Nebraska: A Contemporary Case Study in Public Health Law Reform

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Abstract

The Turning Point Model State Public Health Act (Turning Point Act), published in September 2003, provides a comprehensive template for states interested in public health law reform and modernization. This case study examines the political and policy efforts undertaken in Nebraska following the development of the Turning Point Act. It is the fourth and final of a series of case studies to assess several states' considerations of public health law reform pursuant to the Turning Point Act. Through this analysis and ongoing legislative tracking in all fifty states, this project assesses how (1) the Turning Point Act is codified into state law and (2) modernized state public health laws can influence or change public health practice, leading to improved health outcomes. This case study is designed to provide the public health practice community with evidence and analyses that can facilitate successful modernization of public health statutes and regulations in other jurisdictions and inform scholarship on the role of law and policy in building enhanced public health infrastructure and performance.

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Introduction

For years, many public and private sector policymakers, scholars, and public health officials have argued that state-based public health laws are ripe for reform.[1] Beginning in 2000, the Turning Point National Excellence Collaborative on Public Health Statute Modernization (Turning Point Collaborative) brought together representatives from five core states (Alaska, Colorado, Nebraska, Oregon, and Wisconsin) and other public health partners through a competitive grant application process to fulfill its mission to "transform and strengthen the legal framework for the public health system through a collaborative process to develop a model public health law." Following three years of public meetings, drafting, input, and discussions, the Turning Point Collaborative released the final version of the Turning Point Model State Public Health Act (Turning Point Act) in September 2003.[2] Proposed as a model set of laws for state public health law modernization, the Turning Point Act serves as a template for states, tribal governments, and local municipalities considering public health legal reforms.

This case study is the fourth and final in a series of comparative case studies of states that have considered amendments to their state public health laws subsequent to the development of the Turning Point Act, describing and assessing the ways in which Nebraska actors employed the Turning Point Act to modernize their state public health laws. Our research analyzes the major variables to which Nebraska informants attribute the success of their 2007 regulatory modernization efforts at the state and local levels. In

[1] *E.g.*, Nat'l Ass'n Attys. Gen., *Resolution Urging States to Review Their Public Health Laws*, Dec. 2-6, 2003; LAWRENCE O. GOSTIN & JAMES G. HODGE, JR., STATE PUBLIC HEALTH LAW - ASSESSMENT REPORT (2002), *available at* http://www.publichealthlaw.net/Resources/ResourcesPDFs/PHL_Assess_Rep.pdf.

[2] Turning Point Model Public Health Act (Turning Point Pub. Health Statute Modernization Nat'l Collaborative 2003), *available at* http://www.hss.state.ak.us/dph/improving/turningpoint/MSPHA.htm.

so doing, this case study elucidates generalizable approaches more likely to support passage of modernization efforts, providing information to policy-makers and public health officials in framing future public health law reforms.

I. Background

As governmental entities, state and local public health agencies exist only as creatures of state law and the authority granted through public health statutes. While recent years have seen many studies on the impact of law on the public's health, including analyses of tobacco control legislation[3] or various helmet and seat restraint statutes,[4] few studies have examined the core public health enabling statutes that create the public health agencies and grant them their core powers to prevent disease and promote health.[5] This gap was formally recognized in two 2003 Institute of Medicine (IOM) reports on public health, with the IOM's *The Future of the Public's Health in the 21st Century* pointing out the failure of states to keep public health laws current[6] and its report, *Who Will Keep the Public Healthy?*[7] arguing for increased attention to law and political science in the public health curriculum along with practice-associated research in this and other relevant areas of study.

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[3] UNFILTERED: CONFLICTS OVER TOBACCO POLICY AND PUBLIC HEALTH (Eric A. Feldman & Ronald Bayer, eds. 2004).

[4] Marian Moser Jones & Ronald Bayer, *Paternalism and Its Discontents: Motorcycle Helmet Laws, Libertarian Values, and Public Health*, 97 AM. J. PUBLIC HEALTH 208 (2007).

[5] *See, e.g.*, Kristine M. Gebbie, *State Public Health Laws: An Expression of Constituency Expectations*, 6 J. PUBLIC HEALTH MANAGEMENT & PRACTICE 46 (2000).

[6] INSTITUTE OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY (2003).

[7] COMM. ON EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY, INSTITUTE OF MED., WHO WILL KEEP THE PUBLIC HEALTHY? EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY (2003).

Applications of public health authority have left state and local health authorities familiar with the use of law as a tool for the public's health. Nebraska's economic base has led to continuous public health legal challenges given its use of nuisance regulation in the farming and cattle industry and its use of quarantine regulations in recent tuberculosis outbreaks within its meat packing industry. This familiarity notwithstanding, state communicable disease control in Nebraska is authorized largely by only two general sections of the Nebraska State Code:

- **Neb. Rev. Stat. § 71-502. Communicable diseases; rules and regulations; control; powers of Department of Health and Human Services Regulation and Licensure** – "The Department of Health and Human Services Regulation and Licensure shall have supervision and control of all matters relating to necessary communicable disease control and shall adopt and promulgate such proper and reasonable general rules and regulations as will best serve to promote communicable disease control throughout the state and prevent the introduction or spread of disease…"
- **Neb. Rev. Stat. § 81-601. Department of Health and Human Services Regulation and Licensure; powers** – "The Department of Health and Human Services Regulation and Licensure shall have general supervision and control over matters relating to public health and sanitation and shall provide for examination as provided in section 81-602 and have supervision over all matters of quarantine and quarantine regulations."

Under this framework, all state health activities in Nebraska are organized through the Chief Medical Officer, who represents the Governor's Office in matters of both health and

public health. Under the Chief Medical Officer, administration of health laws is the responsibility of the State Department of Health and Human Services (DHHS), with public health authority currently vested under the Regulation and Licensure section of the communicable disease program.

In considering legal reforms under this structure, Nebraska's legislative structure is triply unique, in its (1) unicameral legislature; (2) apolitical electoral process (i.e., no political party affiliations); and (3) eight-year term limits for senators. Within the legislature, public health legislation is within the purview of the Health and Human Services Committee. As a result of these political conditions and numerous changes to the public health bureaucracy, public health law in Nebraska has been—like many states—largely fragmented, with different provisions enacted beginning in the early twentieth century and since amended by piecemeal regulation in response to specific health concerns.

