Emergency Declarations for Public Health Issues: Expanding Our Definition of Emergency

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I. Introduction

Emergency declarations are a vital legal authority that can activate funds, personnel, and material and change the legal landscape to aid in the response to a public health threat. Traditionally, declarations have been used against immediate threats such as hurricanes, tornadoes, wildfires, and pandemic influenza. Recently, however, states have used emergency declarations to address public health issues that have existed in communities for many months and years, though such use has been called into question.[1] We explore emergency declarations as a legal mechanism for response, describe recent declarations to address a hepatitis A outbreak and the opioid overdose epidemic, and discuss expanding the use of emergency declarations to address a variety of public health threats.

II. Emergency Declarations: A Trigger for Robust Legal Powers

In every state, governors have the authority to issue emergency declarations to enable the use of extraordinary powers to protect the public's health.[2] State emergency declaration powers vary between those states with a single all-hazards disaster declaration and those with multiple declaration types that trigger unique powers.[3] In either case, these declarations serve as a legal trigger for powers that can authorize the ability to access and reallocate funds,[4] change healthcare practitioner licensure rules,[5] seize private property,[6] and suspend any statutes or regulations that inhibit response.[7]

The legal definition of an emergency varies greatly by state.[8] Maryland, for example, provides an exclu-

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sive list of threats, requiring the presence of a biological agent, chemical agent, or radiation before the governor can declare a "catastrophic health emergency."[9] Colorado provides a detailed, but not exclusive, list of causes that constitute an emergency "including but not limited to fire, flood, earthquake, wind, storm, ... hazardous substance incident, oil spill or other water contamination[,] volcanic activity, epidemic, air pollution, blight, drought, infestation, explosion, [or] civil disturbance."[10] Still other states "mention only the magnitude of the potential harm, not its source."[11]

Typically, governors have used emergency declarations for immediate threats to the general population. More recently, however, governors have used declarations to address public health issues that have existed for years and have risk factors such as poverty and substance misuse.[12] Two recent cases exemplify how governors have applied emergency powers to these public health threats to address hepatitis A in California and the opioid overdose epidemic in Arizona.

III. California's Hepatitis A Emergency Declaration

In March 2017, the County of San Diego Health & Human Services Agency noted 19 cases of hepatitis A with symptom onset dating back to November 2016 — more than double what officials would have expected to see during this time.[13] Hepatitis A is a potentially severe viral infection of the liver and can be transmitted person to person. While hepatitis A infection is serious, hepatitis A outbreaks are rarely considered a community-wide emergency and are normally addressed using normal public health control measures. Yet, by April 2017, increased numbers of hepatitis A infection, including several deaths, were reported by multiple local health departments in California. Most cases were among persons experiencing homelessness or using illicit drugs. In response, local health department personnel implemented large-scale vaccination efforts, education and outreach, increased access to public toilets, and enhanced sanitation through strategies that included providing personal hygiene kits and deploying handwashing stations. To aid local efforts, the California Department of Public Health (CDPH) activated the Medical and Health Coordination Center to monitor the outbreak, provide guidance, and procure and distribute vaccine doses.

By May 2017, more than 20 new cases were reported to CDPH every week, exponentially outpacing baseline case rates. San Diego, Santa Cruz, and Los Angeles counties each faced outbreaks. Responders confronted multiple challenges, including a hard-to-reach population; underlying conditions including mental illness, chronic liver disease, lack of sanitation, and lack of education; and a constrained vaccine supply due to dramatically increased demand.

On October 13, 2017, California Governor Edmund Brown, Jr., declared a state of emergency to address the outbreak.[14] The governor's emergency declaration triggered access to state funding to prevent interruption of the vaccine supply and ensured a coordinated effort between the state and local health departments.[15] Specifically, the governor authorized CDPH to "take all measures necessary to obtain hepatitis A vaccines and prioritize the vaccination of at-risk individuals in affected locations."[16] The declaration also ordered all drugs and medical supply stocks intended for wholesale distribution to be held subject to the control and coordination of CDPH and authorized EMT-paramedic licensees in the affected locations to administer vaccines to at-risk populations.[17]

The governor's declaration assisted local health departments and their partners' robust response actions, including intense vaccination efforts, education, vaccine supply management, and sanitation measures. Subsequently, the number of reported outbreak-associated cases decreased in California.[18] With the slowdown in reported cases, on April 11, 2018, CDPH announced the demobilization of the outbreak response and a return to routine disease surveillance and control activities.

IV. Arizona's Opioid Overdose Emergency Declaration and Enhanced Surveillance Advisory

In 2016, Arizona saw 790 deaths related to opioids, the equivalent of two Arizonans dying per day, and a 74% increase in opioid overdose deaths since 2012.[19] To combat this opioid overdose epidemic, emergency action was taken to increase the number of personnel trained to administer naloxone, improve prescribing practices, and collect more robust and accurate data.[20]

On June 5, 2017, under his authority to declare an emergency and respond to an epidemic,[21] Arizona Governor Doug Ducey declared a state of emergency to address Arizona's opioid overdose epidemic.[22] The emergency declaration directed the Arizona Department of Health Services (ADHS) to coordinate the response per the state's public health emergency statute and to take various actions.[23] First, the emergency declaration established a seven day deadline for the ADHS director to consult with the governor on the issuance of an enhanced surveillance advisory.[24] As a result, Governor Ducey issued an enhanced surveillance advisory on June 13, 2017, directing healthcare providers, medical examiners, pharmacists, healthcare institutions, correctional facilities, and law enforcement agencies to report suspected opioid overdoses,

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incidences of nalaxone administration, and cases of neonatal abstinence syndrome to ADHS.

