

Wisconsin: 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 Wisconsin following the development of the Turning Point Act. It is the third of a series of case studies to assess several states' considerations of reform of public health law pursuant to the Turning Point Act. Through this analysis and ongoing legislative tracking in all fifty states, we investigate 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 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 third 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. This case study describes and assesses the ways in which Wisconsin actors employed the Turning Point Act to modernize their state public health laws. Attempts to reform Wisconsin public health law pursuant to the Turning Point Act began well before completion of the Turning Point Act and continue into the future. Our research analyzes the major variables to which Wisconsin informants attribute the success of their 2005-2006 modernization efforts. In so doing, we elucidate approaches more likely to support passage of modernization efforts, providing information to policy-makers and public health officials in framing 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 legislation³ or various helmet and seat restraint statutes,⁴ few studies have examined core public health enabling statutes that create the agencies and grant them their core powers to prevent disease and promote health.⁵ This gap was formally recognized in two 2003 Institute of

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>.

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

⁴ Marian Jones & Ronald Bayer, *Paternalism and Its Discontents: Motorcycle Helmet Laws, Libertarian Values, and Public Health*, AM. J. PUBLIC HEALTH (in press).

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

Medicine (IOM) reports on public health. The IOM's *The Future of the Public's Health in the 21st Century* pointed out the failure of states to keep public health laws current,⁶ while its report, *Who Will Keep the Public Healthy?*⁷ argued for increased attention to law and political science in the public health curriculum as well as practice-associated research in this and other relevant areas of study.

The state of Wisconsin has long been at the forefront of states seeking to improve the public's health through legislative reform. Headquartered in the capitol, Madison, the Department of Health and Family Services is a combined public health and human services agency. Within the Department of Health and Family Services, health priorities for the state are set by the Secretary of Health and Family Services, who oversees the Department's five divisions. One of these is the Division of Public Health, which has control over major public health initiatives in environmental health, occupational health, family and community health, emergency medical services, injury prevention, chronic disease prevention, health promotion, communicable disease prevention, oral health, school health, minority health and women's health. Under the Division of Public Health, state programs and activities are divided into five geographic regions.⁸ In addition, there are seventy-two local government public health agencies, the largest of which exist in Milwaukee and Madison. Although the three largest urban areas in Wisconsin—Milwaukee, Green Bay, and Madison—are all located in the Southeastern corner of the state, a great deal of rural health activity takes place in the western and northern regions of Wisconsin, regions to which informants attribute a resistance to overregulation and consequent marginalization in the regulatory process.

Prior to the statutory reforms that form the basis of this case study, Wisconsin previously underwent a major revision of its public health statutory authority in 1993.⁹ Drawing upon the IOM's 1988 report, *The Future of Public Health*, the Department of Health and Family Services codified the IOM's three "core functions of public health."¹⁰ As a result of these early reforms (drafted over a two year period by a public health advisory committee and met with only minimal legislative resistance), the statutory basis for Wisconsin's public health authority was comparatively less antiquated than that of other states. The administrative rules governing the public health system were revised in 1999, at which point state public health actors felt confident in the legislative authority granted to them. It was only through the IOM's 2003 re-emphasis of ten essential public health services¹¹ that gaps were brought to light in Wisconsin public health law. With interest in public health law reform, Wisconsin joined the Turning Point Collaborative to facilitate the development of a document that could serve as the basis for these needed reforms.

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).

⁸ Within these geographic regions, the state health department staffs the regional offices.

⁹ Wisc. Act 27 (1993).

¹⁰ See INSTITUTE OF MEDICINE, *THE FUTURE OF PUBLIC HEALTH* 10 (1988).

¹¹ See *supra* note 6.

During the course of Wisconsin's participation in the Turning Point Collaborative, the necessity of statutory protection of public health was reinforced through Wisconsin's contribution to and rapid implementation of elements of the Model State Emergency Health Powers Act, 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 after the events of September 11, 2001 and ensuing anthrax exposures that Fall.¹² Many of the actors who took part in the events described below first examined model act language through Wisconsin's efforts to bring together the entire public health community to comment quickly on the Center's early drafts of the Model State Emergency Health Powers Act. Thereafter, in a rush to enact parts of the Model State Emergency Health Powers Act late in the 2001-2002 session, the bill (shepherded by the Vice-Chair of the Committee on Public Health) was subsumed within the final budget process and interspersed within the bi-annual budget rather than as a "stand alone" bill.¹³ Although the Wisconsin bill differed in many respects from the Model State Emergency Health Powers Act and little legislative debate arose, particularly within the Assembly Committee on Public Health, the seeds were laid for a broader modernization of public health law. In the coming years, the structure of the state public health bureaucracy would begin to change. The legislature created the Wisconsin Public Health Council in 2003 to advise the Department of Health and Family Services, the Governor, the Legislature, and the public on progress in implementing the state's 10-year public health plan and coordination of responses to public health emergencies.¹⁴ Many actors were beginning to take notice of deficiencies in the public health system and consider law reform as a tool to improve the public's health.

II. Research Methods

The methods applied to this Wisconsin case study parallel those of the two previous comparative 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 our 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, we can present 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 states, we can begin to identify generalizable major independent variables associated with public health law modernization.

¹² 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).

¹³ Wisc. Act 109 (2001). While the original bill, AB 850 (2001), had advanced through the Assembly, it was decided by Assembly sponsors that there was insufficient time in the legislative session for it to advance through the Senate as a separate bill.

¹⁴ Wisc. Act 186 (2003).

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

Table 1. Wisconsin Case Study Informants

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

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

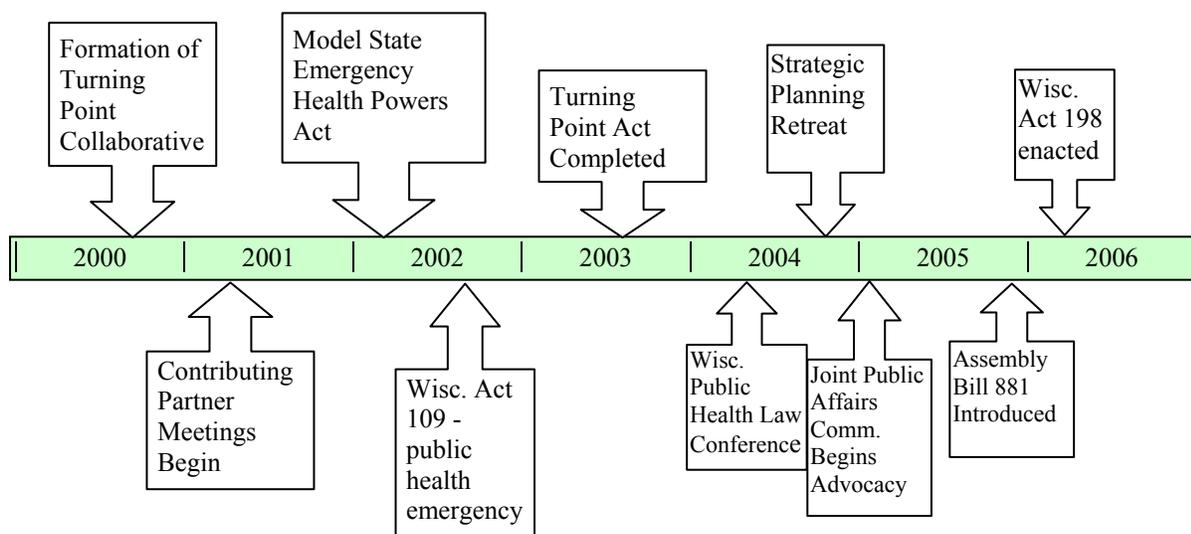
- role of the informant in the legal/regulatory changes;
- public health problems addressed by the changes;
- obstacles to changes in state law and strategies used to overcome these obstacles;
- subsequent changes in public health regulations or programs based on legal reforms; and
- expected changes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

Attempts to reform Wisconsin 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 Wisconsin Public Health Law Reform.

Figure 1. Timeline of Wisconsin Public Health Law Reform



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

A. Wisconsin Enlisted in the Turning Point Collaborative

Public health advocates in Wisconsin have long supported public health law modernization, and they already had in place a network of state and local partners from previous public health system modernization efforts. Because of the success of the 1993 statute modernization effort, the Turning Point Project solicited Wisconsin's participation as a state partner in the Turning Point Collaborative to share its unique insights from earlier efforts to codify the core public health functions. Given budgetary restrictions on state agencies, the Wisconsin Division of Health and Family Services' Division of Public Health sought assistance from its private partners, who would face fewer bureaucratic restrictions in spending grant funds. The Wisconsin Public Health Association (WPHA)—with a membership base encompassing many state and local public health employees, academics,¹⁵ private sector actors, and health advocates—applied on behalf of Wisconsin to become the grantee under the second round of grants for the Turning Point Collaborative Project.

Once funded, WPHA brought together a steering committee of six individuals who had drafted the grant application—consisting of past and current public health officials and local health officers, two of whom had been involved in the 1993 revisions. From among them, the steering committee formally hired a project director, the past president of WPHA, and a project coordinator, a recently-retired member of the City of Milwaukee Health Department, to oversee Wisconsin's contribution to the Collaborative. In quarterly meetings, at least two of the steering committee members met with the national collaborative, preparing language that would become the Turning Point Act.¹⁶ During this period, the steering committee met monthly by conference call to assess its contributions to the national collaborative.

Funding for Wisconsin's WPHA contribution to the Turning Point Collaborative lasted for four years, extending briefly into a fifth year based upon a supplemental grant and concluding officially in January 2005.

B. "Contributing Partners" for Public Health Law Reform

To enlarge its perspective on these issues, the steering committee assembled a substantially larger and broader set of "contributing partners." This group of more than thirty members—including legislators, academics, health advocates, Native American tribal representatives, and private sectors actors—met biannually to receive updates on the work of the Turning Point Collaborative and develop Wisconsin's contribution to the Collaborative. These

¹⁵ Although Wisconsin lacks a formally-designated school of public health, it is home to several public health academics through its medical colleges, nursing schools, and health education specialties.

¹⁶ While the number and members sent to the national collaborative meetings changed over the years, at least two member of the steering committee represented Wisconsin at each meeting.

meetings were divided into two parts: updates and working sessions. Following updates on the progress of the Turning Point Act, the contributing partners were divided into groups that would provide input on key questions related to specific sections of the proposed Act, noting language that was either unclear, missing, or overbroad. Many of these discussions surrounded the definition, mission, and infrastructure of the public health system. During the course of these discussions, work groups expressed their ideas on dry-erase boards, bringing ideas back to the larger group for comment and development of written recommendations. The minutes and recommendations that came out of these meetings were forwarded to James G. Hodge, Jr., then working with the Turning Point Collaborative to draft the Turning Point Act, with major recommendations advanced to the agenda of subsequent Turning Point Collaborative meetings.

A major institutional actor in these contributing partner meetings was the office of the Chair of the Assembly Committee on Public Health. Although this legislative representative had no background in the public health system, he was a proponent of public health systems and expressed his eagerness to learn the substantive issues necessary to give the public health system what it needed to fulfill its mission. He made it clear early in the process that if a bill would need to be introduced based on the Turning Point Act, advocates could turn to him to propose any resulting legislation. In this capacity, he brought to the contributing partner meetings the Chair of the Senate Committee on Health, Children, Families, Aging and Long Term Care, who expressed an interest in introducing any corollary public health law reform bill that had advanced out of the Assembly.

Outside of the contributing partners, members of the steering committee reached out to the larger public health community throughout the state. The steering committee presented to the WPHA Board of Directors on a regular basis, communicating with the WPHA membership through newsletter updates and presentations at the WPHA Annual Conference. To incorporate perspectives from all five public health regions of the state, in particular those in the western and northern regions of the state, steering committee members met with regional representatives of the Wisconsin Association of Local Health Departments and Boards (WALHDAB), an organization made up of local health officers and local boards of health members.¹⁷

Upon completion of the Turning Point Act in September 2003, WPHA, with the assistance of the Department of Health and Family Services, mailed information about the Turning Point Act to all identifiable public health actors throughout the state. The following June, WPHA sponsored the Wisconsin Public Health Law Conference in Madison as a forum for the “unveiling” of the Turning Point Act to a larger group of legislative partners and stakeholders in the public health law process, including the leadership of the Department of Health and Family Services.¹⁸ James G. Hodge, Jr. of the Center for Law and the Public’s Health and Tony Moulton of the Center for Disease Control’s Public Health Law Unit served as keynote speakers at the Conference, providing an overview of how the Turning Point Act could be used as a template for state legislation. In

¹⁷ Based upon WALHDAB’s limited organizational mandate, not all members of WPHA (including academics, state employees, private sector health officers, nongovernmental organization officials) are eligible for membership in WALHDAB, although all members of WALHDAB are eligible for membership in the more-expansive WPHA.

¹⁸ The Secretary of the Department of Health and Family Services, along with a representative of the Division of Public Health, had been briefed on the Turning Point Act just prior to its release.

discussing processes for translating the Turning Point Act into Wisconsin state legislation, the Chair of the Assembly Committee on Public Health provided an opening address, indicating to all those assembled that he would support and introduce any bill that came out of this process.

From among the contributing partners and participants at the Wisconsin Public Health Law Conference, WPHA (now using supplemental grant dollars following the end of its fourth year of Turning Point Funds) held a strategic planning retreat in November 2004 to draft the themes that would form the upcoming state legislation. In drafting this legislation and highlighting the need for its passage, a Senior Staff Attorney on health affairs from the Wisconsin Legislative Council prepared a “gap analysis” (included as an appendix to the present case study), which he had presented at the Public Health Law Conference. The purpose of this analysis was to “summarize[] provisions of the Model State Public Health Act and compare[] them with provisions in Wisconsin statutes and administrative rules.”¹⁹ Working with a professional public health facilitator over a two-day period, the retreat participants worked in groups to draft the components of what would form Assembly Bill 881.

C. Assembly Bill 881 – An Act Related to Public Health

Following the retreat, WPHA had exhausted its funds under the Turning Point grant; however, the Joint Public Affairs Committee of WPHA and WALHDAB agreed to take up the legislative effort beginning in January 2005. The Joint Public Affairs Committee, created by a 2003 memorandum of understanding between the two contributing organizations,²⁰ worked over the course of the next year to construct legislation in accordance with the Turning Point Act and the conclusions of the strategic planning retreat. To do so, it hired a professional lobbying organization,²¹ which communicated with the prospective legislative sponsors of the Assembly and Senate bills and their respective staffs in creating the draft legislation.

