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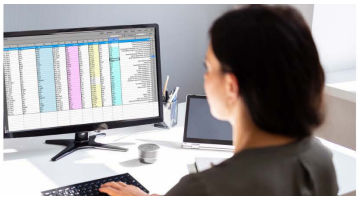


HEALTH INFORMATION AND DATA SHARING
FAQs

COVID-19 FAQs for Michigan Local Health Departments

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I. Executive Decision-Making

In addressing questions regarding executive decision-making, we use the following general approach. Michigan's Public Health Code grants public health officials considerable discretion to protect the public against communicable disease and environmental health threats. To exercise their broad grant of authority, the executive must ask three key questions: Can I? Must I? Should I?

Can I? focuses on whether the agency has the legal authority to act, and if so, in what way. The public health agency's authority is based on the police power, which provides the authority for states to protect the public's health. The parameters of authority are broad, but include constitutional safeguards for individual rights to liberty and due process.

Must I? asks whether there are legal requirements, including funding source directives, that mandate action and define how the agency must act. Usually, the agency has considerable discretion in deciding how to fulfill its obligation. Even if the agency must act, the activity need not address every aspect of the problem.

Should I? is a policy question requiring the executive to determine whether and how to exercise discretionary authority. Discretionary authority must be used reasonably and impartially; never in an arbitrary and capricious manner.

Q: How can state and local health departments maintain their credibility despite COVID-19 death tolls?

A: Above all, health officers at the state and local levels need to protect their credibility with the public. As we saw in the context of the Flint water crisis, once a health department loses credibility, it loses the community's trust. The simple answer on how to maintain credibility is to be honest, communicate directly to the public, be humble about what the epidemiological models show (i.e., make known that they are predictive models and not set in stone), and explain why the death tolls are rising. Further, the public wants to know what the health department is doing to "flatten the curve." Be transparent and, where feasible, allow public input into the health department's decision-making process regarding COVID-19.

Q: What information can and should a local health department disclose to the media?

A: See the Privacy, Confidentiality, and Transparency section of our COVID-19 and Health Data Privacy FAQs.

There is no one-size-fits-all answer. States have different laws and different concerns and attitudes regarding disclosure to the media. The following is a framework for local health departments (LHDs) to work through with their attorneys and epidemiologists that may help them arrive at an answer.

Where HIPAA does not apply: The best guidance right now for health officers to follow and to share with the media can be found in our first FAQ regarding disclosures to the media:

> The Association of State and Territorial Health Officials, the National Association of County & City Health Officials, and the Association of Health Care Journalists developed guidance regarding the release of information concerning deaths, epidemics or emerging diseases. This guidance may assist health departments in determining such questions as whether to include a patient name with a school or whether more general information is appropriate. This guidance requires that public health identify applicable law, such as state law, to ensure that its disclosure stays within the limits of the law.

This press release reflects how one jurisdiction balances the public's right to know against an individual's right to privacy and confidentiality.

Where HIPAA does apply: A health officer could utilize HIPAA's expert de-identification method. The FAQs describe this method as follows:

> The second means of de-identifying information [with the Safe Harbor method, also described in the FAQs, being the first] is known as the expert method. A fully HIPAA covered health department might utilize a HIPAA expert to evaluate the degree of risk the information proposed to be disclosed, alone or in combination with other reasonably available information, could be used to identify an individual. If the expert concludes that the risk of re-identification is "very small", the health department may disclose accordingly. The HIPAA expert must document the results. A HIPAA expert is a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable. 45 CFR § 164.514(b)(1). For more information, please refer to the Network for Public Health Law's quick reference.

Health officers do not typically have resources to engage a HIPAA statistical expert, nor are they able to indemnify the expert, which is always required. If a health officer's jurisdictional requirements preclude indemnification of a statistical HIPAA expert, then we offer a novel legal theory. At this time, it is not supported by the Office of Civil Rights, but it is plausible and supports public health's need to share essential information with the media. It is described within the FAQs as follows:

> If a fully HIPAA-covered health department cannot take advantage of the two de-identification methods [Safe Harbor or HIPAA expert] to share the number of positive COVID-19 cases per day but believes that the information is essential for the people who live in its jurisdiction, it should consider alternatives that would avoid adverse health consequences.
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> For example, fully HIPAA-covered health departments might consider HIPAA's exception to its general rule of state preemption, which preempts any contrary provision of state law. 45 CFR § 160.203. Where HIPAA and state law conflict, HIPAA generally preempts state law. But under certain circumstances, HIPAA preemption does not apply where state law provides "for the conduct of public health surveillance, investigation, or intervention." 45 CFR § 160.203(c). In particular, HIPAA would not control how state and local health departments implement state laws to monitor COVID-19.
>
> Accordingly, the argument is that HIPAA does not limit a health department's disclosure of information as it conducts COVID-19 related surveillance, investigation, and intervention pursuant to State law. This approach is a novel and emerging legal theory to address the COVID-19 pandemic. Please note that to date, we have identified no [Office of Civil Rights] guidance to this effect. This emergency situation could not have been anticipated and time is of the essence.

Q: Can a local health department contract with attorneys or other third parties to issue citations and civil penalties, or does this work have to be performed by the Michigan Attorney General or county prosecutor?

A: The Network uses the "'Can I?' 'Must I?' and 'Should I?'" framework for public health decision-making.

In this case, we did not identify any legal barriers to entering into the proposed contractual arrangements. Instead, this is a policy question within the health department's discretion.

Can I? (Legal Authority)

MDHHS issued an Epidemic Order (EO) under MCL 333.2253 authorizing local health departments to carry out and enforce various COVID-19 measures related to masking, restaurant capacity, public gatherings, etc. The MDHHS Order also specifically authorized local law enforcement officers (as defined in MCL 28.602(f)) to enforce the Order as department representatives. Note that MDHHS is frequently updating its Epidemic Orders; be sure to consult the most up-to-date Order when analyzing legal authority in a particular situation.

To answer the question above, we begin with the local health department's (LHD) authority to enforce the EO. The EO specifically grants enforcement authority to LHDs. But the question at issue is whether the LHD can contract that grant of authority to others. The key Public Health Code provisions follow.

Under MCL 333.2435 a local health department may:

> (c) Enter into an agreement, contract, or arrangement with a governmental entity or other person necessary or appropriate to assist the local health department in carrying out its duties and functions unless otherwise prohibited by law.

Similarly, under MCL 333.2428:

> The local health officer… may take actions and make determinations necessary or appropriate to carry out the local health department's functions under this part or functions delegated under this part and to protect the public health and prevent disease.

MCL 333.2461(2) states:

> If a local health department representative believes that a person has violated this code or a rule promulgated, regulation adopted, or order issued under this code which the local health department has the authority and duty to enforce, the representative may issue a citation at that time or not later than 90 days after discovery of the alleged violation.

According to MCL 333.1106(4):

> Person means an individual, partnership, cooperative, association, private corporation, personal representative, receiver, trustee, assignee, or other legal entity. Person does not include a governmental entity unless specifically provided.

The key interpretive issue, therefore, is the meaning of the term department representative. Since neither the Public Health Code nor the Michigan Administrative Rules defines the term, we first set forth an argument favoring the proposed contractual arrangement, and then a counterargument.

The argument in favor of contracting is reasonably straightforward. First, LHDs have the ability to enter into contractual arrangements to implement their duties and functions. Second, non-LHD attorneys, either individually or in a partnership, meet the Code's definition of a person. Third, nothing in the law prohibits contracting out enforcement responsibilities. Fourth, the ordinary dictionary definition of representative would include a person the LHD designates to issue citations.

A related argument favoring this analysis is that Michigan's municipal law permits local units of government to contract with non-governmental attorneys to enforce local ordinances (MCL 761.1(r)), as long as the violation constitutes a misdemeanor or is not designated as a civil infraction. While not specifically applicable to county-level government, this arrangement suggests a legislative willingness to provide local governmental officials with some flexibility on how its laws are enforced. To be sure, this analogy alone would not be a sufficient basis for an LHD to contract out its responsibility to enforce the EO.

Although there does not appear to be any controlling judicial or Attorney General authority, the case of *Conroy v. City of Battle Creek*, 314 Mich. 210 (Mich. 1946) supports the proposed delegation. In *Conroy*, the court ruled that a municipality could contract with an outside firm to reappraise city property for tax purposes as long as the city retained final authority for tax assessments. The court upheld the appointment of the firm's employees as assistant assessors as a matter of convenience to facilitate collecting the necessary appraisal data.

The argument against the contractual arrangement is a bit more complicated. First, the lack of a definition of "department representative" does not imply approval of a broad delegation of LHD functions to a non-departmental employee. This is particularly true for issuing citations during a contentious public battle over mask-wearing. Second, law enforcement is a unique governmental function that should only be delegated to non-governmental agents in limited circumstances (i.e., severe capacity constraints).

Third, nothing in the EO suggests or discusses non-governmental enforcement. Quite the contrary. The EO states that law enforcement officers, as defined in MCL 28.602(f) "are deemed to be 'department representatives' for purposes of enforcing this order, and are specifically authorized to investigate potential violations of this order." Nothing in MCL 28.602(f) includes an LHD designee in the definition of law enforcement officer. Moreover, the Director of MDHHS issued the EO and did not mention department representatives in granting enforcement authority to LHDs.

Fourth, one could argue that as a matter of public policy only elected officials should authorize any delegation of governmental functions to non-governmental persons or entities. This is especially so when enforcement of the law is being delegated to outside personnel who may lack proper training and accountability for potentially arbitrary actions. As

the dissent argued in *People v. Robinson*, 344 Mich. 353 (Mich., 1955), "If the police function with respect to traffic enforcement can be put on the public auction block, or its sale or purchase negotiated privately, so, it would follow, might any or all other police functions. The possibilities, nay, probabilities of manifold abuse, of untold aggrandizement…we need not elaborate." To be sure, this is a dissenting opinion and is in a criminal rather than a civil matter. Nonetheless, it is a potential line of attack.

In sum, the answer to the *can I* question hinges on a term that the Code does not define. On balance, we think the LHD has the authority to contract with a third party, but it's a close call. Reasonable minds could easily conclude the opposite—i.e., that the LHD lacks specific authority to delegate a core governmental function to a non-LHD designee. LHDs should consult with legal counsel to determine how to proceed. If your jurisdiction's legal counsel agrees with this conclusion, it then becomes a policy determination within the LHD's discretion, which we consider below.