II. Research Methods

The methods applied to this Nebraska case study parallel those of the three previous case studies of states that have considered amendments to their state public health laws subsequent to the development of the Turning Point Act. These studies are being conducted based on the researchers' hypothesis that while the Turning Point Act is a catalyst for state public health law reform, its consideration leads to very different reform initiatives and responses in different states. The study employs process tracing to examine the chain of events and decision-making processes by which case outcomes (in this case, the enactment or failure of a proposed bill) are dictated by yet-unknown independent variables. By examining evidence at each step, this research presents a plausible causal

chain of actions which led or failed to lead to the enactment of modernized state public health laws. By comparing the results from multiple state case studies, conclusions of this project will begin to identify generalizable variables associated with successful public health law modernization.

The present case study is based on ten semi-structured qualitative interviews with Nebraska actors from the public health bureaucracies at the state and local level, public health advocacy groups, and a key legislative office.[8] Table 1, Nebraska Case Study Informants, identifies the interviewees by category.

Table 1. Nebraska Case Study Informants

Informant Role	No. of Informants
Dep't Health & Human Services Officials	4
Legislators/Legislative Staff	1
State & Local Public Health Officials	3
Nongovernmental Advocates & Lobbyists	2

The semi-structured, confidential interviews covered a variety of subjects and issues, focusing on the:

- role of the informant in the legal/regulatory changes;
- public health problems addressed by the changes;
- obstacles to changes in state law and strategies used to overcome these obstacles;
- subsequent changes in public health regulations or programs based on legal reforms; and

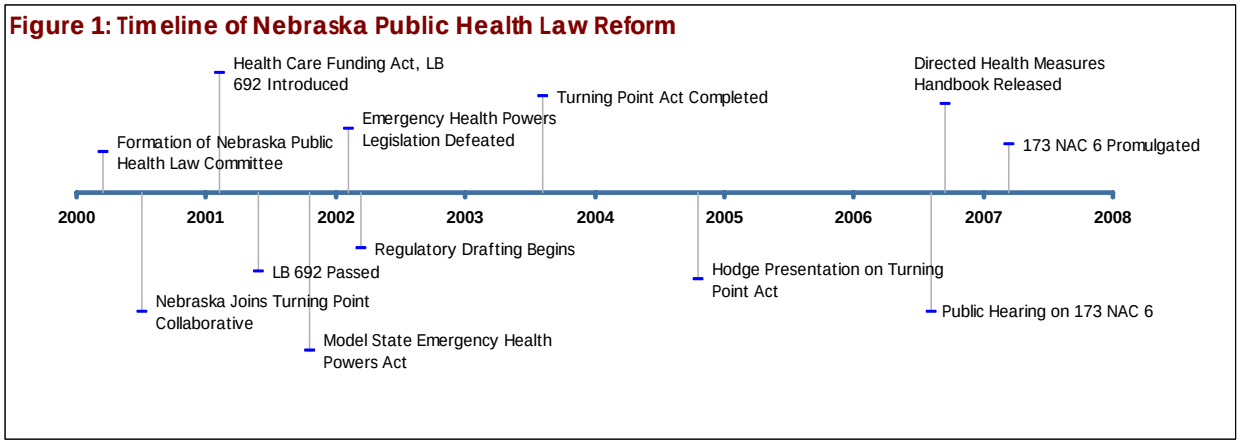
[8] Although legislators who took part in some of the activities described herein are no longer in office, a key legislative staff member was interviewed based on her previous position and integral role in the events described herein.

- expected changes in public health outcomes.

Based upon notes and transcripts of these interviews, and careful reading of the documents, a narrative description of the legislative process was drafted and themes were identified for analysis. All quotations herein are taken from transcripts of those confidential interviews.

III. Transforming The Turning Point Act into Nebraska Public Health Law Reforms

Attempts to reform Nebraska public health law were made before, during, and following the development and publication of the Turning Point Act, as illustrated in Figure 1, Timeline of Nebraska Public Health Law Reform.



This part describes those efforts, which are analyzed thematically in the parts that follow.

A. Turning Point Collaborative

Based on their successful experience in the first phase of the Turning Point Project, Nebraska state actors were eager to join the Turning Point Model Public Health Statute Collaborative. At each Turning Point Collaborative meeting, two individuals from the DHHS public health system attended, bringing with them a rotating local health department director from counties throughout the state. During the three years that the

Collaborative met to develop the Turning Point Act, Nebraska representatives worked with their multi-state counterparts to develop model public health legislation that could form the basis of public health law reforms in a wide-range of states.

Following the release of the Turning Point Act in September 2003, Professor James G. Hodge, Jr. of the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities visited Nebraska in October 2004 to explain the many facets of the Act and discuss possible state legislation with local actors. In this context, Professor Hodge performed a gap analysis of Nebraska law, comparing relevant portions of Nebraska statutes with corresponding concepts in the Turning Point Act. Following a presentation of this gap analysis to the Nebraska public health community, Professor Hodge met privately with a state legal counsel for health matters to discuss specific legislative language commensurate to the needs of the state.

B. Public Health Law Committee

As part of its involvement in the Turning Point Collaborative, the Office of Public Health began in 2000 to organize a Public Health Law Committee—an informal group consisting of state and local public health actors, legislative staff, and various nongovernmental health organizations—meeting every three months to discuss the state's and municipalities' legal needs for improved response to pressing public health issues.[9] Because of the concurrent progression of the Turning Point Act, the Public Health Law Committee reviewed early drafts of the model legislation and provided input to Nebraska representatives on the Turning Point Collaborative. Further, with interest in severe acute

[9] In this context, state actors reported that the intent of these meetings was to understand gaps in state public health law and develop "clean up bills" to address minor needs.

respiratory syndrome (SARS), pandemic influenza, and bioterrorism, early meetings of the Public Health Law Committee focused on emergency preparedness and response. Using bioterrorism funding from the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) for pandemic preparedness, subsequent meetings addressed the drafting of local quarantine and isolation regulations (discussed below).