The declaration also required ADHS to promulgate emergency rules to require new policies for prescribing, ordering, and administering opioids.[25] Assuming opioid overdose deaths continued at the same rate, there would have been nearly 600 deaths in the six to eight months typically required to complete non-emergency rulemaking procedures. Additionally, the emergency declaration directed ADHS to train local law enforcement agencies to carry, handle, and administer naloxone.[26] As a result over 1,000 law enforcement officers were trained by May 2018.[27] Finally, the declaration required ADHS to report findings and recommendations for legislative action to establish lasting solutions to the state's opioid overdose epidemic.[28]

The emergency declaration empowered public health officials at ADHS to coordinate the response to the opioid overdose epidemic immediately while long-term solutions were enacted. Ultimately, on January 25, 2018, the Arizona Legislature drafted and unanimously passed the Arizona Opioid Epidemic Act covering issues such as liability protections, prescription limitations, and requirements for insurers to provide prior authorization for medical treatment services to address the crisis.[29] After ADHS met all of the emergency declaration requirements and completed all items in the opioid action plan, the governor officially terminated the opioid emergency declaration on May 29, 2018.[30] In the year following the declaration, reported opioid overdoses fell by 44%.

V. Looking Ahead: Utilizing Declarations Beyond "Typical" Emergencies

The utility of emergency declarations as a tool to address public health threats is clear. However, these broad authorities can give rise to concerns that emergency powers will "interfere with private business interests[or] restrict individual freedoms and property rights."[31] Critics caution that these powers should be limited to the "archetypal scenario" and not used for health threats related to noncommunicable diseases[32] or communicable disease outbreaks that are not traditionally considered a community-wide emergency. A persuasive argument has been made that if declarations are "used too readily, public health officials may find themselves like the boy who cried wolf: their warnings about emergencies may go unheeded."[33] In one argument, the opioid epidemic is specifically cited as an example, asserting that when "[f]aced with a substantial public health problem such as opioid addiction, officials may be tempted to use their emergency powers. But like opiates, those powers should be used only when needed."[34] While we agree that emergency powers should be used sparingly, the lawfulness and utility of a declaration should weigh more in decision makers' minds than whether the threat resembles traditional emergencies.

Many citizens benefited from the immediate access to the hepatitis A vaccine enabled by California's emergency declaration which avoided the interruption of vaccine supply and relaxed EMT-paramedic licensure rules to administer the vaccine, and from the naloxone distributed by law enforcement personnel trained pursuant to the Arizona governor's emergency order and the targeted response that resulted from real-time reporting pursuant to the enhanced surveillance advisory. In both cases, the emergency orders helped save lives by expediting the legal tools necessary to ensure the deployment of vital emergency response resources.

The California hepatitis A and Arizona opioid emergency declarations, as well as other recent examples,[35] demonstrate that emergency declarations may be used effectively and lawfully to address public health threats that are not typical natural disasters or widespread disease epidemics. Unlike traditional emergencies, the effects of the hepatitis A outbreak and opioid overdose epidemic were focused on specific populations. For these populations, whether the disease or injury resembles past emergencies matters little; what matters is whether our public health system is using all available legal tools to mitigate harm. Certainly, governors can issue emergency declarations only when the situation meets the state's legal definitions. Yet, when considering whether to declare, governors should look to the law as written, rather than limit the

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scope of discussion and reject a declaration because the threat is atypical.

The tangible benefits of these declarations demonstrate their utility when atypical emergencies create the necessity for enhanced action. Emergency declarations have been cited as a politically expedient tool to spur legislative and regulatory action "when legislative gridlock or the influence of special interests has thwarted needed action."[36] Yet, declarations do not merely bring attention or act as alternatives to political action. They allow for harm mitigation while legislative or regulatory processes are carried out, possibly saving lives in the interim. Many citizens benefited from the immediate access to the hepatitis A vaccine enabled by California's emergency declaration which avoided the interruption of vaccine supply and relaxed EMT-paramedic licensure rules to administer the vaccine, and from the naloxone distributed by law enforcement personnel trained pursuant to the Arizona governor's emergency order and the targeted response that resulted from real-time reporting pursuant to the enhanced surveillance advisory. In both cases, the emergency orders helped save lives by expediting the legal tools necessary to ensure the deployment of vital emergency response resources.

