Coordinated Implementation of Community Response Measures (Including Social Distancing) to Control the Spread of Pandemic Respiratory Disease

A Guide for Developing a Memorandum of Understanding for Public Health, Law Enforcement, Corrections, and the Judiciary

Developed by the
Public Health and Law Enforcement Emergency Preparedness Workgroup

Convened by:
Centers for Disease Control and Prevention, DHHS
Bureau of Justice Assistance, USDOJ

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Introduction

This document was developed during 2007-2008 by the Public Health and Law Enforcement Emergency Preparedness Workgroup (hereinafter the Workgroup). The Workgroup received primary support from the Coordinating Office for Terrorism Preparedness and Emergency Response of the Centers for Disease Control and Prevention (CDC) and was established by CDC's Public Health Law Program in partnership with the U.S. Department of Justice's Bureau of Justice Assistance. The Workgroup's composition included experts from local, state, and national organizations representing the sectors of public health, law enforcement, corrections, and the judiciary (see Appendix A).

Workgroup members developed three documents to strengthen cross-sector coordination in public health emergency preparedness, including:

- a broad framework report on improving cross-sector coordination;
- a model memorandum of understanding (MOU) addressing joint public heath and law enforcement investigations of bioterrorism; and
- this guide for developing an MOU for strengthening coordinated cross-sector response to contagious respiratory diseases such as pandemic influenza.

Rationale for the Workgroup

In the last decade, a series of disasters — including the events of 2001, the SARS outbreak in 2003, Hurricanes Katrina and Rita in 2005, and the current threat of a virulent influenza pandemic — has drawn more attention and resources to emergency preparedness. As a result, state and local health departments, law enforcement agencies, the corrections system, the judiciary, and organizations in many other sectors have re-examined their policies and procedures, identified potential gaps, launched task forces and committees, and drafted plans for continuity of operations (COOP) for future emergencies.

Among the many lessons of recent emergency response efforts is the realization that no sector or jurisdiction is likely to face a major disaster or its aftermath in isolation. While emergency preparedness plans aim to maintain or quickly restore the routines and functions of civil society, even the most thorough and prescient plan will fall short if it does not span jurisdictions, sectors, agencies, and organizations. The Public Health and Law Enforcement Emergency Preparedness Workgroup, described above, was convened to help accelerate and focus the jump across sectoral lines by developing tools such as this guide for developing an MOU.

Even though the sectors represented on the Workgroup share overlapping responsibilities for the public's health and welfare, in general and in most jurisdictions, they tend to operate in isolation from one another. Recent emergencies and current disaster scenarios have changed this equation quite radically, to the point where it is difficult to imagine a pandemic influenza scenario that would *not* require the involvement of law enforcement, institutional corrections, community corrections, and the judiciary.

During a serious influenza pandemic or similar contagious disease threat, the decision to implement voluntary social distancing and other community response measures would require many organizations to closely coordinate a spectrum of steps, including initial and ongoing decision-making, implementation, and monitoring the impact of using such measures. Decision-making and actions (or non-actions) would need to be coordinated across levels of government and across jurisdictional lines — potentially involving neighboring towns, counties, states or, in the case of border states, neighboring countries. In addition, these responses would engage numerous sectors, including elected officials, public health, law enforcement, the judiciary, corrections, probation, health care providers, schools, businesses, the media, the military, and others.

The specific ways that each of these sectors might be influenced by the actions and expectations of the others is the focus of this MOU guidance.

Purpose of This Document

This document provides guidance for consideration by state, tribal, local, and other jurisdictions when addressing planning efforts to coordinate cross-sector implementation of community responses (including social distancing) to prevent or limit the spread of a severe, contagious respiratory disease such as pandemic influenza. As described in greater detail below, it covers the set of community measures that would occur when a contagious disease (such as pandemic influenza) already has reached pandemic status. At this point, some measures (e.g., involuntary quarantine and isolation) would have limited, if any, indication because of the substantial spread of the disease in question. Instead, public health officials and their counterparts in other sectors will be relying on other measures that limit contact between people, such as encouraging people to stay home from work and school and banning congregating in groups (e.g., by canceling concerts and sports events in public places). In the absence of a widely available and effective vaccine, these responses remain the most powerful measure for controlling the spread of an infectious disease like pandemic influenza.

The selection of public health control measures in a public health emergency will be dictated by the fundamental characteristics of the disease pathogen that has caused the outbreak in question. Important considerations include (but are not limited to) such critical determinants as the disease's incubation period, whether asymptomatic transmission occurs, the availability of antibiotics or antivirals that can either prevent or cure disease or reduce transmissibility, and the availability of preventive treatment (especially vaccination). Voluntary or mandatory isolation or quarantine and contact tracing would be used based on their ability to have a beneficial effect in interrupting transmission of disease. (As noted above, *mandatory* or *involuntary* measures would not usually be used in an influenza pandemic because the disease already has spread; however, after the disease has spread widely, *voluntary* measures would remain an option.)

The decisions to implement public health control measures must be determined by these critical factors that may vary considerably, depending on the specific pathogen. Generally, implementation of community measures (such as those described in this MOU guidance) would be reserved for scenarios when a disease-causing agent has the capability of widespread

dissemination, and there are few or no effective targeted medical or preventive interventions (such as pandemic influenza).

Disclaimer

The information contained in this document does not constitute legal advice. Use of any provision herein should be contemplated only in conjunction with advice from legal counsel. Provisions may need to be modified, supplemented, or replaced to ensure appropriate citation to or compliance with relevant local and state laws, to accurately reflect the intent of parties to a particular agreement, or to otherwise address the needs or requirement of a specific jurisdiction.