C. LB 692 – Public Health Reorganization

At the end of the twentieth century, Nebraska lacked an office devoted to public health,[10] and only two Nebraska counties (Douglas County (Omaha) and Lancaster County (Lincoln)) possessed any significant support from local taxation for its health departments. While these health departments have authority over nearly 40% of the Nebraska population,[11] there remained vast weaknesses in local, mostly rural, health departments. With a failed 1970s local health department initiative leading to only twelve local county health departments covering twenty-two of Nebraska's ninety-three counties, many regions of the state remained without a single legally-recognized public health worker.[12] (Among those that had a single health worker, the emphasis for many was solely on federally-supported home health care.) Recognizing the need for greater local public health infrastructure, Nebraska began to investigate the best way to provide health departments

[10] Based upon a review of Nebraska's public health laws by Professor Lawrence Gostin of the Center for Law and the Public's Health of Georgetown and Johns Hopkins Universities, the state in 2000 re-established an Office of Public Health within the Nebraska Department of Health and Human Services, Regulation and Licensure.

[11] Although Lincoln and Omaha had long represented only a third of the Nebraska population, recent demographic changes within the state have led to the expansion of these urban centers and contraction in rural areas far removed from the state's largest interstate highway, I-80.

[12] Despite this dearth of local health departments, this was a comparative improvement from Nebraska's 1975 attempts to build on the four then-existing health departments.

across the state, using Kellogg Foundation and Robert Wood Johnson grant money along with matching state funds under the first Turning Point grants.

Pursuant to the Turning Point Program's first-round requirement that states develop a state public health improvement plan, Nebraska state and local health directors met with a steering committee of nongovernmental actors to develop a state strategic plan to, among other things, organize a statewide system for local public health.[13] Although this process led Nebraska to develop and provide funding for four additional multi-county health partnerships (bringing to sixteen the total number of local health organizaitons), the state, loathe to increase local taxes for public health, made no additional legal changes.

This stalled momentum for public health initiatives was altered dramatically following the 1998 multi-state tobacco settlement.[14] As the tobacco settlement was being finalized in late 2000, a longstanding legislative proponent of public health, the Chair of the legislature's Health and Human Services Committee, brought together representatives from across the health spectrum[15] to develop a bill that would reserve these prospective funds for a healthcare fund. These Nebraska actors, organized by the Public Health Association of Nebraska (PHAN) beginning in 1999, raised $20,000 from medical and public health communities and, working with a professional healthcare lobbyist[16] and other interested health organizations (e.g., Nebraska Hospital Association and Nebraska Medical

[13] *See* Cite to state health plan.

[14] As a state public health actor noted in describing the role of the tobacco funds on the state's strategic plan, "although it wasn't specific in our Turning Point plan, our plan was so broad that everything just kind of fell into place for us. And the tobacco settlement money—things just worked well for us."

[15] Because of state regulations, state public health actors did not take part on the drafting of or advocacy for the ensuing bill.

[16] Despite its status as a 501(c)(3) organization, PHAN was able to create separate funds to enable its lobbying work.

Association) developed legislation to assure allocation of tobacco settlement funds for health initiatives. In drafting the public health component of this legislation, the drafters looked to (1) the state's strategic health plan, (2) Professor Lawrence Gostin and Professor Hodge's 1997 legislative review of the state's health authority and (3) ASTHO and NAACHO resources on local health department creation. Working directly with their legislative sponsor and his legislative aide during the fall of 2000, several local public health actors drafted the language that would fund the goals set out in the state's strategic plan. Basing legislation on the state health plan and on the model of the four new Turning Point partnerships, which then had the proclaimed endorsement (if not active support) of the Governor and Chief Medical Officer, the lobbyist worked with senators on the Health and Human Services Committee to develop consensus on the legislative language required for the creation of local health departments throughout the state.

The legislative sponsor introduced the funding legislation, the Health Care Funding Act, LB 692, in January 2001. This legislation would make its way through a joint Appropriations and Health and Human Services Committee, in what one prominent public health actor described as "the first time in the state of Nebraska that we ever had public health debated on the floor of the legislature." With supportive testimony on the public health component of the bill from PHAN, the Nebraska Medical Association and several local health directors,[17] the bill faced little resistance in its funding priorities. Although compromise was necessary in the size of the funding allotment, public health actors remained firm in the need to establish local health departments. LB 692 was passed by the legislature and signed by the Governor in May 2001. As a result of this legislative effort,

[17] Although testimony from the Department of Health was not supportive of the bill, its testimony, expressing individual concerns with the bill, was described repeatedly as "neutral."

Nebraska, in contrast to the vast majority of states, has set aside a minimum of $50 million in interest per year from the tobacco settlement, to be used in perpetuity for health-related activities, including $5.7 million per year specifically for multi-county health departments.

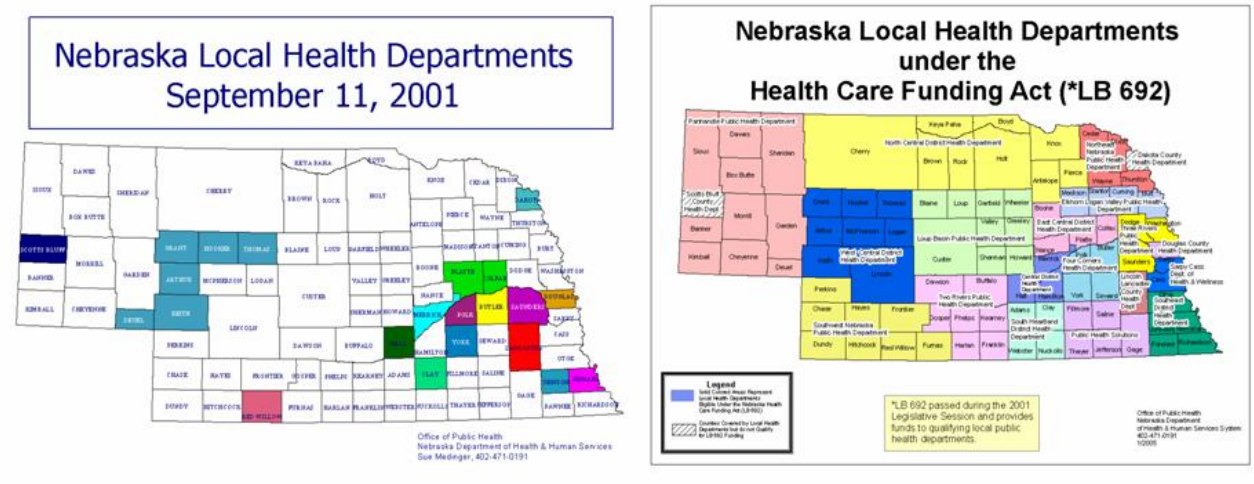
Under this new state public health infrastructure, the Office of Public Health would serve as the base from which all funds would be distributed to local health departments. In furthering this part of the state health plan, many subsequent steps were taken to improve local public health capacity in Nebraska through the $5 million in yearly grants newly awarded by the Office of Public Health. Taking advantage of economies of scale without excessive duplication, Nebraska set up a formula under which counties could apply for funds either as a single county (if the population exceeded 50,000) or as three or more contiguous counties (with a total population of at least 30,000).[18] To incentivize the creation of these multi-county health departments under the healthcare fund, Nebraska offered increments of between $100,000 and $150,000 per year to health departments to build their infrastructure, with the funding amount based on the respective health department's population. Although many counties resisted joining multi-county health departments despite county-by-county presentations from the state's Chief Medical Officer during the summer of 2001, the terrorist attacks that autumn reinforced the need to act quickly, galvanizing the local health department effort.

