

Isolation and Quarantine / 57

Definition of Isolation and Quarantine / 57

Ordering Isolation or Quarantine / 60

Authority to Order Isolation or Quarantine / 60

Decision to Order Isolation or Quarantine / 63

How Isolation or Quarantine Is Ordered / 63

Duration of Isolation or Quarantine Orders / 65

Due Process Rights of Isolated or Quarantined Persons / 67

Chapter 7

Bloodborne Pathogen Exposures / 69

Two Sources of Regulation: OSHA Standards and North Carolina Rules / 70

The Universal Precautions Approach / 70

Other Similarities and Differences / 71

Exposure Incidents / 73

Significant Risk of Transmission / 74

Required Follow-Up / 75

Refusal of Required Tests / 79

Chapter 8

Bioterrorism and Public Health / 81

Public Health Threats Caused by Terrorism / 82

State Health Director Powers over Property / 83

Tests for Contamination / 83

Closing or Evacuating Property for Evacuations / 83

Order to Abate a Public Health Threat / 83

Powers over Persons and Animals / 84

Tests or Examinations / 84

Limitations on Freedom of Movement, Action, or Access / 84

Appendixes

Appendix 1: Communicable Disease Law Glossary / 89

**Appendix 2: Index of North Carolina Communicable
Disease Statutes and Rules, by Topic / 93**

Appendix 3: Selected North Carolina General Statutes / 97

**Appendix 4: Selected Internet Sites Addressing
Communicable Disease Control / 125**

Preface

This book provides an introduction to the law of communicable disease control in North Carolina. It is divided into two parts. Part 1 addresses the core topics in the legal structure for communicable disease control: detecting communicable disease in the population through surveillance and disease reporting laws, investigating communicable disease cases and outbreaks, controlling communicable disease, enforcing communicable disease laws using public health legal remedies, and the interaction of confidentiality laws with public health agencies' communicable disease control activities. Part 2 takes a more in-depth look at three special topics. The first two—*isolation and quarantine authorities and bloodborne pathogen exposures*—represent specialized communicable disease control measures that deserve deeper attention than they receive in the general chapter on controlling communicable disease. The third topic, *public health and bioterrorism*, describes laws that would operate in tandem with communicable disease laws in the event of bioterrorism involving a communicable disease agent.

As the title indicates, the book is intended to be an overview of key topics. It does not attempt to cover every subtopic or answer every question that may arise. The book is supplemented by materials on my North Carolina public health law website, ncphlaw.unc.edu. Follow the link to “Legal Information by Topic” and select the topic “Communicable Disease Control” for links to blog posts, bulletins, and frequently asked questions about some of the topics in this book.

This work has benefitted tremendously from many years of close work with North Carolina state and local public health officials and attorneys. The constant contact between the SOG and the public officials we serve is a pleasure and an honor, and it makes my work better. I am especially grateful to Chris Hoke and John Barkley, who helped me understand the history and practical context of the issues underlying the statutory framework for

public health law, and to my SOG colleague Aimee Wall, who has been my sounding board on more occasions than I can count. I am fortunate to have such talented individuals as colleagues and friends.

Jill D. Moore, MPH, JD
Associate Professor of Public Law and Government
The University of North Carolina at Chapel Hill
September 2016

Chapter 6

Isolation and Quarantine

Isolation and quarantine are legal tools the public health system uses to control the spread of communicable diseases and conditions. The use of these tools in North Carolina is not extraordinary. Isolation and quarantine are used on a regular basis to control the spread of endemic diseases such as tuberculosis, as well as to cope with more unusual outbreaks, such as the measles outbreak the state experienced in 2013¹ or the pertussis (whooping cough) outbreaks that occasionally affect North Carolina schools. On rare occasions, the isolation and quarantine authorities have been used to control a more unusual event, such as the SARS case the state experienced in 2003.² Public health officials need to be aware of their authority to isolate and quarantine, and they need to know how to exercise the authority within the limits of the law.