Through AB 881, the drafters—both at the strategic planning retreat and through the Wisconsin legislative drafting staff, the Legislative Reference Bureau—incorporated (or created functionally equivalent provisions of) many of the major facets of the Turning Point Act. To clarify and expand the public health authority of the state, the bill incorporated much of Articles 1 (definitions) and 2 (scope of authority) of the Turning Point Act, enumerating the roles and responsibilities of the state for its public health function. In addition to the ten essential public health services, the Wisconsin drafters added another two to “promote cooperation and formal collaborative agreements.” As highlighted in Table 2, Comparison of Select Provisions of AB 881

¹⁹ This representative of the Legislative Council’s Office had previously performed a gap analysis on the Model State Emergency Health Powers Act during the drafting of Wisconsin law based on that Act.

²⁰ Although the Joint Public Affairs Committee was created to allow concerted efforts in enacting public health policy, the Turning Point Act was only one of the many issues that the Committee considered.

²¹ WALHDAB is registered as a 501(c)(6) organization under the U.S. Tax Code and, as 501(c)(6) organizations have few federal restrictions on lobbying activities, had hired a contract lobbyist in the past. WPHA is registered as a 501(c)(3) organization and, as such, can engage in lobbying activities as long as its lobbying expenditures do not exceed a level set by federal law. The Joint Public Affairs Committee was these organizations’ first experience working together with the same contract lobbyist.

with the Turning Point Act, language derived from or related to 3 of the 6 substantive articles of the Turning Point Act were included in the draft of AB 881.

SUBJECT	AB 881	TURNING POINT ACT
Legislative Purpose	<p><u>Section 3. 250.03 (1) (k)</u> Promote cooperation and formal collaborative agreements among any of the following with regard to public health planning, priority setting, information and data sharing, reporting, resource allocation, funding, service delivery, and jurisdiction:</p> <ol style="list-style-type: none"> 1. The state. 2. Local health departments. 3. Federally recognized American Indian tribes or bands located in this state. 4. The federal Indian health service. 	<p><u>Section 1-101</u> (8) Promote and build strong relationships among state or local public health agencies and their public and private sector partners within the public health system;</p>
	<p><u>Section 5. 250.04 (12m)</u> In public health planning, the department shall collaborate with local health departments on an ongoing basis and shall consult with private sector entities, as defined in s. 229.41 (9), and with public sector entities, as defined in s. 229.41 (10).</p>	<p><u>Section 1-101</u> (9) Promote cooperation and formal collaborative agreements between the state and tribes, tribal organizations, and the Indian Health Service regarding public health planning, priority setting, information and data sharing, reporting, resource allocation, funding, service delivery, jurisdiction, full faith and credit and comity of state and tribal court orders issued in this [State], and other matters addressed in this Act;</p>
Essential Public Health Services	<p><u>Section 4. 250.03 (1) (L)</u> Perform or facilitate the performance of all of the following services and functions:</p> <ol style="list-style-type: none"> 1. Monitor the health status of populations to identify and solve community health problems. 2. Investigate and diagnose community health problems and health hazards. 3. Inform and educate individuals about health issues. 4. Mobilize public and private sector collaboration and action to identify and solve health problems. 5. Develop policies, plans, and programs that support individual and community health efforts. 6. Enforce statutes and rules that protect health and ensure safety. 7. Link individuals to needed personal health services. 8. Assure a competent public health workforce. 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services. 10. Provide research to develop insights into and innovative solutions for health problems. 	<p><u>Section 2-102. Essential Public Health Services and Functions</u> For the purposes of this Act, “essential public health services and functions” mean services and functions to:</p> <ol style="list-style-type: none"> [a] Monitor health status to identify and solve community health problems; [b] Investigate and diagnose health problems and health hazards in the community; [c] Inform, educate, and empower individuals about health issues; [d] Mobilize public and private sector collaboration and action to identify and solve health problems; [e] Develop policies, and plans, and programs that support individual and community health efforts; [f] Enforce laws and regulations that protect health and ensure safety; [g] Link individuals to needed personal health services and assure the provision of health care when otherwise unavailable; [h] Assure a competent public health workforce; [i] Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and [j] Research for new insights and innovative solutions to health problems.
Reporting	<p>Section 15. 252.05 (2) - amended to read: Each laboratory shall report as prescribed by the department those specimen results that <u>indicate that an individual providing the specimen has a communicable disease, or having a communicable disease, has died, or that the department finds necessary for the surveillance, control, diagnosis, and prevention of communicable diseases.</u></p> <p>SECTION 22. 979.012 (1) – amended to read: If a coroner or medical examiner is aware of the death of a person who, at the time of his or her death, had an illness or a health condition that satisfies s.166.02 (7) (a) <u>or if the coroner or medical examiner knows or suspects that the person had a communicable disease that, under rules promulgated by the department of health and family services, must be reported to a local health officer or to the state epidemiologist,</u> the coroner or medical examiner shall report the illness or health condition, <u>or communicable disease</u> to the department of health and family services and to the local health department, as defined in s. 250.01 (4), in whose jurisdiction the coroner or medical examiner is located in writing or by electronic transmission within 24 hours of learning of the deceased’s illness or health condition, <u>or communicable disease.</u></p>	<p><u>Section 3-103(f) Reporting to Detect and Track a Public Health Emergency</u> (1) In general. A health care provider, coroner, or medical examiner shall report to the state or local public health agency all cases of individuals who harbor any condition of public health importance that may be potential causes or indicators of a public health emergency. (i) Reportable conditions include, but are not limited to, the diseases caused by the biological agents listed in 42 C.F.R. § 72, app. A (2000) and any illnesses or health conditions identified by the state public health agency. (ii) For the purposes of this Section, the definition of “health care provider” includes out-of-state medical laboratories, provided that such laboratories have agreed to state reporting requirements.</p>

As seen in this table, the drafters did not adopt provisions wholesale from the Turning Point Act, deviating from the model Act where it was felt to be either (a) inapplicable to the public health needs of Wisconsin or (b) unpassable given the legislature's resistance to government programs. For example, given Wisconsin's previous passage of legislation based on the Model State Emergency Health Powers Act, AB 881 did not adopt any of the similar language from Article 6 (Public Health Emergencies) of the Turning Point Act. Similar arguments were made for noninclusion of Articles relating to Article 7 (Public Health Information Privacy) or Article 9 (Miscellaneous Provisions) based upon their inclusion in the 1993 revisions. For reasons of political expediency, any passage with the word "quarantine" was removed from the ensuing bill, as were all provisions that would have posed any financial cost to the state. Despite protests from those in the Wisconsin Environmental Health Association, it was decided that proposed "human health hazards" regulation would be disaggregated from the bill and proposed as a separate bill in the following legislative session.

Working with an official Drafter from the Legislative Reference Bureau and the Wisconsin Legislative Council, the Chair of the Assembly Committee on Public Health consulted with the Joint Public Affairs Committee and its lobbyist to create legislative language acceptable to all the actors and amenable to the political climate, arriving at a preliminary draft of the proposed bill in May 2005. Thereafter, despite substantial editing over six months of monthly meetings, three major rewrites of the bill, and last-minute concerns from the Department of Health and Family Services, a final bill was completed by the Legislative Reference Bureau (with the assistance of the Wisconsin Legislative Council) by the end of November 2005.

The Chair of the Assembly Committee on Public Health, who had kept all the relevant actors apprised of the bill during the drafting process, introduced AB 881 on December 19, 2005²² and shortly thereafter stepped down as Chair temporarily to provide testimony on the bill on January 11, 2006. Through each committee, the lobbyist arranged for testimony from representatives of WPHA, WALHDAB, and the Wisconsin Medical Association. The Deputy Division Administrator for the Division of Public Health provided supportive testimony on behalf of the Department of Health and Family Services. No individual or organization presented opposition testimony or lobbied against the bill. During the course of the next three months, AB 881 passed unanimously through the Public Health and Rules²³ Committees in the Assembly followed by the Health, Children, Families, Aging and Long Term Care Committee in the Senate. In this committee process, the Joint Public Affairs Committee worked with its lobbyist and the Chair of the Assembly Committee on Public Health to coordinate testimony before the relevant committees, with many of the original members of the steering committee becoming reengaged in the process as AB 881 made its way through the legislature. In addition, the Joint Public Affairs Committee sent out an e-mail "action alert" to all WPHA and WALHDAB members to contact their respective assemblypersons and senators. Although the

²² Although the Chair of the Assembly Committee on Public Health introduced AB 881, he had enlisted nine Democratic and Republican legislators co-sponsored the bill in the Assembly and another three in the Senate.

²³ AB 881 passed unanimously through the Rules Committee as a formality without any hearing.

Chair of the Assembly Committee on Public Health issued several press releases on the bill, the bill was never covered by the mainstream media, which had focused their health coverage that year on a proposed cigarette tax increase.²⁴

AB 881 eventually passed unanimously through the full legislature,²⁵ with only one “friendly amendment” at the request of the Department of Health and Family Services.²⁶ The bill was signed into law by the Governor on March 24, 2006.²⁷ Since then, the bill has proven instrumental, if still not fully realized, in improving the performance of the public health system. As emblematic of the changed landscape for public health, an original steering committee member recognized that the bill’s passage had “solidified the groundwork, the working relationships between the department [Health and Family Services] and the local health departments.”

IV. Analysis: Lessons Learned From Comprehensive Public Health Legislative Reforms in Wisconsin

AB 881 has been a story of success in transforming the Turning Point Act into state legislation. The actors universally commented on the unexpected ease and speed of this public health modernization effort. As one senior state public health official noted, once the preliminary work had been accomplished, the passage of the bill was a “slam dunk” that “has taken Wisconsin to . . . a very high level of functioning when it comes to statutes.” 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 2 and discussed below predisposed the Wisconsin effort to success.

²⁴ In the case of the Department of Health and Family Services, the Division of Public Health eschewed attention for the bill, avoiding a media strategy to keep attention away from those who might seek to amend the bill in ways not envisioned by its drafters.

²⁵ More specifically, AB 881 was passed unanimously in the Assembly and by a “voice vote” (without dissention) in the Senate.

²⁶ The amendment, added by the Chair of the Assembly Committee on Public Health, requires that the public health agenda must be developed by the Department of Health and Family Services *at least* every ten years, with the “at least” language added to give the Department added flexibility in deciding to develop a public health agenda more often should circumstances warrant. Although the Department offered several other minor suggestions through testimony, the Legislative Council’s Office assured the Department’s representative and Legislative Liaison that such concerns were unnecessary given the expansive language of AB 881.

²⁷ Wisconsin Act 198 (2006).

Figure 2: A Process Model of State Public Health Law Reform*

Stage I: The Emergence and Utilization of the Turning Point Act

Dominant Actors

Turning Point Collaborative
Steering Committee
Contributing Partners

Key Forces

Agenda Setting
Partnership Development

Result

Model Developed for Discussion of Issue
Public Health Law Conference

Stage II: The Development of Draft Law

Dominant Actors

Strategic Planning Retreat Participants
Chair of the Assembly Committee on Public Health
Wisconsin Legislative Council

Key Forces

Gap Analysis
Necessities of Public Health
Political Considerations/Tradeoffs

Result

Law Developed to Pursuant to Turning Point Act but
Specific to State Needs and Political Circumstances

Stage III: Legislative Action

Dominant Actors

Legislative Committee Chairs
Joint Public Affairs Committee of WPHA and WALHDAB

Key Forces

The Turning Point Experience
Politicization of Public Health
Grassroots Advocacy

Result

Reformed State Public Health Law

* 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

Wisconsin's statutory reform process was greatly buttressed by Wisconsin actors' longstanding commitment to public health law modernization and participation in the Turning Point Collaborative. Although the Turning Point Collaborative benefited greatly from Wisconsin's participation, Wisconsin also benefited greatly from its participation in the Collaborative. Despite its relatively recent public health law reform effort in 1993, much had changed in technology and public health practice in the intervening ten years.²⁸ Wisconsin was

²⁸ A local health officer noted that "all kinds of things had happened on the medical, technical side, but the public health laws in Wisconsin were pretty antiquated in a lot of areas." As an example of this

ripe for a subsequent public health law modernization. The Turning Point Act proved to be the tool necessary to make that happen.

Through the Turning Point Collaborative, Wisconsin public health officials familiarized themselves over several years with the need for and process of public health law modernization. Working with the consultants of the Turning Point Collaborative, these public health officials became acquainted with the construction of statutory language and the means to effect change through law. Further, having participated in the Turning Point Collaborative and worked closely with its legal consultants, Wisconsin public health officials were able to speak informally with key national leaders in public health law in drafting the Wisconsin legislation, providing them with the scholarly foundation necessary to support comprehensive public health law reform.

The Turning Point Collaborative experience also helped to forge Wisconsin's leadership for change. Because WPHA took the lead in the Turning Point grant, it could work independent of the state bureaucracy, allowing it to move quickly in contributing to the Collaborative and incorporating Collaborative ideas in prospective Wisconsin legislation.²⁹ Although organizations like WALHDAB and the Wisconsin Environmental Health Association lacked the infrastructure to support such a grant, they could work easily with WPHA through the steering committee to push their ideas into the Turning Point Act and state legislation. With legislative resources perceived to be smaller than many other states, Wisconsin's drafters used the Turning Point Act and well-funded private organizations to provide carefully considered and tested language developed by public health officials from many states.

The Turning Point Act provided legitimacy to legislators' efforts to reform public health law. AB 881 appeared to represent the nation's "best practices" for public health, as carefully considered and derived by experts and policymakers throughout the country, rather than by local special interest groups. In aspects where some Wisconsin public health actors wanted to go beyond the language of the Turning Point Act in ways that the drafters of AB 881 felt would make the resulting bill "dead on arrival"—particularly on issues of public health financing and, as discussed below, environmental health—the Turning Point Act, having been considered over time by the larger number of actors in the Turning Point Collaborative, gave credibility to actors' insistence that the bill remain limited to those considerations included in the national model.

Still, many compromises were necessary to create viable Wisconsin legislation from the Turning Point Act. The Turning Point Act needed to be revised to conform with Wisconsin state laws, public health system, and practices. As noted by the Senior Staff Attorney for the Wisconsin Legislation Council, the Turning Point Act "was drafted to be looked at by all fifty states, not necessarily adopted lock, stock and barrel, but more to fill in the gaps in their public

change, she described advancements in DNA technology as necessitating public health law modernization.

²⁹ When pressed on the reasons underlying the freedom of WPHA relative to the state bureaucracy, a local health officer noted the example that (1) "there are a lot of rules that the division [Division of Public Health] has about lobbying," (2) "on the association side . . . they have much more flexibility with hiring staff," and (3) "just the openness of the discussions that can be had and how you can recruit people to be involved in the process . . . than on the government side where things are really hemmed in by either policies or dollars."

health statutes. And different states are at different levels.” In what was described as the “Wisconsinization” of the Turning Point Act, it was felt that a less expansive bill, eliminating any controversial provisions, could overcome legislative ignorance through committee hearings and guarantee passage on an issue that legislators did not understand well, sponsored by an organization that legislators did not know.³⁰ For example, based upon legislative resistance to mandatory vaccinations in the preliminary debate on the 2001 emergency health powers legislation,³¹ AB 881 would not use the words ‘vaccination’ or ‘quarantine’ to avoid their civil liberties implications. Further, even among those sections employed, the Wisconsin drafters of the AB 881 often pared down or went beyond the language of the Turning Point Act, believing that such changes would lead to fewer questions and concerns from legislators and better prepare public health actors to address the issues relevant to Wisconsin. Legislators have taken comfort in the broad legislative mandate for public health, believing that they have taken the best the Turning Point Act has to offer.