Must I (Legal Requirements)

LHDs are not required to contract with third parties to issue citations or civil penalties. Furthermore, although LHDs must "[i]mplement and enforce laws for which responsibility is vested in the local health department," they have considerable discretion in determining when and how to fulfill this responsibility. This discretion is discussed below.

Should I? (Policy Considerations)

The answer to *should I* remains entirely within the health officer's discretion. We would not presume to advise you on exercising your discretion, but offer the following comments for your further consideration.

As a general proposition, the Michigan Public Health Code offers a broad grant of authority and discretion to both state and local health departments. A defining feature of the Code is the flexibility it provides for health officers to protect the public's health. In normal times, we would tend to err on the side of an expansive interpretation of the term "department representative" for health officers to act based on their professional judgment.

Nevertheless, we would be remiss if we failed to acknowledge that these are not normal times. Nationally, public health officials have been attacked and threatened for enforcing COVID-19 mandates. Hiring non-governmental individuals to enforce the EO may have unintended consequences (including escalation of hostility toward the enforcement officer) that should be addressed up front.

In addition, it seems reasonable to expect a number of citation appeals. Under MCL 333.2462, LHDs must provide an opportunity for alleged violators to appeal citations:

> Not later than 20 days after receipt of the citation, the alleged violator may petition the local health department for an administrative hearing which shall be held within 30 days after the receipt of the petition. After the administrative hearing, the local health officer may affirm, dismiss, or modify the citation.

The department should be prepared to handle appeals under MCL 333.2462 in a way that protects everyone involved from potential exposure to COVID-19.

A potential alternative is for the sheriff to appoint special deputies for the specific purpose of issuing citations under MCL 51.70. This provision allows each sheriff to "…appoint 1 or more deputy sheriffs at the sheriff's pleasure….Persons may also be deputed by a sheriff, by an instrument in writing, to do particular acts, who shall be known as special deputies and each sheriff may revoke those appointments at any time." For support of this approach, see *Kubicki v. Mortgage Electronic Registration Systems*, 292 Mich.App. 287 (2011) and *People v. Van Tubbergen*, 249 Mich.App. 354 (2002). (These cases might also be useful in mitigate concerns noted above about improper delegation).

For these reasons, we offer the following questions to consider in making your decision.

1. What is the rationale for entering into a contractual arrangement?
2. Are there other alternatives that would achieve the same objectives while retaining the department's imprimatur? For example, if the LHD faces capacity constraints, can MDHHS or county government provide supplemental funds to hire temporary enforcement personnel?
3. Do elected officials support the approach?
4. What training will be available to the designees?
5. Will the designees be identified as health department personnel?
6. What controls will be put in place to ensure fair and unbiased enforcement?
7. What oversight will be put in place to monitor the designees?
8. What mechanism will be put in place to handle a larger than expected volume of citation appeals?

II. Local public health powers, including investigative and intervention authority

Q: Which provisions of the Michigan Public Health Code support a local health department's authority to conduct contact tracing?

A: Local health departments and health officers have the duty to protect health and the power to investigate, prevent, and control disease and environmental hazards. The Network's resource *Summary of Authority & Actions Regarding Public Health Emergencies* describes multiple sources of legal authority under the Public Health Code and communicable disease regulations. Public Health Code provisions that may be useful include the following (emphasis added):

- MCL 333.2428(2): Local health officer; appointment; qualifications; powers and duties.

  "[T]he local health officer . . . may take actions and make determinations necessary or appropriate to carry out the local health department's functions under this part or functions delegated under this part and to protect the public health and prevent disease.";

- MCL 333.2433: Local health department; powers and duties generally.

  "[A] local health department shall . . . [m]ake investigations and inquiries" regarding "[t]he causes of disease and especially of epidemics" and morbidity and mortality as well as the "causes, prevention, and control of environmental health hazards, nuisances, and sources of illness" and shall "[h]ave powers necessary or appropriate to perform the duties and exercise the powers given by law to the local health officer".

- MCL 333.2446: Inspection or investigation.

  To assure compliance with laws enforced by a local health department, the local health department may inspect, investigate, or authorize an inspection or investigation to be made of, any matter, thing, premise, place, person, record, vehicle, incident, or event. Sections 2241 to 2247 [allowing the application for an inspection or investigation warrant and set forth warrant issuance, execution, etc.] apply to an inspection or investigation made under this section.

- MCL 333.2453: Epidemic; emergency order and procedures; involuntary detention and treatment.

  If a local health officer determines that **control of an epidemic** is necessary to protect the public health, the **local health officer** may issue an emergency order to prohibit the gathering of people for any purpose and **may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to insure continuation of essential public health services and enforcement of health laws**. Emergency procedures shall not be limited to this code.

A local health department or the department may provide for the involuntary detention and treatment of individuals with hazardous communicable disease in the manner prescribed in sections 5201 to 5238.

- MCL 333.2451: Imminent danger to health or lives; informing individuals affected; order; noncompliance; petition to restrain condition or practice; "imminent danger" and "person" defined.

  Upon a determination that an **imminent danger to the health or lives of individuals exists in the area served by the local health department**, the local health officer immediately shall inform the individuals affected by the imminent danger and issue an order which shall be delivered to a person authorized to avoid, correct, or remove the imminent danger or be posted at or near the imminent danger. The order shall incorporate the findings of the local health department and **require immediate action necessary to avoid, correct, or remove the imminent danger**. The order may specify action to be taken or prohibit the presence of individuals in locations or under conditions where the imminent danger exists, except individuals whose presence is necessary to avoid, correct, or remove the imminent danger. (3) As used in this section:

  "Imminent danger" means a condition or practice which could reasonably be expected to cause death, disease, or serious physical harm immediately or before the imminence of the danger can be eliminated through enforcement procedures otherwise provided.

MDHHS Chief Medical Executive Joneigh S. Khaldun issued a September 22, 2020, memorandum interpreting Michigan and federal law regarding access to information for disease investigations and surveillance. The memo notes that both MDHHS and local health departments (LHDs) may inspect and investigate matters, persons, records, incidents, etc., "in carrying out their duties" (citing MCL 333.2241, 333.2446) and that said MDHHS or LHD investigators "who present their identification **MUST** be promptly provided with" information relevant to the investigation, including information about individuals "who may be a health threat to others, who may have been exposed to a disease, or whose information is needed for an investigation" (citing R 325.174(2)–(3)).

The memo also clarifies that HIPAA does not present a barrier in such investigations, as "HIPAA authorizes covered entities to disclose protected health information to public health authorities . . . for the purpose of preventing or controlling disease . . . , including, but not limited to, the reporting of disease . . . and the conduct of public health surveillance [and] public health investigations" (citing 45 CFR § 164.512(b)(1)(i)), and that no authorization from the individual to whom the records relate is required for this disclosure (citing 45 CFR § 164.512). Further, covered entities are **required** to comply with public health authority requests for protected health information in relation to public health investigative activities (citing 45 CFR § 164.512(a) and Michigan law).

Lastly, the memo states that physicians and laboratories must report certain diseases to LHDs within 24 or 72 hours of diagnosis or discovery (citing generally R 325.173). COVID-19 is one such reportable disease. 2020: Health Care Professional's Guide to Disease Reporting in Michigan. Any "[i]dentifiable medical and epidemiological information reported to MDHHS as part of a disease investigation is confidential, and is not open to public inspection," unless consent is obtained from the individual to whom the information relates or the public health authority "determines that public inspection is necessary to protect the public health" (citing R 325.181(2)).

Q: Which provisions of the Michigan Public Health Code support a local health department's authority to compel an employer to provide employees' contact information for contact tracing and investigation?

A: In addition to the legal authority noted above, Michigan's Communicable and Related Diseases rules state that a "local health department that has jurisdiction where an individual who has a reported condition resides or where an illness or infection is being or may be spread shall," as necessary, investigate. R 325.174(1). When such an investigator presents official LHD identification, they "shall promptly be provided with medical, epidemiologic, and other information" pertaining to "[i]ndividuals, whether ill or well, who are part of a group in which an unusual occurrence, outbreak, or epidemic has occurred," "[i]ndividuals who are not known to have a designated condition but whose medical or epidemiological

information is needed for investigation into the cause of the occurrence of the condition," "[i]ndividuals who were potentially exposed to a designated condition," and "[i]ndividuals who may be a carrier or health threat to others under MCL 333.5201." R 325.174(2).

In terms of enforceability," MCL 333.2443 provides for imprisonment and/or a fine for individuals who violate an LHD regulation or order, and MCL 333.2465 permits local health officers to "maintain injunctive action to restrain, prevent, or correct a violation of a law, rule, or order which the officer has the duty to enforce, or to restrain, prevent, or correct an activity or condition which the officer believes adversely affects the public health."

Q: Does a local health department have legal authority to enforce communicable disease reporting requirements against a noncompliant physician or laboratory?

A: The Communicable and Related Diseases rules, promulgated as required by Section 5111 of the Public Health Code, mandate that physicians and laboratories report cases and suspected cases of certain diseases and conditions. R 325.172; R 325.173. COVID-19 is one such reportable disease. 2020: Health Care Professional's Guide to Disease Reporting in Michigan. R 325.173 provides details on required reporting and the form and frequency of reporting. Further information on communicable disease reporting, including COVID-19 reporting, can be found on MDHHS's website. Laboratories and eligible health care providers may report electronically to the Michigan Disease Surveillance System.

We have not found a provision in the Public Health Code that specifically addresses failure to comply with mandatory reporting. Nonetheless, the general provisions for violating the Public Health Code or its regulations might be used. These include the ability to take injunctive action and to issue citations. In order to "restrain, prevent, or correct a violation of a law, rule, or order which [MDHHS or a local health officer] has the duty to enforce" or "an activity or condition which [MDHHS or the local health officer] believes adversely affects the public health," MDHHS or the local health officer may maintain injunctive action (MCL 333.2255; MCL 333.2465).

MDHHS and local health officers also have enforcement authority to issue citations for violating the Public Health Code and its rules, regulations, or orders (MCL 333.2262; MCL 333.2461). Note that while MDHHS or LHDs may issue citations, their ability to assess civil penalties for violations depends on whether they have adopted a schedule of monetary civil penalties (MCL 333.2262; MCL 333.2461).

In addition, the Public Health Code includes a criminal penalty for violating a state or local public health regulation, rule, or order. Such a violation is a misdemeanor punishable by not more than 6 months' imprisonment, a fine of up to $200, or both (MCL 333.2261; MCL 333.2443).