Definition of Isolation and Quarantine

The terms “isolation” and “quarantine” are often used in conjunction, and they do have common elements. Both are communicable disease control measures—that is, they are means of preventing or containing the spread of disease. In general, medical and public health professionals use the term isolation to refer to disease control measures applied to people who are infected with a disease. The term quarantine generally refers to control measures applied to people who appear well but may nevertheless pose a

1. Kristin Sullivan, Zack S. Moore, & Aaron T. Fleischauer, *Notes from the Field: Measles Outbreak Associated with a Traveler Returning from India—North Carolina, April–May 2013*, MORBIDITY AND MORTALITY WEEKLY REPORT, Sept. 13, 2013, www.cdc.gov/mmwr/preview/mmwrhtml/mm6236a6.htm.

2. N.C. Division of Public Health, *SARS in North Carolina in 2003*, <http://epi.publichealth.nc.gov/cd/sars/SARSinNorthCarolina2003.pdf> (on file with author).

risk of disease to others—usually because they have been exposed to an ill person.

North Carolina’s legal definitions of isolation and quarantine include but go beyond these general definitions. In North Carolina, “isolation authority” is the authority to limit the freedom of movement or freedom of action of a person or animal that has (or is suspected of having) a communicable disease or condition.³ The definition of quarantine authority has three parts. It most often refers to the authority to limit the freedom of movement or action of a person or animal that has been exposed (or is suspected of having been exposed) to a communicable disease or condition. However, it also means the authority to limit access by any person or animal to an area or facility that is contaminated with an infectious agent. Quarantine authority also may be used to limit the freedom of movement or action of unimmunized persons during an outbreak.⁴ For example, in the event of a measles outbreak, quarantine authority could be used to require children who are exempt from the state’s immunization requirements to stay home from school.⁵

Both the isolation and quarantine authorities permit the limitation of a person’s *freedom of movement* or *freedom of action*. The definition of quarantine also authorizes limits on *freedom of access*. No law defines these terms, but several other laws make important distinctions between orders that limit freedom of action and orders that limit freedom of movement or

3. N.C. GEN. STAT. (hereinafter G.S.) § 130A-2(3a).

4. G.S. 130A-2(7a). The term “quarantine” is also used to describe the local health director’s authority to declare an area “under quarantine against rabies” when there is a rabies outbreak extensive enough to endanger the lives of humans. G.S. 130A-194. This book does not address rabies quarantines. For information about rabies quarantines, see Aimee N. Wall, *An Overview of North Carolina’s Rabies Control Laws*, LOCAL GOV’T L. BULL. No. 125 (Oct. 2011), <http://sogpubs.unc.edu/electronicversions/pdfs/lglb125.pdf>.

5. All children in North Carolina are required to be immunized against certain diseases, including measles. G.S. 130A-152. The complete list of required immunizations is in the North Carolina Administrative Code. N.C. ADMIN. CODE (hereinafter N.C.A.C.) tit. 10A, ch. 41A, § .0401. Children who have not received the immunizations may not attend public or private day care centers or schools. G.S. 130A-155. However, a child may be exempt from the requirements if an immunization is medically contraindicated, G.S. 130A-156, 10A N.C.A.C. 41A .0404, or if the child’s parent has a bona fide religious objection to immunization, G.S. 130A-157, 10A N.C.A.C. 41A .0403.

access. For example, Section 130A-145 of the North Carolina General Statutes (hereinafter G.S.), the main isolation and quarantine statute, provides specific procedures for a person to obtain judicial review of an isolation or quarantine order—but only if it is an order limiting freedom of movement or access. It is therefore important to understand the ways in which the limitations differ:

- An order limiting *freedom of movement* essentially prohibits an individual from going somewhere. It may confine the person to a particular place, such as his or her home or a health care facility. Or it may prohibit the person from going to a particular place. For example, it may prevent a person from returning to school or work during the period of communicability.
- An order limiting *freedom of action* affects specific behaviors but not the ability to move freely in society. For example, a person who is required to refrain from sexual activity during the course of treatment for gonorrhea has had his or her freedom of action restricted.
- An order limiting *freedom of access* prohibits a person from obtaining access to a certain place. For example, a quarantine order could be issued to prohibit a person from entering an area where infected people are being treated during an outbreak.