B. Partnerships for Public Health Law Modernization

Although the Turning Point Act gave actors the credibility of a national model, the consideration and adaptation of the Act by a wide range of the Wisconsin public health community improved the state specificity of the resulting legislation and gave that legislation the genuine appearance of organic development rather than the imposition of out-of-state actors or urban elites. The process of building support for public health law modernization happened over a four year period through the prolonged incorporation of a wide range of key actors.³² As noted by a member of the steering committee, “we certainly couldn’t adopt it [the Turning Point Act] full speed,” recognizing, based upon the deliberative development of the 1993 statutory reforms,³³ the need to build partnerships and consensus for statutory reform across a spectrum of state and local public health actors.³⁴ Thus, as noted by another steering committee member, “we didn’t wait for the statutes, the model statutes, to arrive in Wisconsin and then gather a group and inform them and try to sell them on it. We’re doing it concurrently over a several year period.”

³⁰ As to the latter issue, the lobbyist on this bill noted:

I can’t recall one time I ever heard anyone mention Wisconsin Public Health Association or WALHDAB. So it was a challenge for us because number one, we had to educate legislators on who we were, and what we were about. And then we had to talk to them about our legislative items in the Model Act. So what we wanted to do was have a non-controversial bill, that didn’t cost anything

³¹ To alleviate that debate, the emergency health powers legislation was altered from the Model State Emergency Health Powers Act to provide exceptions for reasons of religion or health or personal conviction. *See* Wisc. Act 109 (2002).

³² Despite the perceptions of the steering committee that there was a need to move judiciously in building support for public health law reform, several local health officials expressed frustration with the extended time necessary to get “buy in” from legislators in scheduling hearings and action from the Legislative Reference Bureau in drafting legislation.

³³ *See supra* note 9 and accompanying text.

³⁴ Based upon the complexity of the overlapping state and local public health officers in different geographic regions, a local health officer noted that “you have to get a lot of buy in to do almost anything because there are so many layers and so many people involved.”

Contributing partner meetings brought many additional partners into the process as early as possible, allowing public health actors from across the public health system to give prolonged consideration to the effect of the Turning Point Act on state law and public health practice and thus improve the content and feasibility of the resulting bill. As explained by a senior state public health official “if we introduce the bill, I think we would do a good job, but I don’t think it would be as complete a thinking as if you talk to the people who are potentially affected by the law.”³⁵ In addition to improving Wisconsin’s contributions to the national Turning Point Collaborative, these meetings created awareness of the Turning Point Act among state actors, providing the knowledge base and extended collaborative bonds necessary to create state legislation. Even at this early stage in its development, participants were considering both how to improve the national model in the Turning Point Act and how to translate the Turning Point Act into state legislation necessary to meet Wisconsin’s public health needs. In explaining the decision to bring together contributing partners early in the process, a local public health officer and key member of the steering committee explained:

We’re seeing what’s happening in the state. Let’s give the national group feedback in terms of what . . . this model thing should look at. But at the same time, let’s see what they’re working on to see how we can advance our public health statures here. So we had a similar group operating in Wisconsin on parallel tracks here to be able to take a model statute and then be primed and ready to advance them forward.

These early meetings allowed public health actors to resolve internal conflicts and coordinate responses prior to legislative action, building the “grassroots effort” necessary to sway recalcitrant legislators.³⁶ In these preliminary conversations, legislators and legislative representatives were able to voice concerns over the ability of certain proposals to find support within the state assembly. As explained by the lobbyist for the bill, “we spent a lot more time educating and talking to legislators [in the years leading up to the bill], and once we were ready to roll with this thing, there just were no roadblocks.” When it came time to “unveil” the Turning Point Act at the Wisconsin Public Health Law Conference, it was more announcement than discussion. There was no need for further consideration of the advisability of modernizing public health law in Wisconsin.³⁷ (It should be noted that at no point did the Conference organizers seek out critics of public health or the Turning Point Act, with one steering committee member noting dryly that “basically, it was the choir invited.”) The subsequent retreat—at which participants decided which articles of the Turning Point Act to incorporate in state legislation—served largely to formally reestablish consensus that had already been reached

³⁵ When pressed for actors who were not included in the process, informants discussed the “faith community,” social service agencies, and corporations.

³⁶ The lobbyist for the effort recognized the importance of bringing these activists together, attributing success to: “Grassroots, grassroots, grassroots, grassroots. Strong grassroots effort. Get members to make phone calls. Meet with legislators. Email them to send letters supporting the bill. That is so key.”

³⁷ As the organizer described the purpose of the Conference, it involved the steering committee stating to legislators: “Here it is. What do you think? You know, we need your support.” However, despite an effort to invite all of the state legislators to the Conference, outside of the Chair of the Committee on Public Health, only select legislative assistants attended.

informally during the contributing partner meetings. When the bill reached the legislature, legislators, who had neither the time nor inclination to consider so complicated a bill, were able to rely on the authors and sponsors, knowing that they had invested the effort to assure its success through its complexity.

Even where there were disagreements, early enlistment in the process allowed coordinating actors to gather commitments of support from those actors who took part in the meeting process. One major point of disagreement, both during the development of the Turning Point Act and following its release, was the segregation of environmental health from public health. As a prominent member of the steering committee noted, “in Wisconsin, we are always struggling to remind ourselves and everybody else that environmental health is public health,” and members of the Wisconsin Environment Health Association had pushed for its inclusion throughout the process. Many participants in the contributing partner meetings felt that environmental health regulations, in particular “human health hazards” (e.g., occupational health, drinking water, housing), had been relegated into obscurity through the Turning Point Collaborative.³⁸ Despite this concern, the Chair of the Assembly Committee on Public Health, the major legislative proponent of AB 881, told the contributing partners bluntly “leave the human health hazards piece out [and] you can get your model act law stuff passed,”³⁹ promising the Chair of the Division of Environmental Health and President of the Wisconsin Environmental Health Association that he would, if re-elected, separately introduce this environmental health piece (based upon draft language prepared by a sub-group at the strategic planning retreat) in the upcoming legislative session.⁴⁰ Despite this exclusion of environmental health from the bill, the process of bringing environmental health actors into the preliminary discussions ensured consensus in the final bill and prevented excluded parties from attempting to add amendments in legislative hearings on AB 881, amendments that many actors believe would have derailed the comprehensive bill.⁴¹ With the diverse connections of partners brought together to support AB 881, many actors have developed lasting relationships across disciplines

³⁸ An environmental health partner complained that “I’ll be honest with you, that bothered me significantly. . . . [T]here was a major gap, if you will, in the quote, unquote model statutes and that was environmental health. And I remember one of the national speakers [at the Public Health Law Conference] who admitted that and said ‘Well, that might be a project further down the road.’”

³⁹ This was based on advice to the Chair of the Assembly Committee on Public Health from the lobbyist, who believed that, given the propensities of the Republican legislature, he “didn’t want anything in that bill that would be controversial and that would scare them [legislators] away from doing anything.”

⁴⁰ The Chair of the Assembly Committee on Public Health was reelected, and, subsequent to the initial publication of this case study, has introduced this bill on environment health issues, AB 483, on August 9, 2007.

⁴¹ As a steering committee member explained in regard to this issue, “you have all your stakeholders at the table so when you actually roll out your stature in draft, you don’t have your environmental health people saying ‘Oh, wait a minute. We don’t like this. We didn’t have any say in the matter.’ Well, they were at the table, see. They had representation there.” At the end of the discussion, even the environmental health representatives agreed that a human health hazards component could be a “lightning rod” that would, given the legislature’s aversion to environmental regulation, derail AB 881 and possibly lead to “statutory backsliding” in agency authority for environmental health.

and expect that many of the same partners (even those partners far removed from environmental regulation) will come together again to support this forthcoming environmental bill.⁴²

Several key partners stand out as vital to the success of the public health law reform effort. The primary partner, as mentioned in the description of the events, was the Chair of the Assembly Committee on Public Health. As noted by the project coordinator for WPHA, “it’s a treasure to have somebody who is interested in public health.”⁴³ Although he did not have any background in public health, many actors attributed the legislator’s predilection to public health from his background as a veterinarian, examining public health in humans the way he had examined bovine ailments infecting entire herds of cattle.⁴⁴ As the Chair of the Assembly Committee on Public Health, he, like many other key legislators, was invited by the steering committee to the collaborating partners’ meetings “so they feel they’re part of developing the process so then they can, in turn, be our advocates when we want to move it into the legislator’s area.” He attended the contributing partners meetings, viewing them, as explained by a former aide, as a “chance to learn more about what our current laws were, like what was actually on the books, and then to kind of hear from the players in public health about what you know what needs to be there, what they’re lacking to do their job.” While he had previously been supportive of specific revisions to public health laws in the Assembly Committee on Public Health, this was his first opportunity to sponsor a comprehensive revision of the public health enabling statutes. Despite his personal and professional interest in and commitment to public health law reform, he expressed no independent preference for laws concerning public health authority, giving freedom to the public health partners in deciding what would be in the bill while allowing them to retain the security of knowing that the resulting bill would have the Chair’s full support.

The Chair “was really excited about giving them [the public health community] what they needed,” and with public health credibility and political clout, he had the political capital necessary to advance these ideas into law. Having a bill introduced by the Chair of the Assembly Committee on Public Health, a legislator trusted and respected by his fellow legislators in health matters, changed the legislative calculus in supporting public health modernization, with many legislators, largely ignorant of public health issues,⁴⁵ simply deferring to the Chair’s expertise and judgment in matters of public health.⁴⁶ Although the majority

⁴² To this end, the Joint Public Affairs Committee of WPHA and WALHDAB has already had several post-AB 881 meetings with the Wisconsin Environmental Health Association to coordinate activities on this proposed bill.

⁴³ In recognition of his support, WPHA issued the Chair of the Assembly Committee on Public Health the 2005 “Legislator of the Year Award.”

⁴⁴ As his former aide noted best, “[b]eing a veterinarian, he understands a lot about the various diseases that are coming to the forefront and how will that affect public health, and [he] understood the importance of making sure we’re keeping up-to-date with how to handle emergencies.”

⁴⁵ In describing the declining public health literacy of legislators (outside of the Chair of the Assembly Committee on Public Health), a state public health official commented “I don’t think our legislators understand public health at all. . . . I see them more in a reactive way.”

⁴⁶ Commenting on the personal strengths of the Chair of the Assembly Committee on Public Health in shepherding the AB 881, a co-Chair of the Joint Public Affairs Committee commented that “the members of the legislature really respect the authors and the sponsors of the bill and that carried quite a ways, and

Republican party had never previously expressed any interest in public health reform, widely considered a “democratic issue,” having the bill advanced by a prominent conservative Republican provided little reason or opportunity for either Democratic or Republican legislators to oppose the bill, which the Chair marketed to the legislature simply as a non-controversial way to “clean up to public health laws.” This *pro forma* characterization of the bill and expeditious scheduling⁴⁷ stifled opposition, allowing AB 881 to pass unanimously in the Republican-led legislature and to be signed without any opposition by the Democratic Governor, a rare event in what was viewed as a highly divisive Wisconsin political climate.⁴⁸

A second partner, the Joint Public Affairs Committee of WPHA and WALHDAB, came to this process long after it had begun but was able to work with its lobbyist to finalize the work set in motion by others, pushing AB 881 through the legislature. WPHA and WALHDAB have long been the staunchest and most institutionalized members of the public health system in Wisconsin, meeting annually with the Department of Health and Family Services to chart joint priorities and lobbying often in political areas where the Department is statutorily prohibited from acting.⁴⁹ In considering AB 881, it became clear to WPHA that it could pool financial resources and develop a unified voice for public health law reform by joining forces with WALHDAB.⁵⁰ Often acting through its paid lobbyist, the Joint Public Affairs Committee (as a representative of WPHA and WALHDAB) was able to provide legislative visibility for its constituent organizations, draft talking points, organize legislative testimony, and coordinate a

as a result, there was unanimous support . . . Again, people really trusted this. . . . [T]hey really deferred quite a bit to their colleagues who had worked for months and years on this bill.”

⁴⁷ As one steering committee member explained the scheduling, “it was a short-term time frame for the hearing notice. . . . That being the case, you know [that] even if there was organized resistance, you know they didn’t really have a chance to organize.”

⁴⁸ As one senior political aide noted, “the fact that it passed on a voice vote without even having anybody having to press a button was a good thing.” This was furthered by another senior political aide, who recognized that “it’s a pretty contentious legislature. I mean, there’s a lot of people who just want to argue to argue. There’s silly things. So for them to let this go was . . . wonderful.”

⁴⁹ A local health officer noted WPHA’s strong support for the Department (“WPHA was the biggest, staunchest, right by your side supporter that we had”) and the Department’s strong support for WPHA (“they [Department officials] were like cheerleaders for WPHA . . . because it [statutory reform] was something that if they could have done it, they would have done it and they would have loved to have done it, but they couldn’t.”). For example, employees from the Department of Health and Family Services are prohibited from speaking to legislators without first gaining the written approval from their superiors and subsequently completing extensive paperwork outlining the details of the conversation. Even within the Department, members of the Division of Public Health have found that the higher levels of the Department of Health and Family Services respond more favorable to those working on the outside (i.e., local health officers and independent organizations) than to those working within the Department itself.

⁵⁰ As explained by a co-chair of the Joint Public Affairs Committee and WPHA member, “we thought it was kind of stupid basically to have two organizations out there talking about these sorts of issues. Why didn’t we join forces and become a larger voice for public health in the state.” At this point in the interview, the other co-chair of the Committee added that “there was a mutual interest among both organizations to contract with a lobbyist and . . . by combining resources, we were able to purchase more time.”

unified public health message on AB 881.⁵¹ Although public health organizations in other states have eschewed professional lobbyists, the Joint Public Affairs Committee benefited from lobbyist involvement,⁵² particularly where state and local health officials could not explicitly support this bill themselves. When meeting individually with legislators (focusing on committee chairs, relevant committee members, and key aides), the lobbyist was able to draw upon legislator's fears of terrorism and infectious disease outbreaks (what he referred to as the "disease du jour . . . that's always in the newspapers"), knowing that such fears would be an effective tool in advancing the bill,⁵³ and answer the questions that most concern legislators: "why do we need it and how will it benefit us?"⁵⁴ Because he could "open doors," his services were vital to explaining the bill to legislators. As explained by a senior legislative aide, "when you have someone who is working for you on your behalf that can be down here and meeting with legislators and meetings and things like that, it gets you set up through the process; it makes a huge difference." In marshaling the public health expertise underlying the bill, the lobbyist served not only the Joint Public Affairs Committee but also the Chair of the Assembly Committee on Public Health, the Department of Health and Family Services, and other proponents who needed to keep track of the progress of AB 881. Through this coordination, he was able to bring together these groups for consultations during the drafting of the bill and its progression through the legislature, avoiding pitfalls in the legislative language; selecting appropriate witnesses, polishing their testimony, and preparing them for hearings; and assuring that the Joint Public Affairs Committee would meet its goal of enacting modern public health law reform.