Use and Scope of This Guide

This guide for developing an MOU is designed to assist representatives from public health, law enforcement, institutional and community corrections, and the judiciary in clarifying the expectations each would have of the others during a scenario in which community responses to a severe respiratory disease outbreak (such as an influenza pandemic) would be warranted.

The particular scenario of a pandemic of severe influenza was chosen as an illustrative one for several reasons.

- First, this disease threat (and, by extension, other diseases that meet similar criteria of incubation periods, modes and speed of transmission, severity, and potential for mitigation via non-pharmaceutical interventions) has been the subject of substantial attention, funding, and preparedness planning.

- Second, despite uncertainty about many aspects of pandemic influenza and its mitigation, the *likelihood* of an influenza pandemic is high. Therefore, preparing for this scenario is prudent for jurisdictions, sectors, communities, and individuals.

- Third, the agreements and relationships developed as a result of planning for these types of community response measures can be applied, with appropriate modifications, to other disease-specific scenarios. For example, an influenza pandemic scenario (once established in a locale) is unlikely to require mandatory (involuntary) isolation or quarantine as a community mitigation strategy; by definition, during a pandemic a disease generally has spread widely and such measures would not be feasible or effective in interrupting transmission in the community. However, during the early stages of an outbreak that affects a limited number of specific individuals that can be identified (e.g., during SARS, those persons who traveled to a particular country), mandatory isolation and quarantine may be effective, and thus warranted. Even though the *specific* strategies differ (i.e., voluntary versus mandatory isolation/quarantine), having relationships and tools for rapid implementation in place in advance is expected to improve cross-sectoral and cross-jurisdictional coordination in responding to either type of scenario.

This guide is designed to serve as a focus for initiating conversations and then agreements that would specify and clarify the roles each sector would play, the expectations each would have of

the others, the legal authorities under which each would act, information requirements, and other gaps that need to be addressed to ensure pre-event preparedness.

These commitments can be solidified in the form of an MOU to be executed by all parties, regularly reviewed, and, when appropriate, modified in writing upon mutual consent. In addition, depending on the needs of a given jurisdiction, the contents of the guide contained in this document can function as a checklist, a "fill-in-the-blanks" template, and/or an outline for analyzing, reviewing, and discussing the status of multi-jurisdictional and cross-sectoral preparedness for use of community response measures. This guide also can be applied to other disease-specific scenarios.

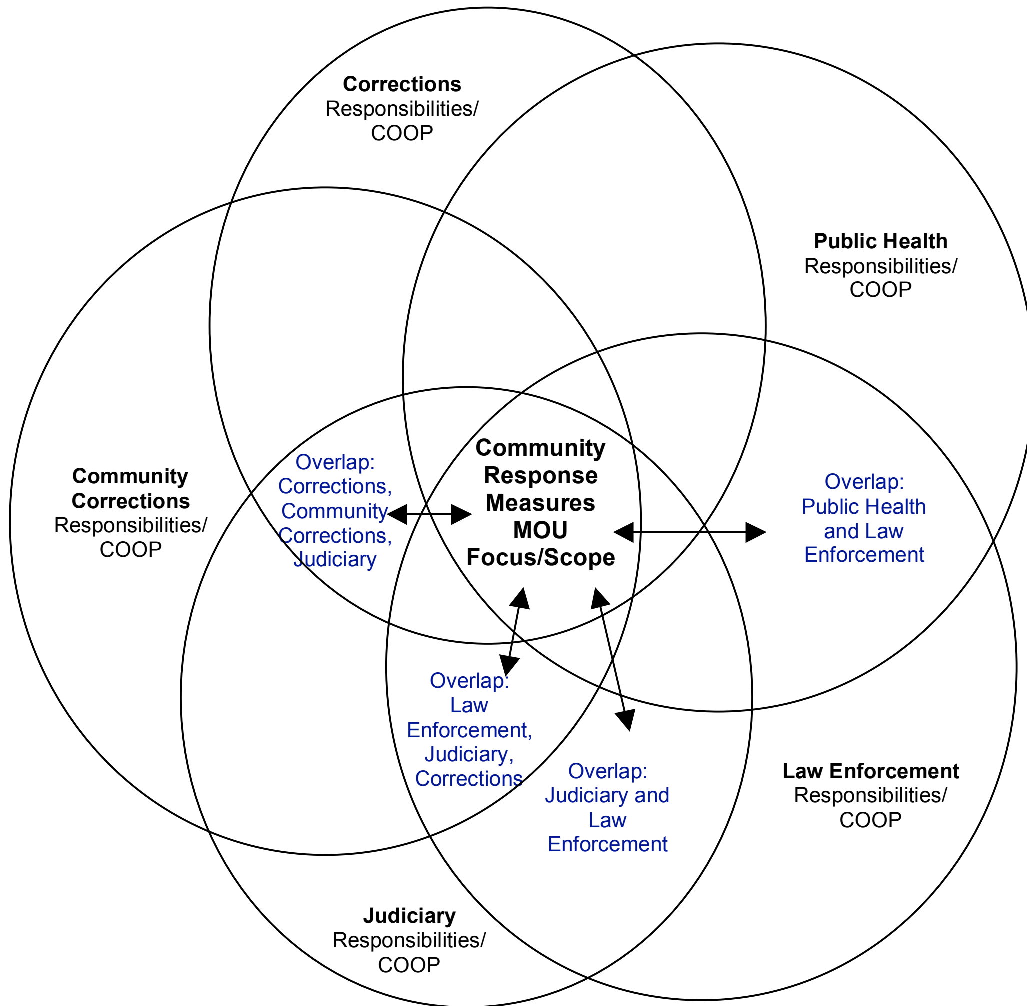
By necessity, decisions regarding the adoption of the generic MOU components provided in this document will vary substantially by jurisdiction to reflect applicable laws and other jurisdiction-specific factors. This guide and the MOU components also assume that, within a given jurisdiction, there already exist pre-event continuity of operations (COOP) plans for different sectors and agencies within the jurisdiction. Thus, the MOU would focus primarily on strengthening coordinated interactions between the multiple categories of players having key roles and responsibilities in implementing community response measures during a public health emergency.