The use of these terms in North Carolina's statutory definitions also means that, in this state, an isolation or quarantine order does not necessarily require a person to be physically separated from the public. Rather, it directs the individual to comply with communicable disease control measures, which vary by disease and which may constitute limitations on freedom of movement, action, or access. For example, the control measures for a person with rubella (German measles) require the person to be isolated for seven days after the onset of the rash.⁶ In contrast, the control measures for a person with HIV do not require physical separation from society but instead affect the individual's behavior.⁷ Among other things,

6. H. McLean et al., *Rubella*, Ch. 14 in *MANUAL FOR THE SURVEILLANCE OF VACCINE-PREVENTABLE DISEASES* (Apr. 1, 2014), www.cdc.gov/vaccines/pubs/surv-manual/chpt14-rubella.html.

7. North Carolina law specifically prohibits public health officials from requiring a person with HIV to remain at home or otherwise be physically separated from

a person with HIV must notify sexual partners of his HIV status and must refrain from donating blood or sharing needles.⁸ However, an order directing a person to comply with control measures for either condition is called an “isolation order.” Similarly, an order directing a person who has been exposed to a communicable disease but is not yet sick is called a “quarantine order,” whether it requires the person’s physical separation from the public or simply directs the person to take (or refrain from taking) specific actions.

Ordering Isolation or Quarantine

Authority to Order Isolation or Quarantine

North Carolina law permits either the state health director or a local health director to order isolation or quarantine.⁹ This authority may be delegated to another public official or employee.¹⁰ Isolation or quarantine orders are permitted only (1) when and for so long as the public health is endangered, (2) when all other reasonable means for correcting the problem have been exhausted, and (3) when no less restrictive alternative exists.¹¹

There is no law in North Carolina that interprets the phrase “all other reasonable means.” The plain words of the statute make clear that, if there are reasonable means of controlling the public health threat short of issuing an isolation or quarantine order, those means should be tried first. But what constitutes reasonable means? The word “reasonable” could be interpreted to mean at least a couple of different things. It almost certainly should be

the general public. 10A N.C.A.C. 41A.0201(d) provides that isolation or quarantine orders for HIV may be no more restrictive than the control measures established in the North Carolina Administrative Code. The control measures for HIV do not include physical isolation. *See* 10A N.C.A.C. 41A .0202.

8. 10A N.C.A.C. 41A .0202.

9. G.S. 130A-145(a).

10. G.S. 130A-6. The statute states that a public official granted authority under G.S. Chapter 130A may delegate that authority to “another person authorized by the public official.” Because isolation and quarantine are exercises of the state’s police power, such a delegation should be made to another public official, not to a private person or entity. As part of their planning for responding to public health emergencies, local health directors in North Carolina have been strongly encouraged to designate health department staff members who are authorized to exercise the isolation or quarantine authority in the event the health director is unavailable.

11. G.S. 130A-145(a).

interpreted to mean that the only other methods that must be tried are those that are likely to be effective at controlling the public health threat. (In some cases there may be no other means believed to be effective.) It could also be interpreted to mean that public health officials need not try means that might be effective but that are unduly expensive or burdensome compared to isolation or quarantine.

Similarly, there is no law in North Carolina that interprets the phrase “less restrictive alternative.” Assuming other reasonable means have been exhausted, when is isolation or quarantine the least restrictive alternative? There is no case law on this in North Carolina. Some other jurisdictions have addressed a similar issue—the involuntary civil confinement of individuals with tuberculosis—and have reached conclusions about when involuntary confinement of individuals with communicable disease is appropriate. Among other things, they have concluded the following:

- Involuntary confinement is not justified unless the person poses an actual danger to others. Even then, it should not be ordered if there is something else that could protect the public as effectively (such as directly observed therapy).¹²
- A person may be confined when he or she demonstrates unwillingness or inability to comply with less restrictive measures.¹³

Many public health scholars have viewed the confinement cases as instructive for isolation and quarantine cases.¹⁴ However, in September 2016, a federal district court suggested that quarantine may require a different

12. *See, e.g., City of Newark v. J.S.*, 652 A.2d 265, 271, 278–79 (N.J. 1993).