⁵¹ As part of this coordinated message, the Joint Public Affairs Committee arranged to have supporters attend the hearings as a way of showing support and inflating the importance of the issue.

⁵² It should be noted that the lobbyist, a former state legislative aide, succeeded despite a lack of training in public health or any experience working on health issues. Based upon his legislative expertise, a co-Chair of the Joint Public Affairs Committee noted that "A lobbyist is able that see all the folks on the wheel [pharmacy society, funeral home directors, etc.] and make sure the right contacts are made. You know, we're experts within public health; we're not experts within the legislative process. Similarly, [the lobbyist] is an expert in the legislative process but not in public health, so I really think we had the right mix of people with different expertise working together and coordinated well to make this happen." In this capacity, the lobbyist saw his role "simply to get the bill passed. . . . To get it introduced, educate legislators, and get it passed."

⁵³ In creating a "hook" to stoke legislators' fears, the lobbyist noted

What I latched onto was at this time bird flue was an issue, SARS was an issue, you know E. coli obviously has been an issue and is today. So I kind of went over to the legislature, and I talked to various key legislators: "Hey, this bill would improve the public health system. It would improve communication and collaboration between different layers of government, and it would be the first line of defense against communicable diseases and event terrorism, you know, bioterrorism."

⁵⁴ In understanding the "benefit" of the bill, the lobbyist explained that he told legislators "how they could, you know, forgive me for being crass, spin it back home as something very positive—protecting the public."

A final partner necessary for public health law reform was the Department of Health and Family Services, whose opposition could have stymied the bill.⁵⁵ Although the Department had not taken an active role in the development of AB 881, deferring to WPHA in drafting and lobbying for law reform, it nevertheless had stayed actively involved. Many individuals within the Department are concurrently members of WPHA (in their private capacity), which kept them apprised of the process of translating the Turning Point Act into state legislation. As technical questions arose, select members of the Division of Public Health would answer questions informally from the Chair of the Assembly Committee on Public Health, providing him with assessments and prioritizations of the needs of the Department of Health and Family Services.⁵⁶ Despite this extended, if tangential, involvement in translating the Turning Point Act into state law, the Department of Health and Family Services, in its official capacity as an executive agency, surprised many actors with several eleventh hour additions to AB 881, some after the introduction of the bill (one minor addition to which was approved as a “friendly amendment”). Many of these additions were for miscellaneous items outside the scope of the Turning Point Act, reflecting a desire of the Department to address all its minor legislative needs in the context of a comprehensive bill that was viewed as likely to become law.⁵⁷ However, with “no one managing the process” within the Department and its hierarchy leading to several “bureaucratic hoops to get something approved” at the last minute, it became necessary to have a second, “trailer” bill (a bill which is drafted but has yet to be introduced) to meet the Department’s needs.⁵⁸ Although these communication problems within the Department caused consternation among actors just prior to and following the introduction of AB 881, many actors took comfort in the Department’s decision not to hold up the first bill based upon its concerns, presenting a “unified front.” In the end, as noted by a steering committee member, “they [the Department] just had a couple concerns, but they didn’t oppose it [AB 881]. They came out saying this is good work.”

⁵⁵ As a counterfactual to this experience, a steering committee member shared the experience of public health law reform in the 1980s, whereupon “the public health organizations got together and were putting drafts together, and at the same time the state of Wisconsin was working on its own version. Then they clashed. It was really ugly, and the whole process crashed and burned.”

⁵⁶ Informants from the Division of Public Health repeatedly and emphatically framed this involvement as permissible legislator educational rather than legally proscribed lobbying. As described by one member of the Division of Public Health, “I think the division provided input on what made sense or what’s really happening . . . to make sure that it [the bill] was reflecting reality.”

⁵⁷ Among other desires, the Department of Health and Family Services hoped to include in AB 881 separate chapters on Emergency Medical Services, physician indemnification, and, as discussed above, the authority of health officers to abate human health hazards.

⁵⁸ In this contentious setting, many of the compromises were reached by understandings between the lobbyist for the Joint Public Affairs Committee and the Legislative Liaison for the Department of Health and Family Services. Although the second bill was drafted by the Legislative Council’s Office, its preparation was not finalized until April 2006, at which point it was felt to be too late in the legislative session for the second bill to advance through the legislature. It is widely expected that this second, similarly non-controversial bill will be introduced and pass through the legislature during the current session.

C. Gap Analysis

A gap analysis was crucial in drafting state legislation based on the Turning Point Act and highlighting the need for that legislation. As soon as the Turning Point Act was released, the Chair of the Assembly Committee on Public Health requested that the Wisconsin Legislative Council draft a “comparison memo” to compare each section of Wisconsin law to the Act. As described by the Senior Staff Attorney for the Wisconsin Legislative Council, each section of the gap analysis would state (1) the language of the Turning Point Act, (2) the then-current language of Wisconsin law, and (3) options for amending Wisconsin law in greater conformity with the Turning Point Act. For those considering the legal authority of the public health system for the first time, this gap analysis was “a good starting point for the discussion.” It was widely distributed following its positive reception at the Wisconsin Public Health Law Conference and aided many actors in preparing for the strategic planning retreat.

Given legislators’ engagement with public health necessity following the anthrax attacks of 2001 and the topicality of emerging diseases,⁵⁹ there existed a newfound imperative to resolve any memorialized weaknesses in the state’s public health authority. As noted by the Senior Staff Attorney in describing the benefits of a gap analysis, “I think somebody needs to say, ‘Here’s the Model Act. Here’s what we got on the books. Here’s the difference.’” Although he insisted that the gap analysis could have been drafted by any person within or outside the state,⁶⁰ the Senior Staff Attorney has gained widespread credibility among legislators through his decades of service, and many actors accepted the gap analysis of the Wisconsin Legislative Council as an imprimatur of legislative want.

This gap analysis enabled those who took part in the Turning Point Collaborative to focus on deciding which articles and passages of the Turning Point Act were most crucial for the Wisconsin public health system, balancing those considerations against their political feasibility. Based on this balancing, the participants at the strategic planning retreat eliminated all provisions dealing with quarantine issues because, as noted by a political actor, “we felt that what we had was strong enough [according to the gap analysis] and just putting the word ‘quarantine’ in anything was going to get people riled up.”⁶¹

⁵⁹ Noting this upsurge in interest in public health, a local public health officer argued that:

They [legislators] wouldn’t even care as much about it [public health law reform] now as they do except for 9/11. It just happens to be a better time for this now. . . . And the other thing is that we have some emerging disease issues that seem to make people more aware, especially the legislators, that these are things that their constituents are interested in. Whereas before 9/11 and before West Nile Virus and before the Anthrax Scares over at the buildings and before some of those things, it was like “eh, like who cares?”

⁶⁰ The Senior Staff Attorney argued that “I think it helped people to look at all you’ve got now on the books, and it didn’t necessarily have to be done by me. It could have been done by the public health community. . . . I think James [Hodge] could have done it.”

⁶¹ This characterization of the political response to quarantine provisions stemmed from public health actors’ experiences in committee hearings dealing with the Model State Emergency Health Powers Act.

Even with the gap analysis, reproduced in the Appendix to this report, there were fears that objections would be raised during the hearings to various bases of AB 881. Like other states that have considered the Turning Point Act, 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 and attestation of fiscal neutrality in the bills language.⁶² Although these fears were never realized and no advocacy groups lobbied or testified against the bill, actors within and outside the legislature felt that their advanced preparation would obviate the need for any major amendments to the language of the bill. Whereas proponents had prepared to use the Legislative Council's gap analysis in committee hearings, this never became necessary.

Conclusion

The Wisconsin process of translating the Turning Point Act into state legislation has been a model of beneficial organization, 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. This public health law reform bill would not have been possible without the passionate and unwavering efforts of actors throughout the public health community, recognizing the importance of Turning Point Act and coming together to advocate for its inclusion in law in the state of Wisconsin. Through their longstanding grassroots dedication to public health law reform, the current modernization effort was characterized by overwhelming support from almost all sectors of the public health system.

The bill has thus far been a success for the Wisconsin public health system, providing renewed confidence among public health actors as they currently amend their administrative rules to confront future, unknown risks and needs. Much like the earlier 1993 reform, the current modernization effort has improved the legislative climate in ways that will ease future reform efforts. As noted by one of the original steering committee members, "if noting else, it [AB 881] established such goodwill, and we've had such a good success with this. . . . [T]he fact that we had this success I think speaks well for pushing future public health legislation through. We've got the right people interested, the right partners, the right support." Given the positive experiences of the public health community in improving the system through law reform, many are prepared to use the law in confronting the public health challenges that lie ahead.

⁶² With reference to the latter concern, one of the steering committee members noted that "[e]ven at the Public Affairs Committee [of WPHA] there was constant discussion about "is this really fiscally neutral and . . . is there gonna be opposition? Are there going to be questions at the wrong time about what this might cost a local health department? And that never happened, but that was an issue that I think was at the forefront of most people's mind. It did go through as fiscal neutral, but there were concerns from the locals' perspective that something in here might end up causing them to have to enact something financially." Although the Department of Health and Family Services had requested that the costs of quarantine be included in the bill, this measure, which would have upset the cost-neutrality of the bill, was refused as an amendment by the Chair of the Committee on Public Health.

Appendix: Gap Analysis

WISCONSIN LEGISLATIVE COUNCIL

TO: [Chair of the Assembly Committee on Public Health]
FROM: [Senior Staff Attorney]
RE: Comparison of the Model State Public Health Act and Wisconsin Laws
DATE: December 2, 2003

This memorandum summarizes provisions of the Model State Public Health Act and compares them with provisions in Wisconsin statutes and administrative rules. The Model Act, dated August 20, 2003, was prepared by the Public Health Statute Modernization Collaborative, which is part of the Turning Point Initiative funded by the Robert Wood Johnson Foundation.

The Model Act consists of the following nine articles:

Article I. Purposes and definitions.

Article II. Mission and functions.

Article III. Public health infrastructure.

Article IV. Collaboration and relationships with public and private sector partners.

Article V. Public health authorities/powers.

Article VI. Public health emergencies.

Article VII. Public health information privacy.

Article VIII. Administrative procedures, civil and criminal enforcement, and immunities.

Article IX. Miscellaneous provisions.

In reviewing the Model Act, there were several nonsubstantive provisions, such as statements of legislative purposes, mission statements, and goals. These types of provisions are generally not included in Wisconsin statutes. Rather, the statutes generally include powers (discretionary authority that is conferred by the use of the word “may”), duties (mandatory actions that are required through the use of the word “shall”), and prohibitions (actions that are prohibited by the use of the words “may not”). The Wisconsin Legislative Reference Bureau generally does not include nonsubstantive provisions such as legislative purpose statements in bill drafts for a variety of reasons, including possible misconstruing of those provisions by a court and possible inconsistencies between statements of purpose and substantive provisions.

As a general comment, although the Model Act describes a number of powers and duties for the state Department of Health and Family Services (DHFS) and local health departments, it does not identify a source of funding for those activities. Persons reviewing the Model Act and considering incorporating certain of its provisions that confer powers or impose duties that have a fiscal effect for state or local government may wish to consider indicating the funding source for those activities.

By way of background, there were two legislative enactments in the past decade that made major changes in the state's public health statutes. Those enactments were as follows:

- 1993 Wisconsin Act 27. This Act moved all of the state's public health statutes from various locations in the statutes to one set of chapters dealing with public health—chs. 250 to 255, Stats. In addition, the Act updated statutory language to reflect current terminology and practice and specified levels of local health departments. The current public health statutes, with the changes made by 1993 Wisconsin Act 27, are organized into chs. 250 (health; administration and supervision); 251 (local health officials); 252 (communicable diseases); 253 (maternal and child health); 254 (environmental health); and 255 (chronic disease and injuries).
- 2001 Wisconsin Act 109. This Act was the 2002 Budget Adjustment Act and included various provisions related to the identification of public health emergencies and actions to be taken during declared public health emergencies. To some extent, the public health emergency provisions in Act 109 were based on the Model State Emergency Health Powers Act. That Model Act was prepared by the Center for Law and the Public's Health at Johns Hopkins and Georgetown Universities. It was prepared for the federal Centers for Disease Control and Prevention (CDC). Some of the provisions of the State Emergency Health Powers Model Act were already in Wisconsin law and other provisions of that Act were not included in Act 109. In addition, some of the provisions of Act 109 did not derive from that Model Act.

Act 109 provisions relating to public health emergencies included those relating to veterinary reporting, health care provider reporting, pharmacist reporting, coroner/medical examiner reporting, a biennial report on preparedness, declarations of public health emergencies, suspension of rules during public health emergencies, the State Laboratory of Hygiene, general DHFS powers and duties during a public health emergency, vaccination and quarantine, disposal of human remains, and hospital staff privileges during public health emergencies.

Article I. Purposes and Definitions

Model Act

Article I of the Model Act has two sections, one which states the legislative purposes of the Act and the other which defines terms used in the Act.

The statement of legislative purpose lists 15 purposes of the Act, which are then described in greater detail in the other articles of the Act. For example, one of the legislative purposes is developing and providing effective training and credentialing for members of the public health workforce; this purpose is addressed in substantive provisions in Article III. Another legislative purpose is addressing privacy and security issues arising from the acquisition, use, disclosure, and storage of identifiable health information by state and local public health agencies; this purpose is addressed in substantive provisions in Article VII.

Wisconsin Law

Wisconsin's public health statutes do not include a statement of legislative purpose.

A number of the definitions included in the Model Act are included in Wisconsin statutes. For example, Wisconsin statutes define the terms "bioterrorism," "health care facility," and "health care provider."

Discussion

As indicated earlier in the memorandum, Wisconsin statutes generally do not contain statements of legislative purpose. There are many reasons for this, including the possibility that a statement of legislative purpose may conflict with the substantive provision to which it relates, by one being amended without the other being amended, either in the legislation creating the provisions or in subsequent legislation. A statement of legislative purpose might be construed by courts in ways not intended by the author of the legislation. For these and other reasons, the Wisconsin Legislative Reference Bureau generally does not draft statements of legislative purpose. Rather, legislative purposes are addressed in substantive provisions of the law through establishment of powers, duties, or prohibitions.