We have not researched physician licensing and whether violation of laws that apply to physicians, such as state disease reporting laws, may be a basis for the Boards of Medicine or Osteopathic Medicine to take disciplinary action. Likewise, we have not researched CLIA requirements and grounds for enforcement. Depending on federal law, it might be possible to file a complaint with the responsible federal agency against a clinical laboratory for violation of laws of the state where the laboratory operates. According to the Michigan Department of Licensing and Regulatory Affairs, "Michigan does not require a state license for clinical laboratory services."

Q: If a university wants to manage COVID-19 cases and outbreaks on their own, independent of a local health department, are they entitled to do so? What legal authority does the local health department have to intervene?

A: We are not aware of a Public Health Code provision or MDHHS rule that specifically requires a university to report cases or outbreaks among students or nonemployees who are not diagnosed by the campus health clinic. Nevertheless, it seems likely that an LHD could exercise its investigative and emergency authority to require this reporting. The following provisions seem most relevant:

- R 325.174: Investigation of diseases, infections, epidemics, and situations with potential for causing diseases (Michigan Communicable and Related Diseases Rule 4)
  (1) The department or the **local health department** that has jurisdiction where an individual who has a reported condition resides or where an **illness or infection is being or may be spread** shall initiate an investigation as necessary.
  (2) An investigator who presents official identification of the local health department or the department **shall** promptly be provided with **medical, epidemiologic, and other information** pertaining to any of the following: (Emphasis added.)
    (a) Individuals who have designated conditions or other conditions of public health significance.
    (b) Individuals, whether ill or well, who are part of a group in which an unusual occurrence, outbreak, or epidemic has occurred.
    (c) Individuals who are not known to have a designated condition but whose medical or epidemiological information is needed for investigation into the cause of the occurrence of the condition.
    (d) Individuals who were potentially exposed to a designated condition.
    (e) Individuals who may be a carrier or health threat to others under MCL 333.5201.
    (f) Any other information that may be relevant to an investigation under this rule.
  (3) Requests for individual medical and epidemiologic information to validate the completeness and accuracy of reporting are specifically authorized. . . .
  (4) A representative of the local health department or the department may obtain human, animal, environmental, or other types of specimens or cause such specimens to be obtained by appropriate means, including venipuncture, in the course of an investigation of a reported disease, infection, or condition.
- MCL 333.2453: Epidemic; emergency order and procedures; involuntary detention and treatment
  (1) If a local health officer determines that **control of an epidemic** is necessary to protect the public health, the **local health officer** may issue an emergency order to prohibit the gathering of people for any purpose and **may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to insure continuation of essential public health services and enforcement of health laws. Emergency procedures shall not be limited to this code.** (Emphasis added.)
  (2) A local health department or the department may provide for the involuntary detention and treatment of individuals with hazardous communicable disease in the manner prescribed in sections 5201 to 5238.

Q: Does a county health department have authority to enforce state and/or local orders issued to prevent the spread of COVID-19?

A: Yes, Michigan's Public Health Code provides for enforcement of violations of orders.

333.2453 Epidemic; emergency order and procedures; involuntary detention and treatment.

(1) If a local health officer determines that control of an epidemic is necessary to protect the public health, the local health officer may issue an emergency order to prohibit the gathering of people for any purpose and may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to insure continuation of essential public health services and enforcement of health laws. Emergency procedures shall not be limited to this code.

333.2443 Violation of regulation or order; misdemeanor; penalty.

Except as otherwise provided in this act, a person who violates a regulation of a local health department or order of a local health officer under this act is guilty of a misdemeanor punishable by imprisonment for not more than 6 months or a fine of not more than $200.00, or both.

Local health officers might want to include the language of MCL 333.2443 in their orders to head off enforceability questions.

Likewise, MCL 333.2261 provides for enforcement of MDHHS rules and orders: a person who violates an MDHHS rule or order is guilty of a misdemeanor publishable by imprisonment for not more than 6 months, or a fine of not more than $200 or both.

An individual may be arrested if a violation occurs in the presence of a police officer or (since the penalty is punishable by imprisonment for more than 92 days) if a police officer has reasonable cause to believe the individual has violated a rule or order. MCL 764.15(1).

As discussed above, the Public Health Code provides a penalty for violation of a local health officer's orders, including those issued under Section 2453. If someone violates the Code or a state or local administrative rule for which no penalty is provided, the following section might apply.

333.1299 Violation as misdemeanor; prosecution.

(1) A person who violates a provision of this code for which a penalty is not otherwise provided is guilty of a misdemeanor.
(2) A prosecuting attorney having jurisdiction and the attorney general knowing of a violation of this code, a rule promulgated under this code, or a local health department regulation the violation of which is punishable by a criminal penalty may prosecute the violator.

A local health officer may also go to court to request an injunction:

333.2465 Injunctive action; liability for damages.

(1) Notwithstanding the existence and pursuit of any other remedy, a local health officer, without posting bond, may maintain injunctive action to restrain, prevent, or correct a violation of a law, rule, or order which the officer has the duty to enforce, or to restrain, prevent, or correct an activity or condition which the officer believes adversely affects the public health.

Q: Does a local health department have legal authority to issue an emergency order that limits seating in restaurants during the COVID-19 pandemic?

A: Yes. In the Michigan Public Health Code (Code), MCL 333.1101 *et seq*., the legislature granted local health officers broad and flexible powers to protect the public's health. The local health officer is appointed by the Board of Commissioners to serve as the administrative officer of the local health department and make determinations and take actions to carry out the local health department's functions. In particular, under the Code, the health officer is empowered to determine that:

- There is an imminent danger to the health or lives of individuals in the area served by the local health department
- Control of an epidemic is necessary to protect the public health
- A building or condition is a nuisance, unsanitary condition, or cause of illness
- An individual is a carrier of a communicable disease and poses a health threat to others

Based on his or her determination, the local health officer has the authority to take action to protect the public. For example, under the Code, the local health officer may issue an order to abate a nuisance, an imminent danger order, or an emergency order to control an epidemic, and direct these orders against businesses as well as individuals. As set out in the Code under MCL 333.2443, a person (including individuals and businesses) who violates the health officer's order

is guilty of a misdemeanor punishable by imprisonment for not more than 6 months or a fine of not more than $200.00, or both.

The local health officer is authorized to make determinations and issue orders within the county even though MDHHS has issued statewide Emergency Orders. In this regard, the local health officer is authorized to impose additional public health measures or safeguards within her jurisdiction. However, the health officer cannot issue orders that weaken statewide requirements that MDHHS has imposed to protect the public.

The local health officer's authority and responsibilities are primarily contained in Part 24 of the Public Health Code. See, e.g.:

- MCL 333.2428(2): Local health officer
  "[T]he local health officer . . . may take actions and make determinations necessary or appropriate to carry out the local health department's functions under this part or functions delegated under this part and to protect the public health and prevent disease.";
- MCL 333.2433: Local health department
  "[A] local health department shall . . . [m]ake investigations and inquiries" regarding "[t]he causes of disease and especially of epidemics" and morbidity and mortality as well as the "causes, prevention, and control of environmental health hazards, nuisances, and sources of illness" and shall "[h]ave powers necessary or appropriate to perform the duties and exercise the powers given by law to the local health officer".

Q: May a county health department use civil money penalties as an enforcement tool?

A: MDHHS Director Gordon has issued orders that local health departments can enforce, including a $1,000 per day civil penalty (see for example, Emergency Order Under MCL 333.2253 – Gatherings and Face Mask Order).

To issue a monetary civil penalty to enforce orders that go beyond what the State imposes, however, the "local governing entity" (defined at MCL 333.2406) must have adopted a schedule of monetary civil penalties in accordance with MCL 333.2461.

> **333.2461 Violation; schedule of monetary civil penalties; issuance, contents, and delivery of citation.**
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> (1) In the manner prescribed in sections 2441 and 2442 a local governing entity may adopt a schedule of monetary civil penalties of not more than $1,000.00 for each violation or day that the violation continues which may be assessed for a specific violation of this code or a rule promulgated, regulation adopted, or order issued which the local health department has the authority and duty to enforce.

As provided by MCL 333.2461, the schedule of civil penalties must be adopted in accordance with the procedures set forth in MCL 333.2441 and 2442.

> **333.2441 Adoption of regulations; purpose; approval; effective date; stringency; conflicting regulations.**
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> A local health department may adopt regulations necessary or appropriate to implement or carry out the duties or functions vested by law in the local health department. The regulations shall be approved or disapproved by the local governing entity. The regulations shall become effective 45 days after approval by the local health department's governing entity or at a time specified by the local health department's governing entity. The regulations shall be at least as stringent as the standard established by state law applicable to the same or similar subject matter. Regulations of a local health department supersede inconsistent or conflicting local ordinances.

333.2442 Adoption of regulation; notice of public hearing.

Before adoption of a regulation the local health department shall give notice of a public hearing and offer any person an opportunity to present data, views, and arguments. The notice shall be given not less than 10 days before the public hearing and not less than 20 days before adoption of the regulation. The notice shall include the time and place of the public hearing and a statement of the terms or substance of the proposed regulation or a description of the subjects and issues involved and the proposed effective date of the regulation. The notice shall be published in a manner calculated to give notice to persons likely to be affected by the proposed regulation. Methods which may be employed, depending on the circumstances, include publication of the notice in a newspaper of general circulation in the jurisdiction, or when appropriate, in a trade, industry, governmental, or professional publication.

As permitted under MCL 333.2441, the local governing entity could make the regulations immediately effective upon their approval; however, the local governing entity must follow the public hearing process described in MCL 333.2442.

MCL 333.2461 of the Public Health Code sets forth the process for issuing a citation and MCL 333.2462 requires an appeal process. An appeals process should be as simple as possible while meeting minimum requirements and should protect everyone involved from potential exposure to COVID.

333.2461 Violation; schedule of monetary civil penalties; issuance, contents, and delivery of citation.

(2) If a local health department representative believes that a person has violated this code or a rule promulgated, regulation adopted, or order issued under this code which the local health department has the authority and duty to enforce, the representative may issue a citation at that time or not later than 90 days after discovery of the alleged violation. The citation shall be written and shall state with particularity the nature of the violation, including reference to the section, rule, order, or regulation alleged to have been violated, the civil penalty established for the violation, if any, and the right to appeal the citation pursuant to section 2462. The citation shall be delivered or sent by registered mail to the alleged violator.

333.2462 Citation; petition for administrative hearing; decision of local health officer; review; petition for judicial review; civil penalty.