“Directly observed therapy” is defined in North Carolina law as “the actual observation of medication ingestion by a health care worker.” 10A N.C.A.C. 41A .0205(g).

13. *See, e.g., City of New York City v. Doe*, 614 N.Y.S.2d 8 (App. Div. 1994) (confinement in hospital for treatment of tuberculosis upheld when the evidence showed that the patient had a history of refusing to cooperate with directly observed therapy).

14. *See, e.g., LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 444* (2d ed.) (“Although modern cases often concern civil commitment of the mentally ill, they should also apply to isolation and quarantine.”); Wendy Parmet, *Ebola Quarantines: Remembering Less Restrictive Alternatives*, HARVARD L. BILL OF HEALTH BLOG (Oct. 26, 2014) (noting the scant case law on quarantine and relying on tuberculosis civil confinement cases to conclude that detention is permissible “only upon a showing that the patient has been non-compliant with less restrictive approaches”).

type of analysis. In *Hickox v. Christie*,¹⁵ the plaintiff was a nurse who had treated Ebola patients in Sierra Leone during the epidemic of 2014–2016. When she returned to the United States, she was quarantined and confined in an isolation tent outside a hospital while her health was monitored. The nurse subsequently brought an action under 42 U.S.C. § 1983, arguing that her constitutional rights were violated by the state officials who confined her. To make her case, the plaintiff needed to demonstrate that the state officials violated clearly established law. The court first reviewed prior cases specifically addressing quarantine, and it concluded that this body of law clearly establishes that quarantine is *not* unconstitutional—on the contrary, it is a valid exercise of the state’s police power, so long as it is not unreasonable or arbitrary.¹⁶ The court then considered the plaintiff’s argument that civil commitment case law put the defendants on notice that their conduct violated clearly established law. It described the analogy to civil commitment law as “highly problematic,”¹⁷ and its misgivings probably foreshadowed its ultimate conclusion that the civil commitment law did not create a clearly established constitutional right that the defendants violated.¹⁸ Nevertheless, it considered the plaintiff’s arguments, including the assertion that quarantine should not be used unless it is the least restrictive means available to protect the public health. The court concluded that “[t]he theoretical availability of less restrictive alternatives does not mean that they are appropriate for a particular individual” and that deference to public health officials was appropriate.¹⁹

If a North Carolina court were called upon to determine when isolation or quarantine is the least restrictive alternative, it is likely that the court would consider other courts’ conclusions about what that means. At present, however, those other courts’ conclusions offer different paths,

15. ___ F. Supp. 3d ___, No. 15-7647, 2016 WL 4744181 (D.N.J. Sept. 2, 2016).

16. *Id.* at *10. The court appeared open to a different conclusion if different facts suggested that quarantine was not warranted, but found that the facts of this case “do not suggest arbitrariness or unreasonableness as recognized in the prior cases—i.e., application of the quarantine laws to a person (or, more commonly, vast numbers of persons) who had no exposure to disease at all.” *Id.*

17. *Id.* at *10.

18. *Id.* at *18.

19. *Id.* at *15 (concluding that the determination is a judgment call, and that the decision to confine the plaintiff in this case was one a reasonable public health official could have reached, even if it “could be criticized, or portrayed as erroneous”).

with the recent federal court decision in the Ebola quarantine case being significantly more deferential to public health officials' judgments.

Decision to Order Isolation or Quarantine

Individuals in North Carolina are legally obliged to comply with communicable disease control measures regardless of whether an isolation or quarantine order has been issued to them.²⁰ Failure to comply is a misdemeanor.²¹ Still, health directors often issue isolation or quarantine orders to ensure that a person who is subject to communicable disease control measures is aware of the measures and of the legal obligation to comply. It is also common for a health director to issue an isolation or quarantine order to an individual who is not complying with control measures, as part of an effort to gain compliance.