Even though each sector may be assumed to have its own internal COOP plan, it should *not* be assumed that these plans have been shared with other sectors. COOP plans are developed primarily for internal purposes, but may rely upon or affect another sector's COOP plan. The approach of this document is to view the sharing of internal COOP plans with other sectors as an essential element of preparedness planning, so that the implications of each sector's plans for others are known, understood, and, if necessary, can be changed. (For more information on COOP planning, including sector-specific checklists for law enforcement and corrections, please see www.pandemicflu.gov/plan/workplaceplanning.)

Figure 1, below, shows that each sector's internal plans may have implications for some or all of the other sectors. The guide in this document addresses points of overlap between two or more sectors and further organizes them into the categories described in CDC's *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions.*[1]

[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007. *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions.* Available at: www.pandemicflu.gov

Figure 1
COOP Planning and Cross-Sectoral Overlap for Community Response Measures



Approach to Developing an MOU

The Workgroup suggests that, before community response measures become necessary in a disease scenario, such as pandemic influenza, representatives from the various sectors/agencies should consider the following initial steps:

1. First, form a cross-sectoral, multi-jurisdictional workgroup or team, preferably using existing emergency planning teams and incorporating incident command system structures. The group would then:
   i. Identify lead and back-up points of contact for each agency/jurisdiction.
   ii. Conduct a review of statutes and legal authorities relevant to the declaration, implementation, and suspension of community response measures.
   iii. Identify, research, gather, and consolidate information on key considerations, including:
      - Legal authorities and gaps in laws necessary for implementing community response measures identified through the review described above
      - Who has authority to make the decision that community response measures should be implemented
      - Who can declare the implementation of community response measures
      - Penalties for violating mandatory or "voluntary" community response measures and situation-specific parameters for enforcement
      - When are "voluntary" measures treated like mandatory measures?
      - Who will enforce such violations and how will they be handled?
      - Duration, renewal and termination of measures
      - Neighboring jurisdictions to be consulted/notified once measures are considered, implemented, and terminated.

2. Second, draft an MOU signed by all parties based on consideration of the above factors and of the combination of general responsibilities and specific factors outlined below.

   Note: Even if all the parties are not available or involved during the initial MOU drafting, this process still can be useful because additional sectors can be included later during periodic reviews and revisions.

Components of an MOU

1. **Preamble**

a. Foundation for a coordinated community response to severe contagious disease threats
   i. This memorandum of understanding (MOU) formalizes the manner in which (*agencies, organizations, and/or sectors*) will coordinate community response

measures in response to widespread severe respiratory disease outbreaks (such as an influenza pandemic) or other severe contagious disease threat affecting (*jurisdiction/s*).

ii. The parties recognize that protecting the health and safety of the public and of response personnel are both priorities during coordinated response efforts for such public health threats to the jurisdiction. However, under the circumstances of a severe contagious disease threat, the health and safety of response personnel may have to take priority over the public's, in order to maintain their capabilities during an extended pandemic or other serious community-wide health threat. This may extend to requiring citizens to take measures that they may not ordinarily be asked to take (e.g., wearing a facemask while in the presence of response personnel).

b. Goals of community containment and response measures

Typically, public health control measures are first aimed at intervening in individual cases or small clusters of disease to delay the spread of a pathogen. These measures have the objectives of preventing those who are already ill from infecting others, preventing or reducing the risk of illness in those who are infected or exposed, and preventing those not infected from becoming infected.

To accomplish these objectives, standard control measures include isolation of cases, identification of contacts, employing voluntary or mandatory (involuntary) isolation and quarantine, employing good infection control measures and administering antibiotics, antivirals, and vaccines if they are available and effective.

If case-based approaches fail or are not available to be used (i.e, transmission cannot be contained), then individual public health interventions transition to community containment or mitigation measures. **The fundamental rationale for the recommended community mitigation measures is that reducing unprotected face-to-face contacts between people will reduce the likelihood of disease transmission.**

c. Key concepts and terms

i. Specific public health measures for case-based containment include isolation and quarantine, either voluntary or mandatory (involuntary).

1. **Isolation** is the separation or restriction of movement of people who are sick with an infectious disease, in order to prevent transmission to others.

2. **Quarantine** is a restraint upon the activities (e.g., physical separation or restriction of movement within the community/work setting) of an individual(s) who has been exposed to an infection, and is not yet but may become ill, to prevent the spread of disease. Many respiratory infections, including pandemic influenza, can be

transmitted by a person before they develop symptoms of the illness.

Both isolation and quarantine may be applied voluntarily or on a compulsory basis, depending on the characteristics of the pathogen and the outbreak, relevant legal authorities, and whether either of these strategies is felt to be beneficial at the time.

ii. **Community mitigation measures** are not limited to isolation and quarantine. Implementation of most of the recommended community measures can be difficult because they rely on the voluntary cooperation of members of the community. Public health community control measures for a Phase 6 pandemic of influenza do not generally include use of mandatory isolation and quarantine or *cordon sanitaire.* (See the section on triggers, below, for an explanation of a Phase 6 pandemic.) These measures may include international travel restrictions, but domestic travel probably would not be restricted. While law enforcement might be called upon to enforce public health community measures, more likely this sector would be needed for other critical priority activities to maintain social order and calm.

iii. This MOU covers the following types of potential responses, all of which are voluntary and designed to encourage people to avoid face-to-face contact, such as:

- **Voluntary isolation of people with confirmed or probable cases of the disease** (e.g., pandemic influenza) and treatment as appropriate. (Depending on the severity of the illness and/or the capacity of the healthcare infrastructure, individuals may be isolated at home or possibly in a healthcare setting, if they need a higher level of medical care.)