The definitions included in Article I of the Model Act should not be reviewed independently of the substantive provisions to which they apply. If a person wishes to include in Wisconsin statutes a portion of the Model Act, and terms used in the provisions are not defined in current law and are in need of definition, the definitions used in the Model Act might be a good beginning point for determining how to define the terms.

Article II. Mission and Functions

Model Act

Article II of the Model Act begins with a mission statement that states that “(i)t is the policy of the state that the health of the public be protected and promoted to the greatest extent possible through the public health system while respecting individual rights to dignity, health information privacy, nondiscrimination, due process, and other legally-protected interests.” The mission of state and local public health agencies is to provide leadership and protect and promote the public’s health by: (1) assuring the conditions in which people can be healthy; (2) providing or assuring the provision of essential public health services and functions that are culturally and linguistically appropriate; (3) encouraging collaboration among public and private sector partners; and (4) seeking adequate funding and other sources to provide essential public health services and functions.

The mission statement states that the Act is not to be construed to require an individual or agency within the public health system to provide specific services or to mandate state or local public health agencies to implement unfunded programs.

The term “essential public health services and functions” is defined to include 10 items. While state and local governments are responsible for assuring that the public health system accomplishes the mission of public health, agencies may actively collaborate with public and private sector partners. All persons within the public health system are required to accomplish the mission of public health while respecting individual rights including: (1) respect for the dignity of each individual; (2) protection of health information privacy; (3) provision of adequate due process; and (4) avoidance of explicit or implicit discrimination.

Article II goes on to list 12 general public health powers of state and local public health agencies. These include services or functions to do the following: (1) utilize a broad range of flexible powers to protect and promote the public’s health; (2) provide public health information programs or messages to the public; (3) promote efforts among public and private sector partners to develop and fund programs or initiatives that identify and ameliorate health problems; (4) conduct, fund, provide, or endorse performance management standards for the system; (5) develop and provide certification, credentialing, or effective training for members of the public health workforce; (6) develop, adopt, and implement public health plans through administrative regulations, formal policies, or collaborative recommendations; (7) establish formal or informal relationships with public or private sector partners within the system; (8) enforce existing laws and rules and propose new laws, amendments to existing laws, or regulations to protect the public’s health; (9) identify, assess, prevent, and ameliorate conditions of public health importance through several specified means; (10) promote the availability and accessibility of quality health care services through health care facilities or providers; (11) promote availability of and access to preventive and primary health care when not otherwise available, including several specified services; and (12) systematically and regularly review the public health system to recommend modifications.

Wisconsin Law

Section 250.03, Stats., is entitled “Public health system”; sub. (1) of that section states general public health duties of DHFS as follows:

250.03 Public health system. (1) The department shall:

- (a) Maintain a public health system in cooperation with local health departments; community organizations; and medical clinics that are operated by the governing bodies, or agencies of the governing bodies, of federally recognized American Indian tribes or bands located in this state.
- (b) Serve as the state lead agency for public health.
- (c) Assess the health needs in the state based on statewide data collection.
- (d) Advise the legislature on the development of an adequate statutory base for health activities in the state.
- (e) Establish statewide health objectives and delegate power to local health departments to achieve the objectives as the department considers appropriate.
- (f) Support local public health service capacity building through grants, consultation and technical assistance.
- (g) Develop policy and provide leadership in public health throughout the state that fosters local involvement and commitment, that emphasizes public health needs and that advocates for equitable distribution of public health resources and complementary private activities commensurate with public health needs.
- (h) Distribute state and federal public health funds under its control in a manner that will promote the development and maintenance of an integrated system of community health services.
- (i) Require, as a condition for distributing funds under par. (h) at the local level, that services at that level be coordinated.
- (j) Advocate for the provision of reasonable and necessary public health services.

In addition, s. 250.03 (2), Stats., allows DHFS to enter into agreements and provide consultation on matters related to human health. Section 250.03 (3), Stats., relates to the authority of DHFS during a declared public health emergency in which DHFS is designated by the Governor as the lead state agency to respond to that emergency. (This will be discussed further under Article VI.)

Additional broad powers and duties of DHFS are set forth in s. 250.04, Stats. For example, sub. (1) of that section states as follows:

250.04 (1) The department has general supervision throughout the state of the health of citizens and shall study especially the vital statistics of the state and use the analysis of the vital statistics for health planning. The department may, upon due notice, enter upon and inspect private property. The department has power to execute what is reasonable and necessary for the prevention and suppression of disease. The department may or, if required, shall advise public boards or officers in regard to heating and ventilation of any public building or institution. The department may investigate the cause and circumstances of any special or unusual disease or mortality or inspect any public building and may do any act necessary for the investigation.

In addition, sub. (2) states that DHFS possesses all powers necessary to fulfill the duties prescribed in the statutes and to bring action in the courts for the enforcement of public health statutes and rules. If local health departments fail to enforce those statutes or rules, DHFS may enforce them and the municipality for which the local health department has jurisdiction is required to reimburse DHFS for expenses that it incurs in enforcing communicable disease statutes and rules.

Additional duties of DHFS include the requirement to establish and maintain surveillance activities sufficient to detect any occurrence of acute, communicable, or chronic diseases, and threat of occupational or environmental hazards, injuries or changes in the health of mothers or children. DHFS is further required to administer programs for the control and prevention of public health problems.

Powers and duties of local health officials are set forth in ch. 251, Stats. Those include powers and duties of local health departments, local boards of health, and local health officers.

Local boards of health are required to: (1) assess public health needs and advocate for the provision of reasonable and necessary public health services; (2) develop policy and provide leadership that fosters local involvement and commitment, that emphasizes public health needs, and that advocates for equitable distribution of public health resources and complementary private activities commensurate with public health needs; and (3) assure that measures are taken to provide an environment in which individuals can be healthy. [s. 251.04 (6) and (7), Stats.]

Local health departments are required to provide at least surveillance, investigation, control and prevention of communicable diseases, other disease prevention, health promotion, and human health hazard control in order to be a level I local health department, and may provide additional specified services in order to be a level II or level III local health department. Statutorily prescribed duties of local health departments are the following: (1) regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems; (2) develop public health policies and procedures for the community; (3) involve key policymakers and the general public in determining a set of high priority public health services and assure access to those services to every member of the community; (4) submit data, as requested, to the local public health data system established by DHFS; and (5) act as the agent of DHFS in public health emergencies if designated by the Secretary of DHFS. [s. 251.05 (3), Stats.]

Duties of a local health officer are set forth in s. 251.06 (3), Stats., which requires a local health officer to do all of the following: (1) administer the local health department in accordance with state statutes and rules; (2) enforce state public health statutes and rules; (3) enforce any regulations that the local board of health adopts and any ordinances that the relevant governing body enacts, if consistent with state public health statutes and rules; (4) administer all funds received by the local health department for public health programs; (5) appoint all necessary subordinate personnel, assure that they meet appropriate qualifications, and have supervisory power over them; (6) investigate and supervise the sanitary condition of all premises within the jurisdictional area of the local health department; (7) have access to vital records and vital statistics from the Register of Deeds; (8) have charge of the local department and perform the duties prescribed by the local board of health; and (9) promote the spread of information as to the causes, nature and prevention of prevalent diseases, and the preservation and improvement of health.

In addition to general powers and duties set forth for DHFS in ch. 250, Stats., and for local health officials in ch. 251, Stats., DHFS and local health officials have specific powers and duties that are spread throughout the chapters dealing with public health. For example, specific powers and duties relating to communicable diseases are set forth in s. 252.02, Stats., for DHFS, and in s. 252.03, Stats., for local health officers. As an example of the board powers of DHFS, s. 252.02 (6), Stats., states that DHFS “. . . may authorize and implement all emergency measures necessary to control communicable diseases.” Similarly, powers and duties of DHFS with regard to maternal and child health are set forth in s. 253.02, Stats.

Discussion

In general, it appears that DHFS and local health boards, departments, and officers in Wisconsin have broader and more specific powers and duties than those specified in the Model Act. This seems to be the case with regard both to across-the-board powers and duties that apply generally to public health and with regard to specific public health activities.

Article III. Public Health Infrastructure

Model Act

Article III of the Model Act sets forth seven goals to be accomplished by the coordinated efforts of state and local public health agencies and their public and private sector partners within the public health system.

The Model Act allows the state public health agency to adopt and administer public health workforce certification or credentialing programs for members of the public health workforce, consistent with any national system of certification or credentialing. In addition, the state public health agency is authorized to directly, or in conjunction with educational institutions or others within the public health system, make available or assure effective programs, continuing education, or other tools for training public health agents and others within the public health workforce.

The state public health agency is given the authority to manage performance related to public health infrastructure and capacity, processes, and outcomes at the state and local levels. In consultation with others, the state public health agency is authorized to seek to establish and implement performance standards, measures, and processes for quality or performance improvement that are accessible, affordable, and nonpunitive. The state public health agency is also authorized to participate in a voluntary national accreditation program for public health agencies and to develop a voluntary accreditation program for local public health agencies or public or private sector partners.

The state public health agency is also authorized to set incentives to meet public health workforce, performance management, or accreditation standards or goals, including organizational accountability awards, recognition for public health agencies or their contractors or volunteers, and other development initiatives, including financial benefits.

The Model Act states that to promote the provision of essential public health services and functions, the state public health agency must assure the development of a comprehensive, statewide public health plan that assesses and sets priorities for the public health system. The plan must be developed in consultation with the public health advisory council, described below, and other representatives from public and private sector partners within the system. The plan must assess and set priorities for the statewide public health system and must do all of the following: (1) guide the public health system in targeting essential public health services and functions through program development, implementation, and evaluation; (2) strive to increase the efficiency and effectiveness of the public health system; (3) identify areas needing greater resource allocation to provide essential public health services and functions; and (4) incorporate goals and priorities of public health plans developed by local public health agencies. In addition, the Act specifies 15 elements that must be included or addressed in the comprehensive public health plan. The state public health agency is required to make the comprehensive public health plan available to the Governor, the Legislature, local public health agencies, and other public and private sector partners.

The Model Act also authorizes local public health agencies to prepare a local health plan that is consistent with the state comprehensive public health plan. The state public health agency is required to encourage and provide technical assistance to local public health agencies that request assistance to generate the plan.

The Model Act authorizes the creation of a public health advisory council to serve as an advisory body to the state public health agency and the Governor on all matters related to the public health system, including the development of the comprehensive public health plan. Members are appointed by the Governor, in consultation with state and local public health agencies or others within the public health system, and are subject to legislative approval.

Wisconsin Law

With regard to credentialing of persons in the public health workforce, most health care professionals are credentialed by examining boards or affiliated credentialing boards in the Department of Regulation and Licensing, such as the Medical Examining Board and the Board of Nursing. DHFS does provide credentialing for emergency medical technicians and first responders. Qualifications for local health officers are set forth in the statutes.

In addition, the statutes require DHFS to register sanitarians and public health nurses. [ss. 250.05 and 250.06, Stats.] The statutes allow DHFS to establish minimum standards and qualifications for the registration of sanitarians and require that qualifications of public health nurses be prescribed by rules promulgated by DHFS. Under the statutes, all public health nurses must be registered nurses. Licensed practical nurses may be employed by local health departments under the supervision of a public health nurse.

Qualifications for public health sanitarians have been established by DHFS in s. HFS 139.06 and ch. HFS 160, Wis. Adm. Code. Requirements for credentialing of public health nurses are set forth in s. HFS 139.08, Wis. Adm. Code. In addition, DHFS by rule has established requirements for directors of environmental health programs and directors of public health nursing programs. [ss. HFS 139.07 and 139.09, Wis. Adm. Code, respectively.]

On the issue of accreditation of local departments, DHFS does not accredit those departments, but the statutes do provide three levels of service at which local departments may be established, with level III providing the most services.

Wisconsin statutes reference a state public health agenda. Under s. 250.07 (1), Stats., at least once every 10 years, DHFS is required to develop a successor document to *Healthier People in Wisconsin, a Public Health Agenda for the Year 2000*, which was published by the department in February 1990. The statutes also reference this public health agenda in requiring additional services for a local health department to be a level II or III local health department. Under s. 251.20 (2) and (3), Stats., DHFS is required to promulgate rules that specify required services for each level, including additional required services for level II that address at least one of the objectives from each section of the public health agenda published in February 1990 and, for level III local health departments, include services that address at least three of the objectives from each section of that agenda.

Under s. 15.04 (1) (c), each head of a department is authorized to create and appoint such councils or committees as the operation of the department requires. Under this authority, the Secretary of DHFS has appointed a Public Health Advisory Committee. This committee includes persons representing both public and private sector organizations.

Discussion

As indicated above, Wisconsin has in place a system for credentialing members of the public health workforce. Generally, physicians and nurses are credentialed by examining boards in the Department of Regulation and Licensing. Qualifications for local health officers are set by

statute. DHFS has administrative rules regarding public health sanitarians, directors of environmental health programs, public health nurses, and directors of public health nursing programs.

In addition, Wisconsin has a comprehensive public health plan. However, the statutory references to that plan are out-of-date and could be updated. Rather than referring in the statutes to the document prepared in February 1990, DHFS could be required to prepare a comprehensive public health plan each decade and the statutory references could refer to the most recent 10-year plan. In addition, language from the Model Act with regard to development of a plan in consultation with the public health advisory council and other persons could be incorporated into the Wisconsin statutes. The four items included in the Model Act under the category of “general scope” and the 15 elements listed in the Act for inclusion in the plan could be examined for possible inclusion in the statutes.

The Wisconsin statutes currently do not refer to a local public health plan, although local boards of health are required to develop policy and provide leadership and to assess public health needs. In addition, the current statutes require DHFS to provide consultation, technical assistance, and training to local health departments. The statutes could be amended to authorize local health departments to create a local public health plan; however, additional authorization for technical assistance from DHFS is not needed since the statutes currently address this.

As stated above, DHFS currently has established a Public Health Advisory Council. However, unlike the council in the Model Act, the Public Health Advisory Council established by DHFS was not appointed by the Governor and members were not subject to legislative approval. You should be aware that there is legislation pending that would statutorily establish a Public Health Council in DHFS consisting of 17 members nominated by the Secretary of DHFS and appointed for three-year terms. 2003 Senate Bill 120 was introduced by the Joint Legislative Council, based on recommendations of the Special Committee on the Public Health System’s Response to Terrorism and Public Health Emergencies. Under that bill, the Public Health Council is required to monitor implementation of the public health agenda and to advise the Governor, the Legislature, DHFS, and the public on progress in implementing the agenda and coordination of responses to public health emergencies. Unlike some boards, members appointed to councils generally are not subject to Senate confirmation.

Article IV. Collaboration and Relationships With Public and Private Sector Partners

Model Act

Article IV of the Model Act requires state and local public health agencies to seek to establish strong working relationships with corresponding federal, tribal, other state or local public health agencies, or other public sector partners. Agreements are authorized between the state public health agency and any federal agency, between the state public health agency and any other state or its agencies, between local public health agencies in this state, and between a local public health agency in this state and an adjoining state or a municipality in an adjoining state, and between a state or local public health agency and a tribe or tribal public health agency. In addition, the Act allows public health districts that consist of two or more local or tribal public health agencies.