(1) Not later than 20 days after receipt of the citation, the alleged violator may petition the local health department for an administrative hearing which shall be held within 30 days after the receipt of the petition. After the administrative hearing, the local health officer may affirm, dismiss, or modify the citation. The decision of the local health officer shall be final, unless within 60 days of the decision the appropriate local governing entity or committee thereof, or in the case of a district department, the district board of health or committee thereof, grants review of the citation. After the review, the local governing entity, board of health, or committee thereof may affirm, dismiss, or modify the citation.

(2) A person aggrieved by a decision of a local health officer, local governing entity, or board of health under this section may petition the circuit court of the county in which the principal office of the local health department is located for review. The petition shall be filed not later than 60 days following receipt of the final decision.

(3) A civil penalty becomes final if a petition for an administrative hearing or review is not received within the time specified in this section. A civil penalty imposed under this part is payable to the appropriate local health department for deposit with the general funds of the local governing entity, or in case of a district, the funds shall be divided according to the formula used to divide other district funds. A civil penalty may be recovered in a civil action brought in the county in which the violation occurred or the defendant resides.

III. State Emergency Legal Authority

Q: Do states have legal authority to suspend court proceedings to prevent the spread of COVID-19?

A: States have authority to suspend court proceedings in declared emergencies. In Michigan, the state Constitution (Article VI, § 4) provides the Supreme Court with "general superintending control over all courts." In response to the COVID-19 declared emergency and to protect the public, the Michigan Supreme Court authorized trial courts to adjourn civil and criminal matters in which the defendant was not in custody.

Q: Do states and municipalities have legal authority to issue eviction moratoria during the COVID-19 pandemic to help mitigate the threat to public health?

A: Yes. Many states, including Michigan, have issued moratoria on evictions. These tend to be temporary and may be limited in scope (for example, applying only to evictions based on non-payment of rent). For the most part, these moratoria have been issued as executive orders by governors, as in Michigan (e.g., Executive Order 2020-118). The Michigan legislature is also considering a bill, Senate Bill No. 912 (2020), to prevent evictions during a declared emergency. See the Eviction Lab's COVID-19 Housing Policy Scorecard for state-by-state information on eviction policy during COVID-19.

Local jurisdictions, such as Los Angeles County, California, and Austin, Texas, have also issued eviction moratoria. The 36th District Court in the City of Detroit also issued an eviction moratorium for Detroit and extended its length to continue after Michigan's state eviction moratorium expired. Functionally, in some jurisdictions, court closures or restrictions (e.g., to hear only emergency cases) have either effectively or specifically eliminated evictions.

Finally, the federal government, via the Department of Housing and Urban Development's Federal Housing Administration, issued a moratorium on foreclosures and evictions for those with FHA-insured mortgages. The Centers for Disease Control and Prevention (CDC) has also issued a moratorium on evictions through December 31, 2020, depending on meeting specific criteria.

Q: Does Michigan's governor have legal authority to close bars and restaurants and prohibit large gatherings to prevent the spread of COVID-19?

A: Yes, the governor has the power to take those actions to contain the outbreak. Under the Emergency Management Act, the governor has the power to declare a state of emergency, which allows her to take necessary action to protect the public's health and safety. On March 10, 2020, the governor issued Executive Order 2020-04, declaring a state of emergency across Michigan, which has been followed by several other executive orders continuing the state of emergency.

Section 3 of the Emergency Management Act, MCL 30.403, states that the governor is responsible for taking the lead in "coping with dangers to this state or the people of this state presented by a disaster or an emergency." To mitigate harm resulting from the emergency, "[t]he governor may issue executive orders, proclamations, and directives having the force . . . of law" to cope with the emergency. However, the Act only allows the Executive Orders to remain in place for 28 days. After that, the Michigan Legislature must agree to any further extensions. [See our FAQ below for a discussion of the Michigan Supreme Court's decision on October 2, 2020, which invalidated the governor's COVID-19 related executive orders issued after April 30, 2020, because the Legislature refused to extend the state of emergency past that date.]

It is worth noting that the Emergency Management Act should only be invoked when the normal efforts to deal with a public health threat are inadequate. The virulence, scale, and infectiousness of this outbreak fully justify the governor's use of her emergency powers.

Q: Does Michigan's governor's legal authority to prohibit all "large gatherings" to prevent the spread of COVID-19 extend to prohibiting people from attending religious services and ceremonies?

A: The governor's Executive Order 2020-11 prohibited "all assemblages of more than 50 people in a single indoor shared space and all events of more than 50 people" in Michigan. "A single indoor shared space include[d] but [wa]s not limited to a room, hall, cafeteria, auditorium, theater, or gallery," though there were limited exceptions, such as for health facilities, workplaces or portions of workplaces not open to the public, the state legislature, and assemblage for mass transit and grocery purchasing. The executive order stated that, consistent with the Emergency Management Act, a violation of the executive order would be a misdemeanor.

Although the governor later clarified that places of worship would not be subject to penalty for violating the order, the executive order was a neutral law of general applicability and, thus, presumptively lawful, even as originally issued without the penalty exemption for places of worship. Employment Div., Dep't of Human Res. of Oregon v. Smith, 494 U.S. 872 (1990). While religious services with more than 50 people were included in the ban, the executive order did not target religious services. It also did not prohibit worship, which could occur online or in services that did not exceed 50 people at a time. The virulence, scale, and infectiousness of this outbreak fully justify the governor's use of her emergency powers, including to limit the number of people who can assemble in an indoor shared space.

A similar analysis also applies to executive orders issued after Executive Order 2020-11 that likewise have the effect of restricting people from attending religious services as neutral laws of general applicability. For example, Executive Order 2020-42 prohibited "all public and private gatherings of any number of people occurring among persons not part of a single household," again with certain exceptions and also exempting places of worship from penalty if they violated the order for the purpose of permitting worship. This order was also presumptively lawful.

Q: What authority does the state have to address COVID-19 in view of the Michigan Supreme Court's October 2, 2020 ruling that after April 30, 2020, the Governor did not have the authority to issue executive orders related to the COVID-19 pandemic?

A: On October 2, 2020, the Michigan Supreme Court (*In re Certified Questions from the United States Dist. Court*, ___ Mich. ___, 2, 12, 35-36 (Docket No. 161492, Oct. 2, 2020)) held that:

- 1) after April 30, 2020, the Governor did not have authority pursuant to the Emergency Management Act of 1976 (EMA) to declare or renew a state of emergency or a state of disaster regarding the COVID-19 pandemic without the consent of the legislature as required under EMA; and
- 2) the Emergency Powers of the Governor Act of 1945 (EPGA) is unconstitutional because it violates the non-delegation doctrine (i.e., it was an unlawful delegation of legislative power to the executive branch of state government).

The Court did not rule that the various subjects of the Governor's COVID-19 orders since April 30, 2020 were invalid. For example, the Court did not address whether mask mandates, limitations on gatherings, capacity limitations at restaurants, and so on were a valid exercise of the Governor's authority. The Court simply found the Governor lacked authority to issue any orders to address the COVID-19 pandemic under the EPGA and, after April 30, 2020, the EMA. On October 12, 2020, the Michigan Supreme Court issued an Order making clear that its October 2nd opinion takes effect immediately.

The Court's Opinion & Order do not affect public health orders issued by the Michigan Department of Health and Human Services (MDHHS) and local health departments (LHDs). The authority of MDHHS and LHDs under the Public Health Code is separate and distinct from the authority the Governor used to address COVID-19:

- The Michigan Constitution states that "[t]he public health and general welfare of the people of this state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health." MI Const. 1963, Art. 5 § 51.
- In 1978, the legislature passed the Public Health Code (PHC). PA 368 of 1978, MCL 333.1101 *et. seq.*
    - The PHC must be "liberally construed for the protection of the health, safety, and welfare of the people of th[e] State." MCL 333.1111(2). The PHC provides broad authority and discretion to MDHHS and LHDs, which enable MDHHS or the LHD to adequately address a variety of public health issues as appropriate under the circumstances.
    - MDHHS and LHDs must "continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs," including, among other things, the "prevention and control of diseases" and "prevention and control of health problems of particularly vulnerable population groups." MCL 333.2221; MCL 333.2433.

Therefore, MDHHS and LHDs retain their broad and generally parallel authority under the Public Health Code to issue orders "necessary or appropriate" to protect the public health, especially in response to an epidemic. MCL 333.2221; MCL 333.2433. Such orders may:

- Prohibit the gathering of people for any purpose;
- Require wearing of masks;
- Establish procedures to ensure continuation of essential public health services;
- Establish procedures for enforcement.

If the MDHHS director or a local health officer determines that control of an epidemic is necessary to protect the public health, then the director or health officer may issue appropriate emergency orders. MCL 333.2253; MCL 333.2261-2263; MCL 333.2443; MCL 333.2453; MCL 333.2461-2462. An epidemic is defined as "any increase in the number of cases, above the number of expected cases, of any disease, infection, or other condition in a specific time period, area, or demographic segment of the population." Mich. Admin. Code R. 325.171(1)(f).

The emergency procedures authorized are not limited to the PHC. MCL 333.2253; MCL 333.2453. This means MDHHS and LHDs have broad and flexible authority to take actions to protect the public health. That is, emergency procedures are not limited to those that are explicitly provided by the code, and include power reasonably inferred, considering general powers and responsibilities and accepted definitions of "public health" and "public health practice." For instance, MDHHS has issued epidemic orders mandating testing in certain circumstances and requiring certain procedures at residential and congregate care facilities. *See* *https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-533660--,00.html* for a list of MDHHS epidemic orders. MDHHS and LHDs have additional authority to issue orders in response to emergent public health issues, including Imminent Danger Orders (MCL 333.2251; MCL 333.2451), and Orders to Abate a Nuisance (MCL 333.2455).

As noted above, MDHHS and LHDs have parallel authority. MDHHS is responsible for the general supervision of the interests of the health and life of the people of the State. MCL 333.2221(2)(a). The LHDs are the primary organizations responsible for the organization, coordination, and delivery of services and programs within their jurisdictions. MCL 333.2235(2). In practice, this means that LHDs are generally responsible for public health matters within their jurisdictions with MDHHS lending support and technical assistance. However, if a public health matter, such as the COVID-19 pandemic, is statewide or crosses several local jurisdictions, then it may make sense for MDHHS to issue emergency orders to protect the public health.