- **Voluntary home quarantine** of household members who have been exposed to someone with confirmed or probable disease. Quarantine may be combined with prophylactic use of medications, if effective medications are available.

- **Social distancing** measures designed to increase the space between people and decrease the frequency of contact among them, such as:

  - **Closing classes in schools and other school-based activities**; closing childcare programs; and reducing out-of-school social contacts among children and youth.

  - **Reducing contact between adults in the community and workplace** (e.g., canceling large public gatherings, altering workplace environments and schedules, changing leave policies).

iv. Measures that are taken to reduce the spread of an infectious disease but do not include pharmaceutical products (e.g., vaccines and medicines) are sometimes referred to as **nonpharmaceutical interventions or NPIs**. Social distancing strategies — keeping students home from school and adults home from work — are examples of NPIs. They may be used independently or in combination with pharmaceutical interventions.

v. The effectiveness and availability of vaccines or treatment medications is one of the factors that will determine whether they are used or not. When pharmaceutical interventions are available and effective, they raise a number of difficult issues about who should receive them first if they are in limited supply and how they would be distributed. These issues are not addressed specifically in this MOU, but are part of existing public health plans. However, the MOU sections below do assume that law enforcement, in particular, may be called upon to protect stockpiles of vaccine or medication or distribution points to ensure safe transport, and/or safe distribution.

d. Triggers for community response measures

Specific community response measures will be selected based on the severity level of a pandemic (in the case of pandemic influenza, primarily determined by case fatality ratios), and would be triggered by the phase or interval of the pandemic, e.g., the arrival and transmission of a virus in a geographic locale.

The threat level a disease poses for a particular jurisdiction typically is assessed by local, state, tribal, federal, or international public health officials, who monitor disease patterns in the local communities and apply knowledge about the disease patterns in other communities.

The tables below compare WHO global pandemic phases for pandemic influenza with those of the U.S. Federal Government and indicate which interventions would be triggered by different stages of an influenza pandemic. Specific community measures and the timing of interventions should be tailored depending on the characteristics of the specific disease in question — such as its incubation period, the possibility of asymptomatic transmission, likelihood of rapid spread, mortality rate, and the effectiveness and availability of antibiotics or antivirals to prevent or cure disease or reduce transmission.

World Health Organization (WHO) Pandemic Phases and the Stages for Federal Government

World Health Organization Phases		Federal Government Response Stages	
Inter-Pandemic Period			
1	No new influenza virus subtypes have been detected in humans. An influenza virus sub-type that has caused human infection may be present in animals. If present in animals, the risk of human disease is considered to be low.	0	New domestic animal outbreak in at-risk country.
2	No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a sub-stantial risk of human disease.		
Pandemic Alert Period			
3	Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.	0	New domestic animal outbreak in at-risk country.
		1	Suspected human outbreak overseas.
4	Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adpated to humans.	2	Confirmed human outbreak overseas.
5	Larger cluster(s) but human-to-human spread still localized; suggesting that the virus is be-coming increasingly better adapted to humans, but may not yet be fully transmissible (sub-stantial pandemic risk).		
Pandemic Period			
6	Pandemic phase: increased and sustained transmission in general population.	3	Widespread human oubreak in multiple locations overseas.
		4	First human case in North America.
		5	Spread througout United States.
		6	Recovery and preparation for subsequent waves.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007. *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions*. Available at: www.pandemicflu.gov

Summary of the Community Mitigation Strategy by Pandemic Severity

	Pandemic Severity Index		
Interventions* by Setting	**1**	**2 and 3**	**4 and 5**
Home **Voluntary isolation** of ill at home (adults and children); combine with use of antiviral treatment as available and indicated	Recommend†§	Recommend†§	Recommend†§
Voluntary quarantine of household members in homes with ill persons¶ (adults and children); consider combining with antiviral prophylaxis if effective, feasible, and quantities sufficient	Generally not recommended	Consider**	Recommend**
School **Child social distancing**			
• dismissal of students from schools and school-based activities, and closure of child care programs	Generally not recommended	Consider: <4 weeks††	Recommend: <12 weeks§§
• reduce out-of-school social contacts and community mixing	Generally not recommended	Consider: <4 weeks††	Recommend: <12 weeks§§
Workplace/Community **Adult social distancing**			
• decrease number of social contacts (e.g., encourage teleconferences, alternatives to face-to-face meetings)	Generally not recommended	Consider	Recommend
• increase distance between persons (e.g., reduce density in public transit, workplace)	Generally not recommended	Consider	Recommend
• modify, postpone, or cancel selected public gatherings to promote social distance (e.g., postpone indoor stadium events, theatre performances)	Generally not recommended	Consider	Recommend
• modify work place schedules and practices (e.g., telework, staggered shifts)	Generally not recommended	Consider	Recommend

Generally Not Recommended = Unless there is a compelling rationale for specific populations or jurisdictions, measures are generally not recommended for entire populations as the consequences may outweigh the benefits.

Consider = Important to consider these alternatives as part of a prudent planning strategy, considering characteristics of the pandemic, such as age-specific illness rate, geographic distribution, and the magnitude of adverse consequences. These factors may vary globally, nationally, and locally.