The authority to order isolation or quarantine is not limited to reportable diseases or conditions. However, for the isolation or quarantine authority to be available, the illness must satisfy the statutory definition of "communicable disease" or "communicable condition."

How Isolation or Quarantine Is Ordered

There is no North Carolina statute or rule that sets forth specific steps to follow in ordering isolation or quarantine of a person. However, by considering all the various laws together, it is possible to reach a few conclusions about how to proceed:

1. A local health director or the state health director should ensure that he or she is authorized to exercise isolation or quarantine authority in the particular situation, as follows:
 - If the person is to be isolated, he or she must be infected or reasonably suspected of being infected with a communicable disease or condition.
 - If the person is to be quarantined, he or she must meet the statutory conditions for quarantine, which usually means that he or she has been exposed or is reasonably suspected

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

21. G.S. 130A-25.

of having been exposed to a communicable disease or condition.²²

- The public health must be endangered as a result.
- All other reasonable means for controlling the disease must have been exhausted.
- There must be no less restrictive means to protect the public health.

2. The local or state health director must determine which of the following communicable disease control measures the recipient of the order will be subject to:

- Control measures for HIV, hepatitis B, sexually transmitted diseases, tuberculosis, smallpox/vaccinia disease, SARS, and hepatitis C, published in the North Carolina Administrative Code.²³
- Control measures for other diseases, derived from recommendations and guidelines issued by the Centers for Disease Control and Prevention (CDC). If there are no CDC guidelines on point, control measures are derived from the American Public Health Association's *Control of Communicable Diseases Manual*. A public health official may also devise control measures if necessary, in accordance with principles set out in a state rule.²⁴

3. The local or state health director must communicate to the person that he or she is being placed under an isolation or quarantine order. Although the law does not state that an isolation or quarantine order must be in writing, it would be unwise to rely solely on an oral order. However, it may be reasonable in some

22. This applies to the most typical situation in which isolation or quarantine is ordered, but quarantine may also be ordered for two additional reasons: to limit access to an area or facility that may be contaminated by an infectious agent or to limit the freedom of movement of unimmunized persons in an outbreak. See G.S. 130A-2(7a).

23. 10A N.C.A.C. 41A .0202 (HIV), .0203 (hepatitis B), .0204 (sexually transmitted diseases), .0205 (tuberculosis), .0208 (smallpox and vaccinia disease), .0213 (SARS), .0214 (hepatitis C).

24. 10 N.C.A.C. 41A .0201(a).

circumstances to issue an oral order and then follow it with a written order as soon as practicable.

4. An isolation or quarantine order should include the following:

- The name of the person who is subject to the order
- The names of the health department and the health director issuing the order
- A statement of the required communicable disease control measures
- A statement that the control measures have been explained to the person
- If the order limits the person's freedom of movement or freedom of access, a statement that the person has a right to have a court review the order
- A statement describing the penalties that may be imposed if the person fails to comply with the order²⁵
- The signature of the health director or official with delegated authority who issued the order
- The date and time the order was issued

The North Carolina Division of Public Health often provides template isolation and quarantine orders during an outbreak. For example, during the SARS outbreak of 2003, the division sent template orders to all local health directors by email. Template orders that may be used in the event of a flu pandemic have been developed and are available on the Internet.²⁶

Duration of Isolation or Quarantine Orders

Public Health Official's Order

The basic limitation on the duration of an isolation or quarantine order is contained in G.S. 130A-145(a), which states that isolation and quarantine may be ordered only when *and for so long as* the public health is endangered. The period of time is therefore likely to vary depending upon the communicable disease or condition and possibly other circumstances.

25. 10A N.C.A.C. 41A .0201(d).

26. The documents are part of the North Carolina Pandemic Influenza Plan. The plan is available at <http://epi.publichealth.nc.gov/cd/flu/plan.html>. The template orders are in Appendix L.