For example, MDHHS's October 29 Emergency Order requires, among other things, mask wearing and limitations on gatherings statewide. A statewide order in these circumstances will help ensure consistency of COVID-19 prevention and mitigation practices across the state by establishing minimum requirements. Nevertheless, an LHD can issue an emergency order that goes farther than an MDHHS order if circumstances in the local jurisdiction warrant it (e.g., additional limitations on gatherings). The LHD can also issue emergency orders to address issues not covered in an MDHHS order., but cannot issue orders that are less strict than MDHHS' statewide requirements.

Under MCL 333.2453, a local health officer may prohibit gatherings or order procedures to control an epidemic upon determining that the orders are necessary, reasonably likely to protect the public's health, and proportional to the threat. To issue an emergency epidemic order pursuant to MCL 333.2453(1), a local health officer must first determine that control of an epidemic is necessary to protect the public health. This means a health officer should first determine that (1) an epidemic exists; and (2) procedures to control the epidemic are necessary to protect the public's health. Following this determination, a health officer may issue an order under MCL 333.2453 "to prohibit the gathering of people for any purpose and may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to ensure continuation of essential public health services and enforcement of health laws." MCL 333.2453(1).

In exercising their authority, local health officers must consider how their orders will impact individual liberties. The procedures ordered must be necessary (i.e., the epidemic poses a threat to the community), reasonable (i.e., the procedures adopted must have a real or substantial relation to protection of public health) and proportional (i.e., the procedures adopted must balance the public good to be achieved with the impact on individuals). *See Jacobson v. Massachusetts*, 197 US 11, at 28, 31, 38-39 (1905); *Hill v. Board of Ed. of City of Lansing*, 224 Mich. 388, 399 (1923). In addition, local health officers should consider whether the procedures might cause harm (i.e., circumstances in which mask wearing is not medically tolerated or vaccinations may cause medical harm) and whether any exceptions to the procedures are warranted. *Jacobson*, 197 U.S. at 39. Local health officers should work with their legal counsel to assess the exercise of police power to protect the public health with the potential impact on individual civil liberties.

Courts have generally upheld the reasonable exercise of police power to protect the public health. For example, during the winter of 1922-23 there were cases of smallpox in Lansing. The local board of health passed a resolution requiring children and adults who had not been vaccinated to be excluded from public schools. The Michigan Supreme Court upheld the resolution as a reasonable exercise of police power to protect the public health. *People ex rel. Hill v. Board of Ed. of City of Lansing*, 224 Mich. 388, 399 (1923). The Hill Court also upheld the legislature's grant of broad authority and discretion to the board of health, stating:

> "There must be some elasticity, in order to effectually meet varying conditions, and the Legislature has seen fit to fix the ultimate purpose of the regulations to be the 'common safety' and to leave details necessary to work out that purpose to an administrative board." *Id.*

The Public Health Code, which was adopted in 1978, provides similarly broad authority and discretion to MDHHS and LHDs to address public health issues, including disease outbreaks (see discussion above).

This precedent dates to at least 1879, when the Legislature created the State Board of Health, which was given "general supervision of the interests of the health and life of citizens of this State." 1873 PA 81, § 2; *see also* 1919 PA 146 *et. seq.*; 1948 CL 329 *et. seq.*; *In re Certified Questions from the United States Dist. Court*, ___ Mich. ___ (Docket No. 161492, Oct. 2, 2020, Vivano concurring in part) (discussing historical statutory context of public health authority to address communicable disease outbreaks). The Hill Court also noted an extensive trend among courts across the country upholding the reasonable exercise of police powers to protect the public health, particularly from the spread of communicable disease. *Id.*; *See also Jacobson*, 197 US 11. This trend continues today. *See, for example*, *McNeil v. Charlevoix County*, 275 Mich. App. 686 (2007); *Nikolao v. Lyon*, 875 F.3d 310 (6th Cir. 2017); and *LaPorte v. Gordon*, 2020 WL 1429496 (Slip Op., Mar. 24, 2020).

Q: Does Michigan's Open Meetings Act (OMA), MCL 15.261, *et seq.*, permit virtual meetings during the coronavirus pandemic?

A: Based on our analysis of the statute and prevailing guidance, there is no specific prohibition on virtual meetings. As a result, we conclude that the OMA allows meetings to be held remotely, with some limitations. First, the meeting must be open and available to the public. Second, proper notice of the meeting must be provided to the public. Third, secret ballots cannot be conducted electronically.

The Statute. As noted, the OMA contains no specific prohibition on virtual meetings. The relevant language of the statute, with an exception noted for military absences, reads as follows.

MCL 15.263 Meetings, decisions, and deliberations of public body; requirements; attending or addressing meeting of public body; tape-recording, videotaping, broadcasting, and telecasting proceedings; rules; exclusion from meeting; exemptions.

Sec. 3 provides as follows:

> (1) All meetings of a public body shall be open to the public and shall be held in a place available to the general public
>
> All persons shall be permitted to attend any meeting except as otherwise provided in this act. The right of a person to attend a meeting of a public body includes the right to tape-record, to videotape, to broadcast live on radio, and to telecast live on television the proceedings of a public body at a public meeting. The exercise of this right does not depend on the prior approval of the public body. However, a public body may establish reasonable rules and regulations in order to minimize the possibility of disrupting the meeting.
>
> (2) All decisions of a public body shall be made at a meeting open to the public. For purposes of any meeting subject to this subsection, except a meeting of any state legislative body, the public body shall establish the following procedures to accommodate the absence of any member of the public due to military duty:
>
> (a) Procedures by which the absent member may participate in, and vote on, business before the public body, including, if feasible, procedures that ensure 2-way communication.
>
> (b) Procedures by which the public is provided notice of the absence of the member and information about how to contact that member sufficiently in advance of a meeting of the public body to provide input on any business that will come before the public body.

Note that the statute does not specifically define the phrase "open to the public." Thus, it is reasonable that during a pandemic the best way to conduct business and still remain open to the public is to use remote technology.

Michigan Attorney General Handbooks. The current Handbook (undated) does not directly discuss the question at hand. Instead, it contains two potential limits when considering the use of virtual meetings. The OMA bars the use of email or other electronic communications to conduct a secret ballot at a public meeting, since it would prevent citizens from knowing how members of the public body have voted. Likewise, the use of electronic communications for discussions or deliberations, which are not, at a minimum, able to be heard by the public in attendance at an open meeting are contrary to OMA's core purpose – the promotion of openness in government.

In 1995, then Attorney General Frank Kelly issued a similar handbook upholding the ability of a school board to use interactive television to enhance the public's access to the meetings. Attorney General Opinion 6835 (1995). The handbook relied on the case of *Goode v. Dep't of Soc. Servs.,* 143 Mich. App. 756, 759–60, 373 N.W.2d 210 (1985) (discussed in the next section), to provide authority for a public body to conduct a meeting under the OMA without all of the participants being physically present in the same room.

As a caveat, it is worth noting that an Assistant Attorney General presented an OMA seminar and appeared to confirm our general approach, but in an indirect way. As described in the Cheboygan Daily Tribune: Attorney generals' seminar offers clarification on transparency laws, Aug. 16, 2019, Assistant Attorney General Quasarano said the attorney general's office has taken the position that a council member can take part in the discussion but should only be able to vote if they are physically present. "We say that. The statute doesn't use the word 'physical.' We say that," he said. "We also say that any member who is absent can remotely participate. They can discuss, they can listen, they can give their opinion, but they can't deliberate, they can't decide, and decide means what? They can't vote."

We suspect that the Attorney General would relax constraints on remote voting during the pandemic, especially because the Assistant Attorney General's assertion above does not seem to derive from the plain language of the statute. Moreover, if remote voting were prohibited, public officials would be unduly and unnecessarily exposing themselves to a deadly virus. Previous Michigan judicial opinion support this conclusion.

Judicial Opinions. The *Goode v. Dep't of Soc. Servs.* opinion appears to be the primary case in this area, even though it does not involve governmental entities. Plaintiffs sought to compel defendant Michigan Department of Social Services to conduct hearings in conformity with the OMA, contending that the OMA was violated by having 75 percent of hearings conducted by telephone conference calls.

The court permitted holding hearings via teleconference calls, noting that such calls are heard through speaker phones and are audible to all in the room.

> The dispositive question is whether the performance of necessary governmental functions is open to the public. *Rochester Community Schools Bd of Ed v State Bd of Ed*, 104 Mich. App. 569, 578; 305 NW2d 541 (1981). We find no problem with the holding of hearings via teleconference calls. Such calls are heard through speaker phones and are audible to all in the room. *Persons who wish to attend the hearing are allowed to do so and may attend at either location*. The conference call setup actually increases the accessibility of the public to attend, as now more than one location is open to the public. (143 Mich. App. 759-760. Emphasis added.)

Although certainly not anticipating today's available technology, the court noted the conference call set-up actually increases the accessibility of the public to attend, as now more than one location is open to the public. As a result, the court concluded that the rights of the public are adequately protected by telephonic hearings as open adjudications of claims and public access to the deliberations can be provided by the telephone hearing procedure. See also, *Detroit Base Coalition for Human Rights of Handicapped v Dep't of Social Servs*, 158 Mich. App. 613, 617-18; 405 NW2d 136 (1987).

Q. Does state law require a high school athletic coach to report a positive COVID-19 test?

Michigan's Communicable Disease Rules require schools to report confirmed or suspected COVID-19 cases to the local health officer:

> **R 325.173 Reporting and surveillance requirements**
> ***
> (9) A primary or secondary school, child day care center, or camp shall report, within 24 hours of suspecting, both of the following to the appropriate local health department:
> (a) The occurrence among those in attendance of any of the serious communicable diseases listed and maintained by the department as required in MCL 333.5111(1), except for human immunodeficiency virus and acquired immunodeficiency syndrome which are governed by MCL 333.5131.
> (b) The unusual occurrence, outbreak, or epidemic of any disease, infection, or condition among those in attendance.

(Emphasis added.) COVID-19 is included in MDHHS's current list of reportable diseases. In addition to mandated reporting, upon reasonable suspicion that a student has a communicable disease, a school official may exclude the student for a period sufficient to obtain a determination by a physician or Local Health Officer as to the presence of a communicable disease. R. 325.175.

The local health department that has jurisdiction where an individual who has a reported condition resides or where an illness or infection is being or may be spread shall initiate an investigation as necessary concerning the individual and others who may have been exposed. R 325.174. MDHHS Chief Medical Executive Joneigh S. Khaldun issued a September 22, 2020, memorandum describing local health departments' authority to investigate, obtain information, and conduct contact tracing and notification, as well as requirements for individuals to cooperate in providing requested information.