As a result of these changes—creating sixteen multi-county health departments, covering eighty-nine of ninety-three counties—Nebraska increased to twenty single or multi-county health departments, which, while only creating four additional health

[18] LB 692 (2001). To incentivize counties to come together to create joint plans these multi-county health departments, the state offered each county $5,000 of initial planning funds to facilitate the creation of inter-county agreements and multi-county boards of health.

departments, now covered all of Nebraska's ninety-three counties. The changes that occurred through this process are illustrated in Figure 2, which shows the distribution of local health departments both before and after the reorganization pursuant to LB 692.

Figure 2. Status of Nebraska Local Health Departments Before (left) and After (right) LB 692



To create these local health departments, Nebraska law was amended to define these departments and codify the nationally-recommended three core functions and ten essential services necessary for their performance. Although these local health departments would be officially independent of the state DHHS—governed by local boards of health and local authorities—the Chief Health Officer retained the power to approve all local health department directors and approve regulations that would then have to be enacted by local regulations. This new infrastructure and funding for the public health system would lay the foundation on which the reforms discussed herein were built.

PHAN has used an active social marketing approach to draw public attention to the new bill, the Office of Public Health, and local health departments. With federal emergency preparedness and bioterrorism grants coming into the state in the wake of the

terrorist attacks, Nebraska has been able provide additional financial assistance to its new local health departments and vest them with a clear preparedness mission, reinforced through the employment of emergency preparedness coordinators and frequent meetings between state and local public health officials.[19] This had led to the unprecedented step of the state allocating $1.8 million of general funds in 2006 for local public health systems.

D. Model State Emergency Health Powers Act

During the course of Nebraska's participation in the Turning Point Collaborative, the necessity of statutory protection of public health was reinforced through Nebraska's consideration of elements of the Model State Emergency Health Powers Act (MSEHPA), drafted by the Center for Law and the Public's Health for the Centers for Disease Control and Prevention and others in the weeks immediately following the events of September 11, 2001 and ensuing anthrax exposures that Fall.[20] Although Nebraska actors considered the applicability of the MSEHPA to state and local public health—with an attorney drafting a gap analysis to compare Nebraska law to the articles of the MSEHPA in response to the requirements of national bioterrorism funding—actors eventually agreed on the overall acceptability of current law, with the 1997 Nebraska Emergency Management Act[21] and LB 692 having already included broad emergency preparedness authorities for local health

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[19] *See* NEBRASKA'S STATE ASSOCIATION OF CITY AND COUNTY HEALTH OFFICIALS, 2006 REPORT ON THE IMPACT OF NEBRASKA'S LOCAL PUBLIC HEALTH DEPARTMENTS (2007) (on file with author).

[20] Model State Emergency Health Powers Act (2001), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. For additional information on the Model State Emergency Health Powers Act, see Lawrence O. Gostin, et al. The Model State Emergency Health *Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622 (2002).

[21] Nebraska Emergency Management Act, Neb. Rev. Stat. §§ 81-829.36 – 81-839.75 (1997). The Nebraska Emergency Management Act is governed by an agency separate from the public health infrastructure, the Nebraska Emergency Management Agency.

departments.[22] Given the widespread impression that current law provided "basically unlimited [authorities] in a government-declared emergency" at the state and local levels, some government officials went so far as to testify against a senator's surprise introduction of a bill reproducing the entirety of the MSEHPA in order to keep it from advancing out of committee. In that testimony, the Chief Medical Officer stated that future reforms would be based not on the MSEHPA but on the broader Turning Point Act.

E. 173 NAC 6 – Regulation for Control of Communicable Disease

As discussed above, the preponderance of state public health authorities in Nebraska fall under either chapter 71 or 81 of the Nebraska Statutes.[23] Given the broadness of these statutes, the Public Health Law Committee had long considered clarifying and elaborating these statutes. Even with the authority for quarantine and isolation in the Nebraska Emergency Management Act, there remained gaps in public health authority for quarantine and isolation in situations outside of a declared emergency. To fill these gaps, state public health actors opted to develop administrative regulations, rather than legislative statutes, to set forth the procedures for health officials to institute a quarantine or isolation order. These regulations would set out to define explicitly the basis of authority and procedures for quarantine and isolation during any public health event.

The regulatory drafting process began in the Regulation & Licensure program office of DHHS in early 2002. With little progress made in its first year, the process of drafting the regulation, customarily left to program staff, was sent directly to the legal

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[22] Because Professor Gostin took part in the drafting of both the MSEHPA and the Nebraska Emergency Management Act, it is not surprising that these documents share similarities in subject matter and language.

[23] Neb. Rev. Stat. §§ 71-502, 81-601 et seq., *available at* http://www.hhs.state.ne.us/aftermath/smpx/laws.pdf (last visited June 15, 2007).

division in mid-2003. During this drafting process, a law school clerk dedicated to public health was assigned to create a preliminary draft of the regulatory language. Working from an outline created by several of the lawyers within the legal division, the intern was first assigned to review the MSEHPA and Turning Point Act, confirming that all the quarantine and isolation concepts discussed in these models would be included in the proposed regulatory framework. From there, through her full-time employment in the summer of 2005 and part-time assistance thereafter, the intern employed the Turning Point Act's language and original research in developing this regulatory language.[24]

As noted in the table below, although some of the regulatory language in Title 173, Chapter 6 of the Nebraska Administrative Code, Directed Health Measures to Prevent or Limit the Spread of Communicable Disease, Illness, or Poisoning (173 NAC 6) reproduced portions of the Turning Point Act, the Turning Point Act provided general themes more than specific language, with 173 NAC 6 diverging from the language of the Turning Point Act where it was felt to be either inapplicable or unnecessarily specific.[25]

[24] In early 2007, DHHS brought together bioterrorism and other funding to reserve a member of the legal division specifically for public health issues, allowing staff to focus on public health law more directly now without the need for free legal assistance through internship programs.