Recommended = Generally recommended as an important component of the planning strategy.

* All these interventions should be used in combination with other infection control measures, including hand hygiene, cough etiquette, and personal protective equipment such as face masks. Additional information on infection control measures is available at www.pandemicflu.gov.

† This intervention may be combined with the treatment of sick individuals using antiviral medications and with vaccine campaigns, if supplies are available.

§ Many sick individuals who are not critically ill may be managed safely at home.

¶ The contribution made by contact with asymptomatically infected individuals to disease transmission is unclear. Household members in homes with ill persons may be at increased risk of contracting pandemic disease from an ill household member. These household members may have asymptomatic illness and may be able to shed influenza virus that promotes community disease transmission. Therefore, household members of homes with sick individuals would be advised to stay home.

** To facilitate compliance and decrease risk of household transmission, this intervention may be combined with provision of antiviral medications to household contacts, depending on drug availability, feasibility of distribution, and effectiveness; policy recommendations for antiviral prophylaxis are addressed in a separate guidance document.

†† Consider short-term implementation of this measure—that is, less than 4 weeks.

§§ Plan for prolonged implementation of this measure—that is, 1 to 3 months; actual duration may vary depending on transmission in the community as the pandemic wave is expected to last 6-8 weeks.

Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007. *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions.* Available at: www.pandemicflu.gov

The CDC *Interim Pre-pandemic Planning Guidance* specifies three escalating phases spanning the recognition that a pandemic is unfolding and the decision to activate a series of community response measures:

- **Alert** — notification of critical systems and personnel regarding potential activation
- **Standby** — initiating decision-making processes for imminent activation, including mobilizing resources and personnel
- **Activate** — implementing specific mitigation measures.

The guide in this document is organized in accordance with these phases and presents each sector's potential roles and responsibilities in relation to alert, standby, and activate conditions.

> Note that the "alert" phase corresponds to a general planning phase — one that is already underway and would include activities such as developing this type of MOU. "Standby" is a phase in which activation may be imminent; and, as a result, the two latter phases are combined in the description of each sector's roles and responsibilities, below.
>
> Note also that the various sectors are likely to become engaged in specific phases at different times. For example, in a pandemic influenza scenario, public health likely will be in a standby and activation phase before the other sectors.

e. Roles in planning for alert, standby, and activation phases

In any affected jurisdiction(s), agencies, organizations and individuals representing the following sectors are likely to be involved in decisions related to each of these phases:

- Elected, designated, and/or appointed government officials
- Public health
- Emergency management officials
- Law enforcement
- Institutional corrections (including local jails)
- Community corrections
- Emergency Medical Services (EMS)

Other agencies, organizations, and groups would be directly affected by such decisions and would play key roles in communicating and responding to community response measures include:

- Judiciary
- Public and private bar

- Private sector health care providers
- Educators, school officials, education administrators, education lawyers, parent-teacher organizations
- Child care providers
- Business leaders and managers
- Critical infrastructure (e.g. water, electric, gas, fuel)
- City and county attorneys and local prosecutors
- Transportation agencies
- Faith-based communities and organizations
- Media
- Hospitals
- Fire department
- Medical examiners
- Military
- Unions whose members staff the agencies, sectors, and services noted above

Appendix B includes a table that highlights each sector's roles during an emergency requiring community mitigation measures.

2. **Terms of MOUs**

The following are examples of options for the terms of interagency MOUs for coordinated implementation of community response measures in response to an influenza pandemic or other severe respiratory disease threat:

a. Such instruments may be in force indefinitely, but may be terminated upon written mutual consent.

b. Such instruments may be reviewed on an annual basis (or more frequently) and modified as appropriate.

c. Modifications should preferably be in writing and signed by authorized representatives of each participating agency.

3. **Legal References and Authorities**

The parties to this agreement should review jurisdictional legal authorities; ensure compliance with applicable laws, rules, and regulations; and determine how these authorities might vary under a declared emergency and in the absence of a declared emergency. Depending on the jurisdiction, relevant authorities may include:

a. Federal laws

- Laws governing federal personnel and property within a jurisdiction (e.g., military bases or federal prisons)
- Health Insurance Portability and Accountability Act (HIPAA)
- Pre-emptive emergency powers and jurisdiction
- Federal isolation or quarantine orders

b. State laws

- Applicable health code (includes powers of the state health official, Commissioner, and Board of Health)
- Reportable disease laws
- Authority for investigating and controlling disease
- Privacy and confidentiality laws including restrictions, if any, on when confidential information can be disclosed to others in order to protect the public's health
- Governor's emergency management powers and duties, including declaring and terminating an emergency
- Authority to declare and implement voluntary quarantine (individual, group, and area), isolation, and closure of public places and travel routes (including laws addressing compensation for affected businesses)
- Laws specifying state and local emergency management structures
- State and local mutual aid arrangements
- Laws addressing declarations of judicial emergencies
- Powers to address violent unrest and maintain order (including curfew orders)
- Applicable rules for implementing the above-mentioned types of laws
- Procedural requirements for adopting, amending, or repealing these rules

c. Local laws (if applicable)

- Applicable health code (includes powers and authorities of the local health officer)
- Local emergency powers authorities
- Mutual aid agreements or agreements granting reciprocity

4. **Shared Principles and Assumptions**

a. This MOU is based on the example of a severe respiratory disease threat, such as pandemic influenza. Depending on multiple factors (e.g., the infectious agent, severity, efficiency of human-to-human transmission, and availability of treatment), other communicable diseases may warrant responses that could differ from the steps described in this document.