A health officer may take various actions based on a school-related confirmed or suspected COVID-19 case to control the spread of disease. Under Rule 325.175, the health officer may:

- Initiate the exclusion from school or group programs of a student or individual who has a communicable disease. A student or individual may be returned when a physician or Local Health Officer indicates that the individual does not represent a risk to others.
- When a Local Health Officer confirms or reasonably suspects that a student or individual attending a school or group program has a communicable disease, he/she may exclude from attendance any individuals lacking documentation of immunity or otherwise considered susceptible to the disease until the Health Officer deems there to be no likely further risk of disease spread.

For additional actions that the health officer may take, see the Network's Michigan Summary of Authority and Actions Regarding Public Health Emergencies.

With regard to enforcement against individuals who do not report as required, or who impede public health in its duty to implement and enforce laws to protect the public's health, these sections from the Michigan Public Health Code might be helpful:

> **333.1291 Obstruction of person enforcing health law.**
> A person shall not wilfully oppose or obstruct a department representative, health officer, or any other person charged with enforcement of a health law in the performance of that person's legal duty to enforce that law.

This appears to be the penalty for obstruction of a person enforcing a health law:

> **333.1299 Violation as misdemeanor; prosecution.**
> (1) A person who violates a provision of this code for which a penalty is not otherwise provided is guilty of a misdemeanor.
> (2) A prosecuting attorney having jurisdiction and the attorney general knowing of a violation of this code, a rule promulgated under this code, or a local health department regulation the violation of which is punishable by a criminal penalty may prosecute the violator.

This section applies to violation of a state regulation (such as the Communicable Disease Rules, discussed above) or an MDHHS Director order:

> **333.2261 Violation as misdemeanor; penalty.**
> Except as otherwise provided by this code, a person who violates a rule or order of the department is guilty of a misdemeanor punishable by imprisonment for not more than 6 months, or a fine of not more than $200.00, or both.

If this person has violated any local health officer order or local health regulation, this section would apply:

> **333.2443 Violation of regulation or order; misdemeanor; penalty.**
> Except as otherwise provided in this act, a person who violates a regulation of a local health department or order of a local health officer under this act is guilty of a misdemeanor punishable by imprisonment for not more than 6 months or a fine of not more than $200.00, or both.

Furthermore, teachers are certified in Michigan. While certain criminal convictions may result in denial, suspension, or revocation of the certificate by the State Superintendent [MCL 380.1535a], we did not locate anything pertaining to a failure to report a communicable disease. Nevertheless, the individual's school district / employer might review the situation for appropriate action.

IV. Privacy, Confidentiality, and Transparency

Q: May a local health department disclose identifiable information, such as names and addresses, to county EMS to indicate persons who are under investigation for or have been diagnosed with COVID-19 so that EMS knows to take precautions if they need to transport such individuals?

A: The Network uses the "'Can I?' 'Must I?' and 'Should I?'" framework for public health decision-making. Much public health decision-making lies in the "Should I?" category because many decisions are discretionary, based on professional judgment and subject matter expertise. For this question, the framework analysis follows:

- **"Can I?"**—does the health officer have the legal authority to disclose this information? Most likely, yes, as discussed below.
- **"Must I?"**—must a health officer warn EMS of COVID-19 status for all individuals in the community who have tested positive? Usually not—while the health officer must protect the public and prevent and control the spread of disease, the health officer has a great deal of discretion in determining how to do this.
- **"Should I?**"—given that a health officer most likely can disclose the information but is likely not obligated to do so, should they still disclose? The health officer has discretion based on his or her determination, using professional judgment (as well as counsel from the medical director regarding medical aspects), that the requested information needs to be disclosed to protect the public's health. Here, the health officer should weigh the competing interests: balancing the individual's interest in privacy relative to protecting EMS employees, the health care system, and the general public.

Can I? (Legal authority)

One legal consideration is the HIPAA Privacy Rule, located at 45 CFR Part 164. HIPAA may or may not apply to a given local health department; it depends on whether the LHD has separated its HIPAA-covered functions (such as health care clinics) from those functions that are not covered by HIPAA (such as public health disease-control functions) through a "hybrid designation." If HIPAA does apply, violation of the rule can result in substantial fines. But even if it does not apply, HIPAA represents a minimum standard that is commonly accepted for health information privacy, so it is often a good starting point.

HIPAA prohibits the use and disclosure of identifiable health information (known as "protected health information" or "PHI") unless the rule otherwise requires or permits disclosure. For example, HIPAA permits a HIPAA-covered entity to disclose PHI to a health care provider for treatment activities. 45 CFR 164.506. In the context of this question, it sounds like EMS is requesting information about PHI of persons diagnosed with COVID-19 even though the information is not—or may not be—needed to transport or treat these particular patients.

Most relevant to this question, HIPAA permits disclosure of PHI to assist certain public health activities, including to "[a] person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a

disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation." 45 CFR 164.512(b)(1)(iv). Disclosure is also permitted if disclosure "[i]s necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public." But the disclosure must be consistent with applicable law and standards of ethical conduct and made "to a person or persons reasonably able to prevent or lessen the threat." 45 CFR 164.512(j)(1)(i). Specifically, the HIPAA Privacy Rule permits a covered entity to disclose the protected health information (PHI) of an individual who has been infected with, or exposed to, COVID-19, to law enforcement, paramedics, other first responders, and public health authorities without the individual's HIPAA authorization. Further guidance on this issue is available from the U.S. Department of Health and Human Services Office for Civil Rights (OCR), the body responsible for enforcing HIPAA.

Typically, the covered entity must make reasonable efforts to limit PHI disclosed to that which is the minimum necessary for the intended purpose (this does not apply to disclosures to health care providers for treatment or disclosures required by law). 45 CFR 164.502(b). The OCR has a webpage, Emergency Situations: Preparedness, Planning, and Response, that discusses HIPAA in such situations and that might be helpful. Of particular assistance may be the office's BULLETIN: HIPAA Privacy and Novel Coronavirus.

Whether or not HIPAA applies, a second legal consideration is Michigan law. MDHHS's Communicable and Related Diseases rules address disclosure by a local health department of "[m]edical and epidemiological information that identifies an individual and that is gathered in connection with an investigation." R 325.181(2). Such information "is confidential and is not open to public inspection without the individual's consent or the consent of the individual's guardian, unless public inspection is **necessary to protect the public health** as determined by a local health officer or the director [of MDHHS]" (emphasis added). No emergency or other declaration is needed for a local health officer to determine that circumstances may require limited disclosure.

Must I? (Legal Requirements)

As noted above, although a local health officer must protect the public and prevent and control the spread of disease, the health officer has a great deal of discretion in determining how to do this.

Should I? (Policy Considerations)

The local health officer should make his or her determination of whether disclosure of the information (e.g., names and addresses of individuals who have tested positive or are under investigation for COVID-19) to EMS is necessary to protect the health of the public, including the general public and EMS and other health care workers. Determining whether or not disclosure is necessary should include consideration of other options that do not involve identifying all individuals who have or are under investigation for having COVID-19, including those who may not need transport or the assistance of EMS. For example, an LHD may instruct individuals who test positive that they should inform EMS of their COVID-19 status. Another consideration is the current concern that personal protective equipment (PPE) is or may be in short supply and whether disclosure might assist EMS in choosing whether and what PPE it should use during its encounter.

The CDC has provided Interim Recommendations for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points/Emergency Communication Centers (PSAP/ECCs) for those who might have close contact with COVID-19 patients that includes a process for identifying a patient who might have COVID-19 before EMS's arrival on the scene. MDHHS has also issued similar guidance, along with other general COVID-19 EMS response resources. In an ideal world, EMS would be provided with someone's COVID-19 status only if it needed to respond to or transport the individual, yet it might not be feasible to develop and implement a system and protocol while LHDs are spread thin in their response efforts.

Whatever decision an LHD makes, it should:

1. Be able to articulate the basis for its decision.

2. Consider what other health departments are doing, if possible.
3. Show that it considered and weighed alternatives. In thinking about its options (such as informing EMS for only those individuals who need transport), an LHD should consider if an option is feasible, if it has the time and resources required for the option, and if the option would cause a delay in response time for someone who needs emergency services.
4. Determine if its decision makes sense. If the decision-maker were the patient, how would he or she react? If the decision-maker were EMS, how would he or she react?
5. Determine if there is a way to be transparent with individuals. For example, for individuals who obtained private testing, could the LHD inform individuals both that they should tell EMS of their positive status if transport is needed and, additionally, that the health department will be providing EMS with names and addresses of individuals who have tested positive?
6. Document its decision and the basis for it.
7. Consider, absent a clear answer, which side it wants to err on.

Also, see the Network's guidance document Disclosure of Individuals' COVID-19 Status to Emergency Responders and first-responder data-sharing FAQ in the Network's COVID-19 and Health Data Privacy FAQs.

Q: May a county health department issue a press release indicating that individuals who attended a party on a specific date at a specific address may have been exposed to COVID-19, where the host refuses to disclose a list of attendees?

A: There are no legal barriers to issuing the proposed press release. Instead, this is a policy question within the health department's discretion.

Can I? (Legal Authority)

Ordinarily, public health officials are obligated to protect the privacy of individuals in connection with public health surveillance, investigations, and interventions. However, a health official is legally authorized – based on professional judgment and discretion – to release information to the public that is connected to an investigation if necessary to protect the public's health. Michigan's Public Health Code, MCL 333.2433, provides a broad grant of authority to local health departments to take necessary action, including the release of information. Similarly, under MCL 333.2428, "The local health officer… may take actions and make determinations necessary or appropriate to carry out the local health department's functions under this part or functions delegated under this part and to protect the public health and prevent disease."

Privacy/Confidentiality. The Public Health Code provides broad power for the local health department to obtain information, including private information, for the investigation of an outbreak and to conduct contact tracing. In this regard, the health department "may inspect, investigate, or authorize an inspection or investigation to be made of, any matter, thing, premise, place, person, record, vehicle, incident, or event" in carrying out its duties. Local health department investigators who present their identification MUST be promptly provided with medical, epidemiologic, or other information relevant to a public health investigation. This includes, but is not limited to, information about persons who may be a health threat to others, who may have been exposed to a disease or whose information is needed for an investigation. MCL 333.2446 R. 325.174(2)-(3).