The Act also authorizes state or local public health agencies to form contracts or agreements with private sector partners, whether in-state or out-of-state. The state public health agency is required to coordinate activities and functions among many public or private sector partners in order to facilitate public health. The Act also states that it does not limit the ability of state and local public health agencies to contract with contractors or other private sector partners for the purpose of providing essential health services and functions directly through private sector entities.

The Act further states that improving public health outcomes is dependent on the active role of health care providers, health care facilities, and health insurers collaborating with state and local public health agencies to provide essential public health services and functions. State and local public health agencies are required to work specifically with these participants in the health care system to build effective relationships and promote the participant's role in furthering the mission of public health. State and local public health agencies are authorized to do any of the following activities with health care providers and health care facilities to ensure coordination: (1) dissemination of information and training regarding the appropriate use of clinical preventive practice guidelines; (2) provision of information regarding the services and resources available through the state public health agency related to patient management or medical care practice; (3) development of contractual agreements covering medical care and patient services related to the provision of essential public health services and functions; (4) development and dissemination of data reporting methods and systems; and (5) development and dissemination of resources and tools for measuring health care provider performance.

In addition, the state public health agency is authorized to develop standards that promote the provision of essential public health services and functions for incorporation into insurance plans. Those standards may include the following: (1) reporting data related to essential public health services and functions; (2) tools and resources for use in measuring quality of care; (3) coverage standards related to the diagnosis, treatment, and management of physical and mental health conditions during a public health emergency; (4) the use of provider networks in the event of a public health emergency, including the designation of certain facilities and providers as "in network" entities during those periods; and (5) the incorporation into the contract of coverage of public health clinical practice guidelines as part of health plans generally and for use in

assessing, treating, or managing physical and mental health conditions during a public health emergency.

Wisconsin Law

The general Wisconsin statute authorizing intergovernmental cooperation is s. 66.0301, Stats. That statute provides that in addition to the provisions of any other statutes specifically authorizing cooperation between municipalities, unless those statutes specifically exclude intergovernmental cooperation, any municipality may contract with other municipalities and with federally recognized Indian tribes and bands in Wisconsin for the receipt or furnishing of services or the joint exercise of any power or duty required or authorized by law. For purposes of this statute, the term “municipality” is defined broadly and includes the state or any department or agency of the state, or any city, village, town, county, or other enumerated entity. The statute states that s. 66.0301, Stats., is to be interpreted liberally in favor of cooperative action between municipalities and between municipalities and Indian tribes and bands in Wisconsin. The statute also states that any contract may provide a plan for administration of the function or project, which may include provisions as to proration of expenses, deposit and disbursement of funds, submission and approval of budgets, creation of a commission, selection and removal of commissioners, and formation and letting of contracts.

In addition, s. 66.0303, Stats., allows a municipality, as defined above, to contract with the municipalities of another state for the receipt or furnishing of services or the joint exercise of any power or duty required or authorized by statute to the extent that laws of the other state and of the United States permit the joint exercise. Such an agreement, before taking effect, must be submitted to the Attorney General who determines whether the agreement is in proper form and compatible with the laws of Wisconsin. The Attorney General is required to approve an agreement unless he or she finds that it does not meet the conditions set forth in the statutes and details in writing the specific respects in which the proposed agreement fails to meet the requirements of law. Failure to disapprove an agreement within 90 days of its submission to the Attorney General constitutes approval. An agreement under this statute between the municipality in Wisconsin and the municipality of another state that relates to the receipt, furnishing, or joint exercise of fire fighting or emergency medical services need not be submitted to or approved by the Attorney General before taking effect.

With regard to interstate cooperation, Wisconsin has codified the Emergency Management Assistance Compact (EMAC) in s. 166.30, Stats. The purpose of that compact is to provide for mutual assistance among party states in managing any emergency or disaster that is declared by the governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspect of resource shortages, community disorders, insurgency, or enemy attack. Currently, 48 states (including Wisconsin), the District of Columbia, and two U.S. territories are parties to the compact.

In addition, DHFS is required, under the statute describing the public health system, to maintain a public health system in cooperation with local health departments, community organizations, and medical clinics that are operated by the governing bodies, or agencies of the governing bodies, of federally recognized American Indian tribes or bands located in Wisconsin. [s. 252.03 (1) (a), Stats.]

With regard to public health districts, the Wisconsin statutes allow multi-jurisdictional health departments in specified cases. The statutes specifically authorize city-county health departments and multi-county health departments. In addition, health departments that cover

more than one municipality in the same county are authorized by statute, but references to multiple municipal local health departments include only such departments in Racine County.

Discussion

With regard to agreements between various health departments, there appears to be adequate authority for those agreements in the current Wisconsin statutes. As noted above, the statute on intergovernmental cooperation allows cooperation between municipalities, a term that is defined to include cities, villages, towns, and counties, but also includes the state and any department or agency of the state. The statute also applies to federally recognized Indian tribes and bands in Wisconsin. Interstate cooperation is covered by EMAC, to which Wisconsin is a party.

Regarding public health districts, as noted above, the statutes that relate to multiple municipal local health departments apply only to such departments in Racine County. However, there is legislation pending to allow multiple municipal local health departments in Milwaukee County (2003 Senate Bill 287 and 2003 Assembly Bill 563) and Winnebago County (2003 Assembly Bill 664).

In addition, there is legislation pending that would provide authority for intrastate mutual aid between local health departments and others—2003 Senate Bill 120, which was introduced by the Joint Legislative Council on the recommendation of the Special Committee on the Public Health System's Response to Terrorism and Public Health Emergencies.

While the statutes recognize private sector entities, there is nothing as specific in the statutes as the portions of Article IV that relate to health care providers and facilities and health insurers. Those provisions in the Model Act relate to activities that state or local health agencies may engage in with health care providers and health care facilities to ensure coordination in the provision of essential public health services and functions and relate to development by the state public health agency of standards relating to insurers. However, DHFS does have performance measures that apply to health maintenance organizations that participate in Medical Assistance; those performance measures include several items in the area of preventive care, including childhood immunizations, blood lead screenings, mammograms, Pap tests, and HealthCheck well-child exams.

Article V. Public Health Authorities/Powers

Model Act

Article V of the Model Act sets forth guiding principles for state or local public health agencies in carrying out their powers and duties under the Act. Included in those guiding principles are to further or support improving or sustaining the public's health, using scientifically sound principles and evidence; using well-targeted interventions; using the least restrictive alternative in the exercise of its authorities or powers, especially compulsory powers; nondiscrimination; respect for dignity of individuals; and community involvement.

The Act states that whenever the state or local public health agency exercises mandatory or compulsory powers relating to mandatory testing, compulsory screening, compulsory medical treatment, isolation and quarantine, or vaccination, the following apply: (1) the agency, whenever possible, should first request that the individual participate voluntarily; (2) an individual may be subjected to the exercise of the power pursuant to a court order if the individual will not be directly harmed; (3) an individual who fails to comply with a court order is guilty of a misdemeanor; and (4) the state or local public health agency may also employ other public health interventions to eliminate the risk or danger to others or to the public's health. A state or local public health agency is authorized to collect, analyze, and maintain databases of identifiable or nonidentifiable information related to risk factors, morbidity and mortality rates, community indicators, and any other data needed to accomplish or further the mission or goals of public health, or provide essential public health services and functions. In addition, the state public health agency is required to establish a list of *reportable diseases* or other conditions of public health importance; the Act includes several details with regard to collecting this information on reportable diseases. Persons who are required to report are to do so using ordinary skill in determining the presence of the reportable disease or condition. Local public health agencies are required to transmit to the state public health agency information related to reportable diseases or conditions, and the state public health agency is required to make information available to federal, tribal, or local public health agencies in this regard. In addition, the state public health agency is authorized to establish statewide systems for electronic reporting.

Specific provisions regarding reporting and tracking apply to health care providers, coroners or medical examiners, pharmacists, veterinarians, and other persons. State and local public health agencies are given authority to investigate conditions of public health importance and also to ascertain the existence of nonemergency disease outbreaks or epidemics. In doing so, the state or local public health agency may identify individuals, interview and test individuals, and examine facilities and materials.

The state or local public health agency is required to establish voluntary, confidential programs for *counseling and referral services*, that would be available and easily accessible to all persons with, or possibly exposed to, a contagious disease. Persons who voluntarily participate in this program must be notified that any identified contacts may be informed of their potential exposure to the contagious disease. A counselor may notify a contact after obtaining the informed consent of the individual with the contagious disease; however, the counselor may inform the contact without the individual's informed consent if the counselor reasonably believes that the individual does not plan to notify known contacts or if the counselor reasonably believes

that the individual is at a significant risk of harm should notification be made to the contact. Notification of contacts must be made in person where possible and in a manner that attempts to protect the privacy of the individual with the contagious disease as well as the contact.

A state or local public health agency is authorized to establish and administer **testing, examination, and screening** procedures or programs to identify conditions of public health importance among persons. For conducting any test, exam, or screening procedure or program, requirements are set forth regarding informed consent, validity, justification, pre-test information, and post-test information. The state or local public health agency may require testing or medical examination of any person who has or may have been exposed to a contagious disease that poses a significant risk or danger to others or the public's health.

With regard to types of screening programs, the Model Act states that a state or local public health agency may establish a compulsory screening program for conditions of public health importance that pose a significant risk or seriously threaten the public's health. In addition, the agency may establish a conditional screening program when necessary to achieve an important public health objective; under such a program, individuals may be subject to screening tests or examination as a condition of participating in or receiving a service or privilege. Finally, the Act allows the state or local public health agency to establish routine, regular, and ongoing screening programs for conditions of public health importance.

The Act's provision on compulsory medical treatment states that any health care provider or public health agent who examines or treats an individual who has a contagious disease must instruct the individual about measures for preventing reinfection and spread of the disease and about the need for treatment. In addition, the state or local public health agency may require any person who has or may have been exposed to a contagious disease that poses a significant risk or danger to others or to the public's health to complete an appropriate prescribed course of medication to treat the contagious disease and to follow infection control provisions for the disease.

The Model Act's provisions on **quarantine and isolation** allow a state or local public health agency to isolate or quarantine a person or group of persons pursuant to rules promulgated by the state public health agency. Several conditions and principles are set forth with regard to isolation and quarantine, including: (1) use of the least restrictive means necessary to prevent the spread of the disease; (2) keeping isolated individuals separate from quarantined individuals; (3) monitoring the health status of isolated and quarantined individuals; (4) removing quarantined individuals to isolation if they become infected or are reasonably believed to have become infected; (5) terminating isolation and quarantine when the person no longer poses a substantial risk of transmitting the disease; (6) providing for the needs of individuals who are isolated and quarantined; (7) maintaining outside premises for isolation and quarantine in a safe and hygienic manner; and (8) to the extent possible, respecting cultural and religious beliefs.

Procedures regarding use of quarantine are also set forth in the Model Act, including temporarily isolating and quarantining persons without notice in cases where a delay would significantly jeopardize the agency's ability to prevent or limit the transmission of a contagious or possibly contagious disease. Within 10 days after doing so, the state or local public health agency must file a petition for a court order authorizing continued isolation or quarantine. Details regarding the petition, notice, hearing, court order, and continuances, are set forth in the Act. In addition, isolated or quarantined individuals may apply to a court for an order to show cause why isolation or quarantine should not be terminated and the court must rule on the application within a specified time.

State and local public health agencies are authorized to require **vaccination** of any persons within their jurisdiction to prevent the introduction or spread of an infectious disease or other condition of public health importance. In administering its vaccine program, the agency is required to adhere to requirements regarding informed consent, validity, justification, and pre-vaccination information. Vaccinations may be administered by specified health care providers who are competent in the administration of the vaccine and who possess, and are capable of administering, medications and equipment as needed to treat any emergency conditions or reaction caused by the vaccine that may endanger the health or life of the recipient. Persons administering vaccines must certify on a form developed by the state public health agency that a person has been vaccinated. The state public health agency is required to collect epidemiological information to establish and maintain a comprehensive vaccination registry. Local public health agencies are required to establish or work with other agencies to establish one or more clinics to provide vaccinations.

The Model Act also provides that persons may not be admitted to a public or private school or licensed child day care facility who have not been age-appropriately vaccinated for infectious diseases or other conditions of public health importance. During a public health emergency, or if there is a vaccine-preventable disease outbreak or epidemic, exempted attendees may be temporarily excluded from attendance.

Exemptions to the vaccination requirement apply when any of the following occur: (1) the individual has an existing physical disability or reasonable certainty of a reaction detrimental to the person that may contraindicate vaccination; (2) the person has produced medical confirmation of experiencing the natural disease against which the vaccination protects, thus rendering the administration of the vaccine ineffectual; (3) the person has produced laboratory confirmation of the presence of existing adequate immunity; or (4) the person objects in a written, signed affidavit issued pursuant to a court order on the basis that the vaccination interferes with the free exercise of the person's sincere religious beliefs.

The Model Act also states that a person who administers or authorizes the administration of a vaccine under these provisions is immune from civil or criminal liability for any injury caused by the vaccine (unless there was willful misconduct or gross negligence) or the failure to vaccinate a minor or other dependent because of the failure or refusal of a legal representative to consent. The state or local public health agencies are required to promulgate regulations requiring a license to own or operate a place of business or engage in an activity that may be detrimental to the public's health. These include child care facilities, food service establishments, health care facilities, nail salons, nursing facilities, retail establishments, tattoo parlors, and temporary vendors. The Model Act has provisions relating to application for a license, issuance of a license, renewal of a license, and violations that may occur.

Under the Model Act, it is unlawful for any person to create, aggravate, or allow the existence of a nuisance. The term **nuisance** is defined in Article I as “. . . a condition, act, or failure to act that unreasonably interferes with the health or safety of the community by endangering life, generating or spreading infectious diseases, or otherwise injuriously affecting the public's health.” State or local public health agencies are authorized to investigate suspected nuisances and to issue orders for their abatement. The Act also has provisions regarding searches and inspections to determine the existence of a nuisance.

Wisconsin Law

The statutes currently require DHFS to establish and maintain *surveillance activities* sufficient to detect any occurrence of acute, communicable, or chronic diseases and threat of occupational or environmental hazards, injuries, or changes in the health of mothers and children. The department is required to analyze occurrences, trends, and patterns in this regard. In addition, DHFS is authorized to conduct investigations, studies, experiments, and research pertaining to any public health problems that are a cause or potential cause of morbidity or mortality and methods for the prevention or amelioration of those problems. [s. 250.04 (3), Stats.]