[25] For an analysis of this use of the Turning Point Act, see *infra* Part III.A.

Table 2. Comparison of 173 NAC 6 with select provisions of the Turning Point Act

SUBJECT	173 NAC 6	TURNING POINT ACT
Definitions	Section 6-002 Definitions Isolation means the separation of people who have a specific communicable disease, illness, or poisoning from healthy people and the restriction of their movement to stop the spread of that disease, illness, or poison. In circumstances where animals are agents of spread of communicable disease, illness, or poisoning, isolation may apply to such animals. Quarantine directed to identified individuals or defined populations means the restriction of, or conditions upon, the movement and activities of people who are not yet ill, but who have been or may have been exposed to an agent of communicable disease, illness, or poisoning and are therefore potentially capable of communicating a disease, illness, or poison. The purpose is to prevent or limit the spread of communicable disease, illness, or poison. Quarantine of individuals or defined populations generally involves the separation of the quarantined from the general population. In circumstances where animals are agents of spread of communicable disease, illness, or poisoning, quarantine may apply to such animals.	Section 1-102 Definitions (30) "Isolate," "Isolated," or "Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals. (53) "Quarantine" means the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a contagious or possibly contagious disease and who do not show signs or symptoms of a contagious disease, from non-quarantined individuals, to prevent or limit the transmission of the disease to non-quarantined individuals.
Procedures	Section 6-005 Procedures 6-005.02 In determining the nature, scope, and duration of the Directed Health Measure ordered, the Director, based on the information available at the time of the determination, will: 1. Assess the situation and identify the least restrictive practical means of isolating, quarantining, or decontaminating an individual that effectively protects unexposed and susceptible individuals; 2. Select a place of isolation or quarantine that will allow the most freedom of movement and communication with family members and other contacts without allowing disease transmission to others and allow the appropriate level of medical care needed by isolated or quarantined individuals to the extent practicable; 3. For communicable diseases, order that the duration of the Directed Health Measure should be no longer than necessary to ensure that the affected individual or group no longer poses a public health threat; 4. Give consideration to separation of isolated individuals from	Section 5-108 Quarantine and Isolation [b] Conditions and Principles. The state or local public health agency shall adhere to the following conditions and principles when isolating or quarantining individuals or groups of individuals: (1) Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a contagious or possibly contagious disease to others and may include, but are not limited to, confinement to private homes or other private and public premises. (2) Isolated individuals must be confined separately from quarantined individuals. (3) The health status of isolated and quarantined individuals must be monitored regularly to determine if they continue to require isolation or quarantine. (4) If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a contagious or possibly contagious disease he or she must promptly be removed to isolation.

	quarantined individuals. However, if quarantine or isolation is possible in the home(s) of the affected individual(s), individuals may be isolated with quarantined individuals; and 5. Give consideration to providing for termination of the Order under the following circumstances: a. If laboratory testing or examination is available to rule out a communicable condition, the Order may provide that proof of the negative result will be accepted to terminate a Directed Health Measure; or b. If treatment is available to remedy a communicable condition, the Order may provide that proof of successful treatment will be accepted to terminate a Directed Health Measure.	(5) Isolation and quarantine must be immediately terminated when an individual poses no substantial risk of transmitting a contagious or possibly contagious disease to others. (6) The needs of individuals who are isolated or quarantined shall be addressed in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in isolation or quarantine and outside these settings, and competent medical care. (7) Outside premises used for isolation and quarantine shall be maintained in a safe and hygienic manner and be designed to minimize the likelihood of further transmission of infection or other harms to individuals isolated and quarantined. (8) To the extent possible, cultural and religious beliefs shall be respected in addressing the needs of individuals, and establishing and maintaining isolation and quarantine premises.
Due Process	6-008 Hearing Process 6-008.01 Request for Hearing: Any person subject to an Order under 173 NAC 6 may request a contested case hearing to contest the validity of the Order, in accord with the Department's rules of practice and procedure adopted pursuant to the Administrative Procedure Act. 6-008.02 Scheduling of Hearing: Upon request, the Department will schedule a hearing to be held as soon as reasonably possible under the circumstances. Unless the person subject to an Order requests otherwise, the hearing will be scheduled no sooner than three days after the request is received by the Department. The hearing will be conducted in accord with the Department's	Section 5-108 Quarantine and Isolation [f] Relief from Isolation and Quarantine. An isolated or quarantined individual or group of individuals may apply to a court for an order to show cause why isolation or quarantine should not be terminated. The court shall rule on the application to show cause within [forty-eight (48)] hours of its filing. (1) Remedies for breach of conditions. An isolated or quarantined individual or groups of individuals may request a hearing in the court for remedies regarding breaches of the conditions of isolation or quarantine. A request for a hearing shall not stay or enjoin an isolation or quarantine order. (i) Where extraordinary circumstances justify the immediate granting of relief, the court shall fix a date for hearing on the alleged matters within [twenty-four (24)] hours upon receipt of the request. (ii) Otherwise, the court shall fix a date for hearing on the alleged matters within [five (5)] days upon receipt of the request.

Once the legal division had drafted these regulations and the Public Health Law Committee had provided feedback, 173 NAC 6 was forwarded, beginning in April 2006, to (1) the Office of the Attorney General to assure consistency with the state constitution and statutes, (2) the Governor's Policy Cabinet—consisting of the three agency leaders, Governor's Policy Secretary and Chief Medical Officer—for approval as a matter of policy, and, following public hearings, (3) the Governor's Office for final signature. The DHHS wanted to avoid possible concerns of the Office of the Attorney General as to whether 173 NAC 6 fell outside the grant of authority to public health under Neb. Rev. Stats. §§ 71-502 and 81-601, and thus was not an accurate interpretation of the statutes on which it is based. Prior to submission of the draft reglation, legal counsel from DHHS sent corresponding documentation indicative of (1) the Chief Medical Officer's previous emergency preparedness testimony that Nebraska already possessed legislative authority for quarantine and isolation and (2) the plenary power to prevent communicable disease inherent within in the state's fundamental public health authority.