Ideally, it would be better to avoid publicly disclosing private or confidential data. In this instance, that may not be possible, since the individual with the list of attendees refuses to provide it to the health department. The Communicable Disease Rules require that identifiable information obtained by the health department be kept private, and protects identifiable information against public requests for it:

> **R 325.181 Confidentiality of reports, records, and data pertaining to testing, diagnosis, care, treatment, reporting, and research.**

> Rule 11. (1) This rule applies to the communicable, serious communicable, chronic and noncommunicable diseases, infections, and disabilities listed and maintained by the department as required in MCL 333.5111 (1), except for human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS).
> (2) Medical and epidemiological information that identifies an individual and that is gathered in connection with an investigation is confidential and is not open to public inspection without the individual's consent or the consent of the individual's guardian, unless public inspection is necessary to protect the public health as determined by a local health officer or the director.
> (3) Medical and epidemiological information that is released to a legislative body shall not contain information that identifies a specific individual.

An individual's address is epidemiological information connected to an investigation that identifies the individual. Unfortunately, public inspection is not defined. But in conjunction with what follows under HIPAA and the previous discussion of the health officer's grant of authority, we do not believe that Rule 11 prohibits the disclosure of personally identifiable data.

HIPAA. Even if the health department is a fully covered entity under HIPAA, and the information to be released would be considered "protected health information," HIPAA permits disclosure of PHI if necessary to avert a serious threat to health or safety of the person or to the public. The disclosure must involve someone the covered entity believes can prevent or lessen the threat, and may include the target of the threat. See, 45 CFR 164.512(j), which reads in relevant part as follows:

> (j) *Standard: Uses and disclosures to avert a serious threat to health or safety—*
> (1) *Permitted disclosures.* A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:
> (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and
> (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or
> (ii) Is necessary for law enforcement authorities to identify or apprehend an individual…

In short, even if HIPAA applies, it would not be a barrier to the proposed press release. See also, the September 22, 2020, memo from MDHHS Chief Medical Executive Joneigh Khaldun on HIPAA disclosure.

Must I? (Legal Requirements)

Although a local health officer must protect the public and prevent and control the spread of disease, the health officer has a great deal of discretion in determining how to do this.

Should I? (Policy Considerations)

As a general proposition, in the context of disclosing COVID-19 information, health departments should assess whether the press release is intended to avert a serious threat to health. Does the health department need the public to respond differently to the COVID-19 threat once a particular source of COVID-19 exposure is identified as having an active case? Health departments should establish a nexus between the information disclosed and the intended action by recipients of the information that will prevent or lessen the threat of COVID-19 spread.

We would be remiss if we failed to acknowledge that these are not normal times; indeed, our nation's volatile political climate has led to public health officials being attacked and threatened for enforcing COVID-19 mandates. Publishing a name or address associated with an individual is certainly more sensitive than for a business location and may have

unintended consequences (including escalation of hostility toward public health, threats to members of the household, or the person who hosted the party, and generally accusing the government of interfering with their civil liberties).

In response to previous similar requests, we have encouraged health officers to consider the following questions in evaluating whether proposed disclosure to the media complies with 45 CFR § 164.512(j):

1. Has the health department documented the factual analysis and thinking that led it to the decision to disclose or not?
2. Who at the health department formed a good faith belief that disclosing the information is necessary to avert a serious threat to the health or safety of the person or to the public (as required under HIPAA)? Is it the product of professional judgment based on professional services? What are the individual's credentials?
3. What is the context for the belief? Is it based upon the statement or action of a particular individual?
4. What are the alternative options that would achieve the same result without disclosing individually identifiable data?
5. Does state law provide a more stringent standard?

The Association of State and Territorial Health Officials, the National Association of County & City Health Officials, and the Association of Health Care Journalists developed guidance regarding the release of information concerning deaths, epidemics or emerging diseases. This guidance may assist you in framing the press release.

Q: May a local health department release the results of on-site COVID-19 testing of congregate care employees to the facility's HR department?

A: According to the Office for Civil Rights (OCR), "[a] covered health care provider who provides a health care service to an individual at the request of the individual's employer, or provides the service in the capacity of a member of the employer's workforce, may disclose the individual's protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. The information disclosed must be limited to the provider's findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(1)(v)." Therefore, the LHD may disclose employees' COVID-19 test results to the facility's HR department for purposes of workplace medical surveillance required by OSHA, MSHA, or state law, but must provide written notice to the employees at the time the testing is provided.

An OCR FAQ also provides an explanation of HIPAA's data sharing requirements for medical surveillance.

V. Liability Concerns

Q: If a local health department's medical director issues a standing order for diagnostic testing of COVID-19 infection, does the order establish a patient-physician relationship?

A: The medical director would have, basically, a limited physician-patient relationship but with immunity from personal liability. Under Michigan law, the medical director would not have a traditional physician-patient relationship as a result of ordering a test. Clearly, no explicit or implicit contractual arrangement exists in conducting a COVID-19 test and sending the results to a lab for analysis.

But the Michigan Supreme Court appears to have created what it terms a "limited physician-patient relationship" in *Dyer v. Trachtman*, 679 N.W.2d 311 (Mich. 2004). This relationship "does not involve the full panoply of the physician's typical responsibilities to diagnose and treat the examinee for medical conditions" and is thus not a "traditional" physician-patient

relationship. In *Dyer*, which involved an independent medical examination (IME) where the examining physician aggravated the plaintiff's existing injury, the court concluded that:

> an IME physician has a limited physician-patient relationship with the examinee that gives rise to limited duties to exercise professional care. . . . The limited relationship imposes fewer duties on the examining physician than does a traditional physician-patient relationship. But it still **requires that the examiner conduct the examination in such a way as not to cause harm**. (Emphasis added.)

In *Paul v. Glendale Neurological Associates, P.C.*, 848 N.W.2d 400 (Mich. App. 2014), the court, citing *Dyer*, said that "this duty does not constitute a duty to diagnose or treat an examinee's medical conditions." (For a similar conclusion, see also *Hawthorne-Burdine v. Banks*, 2018 Mich. App. LEXIS 563.)

Certainly, testing is very different from the IME process. Even if the two are analogous, it is difficult to imagine a scenario where administering a COVID-19 test causes harm satisfying the elements of the medical liability standard. In the unlikely event of a medical liability claim, MCL 333.2465 provides liability protection for local public health officials. See our FAQ below for information on immunity from liability.

Q: If a local health department's medical director issues a standing order for diagnostic testing of COVID-19 infection, to what extent is the medical director protected by governmental immunity?

A: In the unlikely event of a medical liability claim (see FAQ above), a medical director would likely have qualified immunity.

MCL 333.2465(2) provides protection for local public health officials. It states the following:

> A local health officer or an employee or representative of a local health department is not personally liable for damage sustained in the performance of local health department functions, except for wanton and willful misconduct.

Note that, although the Public Health Code does not define willful and wanton misconduct, Michigan case law holds that it may be found "if the conduct alleged shows an intent to harm, or, if not that, such indifference to whether harm will result as to be the equivalent of a willingness that it does." Odom v. Wayne Cty., 482 Mich. 459 (2008).

The federal PREP Act also offers liability protection for medical directors administering or using "covered countermeasures." It sets a high threshold for claims. Medical directors are "covered persons" under the act if they are "a licensed health professional . . . authorized to prescribe, administer, or dispense" covered countermeasures under their state's law. PREP Act Declaration for COVID-19 and the Advisory Opinion on the Public Readiness and Emergency Preparedness Act and the March 10, 2020 Declaration Under the Act (modified on May 19, 2020).

One requirement under the PREP Act is that the COVID-19 test being used be a "covered countermeasure." According to the advisory opinion, this includes a device that is "approved, cleared, or licensed by the FDA and is used to diagnose, mitigate, prevent, treat, cure, or limit the harm of COVID-19" or a "device . . . authorized for emergency use with respect to COVID-19 under an EUA, described in Emergency Use Instructions (EUI) issued by the CDC, or being researched under certain investigational provisions (i.e., IND, IDE) to treat COVID-19." The list of EUA-covered in vitro diagnostic tests for the detection and/or diagnosis of the virus that causes COVID-19 is located here. While it is likely that tests performed on individuals at the order of a medical director would be covered by an EUA or approved, licensed, or cleared by the FDA, a medical director might want to confirm.

Further information related to protections from liability for government employees and volunteers can be found in the Network's resource Federal and Michigan Laws Protecting Individuals from Tort Liability, which is posted on the Network's

website. It describes the many (and strong) sources of protection from tort liability, including the PREP Act, which provides for immunity for prescribing, administering, or using covered countermeasures.

Q: If a local health department's medical director orders diagnostic testing of COVID-19 infection via standing order, must the medical director directly consult with the test subject regarding the test results?

A: No, the medical director does not need to directly consult with the test subject regarding the test results; however, all testing should be conducted by licensed medical personnel and the local health department should ensure test results are communicated to test subjects.

Public health professionals and physicians frequently conduct similar tests. In addition, standing orders are commonly used in public health for these purposes. For example, health departments in Michigan are required to conduct screening programs, including newborn screening, MCL 333.5431 (requiring positive results to be conveyed to the parents or guardian), regardless of any subsequent treatment. Screening for vision and hearing is instructive:

- MCL 333.9303(1): [MDHHS] shall establish and administer a program to assist local health departments in developing and maintaining periodic hearing and vision testing and screening programs for children.
- MCL 333.9309. If it appears as the result of a testing and screening program that the hearing of a child may be impaired, [MDHHS] shall conduct or cause to be administered individual testing and screening with approved scientific instruments for determining the hearing efficiency of the child.
- MCL 333.9305: (1) When the result of a hearing or vision testing or screening indicates that a child requires follow-up care, a professional authorized by law, a local health department, or other agency shall present the person bringing the child a written statement clearly indicating that follow-up treatment is required. (2) The local health department, upon request, shall provide information concerning the availability and sources of vision and hearing treatment required to eliminate or reduce an identified problem.

Taken together, these sections indicate an expectation that the state or local health department will communicate test results, but not take responsibility for providing follow-up assessment or treatment. Presumably, a licensed medical practitioner would conduct the screening.

Q: If a local health department employee administers a COVID-19 vaccine, to what extent are the employee and the health department protected from liability?

A: The Federal PREP Act provides liability protection to local health departments and their employees for "Recommended Activities" associated with "Covered Countermeasures" such as administering FDA-authorized vaccines. The "sole exception" to the PREP Act's liability protection is for death or injury caused by a Covered Person's willful misconduct. Absent willful misconduct, an injured party's only remedy is to seek compensation through the Countermeasures Injury Compensation Program (CICP). Thus, the Federal PREP Act provides liability protection to local health departments and their employees for prescribing and administering FDA-authorized COVID-19 vaccines.