Section 252.02 (1), Stats., allows DHFS to establish systems of disease surveillance and inspection to ascertain the presence of any *communicable disease*. Agents of DHFS are authorized, with a special inspection warrant, to enter any building, vessel, or conveyance to inspect it and remove persons affected by a communicable disease. In addition, DHFS has the authority to close schools and forbid public gatherings at schools, churches, and other places to control outbreaks and epidemics.

DHFS has the authority to promulgate and enforce rules or issue orders for guarding against the introduction of any communicable disease into Wisconsin; for the control and suppression of communicable diseases; for the quarantine and disinfection of persons, localities, or things infected or suspected of being infected by a communicable disease; and for the sanitary care of jails, state prisons, mental health institutions, schools, hotels, and public buildings and connected premises. If persons in charge of those facilities fail to comply with a rule or order of DHFS, the department may appoint an agent to execute its rule or order.

Under s. 252.02 (6), Stats., DHFS has the broad authority to authorize and implement all emergency measures necessary to control communicable diseases.

Local health officers, upon the appearance of any communicable disease, must immediately investigate the circumstances and make a full report to the appropriate governing body and to DHFS. Local health officers are required to promptly take all measures necessary to prevent, suppress, and control communicable diseases. In addition, local health officers may do what is reasonable and necessary for the prevention and suppression of disease, may forbid public gatherings when deemed necessary to control outbreaks and epidemics, and must advise DHFS on measures taken.

Health care providers who know or have reason to believe that a person treated or visited by him or her has a communicable disease must report the appearance of the disease or the death of that person to the local health officer. The local health officer is required to report this to DHFS or direct the person reporting to report to DHFS. All reports must be made within 24 hours, unless otherwise specified by DHFS, by telephone, telegraph, mail, or electronic means or by deposit at the office of the local health officer. DHFS is required to store records of reports and treat them as patient health care records under the statutes dealing with confidentiality of those records. All persons credentialed under ch. 441 or 448, Stats. (e.g., physicians and nurses), must use ordinary skill in determining the presence of a communicable disease. [s. 252.05, Stats.]

When an outbreak or an epidemic occurs, the local health officer must immediately report this to DHFS, and keep DHFS informed of the prevalence of communicable diseases in the locality in the manner and with the facts that DHFS requires.

The provisions of Wisconsin statutes dealing with *isolation and quarantine* are set forth in s. 252.06, Stats. DHFS or a local health officer acting on behalf of DHFS may require isolation of a patient, quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures as may be necessary and as are determined by DHFS by rule. If a local health officer

suspects or is informed of the existence of a communicable disease, the officer must at once investigate and make or cause such examinations to be made as are necessary. The statutes provide that the diagnostic report of a physician, the notification or confirmatory report of a parent or caretaker of the patient, or a reasonable belief in the existence of a communicable disease, shall require the local health officer immediately to quarantine, isolate, require restrictions, or take other communicable disease control measures in the manner, upon the persons, and for the time specified in rules promulgated by DHFS.

A local health officer is required to employ as many persons as are necessary to execute his or her orders and properly guard any place if quarantine or other restrictions on communicable disease are violated or an intent to violate is manifested. When the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer must remove the person if it can be done without danger to the person's health.

Expenses for necessary medical care, food, and other articles needed for the care of the infected person are to be charged against the person or whoever is liable for the person's support. The county or municipality in which a person with a communicable disease resides is liable for the expense of employing guards, the expense of maintaining quarantine and enforcing isolation, the expense of conducting examinations and tests for disease carriers, and the expense of providing care to dependent persons, unless the costs are payable through third-party liability or through any benefit system.

The state's laws on *immunization and vaccination* fall within two general areas--childhood immunizations in order to be admitted to school, and compulsory vaccinations during a declared public health emergency. In the first area, any student admitted to a school, day care center, or nursery school must, within 30 days, present written evidence of having completed the first immunization for each vaccine required for the student's grade and being on schedule for the remainder. The immunization requirement is waived if the student's parent, guardian, or legal custodian (or an adult student) submits a written statement to the school, day care center, or nursery school objecting to the immunization for reasons of health, religion, or personal conviction. [s. 252.04, Stats.] In addition, DHFS has established the Wisconsin Immunization Registry, which is a computerized database that records and tracks immunization.

Under the provision of the statutes dealing with compulsory vaccination during a declared public health emergency, DHFS is authorized to order any person to receive a vaccination during such a declared emergency, unless the vaccination is reasonably likely to lead to serious harm to the individual or unless the individual, for reasons of religion or conscience, refuses to obtain the vaccination. In addition, DHFS is authorized to isolate or quarantine any person who is unable or unwilling to receive a vaccination. [s. 252.041, Stats.]

Administrative rules regarding control of communicable diseases are set forth in ch. 145, Wis. Adm. Code. Contents of required reports regarding a case or suspected case of a communicable disease are set forth in s. HFS 145.04 (2), Wis. Adm. Code. The reports must include specified information and other facts that DHFS or a local health officer requires for purposes of surveillance, control, and prevention of communicable disease.

The administrative rules require the local health officer to use all reasonable means to confirm in a timely manner any case or suspected case of a communicable disease and to ascertain so far as possible all sources of infection and exposures to the infection. Follow-up and investigative information must be completed by the local health officer and reported to the state epidemiologist on forms provided by DHFS. Local health officers are required to follow the methods of control set out in Section 9 under each communicable disease listed in the 16th

edition of *Control of Communicable Diseases Manual*, unless specified otherwise by the state epidemiologist.

With regard to required reports, ch. HFS 145, Wis. Adm. Code, divides communicable diseases into Categories I, II, and III. Persons required to report must report communicable diseases of urgent public health importance listed in Category I to the local health officer immediately upon identification of a case or suspected case. Reports of diseases in Categories II and III must be made within 72 hours.

Section HFS 145.06 (1), Wis. Adm. Code, provides that a person may be considered to have a contagious medical condition that poses a threat to others if the person has been medically diagnosed as having a communicable disease and exhibits any specified behaviors (e.g., careless disregard for the transmission of the diseases to others). If a person meets this standard, health officials may direct the person to do any of the following: (1) participate in a designated program of education or counseling; (2) participate in a defined program of treatment for the known or suspected condition; (3) undergo examination and tests necessary to identify disease, monitor its status, or evaluate the effects of treatment on it; (4) notify or appear before designated health officials for verification of status, testing, or direct observation of treatment; (5) cease and desist in conduct or employment that constitutes a threat to others; (6) reside part-time or full-time in an isolated or segregated setting that decreases the danger of transmission; or (7) be placed in an appropriate institutional treatment facility until the person has become noninfectious.

If a person fails to comply with such a directive, the health official may petition a court to order persons to comply. The petitioner must ensure all of the following: (1) that the petition is supported by clear and convincing evidence of the allegation; (2) that the respondent has been given the directive in writing, including the evidence that supports the allegation, and has been afforded the opportunity to seek counsel; and (3) that the remedy proposed is the least restrictive on the respondent that would serve to correct the situation and protect the public's health.

Discussion

One portion of Article V of the Model Act that is not explicit in the Wisconsin statutes dealing with quarantine and isolation is the duty to first request that the individual participate voluntarily. In addition, the Wisconsin statute dealing with isolation and quarantine does not explicitly require that this be done in the manner that is least restrictive on the person, consistent with the agency's objectives. In general, the provisions of the Model Act regarding quarantine and isolation are more comprehensive than those in Wisconsin law.

The Wisconsin statutes and DHFS rules set forth communicable disease reporting requirements and procedures that seem to be more comprehensive than those in the Model Act. In addition, the issue of reporting was addressed to some extent in 2001 Wisconsin Act 109 with regard to reporting by health care providers, coroners, pharmacists, and veterinarians.

It does not appear that there is anything in the Wisconsin statutes similar to the provisions in the Model Act that require the state or local public health agencies to establish voluntary, confidential programs for counseling and referral services for individuals with, or possibly exposed to, a contagious disease.

Unlike the Wisconsin statutes on vaccination that seem to be limited to childhood immunizations and vaccinations during declared public health emergencies, the Model Act allows state and local public health agencies to require vaccination of any individual within their jurisdictions to

prevent the introduction or spread of an infectious disease or other condition of public health importance.

The Model Act's exemptions from vaccination requirements are narrower than the exemptions in Wisconsin law. The Wisconsin statutes dealing with childhood immunizations allow exemptions for reasons of health, religion, or personal conviction, while the statutes dealing with compulsory vaccinations during declared public health emergencies allow exemptions for serious harm, or reasons of religion or conscience. The Model Act's health exemption requires that the person have an existing physical disability or a reasonable certainty of a reaction detrimental to the person which may contraindicate vaccination based on the recommendations of the CDC's advisory committee dealing with immunization. In addition, in order to claim a religious exemption under the Model Act, the person must object in a written, signed affidavit issued pursuant to a court order on the basis that the vaccination interferes with the free exercise of the individual's sincere religious beliefs. The Model Act does not include an exemption for reasons of personal conviction or conscience.

The Model Act states that a person who administers or authorizes the administration of vaccine is immune from criminal or civil liability for any injury caused by the vaccine if the vaccination was required by the state public health agency, and the administration did not involve willful misconduct or gross negligence. In addition, such a person is immune from criminal or civil liability for the failure to vaccinate a minor or other dependent person because of the failure or refusal or a legal representative to consent to the vaccination. While Wisconsin statutes do not provide this immunity, they do provide that if a physician supervises an immunization program and is selected by the school district or local health department, is not an employee of the county, city, village, or school district, receives no compensation for his or her services, and acts in accordance with written protocols issued by DHFS, he or she is considered an agent of DHFS for purposes of statutes dealing with legal representation and payment of judgments.

The Wisconsin statutes are more restrictive with respect to the ability of a state or local public health agency to order treatment. Under the Model Act, the agency may require an individual who has or may have been exposed to a contagious disease that poses a significant risk of danger to others or to the public's health to complete an appropriate prescribed course of medication and to follow infection control provisions. Rules of DHFS allow specified health officials to order participation in a defined program of treatment and to undergo examination and tests only if the person is known to have or is suspected of having a contagious medical condition and if the person has exhibited behaviors that fall under the category of making the condition a threat to others (e.g., a behavior that has been demonstrated epidemiologically to transmit the disease or which evidences a careless disregard for the transmission of the disease). Also, in order to require the person to participate in that defined program of treatment, the health official must seek a court order.

The provisions of the Model Act dealing with public health nuisances are somewhat similar to the Wisconsin statutory provisions dealing with human health hazards in ss. 254.59 and 254.595, Stats. However, the Wisconsin statutes on this topic seem to be somewhat more detailed than the provisions in the Model Act and provide a more specific time period for abatement.

Article VI. Public Health Emergencies

Model Act

Article VI of the Model Act is based on provisions of another model act, the Model State Emergency Health Powers Act, which was prepared by the Center for Law and the Public's Health following terrorist attacks of September 11, 2001 and subsequent anthrax threats and attacks.

Article VI requires the Governor to appoint a public health emergency planning commission, consisting of the directors (or their designees) of federal, tribal, state, and local public health agencies and other agencies that the Governor deems relevant to public health emergency preparedness, a representative group of state legislators, members of the judiciary, representatives of tribal governments, and any other persons chosen by the Governor. The commission is required to establish a plan for responding to public health emergencies. That plan must include 12 specified components.

The Model Act also includes provisions for declaring a state of public health emergency. Such an emergency may be declared by the Governor, in consultation with state and local public health agencies. However, the Governor is permitted to declare a public health emergency without these consultations when the situation calls for prompt and timely action. The Model Act includes provisions regarding the content of the declaration, the effect of the declaration, emergency powers that are conferred, coordination by the state public health agency, identification of persons within the public health system, enforcement, and termination of a declaration.

The Model Act also has a section regarding management of property during a public health emergency. That section includes provisions relating to emergency measures concerning facilities and material, control of roads and public areas, safe disposal of infectious waste or contaminated material, safe disposal of human remains, control of health care supplies, and civil proceedings concerning property to be destroyed.

In addition, the Model Act has a section relating to protection of individuals during a public health emergency. That provision allows a state or local health agency to perform and administer tests, examinations, screenings, treatment, isolation, quarantine, decontamination, or vaccination consistent with provisions in Article V of the Act. That section also allows collection of specimens or environmental samples and performing of tests on persons or animals if the tests are reasonable and necessary to respond to the public health emergency.

A state or local health agency, during a public health emergency, is authorized to require in-state health care providers to assist in the performance of vaccination, treatment, examination, testing, decontamination, quarantine or isolation as a condition of licensure or the ability to continue to function as a health care provider in the state. In addition, the state or local public health agency is authorized to appoint and prescribe the duties of out-of-state emergency health care providers and to appoint and prescribe duties of emergency assistant medical examiners or coroners.

During and after the declaration of a public health emergency, the state or local public health agency must provide public information about and referrals to mental health support personnel. During a declared public health emergency, any person owning or controlling real estate or other premises who voluntarily and without compensation permits the designation or use of the premises for the purpose of sheltering persons, is not civilly liable for negligently causing the death of, or injury to, any person on the premises under permission or for negligently causing

loss of, or damage to, the property of such a person. Also, during a declared public health emergency, any nongovernmental person and employees and agents of such a person in the performance of a contract with, or under the direction of, the state or its political subdivisions, or who renders assistance or advice at the request of the state or its political subdivisions under Article VI, is not civilly liable for causing the death of, or injury to, any person or damage to any property except in the event of gross negligence or willful misconduct.

The Model Act also addresses the issue of compensation to owners of facilities or materials that are lawfully used or appropriated by a state or local public health agency for use during a declared public health emergency; the state is required to pay just compensation for such use. Compensation is not required for facilities or materials that are closed, evacuated, decontaminated, or destroyed when there is reasonable cause to believe that they may endanger the public's health.

Wisconsin Law

As noted in the introductory comments in this memorandum, during the 2001-02 Legislative Session, the Legislature enacted into law various statutory provisions dealing with public health emergencies. Although many of the provisions originated in 2001 Assembly Bills 849 and 850, they were enacted as part of 2001 Wisconsin Act 109 (the 2002 Budget Adjustment Act).

The Wisconsin statutes require that DHFS biennially submit to the Legislature and the Governor a report on the preparedness of the public health system to address public health emergencies. DHFS must do so after consulting with the Adjutant General, local health departments, health care providers, and law enforcement agencies. [s. 250.03 (3) (b), Stats.]

Declarations of emergencies, including declarations of public health emergencies, are governed by ch. 166, Stats. That statute allows the Governor to proclaim a state of emergency if he or she determines that an emergency exists resulting from enemy action or natural or man-made disaster. If the Governor determines that a public health emergency exists, he or she may declare a state of emergency related to public health and may designate DHFS to serve as the lead state agency to respond to that emergency. Section 166.02 (7), Stats., defines the term "public health emergency" as follows:

166.02 (7) "Public health emergency" means the occurrence or imminent threat of an illness or health condition that meets all of the following criteria:

- (a) Is believed to be caused by bioterrorism or a novel or previously controlled or eradicated biological agent.
- (b) Poses a high probability of any of the following:
 - 1. A large number of deaths or serious or long-term disabilities among humans.
 - 2. A high probability of widespread exposure to a biological, chemical, or radiological agent that creates a significant risk of substantial future harm to a large number of people.