There is no maximum time limit for orders limiting *freedom of action*, other than the statute's requirement that the orders end when the public health is no longer endangered. For example, an order directing a person with HIV to refrain from donating blood could be in place for years,²⁷ while an order directing a person with a suspected low-risk exposure to the Ebola virus to participate in symptom monitoring would last only for the incubation period of the virus (presently recognized to be 21 days following the last exposure).²⁸

Orders limiting *freedom of movement* or *freedom of access* are subject to a statutory maximum period of 30 days.²⁹ This is *in addition to* the requirement that the order last only for so long as the public health is endangered. As previously noted, an order limiting freedom of movement or access might be for less than 30 days—if, for example, it was a quarantine order issued to a person exposed to a disease with an incubation period of 21 days—but it may never exceed 30 days, even if the person is still a threat to the public health at the end of that period. As discussed below, however, a health director may petition a superior court to extend an order.

Petitions to Extend an Order beyond 30 Days

In some instances, the state health director or a local health director may determine that a person's freedom of movement must be restricted for more than 30 days in order to protect the public health. However, the health director does not have the authority to extend the initial order or to issue a second order to the same individual for the same communicable disease event. Instead, the director may petition a superior court to extend the order. Ordinarily, this action is instituted in the superior court in the county in which the limitation on freedom of movement was imposed. However, if the individual who is the subject of the order has already sought review of the order in Wake County superior court (see the next section on due process rights), then the action must be instituted in Wake County.³⁰

The health director has the burden of producing sufficient evidence to support the extension. If the court determines by a preponderance of the evidence that the limitation on freedom of movement is reasonably neces-

27. 10A N.C.A.C. 41A .0202(a)(3) establishes this control measure.

28. See www.apha.org/~media/files/pdf/pubs/ccdm Ebola.ashx.

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

30. *Id.*

sary to prevent or limit the spread of the disease or condition, the court shall continue the limitation for a period of up to 30 days for any communicable disease or condition but tuberculosis. For tuberculosis, the court may extend the order for up to one year.

When necessary, the health director may return to court and ask the court to continue a limitation for additional periods of up to 30 days each (or up to one year each if the person has tuberculosis).

Due Process Rights of Isolated or Quarantined Persons

North Carolina law explains specifically how a person who is substantially affected by a limitation on freedom of movement or access may obtain a review of the order.³¹ The person may institute an action in superior court seeking review of the limitation, and the court must respond by conducting a hearing within 72 hours (excluding Saturdays and Sundays). The person is entitled to an attorney. If he or she is indigent, a court-appointed attorney must be provided.

The court must terminate or reduce the limitation if it determines by a preponderance of the evidence that the limitation is not reasonably necessary to prevent or limit the spread of the disease or condition. The burden of producing sufficient evidence to show that the limitation is not reasonably necessary is on the person affected by the order. The person has a choice of where to file this action: either in the superior court of the county where the limitation is imposed or in the Wake County superior court.

A person who is subject to a limitation on freedom of action has a right to due process, which includes the opportunity for his or her objections to the order to be heard. However, North Carolina law does not spell out how a person subject to this kind of limitation may exercise this right. Most likely, the person would file an action in superior court seeking a declaratory judgment about the validity of the order, or the person would seek an injunction barring enforcement of the order.

31. *Id.* The statute does not define the term *substantially affected person*. It seems clear that the person who is the subject of the order would be a substantially affected person, but whether the term might include others is an open question.

Appendix 4

Selected Internet Sites Addressing Communicable Disease Control

University of North Carolina Resources

UNC School of Government North Carolina Public Health Law Microsite
ncphlaw.unc.edu

The North Carolina Public Health Law microsite contains legal information by topic (including communicable disease control law), legislative updates, and information about North Carolina-specific public health law training opportunities. It was designed for people who work with the North Carolina public health system, but it is publicly available for anyone seeking information about North Carolina public health law.

Coates' Canons Local Government Law Blog

<http://canons.sog.unc.edu/>

More than a dozen faculty members contribute to the School of Government's local government law blog, which is updated two to three times weekly with posts on various legal issues of interest to local government. Posts about communicable disease law can be found by using a keyword search or clicking on the public health topic link.