b. If community response measures are required in a particular jurisdiction, the context will be one of a serious threat to the public's health. Because these measures may cause substantial social and economic disruption, and might be in effect for prolonged periods (e.g., from many weeks to months), they warrant comprehensive planning with agencies and organizations representing multiple sectors.

c. An emergency of this scope will require a balancing of public and private goods, rights, and needs. Note: related ethical challenges (e.g., prioritizing some groups for health care, vaccine or antivirals) will require conscious, careful thought — beyond the scope of this MOU.

d. For a given jurisdiction, plans for implementing community response measures would be developed and may be most effectively implemented within the context of an existing Incident Command Structure (ICS) to optimize coordination and minimize duplication of effort (since the ICS is in place to set overall priorities and guide activities accordingly).

e. The involvement of numerous agencies and organizations representing multiple sectors highlights the paramount importance of accurate information to foster public trust. In most jurisdictions, public health likely will be the lead for communicating disease-specific information, although elected officials and other agencies and organizations have key roles for reinforcing those messages (especially to counter rumors and other types of misinformation that could cause panic) and for explaining or supporting the social or governmental actions related to the disease situation.

f. If social distancing measures are implemented that involve either flexible leave policies or the restriction of workplaces to mission-critical staff, the agencies involved in implementing the measures should not exempt themselves from such interventions. In addition to the cross-sectoral and multi-jurisdictional roles and activities described in this MOU, each agency and organization should develop and periodically review its own COOP regarding workforce leave policies, telecommuting, sheltering in place, and protecting workers (i.e., internal COOP activities are not discussed here in detail but are assumed to be in place).

g. During an influenza pandemic or different severe disease threat scenario, priorities may shift from providing maximum health and safety protection to the public first, to protecting the health and safety of responders first to enable the latter to maintain order and stability in the community.

h. The nature of a rapidly spreading, highly contagious disease will require coordination not only between multiple sectors, but also across jurisdictional lines (e.g., with neighboring towns, counties, states, and countries) and across levels of government. In many such scenarios, social distancing measures will have to be implemented, coordinated, and sustained over a wide geographic area. In communities that have international ports of entry (airports, seaports or land border crossings) this may include intense coordination with non-traditional federal partners such as Customs and Border Protection, Immigration and Customs Enforcement, TSA, and CDC Quarantine Stations.

5. **Specific Responsibilities During Alert Phase**

During the "alert" or planning phase (which, for pandemic influenza, is the current phase), critical systems, personnel, and procedures are put in place and tested. As a result, most of the responsibilities listed below involve planning and coordination functions that would then be implemented or activated in later phases.

a. Public health responsibilities:

i. Local health officers routinely consult with state health officers and review information provided by CDC and WHO regarding the epidemiology and impact of the communicable disease threat warranting use of community response measures.

ii. Public health officials will review epidemiological data and coordinate with elected officials [including X, Y, and Z] regarding community response measures being considered to halt, interrupt, or limit the spread of disease.

iii. *[Designated agency]* will assist vulnerable populations (e.g., disabled persons, homeless persons) in adhering to voluntary community response measures; public health and/or (*designated agency)* will assist with planning for related needs, including providing food, medications, and disease-specific information to vulnerable populations.

b. Law enforcement responsibilities:

i. Law enforcement will designate [*representative to Unified Command or other*] as a point of contact to serve as a liaison to public health for information on and decisions regarding community response measures.

ii. In consultation with legal counsel and public health, law enforcement agencies will review indications for and procedures guiding the enforcement of community response measures.

c. Judiciary responsibilities:

i. Court administrators and others representing the judiciary will confer and plan with judicial management, public health, emergency management, law

enforcement, and corrections regarding steps the judiciary can take to be prepared for modifications of court operations during a severe contagious disease epidemic for which community response measures would be implemented.

ii. The judiciary will identify and designate points of contact to serve as liaison to law enforcement, corrections, public health and the media regarding community response measures.

iii. The judiciary will identify options for courtroom and judicial procedures to use for reducing face-to-face contact (e.g., tele- or videoconferencing, rescheduling traffic and civil cases, expedited reviews) under circumstances requiring the implementation of community response measures.

iv. The judiciary will plan and coordinate with corrections regarding plans for modifying jail and prison flow to prevent unnecessary face-to-face contact during periods requiring the implementation of community response measures.

v. The judiciary will plan and coordinate with law enforcement to assure the continuity, security and effectiveness of court operations in connection with potential case surges, protective measures in the court facility and enforcement of court orders.

vi. The judiciary will conduct a review of applicable laws and relevant legal considerations regarding community response measures.

vii. The judiciary will identify options and plans for recruitment of additional judges (e.g., retired judges or attorneys) if needed to cover workforce reductions resulting from illness or community response measures during an influenza pandemic.

d. Institutional Corrections Responsibilities:

i. Corrections and jail officials will plan and coordinate with public health, law enforcement, the judiciary, and community corrections regarding steps corrections can take to be prepared for modifications of systems operations during a severe contagious disease epidemic for which community response measures would be implemented.

ii. Corrections and jail officials and facilities will plan and prepare for implementation of measures to restrict contact (e.g., limit family visits, limit inmate intakes, restrict inmate trips to parole hearings) during an influenza pandemic or other similar contagious disease epidemic.

iii. Corrections and jail officials will develop a plan for caring for ill inmates, with attention to preventing spread to the general inmate population and protecting staff. Decisions should be made in advance for what will happen with critically ill patients if area hospitals are unable to handle transfers from the institution.

e. Community Corrections Responsibilities:

i. Community corrections officials will plan and coordinate with public health, law enforcement, emergency management, the judiciary, and corrections regarding systems operations during a severe contagious disease epidemic for which community response measures would be implemented.

ii. Community corrections officials will plan and coordinate with courts and other releasing authorities to reduce or restructure monitoring of probationers, including pretrial supervision clients and parolees, during an influenza pandemic or other similar contagious disease epidemic.