Section 166.02, Stats., defines the term "bioterrorism" and three terms that are used in the definition of "bioterrorism"--"biological agent," "chemical agent," and "radiological agent."

During a public health emergency, the Governor may suspend the provisions of any administrative rule if strict compliance with that rule would prevent, hinder, or delay necessary actions to respond to the emergency and would increase the health threat to the population. As part of Act 109, the state also created a statute relating to disposal of human remains during a declared public health emergency. [s. 157.055, Stats.] In addition, s. 157.055 (2) (g), Stats., allows DHFS as the lead state agency during a declared public health emergency to authorize a county medical examiner or a county coroner to appoint emergency assistant medical examiners or emergency deputy coroners if necessary.

With regard to licensing of health care providers from other jurisdictions, EMAC in s. 166.30, Stats., provides that whenever a person holds a credential issued by any party state evidencing that the person meets qualifications for professional, mechanical, or other skills, and when this assistance is requested by the receiving party state, that person is deemed to be credentialed by the state requesting assistance to render aid involving the skill to meet a declared emergency or disaster, subject to any limitations and conditions that the governor of the receiving state prescribes.

Under s. 166.03 (10), Stats., a person who provides equipment or services under the direction of the Governor, the Adjutant General, or the head of emergency management services in any county, town, or municipality during a state of emergency declared by the Governor is not liable for the death of or injury to any person or damage to any property caused by his or her actions, except when the person has acted intentionally or with gross negligence.

In addition, while the Wisconsin statutes do not create a public health emergency planning commission like that created in the Model Act, the Governor has created a Homeland Security Council, which includes a representative from DHFS.

Discussion

As noted earlier in the memorandum, Article VI of the Model State Public Health Act is based on the earlier Model State Emergency Health Powers Act. Following the events of September 11, 2001, and the anthrax threats and attacks that occurred after that day, legislative hearings were held in Wisconsin on the issue of terrorism preparedness and legislation was introduced to address the issue of terrorism preparedness. 2001 Assembly Bills 849 and 850 were introduced and incorporated some of the provisions of the earlier Model Act that are also included in the Model State Public Health Act. Some of the provisions of the earlier Model Act were incorporated into what became 2001 Wisconsin Act 109 (the 2002 Budget Adjustment Act), with modifications, and some of the provisions of Act 109 that addressed public health emergencies did not derive from the earlier Model Act.

Since the Model State Emergency Health Powers Act was examined by the Legislature in the 2001-02 Legislative Session and portions of it were incorporated into the Wisconsin statutes, and since Article VI of the Model State Public Health Act is based upon the earlier Model Act, persons determining whether to include portions of the Model State Public Health Act into the Wisconsin statutes may find that it is unnecessary to reexamine all of Article VI of the later Model Act.

One area in which there is legislation pending that relates to one of the issues identified in Article VI, namely private liability, is 2003 Senate Bill 120. That bill was introduced by the Joint Legislative Council on the recommendation of the Special Committee on the Public Health System's Response to Terrorism and Public Health Emergencies. The bill modifies the current law that provides an exemption from liability for persons who provide equipment or services

during a declared emergency, including a declared public health emergency. Under current law, the exemption from liability applies if the person acts under the direction of the Governor, the Adjutant General, or the head of emergency management services in any county, town, or municipality. Senate Bill 120 amends this so that the exemption from liability also applies if the person provides the equipment or services under the direction of DHFS if that department is designated by the Governor as the lead state agency to address a public health emergency, or under the direction of a local health department that is acting as the agent of DHFS.

Article VII. Public Health Information Privacy

Model Act

Article VII of the Model Act provides that identifiable health information may not be secretly acquired by a state or local health agency. In addition, the Model Act provides that a state or local health agency may acquire identifiable health information only if: (1) the acquisition relates directly to a public health purpose; (2) the acquisition is reasonably likely to achieve that purpose; and (3) the public health purpose cannot otherwise be achieved as well or better with nonidentifiable health information. Prior to implementing a determination by a state or local public health agency to acquire or store identifiable health information, the agency must provide written public notice.

Additional provisions talk about uses of identifiable health information, including prohibitions on commercial uses of the information, and use of identifiable health information for public health, epidemiological, medical, or health services research if certain conditions are met.

The Model Act also states identifiable health information is not public information and may not be disclosed without the written authorization of the person who is the subject of the information, with specified exceptions. Contents of the written authorization are specified. Identifiable health information may be disclosed without written authorization where the disclosures are made: (1) directly to the subject individual; (2) to appropriate federal agencies or authorities as required or authorized by federal or state law; (3) to health care personnel to the extent necessary in a medical emergency or a state of public health emergency to protect the person; (4) to a health oversight agency to perform a health oversight function authorized by law if specified conditions are met; (5) to report information in a certificate of death, autopsy report, or related documents; or (6) to identify a deceased person or the manner of death or to provide necessary information about a deceased person who is a donor or prospective donor of an anatomical gift. No identifiable health information may be disclosed, discoverable, or compelled to be produced pursuant to a subpoena, or testimony compelled of public health agents, in any civil, criminal, administrative, or other legal proceeding, with five specified exceptions. In addition, the Model Act prohibits secondary disclosures of identifiable health information except to persons who would be authorized under the Model Act to receive the information.

The Model Act also has a section relating to security safeguards for identifiable health information. State and local public health agencies must acquire, use, disclose, and store identifiable health information in a confidential manner that safeguards the security of the information using specified security measures. There must be a written display of the agency's disclosure policy and persons on premises must undertake specified activities. In addition, state and local public health agencies are required to appoint or designate a public health information officer, who would have overall responsibility for preserving the security of all identifiable health information and other specified duties. State and local public health agencies are required to prepare an annual report concerning the status of security protections for identifiable health information.

The Model Act also has a section relating to access by persons to identifiable health information. Within 14 days of the receipt of a request to review identifiable health information, a state or local public health agency must provide the requester an opportunity during regular business hours to inspect copies of information in the possession of the agency that concerns or relates to the requester. Within 10 days of receipt of a request for copies of a requester's identifiable

health information, a state or local public health agency must provide copies to the requester without charge. The Model Act does allow the agency to place reasonable limitations on the time, place, and frequency of any inspection and copying request. In addition, it requires confidential information of other individuals to be deleted for purposes of inspection and copying.

A state or public health agency may deny a request to inspect or copy identifiable health information if any of the following apply: (1) the agency can show by clear and convincing evidence that the review will cause substantial and identifiable harm to the requester or others that outweighs the requester's right to access the information; (2) a parent or guardian has requested access to identifiable health information about a person who is over a certain age and the person objects to that access within seven days of receipt of a notice; or (3) the information is compiled principally in anticipation of, or for use in, a legal proceeding.

In addition, requesters may ask that the state or local public health agency correct, amend, or delete erroneous, incomplete, or false information. The agency is required to do so if it determines that the modification is reasonably supported and, in this regard, the requester has the burden of proving that the information needs to be corrected, amended, or deleted. A state or local public health agency is required to retain a brief, written statement from the requester challenging the veracity of the identifiable health information for as long as the information is retained. That statement must be provided to any person who is authorized to receive the identifiable health information.

Wisconsin Law

Wisconsin has three major laws that apply to health care records that might apply to certain information retained by DHFS or local health departments: (1) ss. 146.81 to 146.84, Stats., which relate generally to patient health care records; (2) s. 51.30, Stats., which relates to mental health records; and (3) s. 252.15, Stats., which relates to records of HIV tests. Those laws generally require confidentiality of records, except with the consent of the subject of the records or in the case of specified exceptions. In addition, they generally allow for access by the subject individual to records about himself or herself.

Section 146.82, Stats., states that all patient health care records (records that are related to the health of a patient prepared by or under the supervision of a health care provider, with certain exceptions) are confidential and may be released only to persons designated in that statute or to other persons with the informed consent of the patient or of a person authorized by the patient. However, the law allows for release without informed consent if the circumstances fall within one of 22 exceptions provided in the law. In addition, s. 146.83, Stats., allows any person to, upon submitting a statement of informed consent, inspect the health care records of a health care provider pertaining to a particular patient at any time during regular business hours, upon reasonable notice. Such a person may receive a copy of the patient's health care records upon payment of fees.

Section 51.30, Stats., provides that mental health treatment records remain confidential and are privileged to the subject individual. However, treatment records may be released without the informed consent of the subject individual under one of the 29 exceptions provided in the law. The law also allows for access by a subject individual to treatment records but allows access to be restricted during treatment as specified in s. 51.30 (4) (d), Stats. In addition, s. 51.30 (4) (f), Stats., allows a subject individual, or the parent, guardian, or the person in place of a parent of a minor, or the guardian of an incompetent person, to challenge the accuracy, completeness,

timeliness, or relevance of factual information in a treatment record and request in writing that the facility maintaining the record correct the challenged information. The request must be granted or denied within 30 days and reasons for denial must be given. If the request is denied, the person is allowed to insert into the record a statement correcting or amending the information at issue; this statement becomes a part of the record and must be released whenever the information at issue is released.

Section 252.15, Stats., places restrictions on the disclosure of human immunodeficiency virus (HIV) test results. Generally, the results of an HIV test are confidential and may not be released unless specifically authorized by the subject individual or under one of 19 specified exceptions. In addition, DHFS has an administrative rule that requires confidentiality of reports of communicable diseases. Under s. HFS 145.04 (2) (d), Wis. Adm. Code, all information provided in reports of communicable diseases remains confidential except as may be needed for the purposes of investigation, control, and prevention of communicable diseases.

Discussion

Wisconsin's general statutes on confidentiality of, and access to, health care records are generally more comprehensive than the provisions of Article VII of the Model Act. Those statutes dealing with general patient health care records, mental health records, and HIV test results all provide for confidentiality, with certain exceptions, and provide for access to records by subject individuals.

One area in which the statutes differ somewhat from the provisions of the Model Act is with respect to correcting health care records. The Model Act allows for corrections by subject individuals or insertion of correcting statements into the record. While s. 51.30 (4) (f), Stats., allows this for mental health records, there is no provision in the statutes dealing with general patient health care records and HIV test results that allow for correction by the subject individual or insertion of a statement into the record by the subject individual.

Article VIII. Administrative Procedures, Civil and Criminal Enforcement, and Immunities

Model Act

Article VIII of the Model Act authorizes the state or local public health agency and other affected agencies to promulgate and implement rules that are reasonable and necessary to implement and effectuate the provisions of the Act. In addition, any applicable actions of a state or local public health agency in rendering adjudications, issuing orders, and declaring regulations, are governed by the state's administrative procedure laws. Further, the Model Act provides that in every formal or informal administrative adjudication, certain procedural due process rights apply.

Any public health agent who willfully violates or obstructs the execution of the Act or rules promulgated under the Act, for which no other penalty is prescribed is guilty of a misdemeanor. Penalties suggested in brackets are a fine not to exceed \$1,000, imprisonment for a period not to exceed one year, or both. The same penalty is suggested for other persons who violate the Act or rules promulgated under the Act or who fail to follow any court order under the Act.

In addition, the Model Act states that any person aggrieved by a violation of the Act may maintain an action for appropriate relief in court. The Act provides for compensatory damages and punitive damages, in addition to attorney fees.

The Model Act also provides for certain immunities. Neither the state, its political subdivisions, the Governor, a state or local public health agency, or any other state or local agent is liable for the death of or injury to persons, or damage to property, as a result of complying with or attempting to comply with the Act or any rules promulgated under it. Immunity does not apply in the case of gross negligence or willful misconduct.

Wisconsin Law

Chapter 227, Stats., is the state's administrative procedure law and governs both rule-making and contested case hearings. Chapter 68, Stats., relates to administrative procedures for local governmental units. Subchapter II of ch. 227, Stats., describes agencies' duties with regard to the promulgation of rules and the process used for rule promulgation and review. Subchapter III of ch. 227, Stats., deals with administrative actions and judicial review and specifies due process rights of parties.

Many of the provisions of chs. 250 to 255, Stats., which relate to public health, do not include penalty provisions. However, there is a general law providing for penalties. Section 252.25, Stats., states as follows:

252.25 Violation of law relating to health. Any person who willfully violates or obstructs the execution of any state statute or rule, county, city or village ordinance or departmental order under this chapter and relating to the public health, for which no other penalty is prescribed, shall be imprisoned for not more than 30 days or fined not more than \$500 or both.

In addition, some of the specific public health statutes have penalties for violators--e.g. s. 252.06 (4) (b) regarding entering a quarantine or isolation area, s. 254.20 regarding asbestos, s. 254.45 regarding radiation, and s. 254.59 regarding human health hazards.

DHFS is authorized under the statutes to promulgate and enforce rules and issue and enforce orders governing the duties of all local health officers and local boards of health and relating to any subject matter under DHFS's supervision that are necessary to provide efficient administration and to protect health. Whoever violates such a rule or order is to be fined not less than \$10 nor more than \$100 for each offense, unless a different penalty is provided.

Discussion

Much of Article VIII of the Model Act is already covered by ch. 227, Stats., with respect to rule-making and administrative procedure.

As noted above under the discussion of Wisconsin law, there are general statutes that provide penalties for violations of public health laws and penalty provisions for some specific public health laws. Persons reviewing the Model Act may wish to ascertain from state or local health officials whether or not penalties provided in current law have proven to be adequate.

Article IX. Miscellaneous Provisions

Model Act

Article IX of the Model Act sets forth the title of the Act and provisions regarding uniformity and severability. In addition, it states that it does not restrict any person from complying with federal laws or regulations. It also states that in the event of a conflict between the Model Act or any other state law or regulations, the provisions of the Model Act prevail.

The Model Act also states that within a certain number of months after enactment (suggested to be six months), the public health official at each state or local public health agency must prepare and submit a report concerning the impact and effect of the Act on each agency. No later than a certain number of months after enactment (suggested as nine months), the state public health agency must issue a comprehensive report, including any recommendations for legislative amendments.

Wisconsin Law

Section 990.001 (11), Stats., sets forth a general severability provision for the statutes. That law states that if any provision of the statutes or of a session law is invalid, or if the application of the provision to any person or circumstance is invalid, the invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application.

Discussion

Generally, the miscellaneous provisions in Article IX are unnecessary in the Wisconsin statutes. As noted above, there is already a general provision on severability. Titles for Acts are generally not included in the statutes.

If any of the provisions of the Model Act are enacted by the Legislature, there could be a requirement for a follow-up report by either a local health department or DHFS that would comment on the effect of the provisions enacted, including recommendations for changes. Reports of this nature are usually included as nonstatutory provisions in legislation.

RNS:wu:jal:ksm:tlu;wu