VI. Conclusion

Public health is sometimes faced with alarmingly sharp increases in morbidity and mortality. Day-to-day legal authorities are often sufficient to address these increases; communities regularly experience disease outbreaks, which are reported, investigated, and controlled expeditiously with traditional public health authorities and resources. At times, however, public health initiates a response and discovers a gap — legal authorities present a barrier to the response, or the necessary money or supplies are not available through the usual procedures. The fundamental questions when considering whether to use an emergency declaration are whether the situation meets legal definitions and whether the declaration would activate a resource or authority that could fill the gap and mitigate injury and death. Although these crises do not always look like typical disasters, emergency declarations can still be an appropriate tool to augment responses as long as they are used when lawful and necessary to protect the public's health.

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Note

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References

1. R. Haffajee, W. E. Parmet, M. M. Mello, "What Is a Public Health 'Emergency'?" *New England Journal of Medicine* 371, no. 11 (2014): 986-988.
2. J. G. Hodge, Jr., and E. D. Anderson, "Principles and Practice of Legal Triage During Public Health Emergencies," *New York University Annual Survey of American Law* 64 (2008): 249-290, at 264-269.
3. G. Sunshine, "The Case for Streamlining Emergency Declaration Authorities and Adapting Legal Requirements to Ever-Changing Public Health Threats," *Emory Law Journal* 67 (2018): 397-414, at 400-401.
4. See, e.g., Ark. Code Ann. § 12-75-114; Fla. Stat. Ann. § 252.37(2).
5. See Hodge and Anderson, *supra* note 2.
6. See Haffajee et al., *supra* note 1.
7. D. G. Orenstein, "When Law Is Not Law: Setting Aside Legal Provisions during Declared Emergencies," *Journal of Law, Medicine & Ethics* 41, Suppl. 1 (2013): 73-76; G. Sunshine, K. Thompson, A. N. Menon, N. Anderson, M. Penn, L. M. Koonin, "An Assessment of State Laws Providing Gubernatorial Authority to Remove Legal Barriers to Emergency Response," *Health Security* 17, no. 2 (2019): 156-161.
8. See Haffajee et al., *supra* note 1.
9. Md. Code Ann., Pub. Safety § 14-3A-01(c).
10. Colo. Rev. Stat. Ann. § 24-33.5-703.
11. See Haffajee et al., *supra* note 1.
12. *Id.*; L. Rutkow and J. S. Vernick, "Emergency Legal Authority and the Opioid Crisis," *New England Journal of Medicine* 377, no. 26 (2017): 2512-2514; Ind. Exec. Order No. 17-13 (Feb. 9, 2017).
13. County of San Diego, *Hepatitis A Outbreak: After Action Report*, at E-1, *available at* <https://www.sandiegocounty.gov/content/dam/sdc/cosd/SanDiegoHepatitisAOutbreak-2017-18-AfterActionReport.pdf> (last visited February 22, 2019).
14. Gov. Edmund Brown Jr., Cal. Proc. (Oct. 13, 2017), *available at* <https://www.ca.gov/archive/gov39/wp-content/uploads/2017/11/10.13.17_Hepatitis_A_Emergency_Proclamation_-_Attested.pdf> (last visited May 6, 2019).
15. *Id.*
16. *Id.*
17. *Id.*
18. M. Foster et al., "Hepatitis A Virus Outbreaks Associated with Drug Use and Homelessness — California, Kentucky, Michigan, and Utah, 2017," *Morbidity and Mortality Weekly Report* 67 (2018): 1208–1210.
19. Office of the Governor Doug Ducey, "Arizona Opioid Epidemic Act Policy Primer," *available at* <https://azgovernor.gov/sites/default/files/related-docs/arizona_opioid_epidemic_act_policy_primer.pdf> (last visited February 22, 2019); Arizona Department of Health Services, "Arizona Opioid Emergency Response: June 2017 to June 2018," *available at* <https://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/2017-

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opioid-emergency-response-report.pdf> (last visited February 22, 2019).
20. Gov. Doug Ducey, "Declaration of Emergency and Notification of Enhanced Surveillance Advisory *Opioid Overdose Epidemic*," June 5, 2017, *available at* <https://azgovernor.gov/sites/default/files/related-docs/opioid_declaration.pdf> (last visited February 22, 2019).
21. Ariz. Rev. Stat. §§ 36-301(15), 36-303(D), & 36-787.
22. See *supra* note 20.
23. *Id.*
24. While an emergency declaration is not required to issue an enhanced surveillance advisory, consultation with the ADHS director must occur. Ariz. Rev. Stat. § 36-782(A).
25. See *supra* note 20; *see also* Ariz. Admin. Code R9-10-120.
26. See *supra* note 20.
27. See Arizona Opioid Emergency Response: June 2017 to June 2018, *supra* note 19.
28. See *supra* note 20.
29. Arizona Opioid Epidemic Act of 2018, S.B. 1001, 53rd Ariz. Leg. Spec. Session 1 (enacted Jan. 26, 2018).
30. See Arizona Opioid Emergency Response: June 2017 to June 2018, *supra* note 19.
31. See Haffajee et al., *supra* note 1.
32. *Id.*
33. *Id.*
34. *Id.*
35. Ind. Exec. Order No. 15-05 (Mar. 26, 2015); See Ind. Exec. Order No. 17-13, *supra* note 12; See Rutkow & Vernick, *supra* note 12.
36. See Haffajee et al., *supra* note 1.

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