6. **Specific Responsibilities During Standby and Activation Phases**

During the **standby** phase, the need for full activation is imminent and measures (e.g., voluntary isolation and quarantine, school closures, cancellation of public events) are being actively contemplated and organized. During **activation**, at least some of the measures described here may have been declared in a jurisdiction and may be in full effect.

a. Shared/joint responsibilities:

i. Any decisions about implementing specific community response measures (e.g., voluntary isolation and quarantine, closures, cancellations, suspension of non-critical work) will be made in adherence with authorities and procedures as specified by law for (*jurisdiction[s]*) and in coordination with existing emergency operations plans, on the premise that decisions that may originate in one sector nevertheless have implications for the others.

ii. (*Party[ies] to be determined*) will be responsible for communicating to and coordinating with neighboring jurisdictions the timing, implementation, and duration of any community response measures potentially involving the neighboring jurisdictions, including but not limited to (*town, county, state, other*).

iii. Even if public health, elected officials, or others have a lead role in communicating with the public, all parties to this MOU share a responsibility for disseminating clear, accurate information to their own constituencies, staff, partners, and client populations.

iv. Decisions to close schools will be made in coordination/consultation with (public health authorities, *school superintendents, elected officials, other*). (Note: authority for taking this step varies, but often rests with the public health official.)

v. All participating agencies and organizations will implement their own COOP and follow public health guidance regarding protective measures, flexible leave policies, transition to mission-critical workforce, or other measures recommended for the community at-large, as indicated and appropriate.

b. Public health responsibilities:

   i. During a public health threat of severity sufficient to warrant use of community response measures, a state of emergency will likely be declared by (*the Governor, other*), based on public health assessments of the necessity for such measures, and a Unified Command/Incident Management System will be activated.

   ii. Public health will take the lead in informing partners in law enforcement, corrections, the judiciary, emergency management and the public about disease-specific risk information, recommended personal protective measures (e.g., use of face masks or respirators and hand washing), and context for potential uses of community response measures (e.g., geographic scope of measures, involvement of other jurisdictions, likely duration).

   iii. Public health will provide specific guidance and instructions regarding infection control for populations in congregate facilities (e.g., correctional facilities, shelters for the homeless, dormitories, nursing facilities, hospitals) and for those responsible for the care of such populations.

   iv. Public health, in consultation with legal counsel, will provide guidance on the release (and limitations on the sharing) of private and/or sensitive medical information concerning persons who are infected or thought to be infected.

   v. Public health will continue to provide accurate risk communication and other information to partners, the public, and the media.

   vi. Public health will help facilitate access to preventive measures (e.g., vaccinations and post-exposure prophylaxis) and/or appropriate protective equipment for all law enforcement officers, corrections staff, and critical infrastructure support workers, to the extent that these measures are appropriate, available and consistent with the priorities of the community's disaster response plan.

c. Law enforcement responsibilities:

   i. Law enforcement will designate [*representative to Unified Command or other*] as a point of contact to serve as a liaison to public health for information on and decisions regarding community response measures.

   ii. In conjunction with the judiciary, corrections, community corrections, and emergency management, law enforcement will, if needed, exercise discretion on arrests and court appearances to minimize contact between infected and uninfected people.

   iii. Law enforcement, in conjunction with other criminal justice agencies and in consultation with public health, will provide officers and other staff, as indicated, with recommended protective measures (e.g., masks and arrangements for vaccinations).

iv. Roles for law enforcement during the implementation of community response measures include maintaining order and protecting property.

v. Law enforcement will monitor and provide information on the need for additional security or assistance from other jurisdictions and/or from the National Guard; if such assistance is desired, law enforcement will inform (*official[s]*) on the need to activate mutual aid agreements and/or other procedures (e.g., deputizing officers from other jurisdictions).

vi. When requested, law enforcement will provide support to other departments and agencies (e.g., protecting caches of vaccines and distribution sites), depending on available resources and input from the Unified Command, which will set overarching priorities and guide the responses of individual agencies/sectors during an emergency.

d. Judiciary responsibilities

i. The judiciary will implement plans for expedited and prioritized hearings (e.g., parties challenging social distancing restrictions).

ii. The judiciary will implement plans regarding the recruitment and allocation of additional judges to cover workforce reductions.

iii. The judiciary will implement plans to reduce the flow of prisoners, parties and the public into the court facility.

iv. The judiciary will communicate with the bench, bar and the public regarding emergency court operations and scheduling.

e. Institutional Corrections responsibilities:

i. Corrections and jail officials will review release dates and transportation issues as options for minimizing face-to-face contact during an influenza pandemic or similar contagious disease epidemic.

ii. Corrections and jail medical staff will plan and coordinate with public health regarding internal medical management decisions likely to be encountered in the setting of an influenza pandemic or similar contagious disease epidemic.

iii. During periods of increased risk for introduction of contagious respiratory and airborne pathogens (e.g., during an influenza pandemic or similar contagious disease epidemic), corrections staff will increase medical and public health surveillance in congregate settings and will conduct heightened medical triage of new arrivals.

iv. Prior to and during periods of pandemic influenza and other contagious disease epidemics, corrections medical staff and other officials will transmit accurate public health information to prisoners and staff.

v. Corrections, jail, and community corrections staff will work closely with the state parole board or other such authority to ensure that all parole-related activities are addressed in an appropriate manner.