In addition, the Michigan Public Health Code protects local health department employees when performing health department functions, including participation in an immunization program approved by the Michigan Department of Health and Human Services. However, protection of the local health department itself may be narrower with regard to medical care or treatment of a patient as discussed below.

Federal PREP Act

Click here to view our latest analysis of the federal PREP Act's application to local health departments and their employees involved in prescribing and administering COVID-19 vaccines.

Michigan Public Health Code

The Michigan Public Health Code provides additional liability protections for local health department officers and employees at MCL 333.9203 and MCL 333.2465(2).

First, MCL 333.9203(3) provides liability protections for local health department employees and other individuals authorized by the state or local health department to participate in a mass immunization program approved by MDHHS:

> When [MDHHS] approves a mass immunization program to be administered in this state, health personnel employed by a governmental entity who are required to participate in the program, or any other individual authorized by the [MDHHS] director or a local health officer to participate in the program without compensation, is not liable to any person for civil damages as a result of an act or omission causing illness, reaction, or adverse effect from the use of a drug or vaccine in the program, except for gross negligence or wilful and wanton misconduct. This subsection does not exempt a drug manufacturer from liability for a drug or vaccine used in the program.

In addition, MCL 333.2465(2) provides general liability protections for local health officers and a local health department's employees and representatives, including medical directors, when performing local health department functions:

> A local health officer or an employee or representative of a local health department is not personally liable for damages sustained in the performance of local health department functions, except for wanton and wilful misconduct.

Although willful and wanton misconduct is not defined in the Public Health Code, Michigan case law provides that willful and wanton misconduct may be found "if the conduct alleged shows an intent to harm or, if not that, such indifference to whether harm will result as to be the equivalent of a willingness that it does." Likewise, gross negligence is not defined in the public health code but is defined in Michigan's Governmental Tort Liability Act (GTLA) as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results."

The GTLA provides additional liability protection to local health departments and their employees, but it does not apply to the provision of medical care except in certain circumstances; accordingly, the GTLA may have limited application to a local health department's administration of vaccines.

Further information about protections from tort liability for government employees and volunteers can be found in the Network's resource Federal and Michigan Laws Protecting Individuals from Tort Liability, which is posted on the Network's website.

Conclusion

Federal and state law, via the federal PREP Act and the Michigan Public Health Code, respectively, provide liability protection to local health department employees who prescribe and/or administer FDA-authorized COVID-19 vaccines. The federal PREP Act also provides immunity to local health departments that supervise and administer COVID-19 vaccination programs.

Q: If a local health department's volunteer physician administers a COVID-19 vaccine, to what extent are the volunteer and the health department protected from liability?

A: The Federal PREP Act provides liability protection to local health departments and to their qualified volunteer health care professionals for "Recommended Activities" associated with "Covered Countermeasures" such as administering FDA-authorized vaccines. The "sole exception" to the PREP Act's liability protection is for death or injury caused by a

Covered Person's willful misconduct. Absent willful misconduct, an injured party's only remedy is to seek compensation through the Countermeasures Injury Compensation Program (CICP). Thus, the Federal PREP Act provides liability protection to local health departments and to their qualified volunteer health care professionals for prescribing and administering FDA-authorized COVID-19 vaccines.

In addition, the Michigan Public Health Code protects local health department representatives when performing health department functions, including participating in an immunization program approved by the Michigan Department of Health and Human Services. However, protection of the local health department itself may be narrower with regard to medical care or treatment of a patient as discussed below.

Federal PREP Act

In short, the COVID-19 PREP Act Declaration provides immunity to a local health department volunteer health care provider who is (1) authorized as a part of the agency's public health and medical response following a Declaration of Emergency and (2) is a "qualified person" due to status as a qualifying health care provider, including recently retired or inactive health care providers, health care providers licensed in other states, and certain providers and students not ordinarily permitted to prescribe, dispense, or administer vaccines, if specified requirements are met. The federal PREP Act also provides immunity to local health departments that supervise and administer COVID-19 vaccination programs.

Click here to review our in-depth analysis of the federal PREP Act's application to local health departments and their employees involved in prescribing and administering COVID-19 vaccines, as much of the memo is relevant to a local health department's volunteer health care providers as well.

Michigan Public Health Code

The Michigan Public Health Code provides additional liability protections for local health department representatives at MCL 333.9203 and MCL 333.2465(2).

First, MCL 333.9203(3) provides liability protections for local health department employees and uncompensated volunteers authorized by the state or local health department to participate in a mass immunization program approved by MDHHS:

> When [MDHHS] approves a mass immunization program to be administered in this state, health personnel employed by a governmental entity who are required to participate in the program, or any other individual authorized by the [MDHHS] director or a local health officer to participate in the program without compensation, is not liable to any person for civil damages as a result of an act or omission causing illness, reaction, or adverse effect from the use of a drug or vaccine in the program, except for gross negligence or wilful and wanton misconduct. This subsection does not exempt a drug manufacturer from liability for a drug or vaccine used in the program.

In addition, MCL 333.2465(2) provides general liability protection for local health officers and a local health department's employees and representatives, including medical directors, when performing local health department functions:

> A local health officer or an employee or representative of a local health department is not personally liable for damages sustained in the performance of local health department functions, except for wanton and wilful misconduct.

Courts have applied this provision to protect local health department employees against medical malpractice claims. *See, e.g.*, *Jamieson v. Luce-Mackinac-Alger Schoolcraft Dist. Health Dept.,* 198 Mich. App. 103 (Mich. Ct. App. 1993); *Fineis v. Sienko*, 2011 WL 520262 (Mich. Ct. App. 2011) (unpublished).

Although willful and wanton misconduct is not defined in the Public Health Code, Michigan case law provides that willful and wanton misconduct may be found "if the conduct alleged shows an intent to harm or, if not that, such indifference to whether harm will result as to be the equivalent of a willingness that it does." *Jameison*, 198 Mich. App. at 113 (citing *Burnett v. City of Adrian*, 414 Mich. 448 (1982)). Likewise, gross negligence is not defined in the public health code but is defined in Michigan's Governmental Tort Liability Act (GTLA) as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results."

The GTLA provides additional liability protection to local health departments and their employees and volunteers, but it does not apply to the provision of medical care except in certain circumstances; accordingly, the GTLA may have limited application to a local health department's administration of vaccines.

Further information about protections from tort liability for government employees and volunteers can be found in the Network's resource Federal and Michigan Laws Protecting Individuals from Tort Liability, which is posted on the Network's website.

Conclusion

Federal and state law, via the federal PREP Act and the Michigan Public Health Code, respectively, provide liability protection to a local health department's qualified volunteer health care professionals who prescribe and/or administer FDA-authorized COVID-19 vaccines. The federal PREP Act also provides immunity to local health departments that supervise and administer COVID-19 vaccination programs.

VI. Vaccination laws

Q: Does Michigan law permit a minor to consent to receive a COVID-19 vaccine?

A: Generally no. Unless a minor is emancipated under Michigan law, it appears that a parent, guardian, or other legally authorized representative must consent to vaccination of a minor against COVID-19. *See* Emancipation of Minors Act, MCL 722.1; Age of Majority Act, MCL 722.52. Although Michigan's communicable disease rules mandate immunizing children against specified diseases and infections, R 325.176, the immunization requirements do not eliminate the general parental consent requirement for minors under 18 years old.

Michigan case law provides an exception to this consent requirement in emergencies. As described in the Network's resource, Michigan Laws Related to Right of a Minor to Obtain Health Care without Consent or Knowledge of Parents, "parental consent can be implied for emergency care if actual consent cannot be obtained" (citations provided in document). Michigan's Attorney General has summarized the law regarding minors' consent to medical care as follows:

> [I]n the absence of parental consent or a medical emergency, physicians may not treat unemancipated minor patients unless the Legislature expressly authorizes such treatment.

Mich Atty Gen Op No 6596 (August 9, 1989) (emphasis added) (citations omitted).

Although the COVID-19 pandemic is a national public health emergency, immediate vaccination is unlikely to be considered necessary to protect a minor from life-threatening circumstances. However, a health care provider would need to use their professional judgement to determine whether a particular situation is a medical emergency that warrants immediate medical care before parents have an opportunity to consent.

Note that the governor has power to issue executive orders and directives, which could allow prophylaxis or medical care to an unaccompanied minor during a declared emergency or disaster under the Emergency Management Act, MCL 30.401 et seq.

We are not aware of any emergency law or order in place that authorizes vaccination of unemancipated minors in Michigan without parental consent.

Q: May an employer require their employees to receive COVID-19 vaccines even though the COVID-19 vaccines are being distributed under Emergency Use Authorizations (EUA)?

A: Most likely yes. Click here to see the Network's guidance memo regarding the COVID-19 Vaccine and Employer Mandates, which provides an in-depth analysis of the following questions:

1. What is the difference between mandatory vaccination and compulsory vaccination?
2. Can public and private sector employers mandate employees to obtain vaccines?
3. As current COVID-19 vaccines are authorized by FDA via an EUA, rather than a full biologics license, does the EUA status of a vaccine impact whether an employer can mandate it?

As concluded in the memo, "there is currently no express limitation preventing employers from mandating a vaccine distributed pursuant to EUA, rather than one issued through a full [biologics license application], provided (1) anti-discrimination protections are assured and (2) any applicable state laws or exemptions are honored."

Federal anti-discrimination protections are discussed in the memo. Employers must carefully consider all applicable civil rights laws when developing mandatory vaccine policies, asking pre-screening questions prior to vaccination, and particularly when handling exemption requests relating to disability or religious beliefs. Note that even employers who are not subject to federal civil rights laws (e.g., because they have fewer than 15 employees) may be subject to comparable Michigan civil rights laws.

Furthermore, some states have recently introduced and/or passed legislation that limits EUA vaccine mandates or vaccine mandates generally. To our knowledge, states generally did not limit EUA vaccine mandates prior to the pandemic, perhaps because we've never confronted a similar situation where an FDA EUA authorized product might be mandated on such a wide scale. Michigan currently has a pending bill that would disallow employer vaccine mandates even beyond the COVID-19 vaccine. Michigan House Bill 4471 would prohibit employers from mandating influenza, Tdap, or COVID-19 vaccinations and would further prohibit employers from requiring unvaccinated employees to wear surgical face masks or wear a marker indicating their vaccination status. The bill was introduced on March 9 and has been referred to committee.

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