Given this lengthy process, although the drafting process began in 2002, it was not until June 2006 that the state held its administratively-required public hearing and not until February 2007 that the Governor formally approved the regulation.[26]

F. Directive Health Measures Handbook

The SARS and potential avian influenza pandemics reinforced the need for implementation procedures for local quarantine and isolation in the event of a public health emergency. During the process of developing the state regulations, the Great Plains Public

[26] Nebraska Health and Human Services, Regulation and Licensure, Control of Communicable Disease, Title 173, Chapter 6, Feb. 21, 2007.

Health Leadership Institute, which includes several state and local public health actors in Nebraska, worked with DHHS officials to develop guidance consistent with 173 NAC 6 for local health department directors. When the legal division of DHHS became aware of this proposed guidance statement, the Department informed these local actors that the adoption of regulations would be required to implement the legal authorities of local health departments to control communicable diseases. Assisted by an attorney from the legal division, the Great Plains Public Health Leadership Institute published the *Directed Health Measures Handbook* to create legal guidance for these local public health actors in drafting local regulations, a copy of which is attached as an appendix to the present report.

This *Directed Health Measures Handbook* sought to clarify the legal authority for local health officials to issue an order for mandatory quarantine and isolation, obviating the need for counties to go to the state to issue orders for local epidemics. This *Handbook* first seeks to create a roadmap of the process of developing draft regulations at the local level and promulgating them through local boards of health and county commissioners. To do so, it lays out models of relevant documents for local boards of health, including sample resolutions, public notices, and memoranda of understanding, with these documents published and sent (in hard copy and compact disk) to all local health directors to be used as templates for local ordinances. As justified by a DHHS actor, “we try to give them as many examples and make it as easy as possible. Not that they had to use these things, but sometimes it’s easy to start from something instead of start from nothing.”

G. Local Implementation of State Regulations

In pushing this authority forward, local boards of health could employ quarantine and isolation but only if done by way of local regulations.[27] Thus, in implementing local quarantine and isolation regulations, each multi-country health agency would have to schedule a meeting of its board of health, develop a local regulation, pass a local regulation, and provide a public comment period before implementation. Even once these regulations are approved by the local health agency and state Chief Medical Officer, multi-county boards of health must receive approval of each constituent county by way of resolution (municipalities may opt in by way of ordinance or memorandum of understanding).

To undertake these steps, counties needed to be persuaded to develop their multi-county health departments under LB 692 and, within that local health department, to develop the implementing regulations permitted under state law. As a preliminary step, the legal department created a brief *Overview of Nebraska Law on Quarantine, Isolation and Related Measures* to educate health districts on the new state regulatory authority for public health. Reinforcing this call to local health actors, a team of local activists and state personnel, who had come together under the Public Health Law Committee, have worked with each local health department to persuade officials to modernize their local health regulations.

[27] 71-1631 ("The board of health shall, with the approval of the county board and the municipality, whenever a city is a party in such a city-county health department: . . . (7) Enact rules and regulations, subsequent to public hearing held after due public notice of such hearing by publication at least once in a newspaper having general circulation in the county or district at least ten days prior to such hearing, and enforce the same for the protection of public health and the prevention of communicable diseases within its jurisdiction, subject to the review and approval of such rules and regulations by the Department of Health and Human Services Regulation and Licensure.").

IV. Analysis: Lessons Learned From Public Health Reforms in Nebraska

The public health law initiatives presented here have been a story of success in employing the Turning Point Act to spur state and local legislation. Although Nebraska actors did not comprehensively draw on the language of the Turning Point Act, they took guidance from its provisions, employing it as a resource in framing considerations of public health legislation and regulation at the state and local level. While no specific causal lynchpin can be identified based upon this single case, it is clear from the themes of informant interviews that the variables outlined in Figure 3 and discussed below predisposed the Nebraska effort to its conclusion.

Figure 3: A Process Model of Nebraska Public Health Law Reform *

Stage I: The Emergence and Utilization of the Turning Point Act
- *Dominant Actors*
  - Turning Point Collaborative
  - Department of Health and Human Services
  - Public Health Law Committee
- *Key Forces*
  - Agenda Setting
  - Partnership Development
- *Result*
  - Model Developed for Discussion of Issue
  - Public Health System Reorganization

Stage II: The Development of Draft Law
- *Dominant Actors*
  - Department of Health and Human Services, Legal Division
  - Public Health Law Committee
- *Key Forces*
  - Gap Analysis
  - Necessities of Public Health/Bioterrorism Funding
  - Political Considerations/Tradeoffs
- *Result*
  - Regulation on Quarantine and Isolation Developed Pursuant to Turning Point Act but Specific to State Needs and Political Circumstances

Stage III: Regulatory Action
- *Dominant Actors*
  - Department of Health and Human Services
  - Local Health Departments
  - Public Health Association of Nebraska
- *Key Forces*
  - Directed Health Measures Handbook
  - Grassroots Advocacy
- *Result*
  - Local Adoption of Quarantine and Isolation Regulations

* This chart has been adapted from Kristine M. Gebbie, *Washington State Reorganization: More of the Story*, 18 J. PUB. HEALTH POL. 188, 213 (1997).

A. The Turning Point Experience

The Turning Point Experience, both through the Turning Point Collaborative and the Turning Point Act, proved instrumental in state public health law modernization efforts. During the Turning Point Collaborative process, Nebraska representatives to the Collaborative met with the Public Health Law Committee to begin to discuss application of model legislation to state law. As noted by one of the Collaboration participants, "looking

at it from the broad perspective of the national model, we used a lot of things that were in the national model to bring back to our local collaborative to have them take a look at our law."

In this regard, the Turning Point Act served as much as inspiration to engender regulatory reform as it provided regulatory language. Prior to the completion of the Turning Point Act, the Turning Point process was the impetus for the (1) organization of the Public Health Law Committee and (2) reorganization of the public health system under LB 692. Presentations on the Turning Point Act at various public health conferences reinforced the need for change and the use of model laws in facilitating that change.[28] In drafting subsequent regulation, a state public health official noted that the Turning Point Act

> served as a really good template to get us, particularly in Nebraska and I think other states, interested in knowing that they really need to do something and that was really need to improve our public health laws. And I think this made us take a look at . . . whether we wanted to continue to do that or do something different like go back to the model acts all the time and take a look at them and compare them to what we're doing.

This referencing of model legislation allowed the Turning Point Act to serve as a template, not necessarily for the language but for the substance of public health law reform.