vi. Prior to and during periods of pandemic influenza and other contagious disease epidemics, corrections medical staff and other officials will transmit accurate public health and operational information to families of prisoners, the media and the general public. Consideration should be given to establishing a mechanism for families to obtain general information on the health and well being of specific incarcerated offenders.

f. Community Corrections responsibilities:

i. Community corrections officials will identify alternative methods of validation (e.g., by phone) to reduce face-to-face contact during an influenza pandemic or other similar contagious disease epidemic.

ii. Community corrections officials will identify options for decreasing waiting area contacts during severe contagious disease epidemics by coordinating scheduling for appointments.

iii. Community corrections officials will develop plans for assisting with law enforcement functions, as needed, during an influenza pandemic or similar contagious disease epidemic.

iv. Community corrections officials will develop plans to coordinate activities with treatment and service providers (such as: substance abuse, mental health, health, education, housing, domestic violence, victim assistance, and employment).

7. **Maintaining Preparedness for Coordinated Response**

a. Agencies that have signed this MOU agree to meet at [*XXX*] intervals to review and update the terms of the MOU, as needed.

b. As part of the ongoing standby/planning phase for a pandemic influenza or similar contagious disease scenario, agencies agree to:

i. Review existing COOP plans, verify that back-up personnel have been identified, refresh material as needed, and update call lists.

ii. Participate in joint exercises or training to test existing communication, information-sharing, and other systems.

8. **(Signed by . . .)**

Selected Resources

1. Bullard CH, Hogan RD, Penn MS, Feris J, Cleland J, Stier D, Davis RM, Allan S, Van de Putte L, Caine V, Besser RE, and Gravely S. 2007. Improving cross-sectoral and cross-jurisdictional coordination for public health emergency legal preparedness. *Journal of Law, Medicine and Ethics*. [Special Supplement to 2008;36(1):57-63.]

2. Cetron M. Non-pharmaceutical strategies to limit spread of pandemic influenza. [PDF of presentation slides.]

3. Glass RJ, Glass LM, Beyeler WE, Min HJ. Targeted social distancing design for pandemic influenza. Emerg Infect Dis [serial on the Internet]. 2006 Nov. Available from http://www.cdc.gov/ncidod/EID/vol12no1106-255.htm.4

4. Heymann A, Chodick, G, Reichman B, Kokia E, Laufer J. Influence of school closure on the incidence of viral respiratory diseases among children and on health care utilization. *Pediatr Infect Dis J*. 2004;23(7):675-7.

5. Naylor CD, Chantler C, Griffiths S. Learning From SARS in Hong Kong and Toronto. *JAMA* 2004;291:2483-2487.

6. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 2007. *Interim Pre-pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States — Early, Targeted, Layered Use of Nonpharmaceutical Interventions.* Available at: www.pandemicflu.gov

7. Task Force on Pandemic Preparedness Planning for the Courts. *Guidelines for pandemic emergency preparedness planning: a road map for courts.* Criminal Courts Technical Assistance Project at American University, U.S. Department of Justice grant number 2006-DD-BX-K013, April 2007.

Appendix A : Organizations Represented within the Workgroup

Administrative Office of U.S. Courts
Association of Public Health Laboratories
Association of State Correctional Administrators
Association of State and Territorial Health Officials
Council of State and Territorial Epidemiologists
Federal Bureau of Investigation, WMD Directorate
National Association of Attorneys General
National Association of County and City Health Officials
National Center for State Courts
U.S. Department of Health and Human Services, Centers for Disease Control and Prevention
U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response
U.S. Department of Homeland Security
U.S. Department of Justice, Bureau of Justice Assistance
U.S. Department of Justice, Counterterrorism Section
U.S. Department of Justice, National Institute of Corrections

Other:

City, County, University, and Transit Law Enforcement Agencies
State Departments of Public Safety

Appendix B: Roles During a Pandemic Influenza Emergency

Sector/Agency	General Roles in Community Response Alert, Stand-by, and Activation Steps
All Sectors	• Identify relevant legal authorities for community response measures, including who has authority to decide on and declare measures, due process considerations, duration, renewal and termination of measures, and gaps in existing laws. • Participate in joint planning/implementation team, either as part of existing Incident Command Structure or standalone • Coordinate with counterparts in neighboring jurisdictions • Implement internal COOP plans • "Walk the talk" • Inform/protect staff as they fulfill essential duties to maintain public health infrastructure, law and order, and court and corrections systems • Prepare for potential workforce reductions
Public Health (local and/or state, possibly in conjunction with CDC and/or WHO depending on the type of outbreak)	• Coordinate with law enforcement, judiciary, corrections, and community corrections • Coordinate with other sectors (especially schools, childcare, and business sectors) on planning measures if voluntary child and adult social distancing measures are declared • Identify need for and present persuasive justification for community response measures • Monitor changes in disease spread requiring different measures • Communicate disease-specific information to partners, the public, and the media • Provide accurate risk communication that increases public confidence and minimizes panic and over-reactions
Law Enforcement	• Maintain law, order, and calm
Judiciary	• Plan to coordinate with public health, corrections, and probation • Plan for measures that reduce face-to-face contact • Be informed and prepared for court orders and challenges related to community response measures • Prepare to communicate with the bench, bar, and media
Corrections	• Coordinate internal medical decisions/information with public health and increase disease surveillance for inmate populations • Transmit accurate public health information to offenders and officers • Implement interventions to restrict face-to-face contact
Community Corrections	• Coordinate with public health, law enforcement, judiciary, corrections • Anticipate measures to reduce face-to-face contact • Assist with law enforcement functions, as needed