North Carolina Institute for Public Health (NCIPH) Training Website

<https://nciph.sph.unc.edu/tws/index.php>

NCIPH is part of the UNC Gillings School of Global Public Health. Its training website offers several brief modules about topics in public health, including modules addressing infectious disease epidemiology, public health preparedness, and communicable disease law.

North Carolina Government Resources

NC Division of Public Health, Epidemiology Section, Communicable Disease Branch

<http://epi.publichealth.nc.gov/cd/>

This website includes information and North Carolina-specific data about communicable diseases, as well as the activities of the state communicable disease branch and local health departments. It also includes links to the state's communicable disease manuals and to related programs, such as the state laboratory of public health.

Direct link to NC communicable disease manuals: <http://epi.publichealth.nc.gov/cd/lhds/manuals/cd/toc.html>.

North Carolina General Assembly

www.ncleg.net

Information about proposed and enacted North Carolina legislation can be found on this site, along with an unofficial version of the state statutes.

Direct link to the North Carolina General Statutes:

www.ncleg.net/gascripts/statutes/Statutes.asp

North Carolina Administrative Code

<http://reports.oah.state.nc.us/ncac.asp>

The North Carolina Administrative Code compiles the state's administrative rules. Most of the state's communicable disease rules may be found in Title 10A, Chapter 41, Subchapter A.

Federal Government Resources

Centers for Disease Control and Prevention (CDC)

www.cdc.gov

The CDC is the federal government agency that is responsible for tracking, investigating, and researching public health issues and trends. It is part of the U.S. Department of Health and Human Services. The agency's website has detailed information about diseases and conditions, including the guidance documents and recommended actions that form the basis for required communicable disease control measures in North Carolina.

CDC Public Health Law Program

<https://www.cdc.gov/phlp/>

The CDC Public Health Law Program website has publications and other resources for public health practitioners and their attorneys.

**Occupational Safety and Health Administration (OSHA),
Bloodborne Pathogens and Needlestick Prevention**

<https://www.osha.gov/SLTC/bloodbornepathogens/>

This website provides guidance documents, FAQs, and other information from OSHA about bloodborne pathogens and the associated federal rules.

Other Resources**Association of State and Territorial Health Officers (ASTHO)**

www.astho.org/

ASTHO is a nonprofit organization that represents and serves U.S. state and territorial public health agencies and their employees. It has a program on infectious disease that provides resources and information on public health infrastructure for disease control, as well as other more specific topics.

Direct link to the infectious disease program:

www.astho.org/Programs/Infectious-Disease/

Council of State and Territorial Epidemiologists (CSTE)

CSTE is a professional organization devoted to advancing public health policy and epidemiologic capacity. It has an infectious disease steering committee that works to facilitate prevention, detection, investigation, and control of infectious diseases.

Direct link to the infectious disease task force's information and resources:

<http://www.cste.org/group/IDOV>

National Association of County and City Health Officials (NACCHO)

www.naccho.org/

NACCHO's members come from local health departments across the United States. The organization promotes public health while adhering to a set of core values, including equity, excellence, leadership, and science.

Its website includes a “toolbox” with information and resources in a number of public health areas, plus a model practices database.

Network for Public Health Law

<https://www.networkforphl.org/>

The Network for Public Health Law is made up of public health practitioners and attorneys. Its website contains legal information and policy resources. Information that is relevant to communicable disease control is included in the topic of emergency legal preparedness and response.



COVID-19 Information for Law Enforcement: General Fact Sheet

Educate Yourself. Stay Informed. Be Safe.

What is COVID-19?

Coronavirus Disease 2019 (COVID-19) is the name given by the World Health Organization for a new respiratory disease first identified in Wuhan, China, in December 2019. It has now been identified in more than 90 countries. Coronaviruses are a family of viruses found in people and animals causing a range of illnesses from the common cold to severe respiratory infection. Due to the increased availability of testing, more COVID-19 infections are being identified every day. As it is a newly-identified virus, this is an emerging and rapidly-evolving situation and new information becomes available daily. Stay updated.

How does the COVID-19 Virus Spread?