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[28] In reflecting on the effect of conference discussion of the Turning Point Act, a member of the legal division commented:

> I had been aware of the Model Act [MSEHPA] and then the Turning Point Act itself and had been at a number of conferences where we discussed this stuff. So subconsciously, in addition to consciously, I was going to these conferences thinking "here's what we need to do and here's where it is in here." Because the conferences, of course, were all largely structured on "here we have this model thing to talk about: why should we talk about Rhode Island or Nebraska's law? We're going to go through the concepts here: boom, boom, boom." So it was sinking in to me even before we sat down and did a conscious line by line.

Despite this understanding of the Turning Point Act, many Nebraska actors felt the Act's provisions "more specific than they needed to be" for application to their state. As one state public health actor noted in considering the application of the Turning Point Act:

> Some of the things in the model public health law will need to be stripped out or simpler because we're starting from scratch, and rather than start with all this stuff, I'd rather start somewhere and build up. . . . We're starting new, and I think we're unique in the fact that we do have such a new public health system, and people don't really know what to do. So we're stopping and researching and finding the best way to go.

Consequently, Nebraska's regulatory language was drafted to be less specific than the language of the Turning Point Act. Actors frequently noted that many Nebraska legislators, in comparison to those in other states, prefer less specific legislation and regulation, giving executive agencies the flexibility to make additional changes as needed. Further, actors believe that the legislature would have been resistant to national models, particularly models perceived to be mandated in their entirety, preferring to be in control of all matters of state concern. As lamented by a senior DHHS official, "I naively thought at the time [of the release of the Turning Point Act] that we would be able to take pieces of the model act and sort of incrementally begin to revise our statutes, and that has not happened…." Given these obstacles, public health actors chose selectively among those aspects most important in clarifying Nebraska's public health powers—quarantine and isolation authority—filling those gaps in state public health law through regulation rather than legislation.

B. Necessity of Reorganization

Public health system reorganization had long been at the forefront of the "wish list" of Nebraska's public health actors. As explained by a senior state public health official:

> At the time we formed our public health law team . . . we felt that our number one problem was a lack of a public health infrastructure across the state. And if you're going to address environmental problems or health disparities or any other complex public health issue, obviously following up on communicable disease outbreaks, we had to build our infrastructure for that. . .We didn't have anything else in place, so that became our primary focus and as the new legislation was being developed . . .

The creation of a state strategic public health plan—required by the Turning Point process—gave these actors the documentary evidence necessary to attest to this need when tobacco settlement funding became available. This strategic plan was employed first as a memorialization of consensus within the public health community on public health infrastructure and second "as an educational tool to show the legislators, and frankly the Governor's Office . . . why we need this new infrastructure and of what value it would be."

Reorganization of the public health system has played a significant role in generating visibility for public health issues across the state. Although some local health actors were initially skeptical of the creation of a statewide system for public health action at the local level, the reorganization was able to align state and local legislative priorities while creating a unified message for change. Local-state collaboration has steadily improved since that time. While local-state alliances existed since the 1980s among the select city health departments, LB 692 strengthened, enlarged, and funded gatherings of these actors. With regard to funding issues, a local health leader explained:

> Before 692, local Nebraska public health departments were on their own because there weren't state resources. We received no funding from the state other than pass through federal dollars. We didn't receive a dime of general fund dollars. That's changed so now we're able to have some discussions. And we're not isolated any longer. So not only are we building relationships with the state—because we're actually functioning partnerships—but we're trying to produce results that have some responsibilities both from the local level and from the state level.

These local collaborations have yielded tangible benefits for state public health priorities. Although little notice was taken of the local health reorganization immediately after the changes in LB 692 took effect, the terrorist attacks of September 11, 2001 and anthrax attacks that fall led to reflective praise for the legislature's foresight in public health preparedness. As one public health activist reflected on the time period:

> We'd given them [the legislators] a lot of praise and so did everybody else for their foresight in enacting this because now all the bioterrorism things were coming. If we hadn't had this bill [LB 692] passed and we didn't have opportunity for development of the local public health systems, Nebraska would have . . . had a lot of problems getting the bioterrorism dollars that they got. . . . It was just kind of like a win-win for everybody. You know, it was a win for the Office of Public Health. It was a win for the Governor. It was a win for the legislature because they could all say "See! We knew we needed to do something. Now, we'll be prepared."

In moving forward, this reorganization has also proven pivotal to the adoption of necessary local regulations to supplement state regulations. This need was clarified by a senior DHHS official, who noted the circumstance where "an outbreak would occur and the Governor may not declare an emergency, and so we [the state] couldn't use our authority to quarantine and isolate someone; and so we've encouraged local health departments to develop their own quarantine and isolation regulations." Only with this reorganization could these necessary steps in local quarantine and isolation take place.

C. Regulation over Legislation

For actors in Nebraska, regulation proved to be a less politically cumbersome approach to public health law reform than statutory change. The Governor was not a proponent of public health law reform, and the Governor's Policy Cabinet had long been reluctant to propose new legislation on health issues. With comprehensive public health legislation long considered to be politically infeasible in the state, actors have preferred to

take a "patchwork" approach to public health law through administrative regulation. While legal reform purists might object, the regulatory approach allowed state actors to employ the Turning Point Act's legislative template in crafting modernized public health approaches for the state.

Like other states that have considered the Turning Point Act, the prospect of changes to public health laws led to fears of legislative "backsliding" among modernization proponents, with the costs and civil liberties implications of these changes forcing anticipatory compromises. A state public health actor argued:

> Basically, we decided that we'd be better off to change some of our laws by regulation rather than changing the [statutory] laws because when we change the broad laws . . . it's like opening up Pandora's Box, and there's just so many things to look at. So some of the changes that we've made, really made, have been by rules and regs.

Statutory reform was felt to pose a comparatively greater risk for backsliding, comprehensive statutory reform more so, with actors feeling that no crisis situation had arisen to warrant a legislative champion taking up the Turning Point Act in fashioning a legislative response. Where there was a perceived crisis in public health law, as there was in the case of the SARS pandemic,[29] it was felt that, given the lack of vocal leadership within the legislature or Governor's Office, regulatory changes could best address these crises. Fearing legislative retrenchment of public health authority as a result of attempts at legislative expansion, public health actors in Nebraska believe regulation to protect the public's health while posing far less risk of sacrificing state public health authorities in an effort to improve them.

[29] As a senior state public health official described the regulatory impetus created by global SARS fears, "of course with the SARS outbreak in Canada . . . I think people really began to understand that we might actually have to enforce quarantine and isolation." With several pandemics traversing the globe simultaneously, the need for explicit and robust quarantine and isolation authority became apparent.

Although all actors agreed that legislation is preferable to regulation, adding greater authority and specificity in areas not yet addressed by previous legislation, a regulatory approach can achieve many of the goals of legislation in specific subject areas. Despite concerns throughout the regulatory process that 173 NAC 6 did not faithfully interpret existing statutory language, with the DHHS legal division having to engage in dialogue with both the Office of the Attorney General and the Governor's Policy Research Office to show that the legal changes did not necessitate a change in statutes, this approach passed statutory muster to expand public health authority. As concluded by a senior state public health official:

> Is it as clean? . . . Probably not in some cases, but it can be workable. And obviously when you're looking at the model act, not everything can be fixed through regulation, but quarantine and isolation regulations [are] probably an area where you can make some significant changes.

D. Partners for Public Health Law Modernization

Pursuing this regulatory avenue to public health improvement, the partnerships that existed between PHAN and DHHS have bolstered efforts to reorganize the health system, draft regulations, and embolden legal modernization efforts among local health officials. State governmental actors in Nebraska could turn to PHAN for collaboration in fulfilling joint goals. Because of difficulties in creating positions at the state level for the past several years, many community partners (who are members of PHAN) were serving as state contractors, making them accessible, available, and closely linked with state actors. When the state first became interested in public health law reform, state actors turned to the PHAN leadership, getting feedback and "buy in" from organizational actors and deciding whether the state or the organization would spearhead the legislative initiative. As one DHHS actor recognized, "sometimes it's easier for them [private organizations] to

initiate legislation than it is for us at the state." For state actors, the process of approval for a legislative initiative is long, cumbersome, and fraught with political calculations as it moves through the proposal process of the Governor's Policy Cabinet. By working through informal groupings like the Public Health Law Committee, the state can meet with partners for advice and information, forwarding to these partners any legislative initiatives that could not be organized exclusively through the Administration.[30] As an example recognized by a senior state public health official, "I certainly wouldn't go over and talk with a legislator about something the Governor may or may not want to do, so the public health association went to a couple key state senators . . . ." In pushing for the passage of LB 692, PHAN—through its lobbying arm, Friends of Public Health,[31] and with its professional lobbyist—worked to finalize the work set in motion by others.

To do so, PHAN actors were able to work closely with their governmental colleagues to incorporate many new local actors into the public health system, gather their thoughts in creating state policy, and educate them on their roles in fulfilling public health priorities. This was particularly advantageous for state public health actors. Because quarantine and isolation regulations would need to be addressed at the local level, it was essential for local public health directors to meet with state DHHS actors through the Public Health Law Committee to discuss uniform approaches to regulatory public hearings. When the time came to advocate to local health departments to organize into

[30] Further, larger partnerships for strategic planning complemented the public health law group, bringing together 30-40 professionals and activists from across the subject matter spectrum of public health to discuss priorities.

[31] Because PHAN serves as a 501(c)(3) organization, it was necessary for PHAN to create an institutionally distinct entity to spearhead its lobbying activities.

district health offices and adopt corresponding regulation, PHAN members were among the most vocal in pressing for active multi-county health departments.

Likewise, DHHS became an indispensable partner to PHAN for public health law reform. Working with their non-governmental partners, the DHHS public health staff was able to develop the state's strategic health plan and the legal division was able to provide the detailed legal analysis necessary to buttress the efforts of nongovernmental actors and local public health officials. Even though Nebraska possesses comparatively limited bureaucratic capacity for public health law, it took only one lawyer—working closely with a legal intern[32]—to create the detailed legal analysis necessary to support public health law reform. In this role, the DHHS attorney, dedicated to issues of public health and emergency response at the state and local level,[33] was able to cut through the scatter of public health laws and streamline disparate regulations in a comprehensive summary. This was particularly necessary in the wake of September 11, 2001, where subsequent CDC funding required that states complete a detailed analysis of their laws and regulations. Drawing on CDC efforts, DHHS legal counsel were able (1) to attend CDC conferences and public health emergency law courses to discuss approaches used by other states and (2) to employ CDC resources (including template Powerpoint presentations) when presenting to local actors on the state's quarantine and isolation authority. Following up on these national efforts, the DHHS legal division "would go through and do searches and identify for [DHHS leadership] the statute that would have anything to do with controlling

[32] It is common practice for law students to serve as legal interns or associates in the summer following the second year of their legal training.

[33] Many actors noted that it was unusual for a DHHS employee to be both dedicated to a specific subject matter and given so much liberty to work with local public health officials in addition to his state client, but that this situation was developed because of excessive need for legal assistance and bioterrorism funding from the Office of Public Health.

communicable disease at the state level." This served to jumpstart the legal reform initiatives, which had been stalled since the release of the Turning Point Act, through the promulgation and local implementation of 173 NAC 6.[34]

Conclusion

The Nebraska process of translating the Turning Point Act into state and local regulation has served to meet the needs of the public health system through non-legislative means, with an effort carefully calculated, well-funded, and built upon the coordinated actions of individuals and organizations throughout the state and local public health system. With the Nebraska Emergency Management Act, public health reorganization, and the three core functions and ten essential services of public health already written into law, Nebraska actors felt that the initial steps for public health law modernization could be taken by way of regulation rather than legislation. In doing so, the Turning Point process in Nebraska has proven a success in bringing together actors for public health law modernization, setting the stage for future legislative and regulatory collaborations. As state and local actors move forward—developing (1) legislation for periodic public health improvement plans and volunteer health professionals; (2) regulations for nuisance and methamphetamines; and (3) consistent standards for public heath data privacy—they are cognizant of the role of the Turning Point Act in providing model approaches. Reflecting on their public health law experience to date, a senior DHHS public health official applauded the Turning Point process for creating a template "to be specific, to be on the cutting edge, but also to be practical." With the Public Health Law Committee continuing

[34] As described by one DHHS actor, "I think they [the regulations] kind of got stalled there because staff just didn't have time to work on them, and then that's when [the attorney] stepped in, was given the assignment, and moved forward."

to discuss public health law modernization, actors continue to take lessons from their experiences in employing the Turning Point Act, preparing themselves to use the law in confronting the public health challenges that lie ahead for Nebraska.