The virus is thought to spread mainly by “person-to-person” contact. This means close contact within six feet and through respiratory droplets produced when an infected person coughs or sneezes.¹ While humans are thought to be most contagious when symptomatic, the virus can spread even when an infected person is not showing symptoms.² 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 his/her mouth, nose, or possibly eyes, but this is not thought to be the main way the virus spreads.^{3,4}

What are COVID-19 Symptoms?

Symptoms of a COVID-19 infection may appear 2-14 days after being exposed to the virus. Symptoms range from mild to severe respiratory illness.⁵ The most common symptoms include:^{6,7}



- Fever
- Cough
- Shortness of Breath or difficulty in breathing
- Tiredness/fatigue

While less common, individuals with COVID-19 may also experience⁸:

- Aches and pains
- Sore throat
- Nasal Congestion
- Chills
- Nausea and vomiting

Vulnerable Populations

Current COVID-19 cases and prior coronavirus infections suggest that the most vulnerable populations include⁹:

- Older persons
- Individuals with pre-existing medical conditions, such as:
 - Heart disease
 - Lung disease
 - Diabetes
 - Pregnant women

Treatment and Recovery

- The overwhelming majority of people infected with COVID-19 experience mild symptoms and recover from the disease without needing special treatment.^{10,11}
- There is no specific antiviral treatment or vaccine for COVID-19.¹²
- Individuals with COVID-19 typically successfully receive treatment to relieve systems.¹³

Live Update of Global Cases of COVID-19

<https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>

COVID-19 Resources:

<https://www.cdc.gov/coronavirus/2019-ncov/index.html>
<https://www.ecdc.europa.eu/en/novel-coronavirus-china>
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>

1 <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>
2 <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>
3 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
4 <https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html>
5 <https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>
6 <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>
7 <https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf>

8 <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>
9 <https://www.who.int/images/default-source/health-topics/coronavirus/myth-busters/mythbuster-2.png>
10 <https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6>
11 <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>
12 <https://www.who.int/images/default-source/health-topics/coronavirus/myth-busters/mythbuster-4.png>
13 <https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html>



COVID-19: Staying Healthy as a Police Officer

Educate Yourself. Stay Informed. Be Safe.

Take the following steps to protect yourself to reduce the likelihood of contracting COVID-19.

- **Practice proper hand hygiene** by promptly washing or sanitizing hands after coughing, sneezing, or physically interacting with others. Wash your hands for at least 20 seconds with soap and water.
- **Avoid touching your face** (eyes, nose, and mouth).
- **Cover your mouth and nose** with your bent elbow or tissue when you cough or sneeze. Make sure to dispose of the tissue immediately.¹ Wash your hands with soap immediately after sneezing or coughing.
- **Avoid close physical contact** with others, including shaking hands and hugging.
- Maintain at least **6 feet distance** between yourself and anyone who is coughing or sneezing, when possible.²
- Promptly **disinfect your gear** including your duty belt after physical contact with any individual.³
- Keep **disinfectant wipes and hand sanitizer** in an easily accessible place while on-duty.
- Only wear a **mask** if coming into contact with someone who has the COVID-19 virus and make sure to know how to properly use and dispose of it.
- Educate yourself and participate in training on the use of **Personal Protective Equipment (PPE)** for respiratory protection, if available at your agency. Ensure only trained personnel wearing appropriate PPE have contact with individuals who have or may have COVID-19.
- Make sure to know your **agency's plans and protocols** for exposure control.
- **Seek medical care early** if you have a fever, cough and difficulty breathing.

COVID-19-infected droplets may be able to live on nearly any surface.⁴ Consider sanitizing items you frequently touch during a shift:

- Phone
- Laptop
- Clipboard
- Patrol car equipment
 - Steering wheel
 - Gear shift
 - Dispatch radio module
 - Door handles and edges

Insert local agency Logo here,
and delete this text box.

Contact

Reporting Procedures

What to do if you get sick

Resources for Law Enforcement:

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>

<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-law-enforcement.html>

<https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>

1 <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
2 <https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html>

3 <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-law-enforcement.html>
4 <https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf>