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September 30, 2021

LEGAL MEMO

FROM: Livingston City Attorney's Office, Courtney Lawellin

TO: City of Livingston Commissioners, City Manager

Re: *Health Boards, Health Officers, Decision Making, and Health Information Releases*

Executive Summary.

1. If emergency orders or mandates are made during a state of emergency, by a health board or health officer, such decisions are reviewed by local governing bodies, as soon as they can have a meeting, and remain in effect only during the declared emergency.

2. A board of health must create policy for the local health officer to follow for the control of communicable disease, including quarantine and isolation measures. This is a non-delegable non-emergency power that does not require local government body oversight. This power can also be exercised in an emergency, but then requires government oversight. A local health officer does not have the ability to create policy related to control of communicable disease or to enact local regulations to ameliorate public health conditions.

3. The appointment of a local health officer must be reviewed by local governing bodies. Local governing bodies are the bodies that created the board of health. The City of Livingston would ratify decisions of the board or health officer for implementation for the City and the County Commission would ratify decisions for implementation in the County, absent an agreement to the contrary.

4. Regulations created by a board of health to be carried out by a local health officer are reviewable by local governing bodies. A local health officer can issue orders based on department (DPHHS) rules or rules of the local health board as approved by local

governing bodies. In a City-County Health Board the City adopts for its jurisdiction and the County adopts for its jurisdiction, absent an agreement to the contrary.

5. Neither HIPAA or the Montana Government Healthcare Information Act prevent the government disclosure of names and address of patients with a communicable disease to protect emergency responders. There is no liability for such a disclosure based on the exceptions in the law, as well as governmental immunity. Public policy and state statutes dictate that a health board, health department, or health officer must protect public health to the extent practicable through the public health system while respecting individual rights to dignity, privacy, and nondiscrimination", and "collaborate with federal, state, and local partners" to do so. This leads to only one logical conclusion: that public health entities must provide at least names and addresses to protect emergency responders during a pandemic.

Requirement for a board of health, a health officer, and their statutory powers and duties

The state law mandates that there is in each city and in each county a board of health. [1] By mutual agreement between a city and county there can be a city-county board of health which satisfies the requirement for there to be a board of health for each city and county.[2] In Livingston, Park County, Montana we have a City-County board of health. This was agreed upon by the governing bodies and set forth in the City County Compact of 2012. The composition of the board of health is set forth in the statute[3], in the compact, and in the bylaws. For our City County Board of Health, there are 7 members total, four county members, including a County Commissioner, and three City members including a City Commissioner. The operation of the board of health is governed by its by-laws.

Prior to the 2021 legislature, and the 2020-2021 pandemic[4], the statutes governing boards of health **and** health officers did not make any distinction between, (a) non-emergency powers and (b) powers during a declared state of emergency lasting more than 7

[1] Section 50-2-104 MCA (County), Section 50-2-105 MCA.

[2] Section 50-2-106 MCA, and "County boards of health are also local boards of health. § 50-2-101(3), MCA. Both a county board of health and a local health officer must comply with the powers and duties of local boards of health and the powers and duties of local health officers prescribed by section 50-2-116, MCA, and section 50-2-118, MCA, respectively." 41 Mont. Op. Atty. Gen. 75 (Mont.A.G.), 41 Mont. Op. Atty. Gen. No. 22, 1985 WL 206557

[3] Section 50-2-106 MCA.

[4] Or as long as it may last.

days[5]. After the 2021 legislature a local board of health's decision must be ratified by the local governing body/bodies for appointment of a local health officer. Most, if not all, of a health officer or health board's directives, mandates, or orders must be ratified by local governing bodies in a state of emergency. Non-emergency power may be exercised without the ratification of local governing bodies. However, both a board of health and a health officer **must** "carry out the purposes of the public health system, ***in collaboration with federal, state, and local partners***".[6] Emphasis supplied.

The term local governing body did not exist in the law until the 2021 Legislature. HB 121 modified the definitions in Section 50-1-101 MCA to include those definitions and limited the definitions of isolation and quarantine. That amendment stated in relevant part: (additions are underlined, deletions are strikethroughs)

> (6) "Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected ~~or reasonably believed to be infected~~ with a communicable disease ~~or possibly communicable disease~~ from nonisolated individuals to prevent or limit the transmission of the communicable disease to nonisolated individuals.
>
> (7) "Local board of health" or "local board" means a county, city, city-county, or district board of health.
>
> (8) "Local governing body" or "governing body" means:
>
> (a) the board of county commissioners that oversees a county local board of health;
>
> (b) the elected governing body of a city that oversees a city local board of health; or
>
> (c) the entity identified as the governing body as established in the bylaws, interlocal agreement, or memorandum of understanding creating a city-county local board of health or a local district board of health.
>
> ~~(8)~~(9) "Local health officer" means a county, city, city-county, or district health officer appointed by a local board of health. With regard to the exercise of the duties and authorities of a local health officer, the term may include an authorized representative of the local health officer.
>
> ~~(9)~~(10) "Local public health agency" means an organization operated by a local government in the state, including local boards of health or local health officers, that principally acts to protect or preserve the public health. * * *
>
> ~~(13)~~(14) "Quarantine" means the physical separation and confinement of an individual or groups of individuals who ~~are or may~~ have been exposed to a communicable disease ~~or possibly communicable disease~~ and who do not show signs or symptoms of a communicable disease from nonquarantined individuals to prevent or limit the transmission of the communicable disease to nonquarantined individuals.

[5] Section 50-2-116 (1) and (5) MCA.
[6] Section 50-2-118 (1) and 50-2-116 (2)

Because the City and the County have a City-County Health Board the local governing body or bodies are defined in the bylaws and the City County Compact. Preliminarily, there was no need to define a governing body or bodies in the 2012 Compact or the 2014 and 2018 bylaws, because a local governing body was not contemplated in the law until 2021. Furthermore, though the compact calls out that the board will act under the statutory authority of Title 50 Chapter 2, local boards of health, which does call out the process for dealing with communicable disease, the compact is completely silent as to emergencies or communicable disease. The bylaws however mandate that the board operate under Section 50-2-106 and Section 50-2-116 MCA. Finally, any guidance in the compact is not based on an intentional city or county decision to decide how the "local governing bodies" will operate to oversee the City-County Health Board, but are based instead on the 2012 (compact) agreement that did not contemplate a pandemic. Consequently, the compact has very limited utility in defining local governing bodies. The 2018 bylaws simply require the board to follow the law regarding city-county health boards[7]. The default under the plain meaning of the law and the other documents as they exist require that the City and the County both ratify the decisions of the health board, where such ratification is required. Finally, the principles of legislative intent and statutory construction must be used logically. "Legislative intent must be ascertained from an examination of all of the statutes on one subject matter as a whole, not just the wording of one particular section."[8] And, "[s]tatutes dealing with the same subject matter are to be construed together and harmonized if possible"[9]. *46 Mont. Op. Atty. Gen. No. 3* (Mont.A.G.), 1995 WL 111242, ¶ 2.

The boards of health have two functions under the law, 1) to receive funds allocated by the department (DPHHS) to local boards, from the federal government or any other agency[10]; and 2) to carry out the powers and duties in Section 50-2-116 MCA which sets forth a board's policy and rule making power. That section was modified in the 2021 legislature to allow for additional oversight, in some instances, by the local governing bodies. That 2021 statute sets forth the powers and duties of local boards as follows: (underlined sections are additions deletions are noted with strikethroughs).

[7] Bylaws Article III Statutory Powers and Duties
[8] *Vita-Rich Dairy, Inc. v. Department of Business Regulation*, 170 Mont. 341, 553 P.2d 980, 984 (1976)
[9] *Crist v. Segna*, 191 Mont. 210, 622 P.2d 1028, 1029 (1981)
[10] Section 50-2-103 MCA

50-2-116. Powers and duties of local boards of health. (1) It is a purpose of this chapter to address ongoing issues or conditions created during a declared state of emergency as a result of orders, directives, or mandates issued by the governor as allowed under Title 10, chapter 3, for a state of emergency acting longer than 7 days. It is not a purpose of this chapter to hinder, slow, or remove nonemergency-related powers granted to a local board of health.

(2) In order to carry out the purposes of the public health system, in collaboration with federal, state, and local partners, each local board of health shall:

(a) ~~appoint and fix the salary~~ recommend to the governing body the appointment of a local health officer who is:

(i) a physician;

(ii) a person with a master's degree in public health; or

(iii) a person with equivalent education and experience, as determined by the department;

(b) elect a presiding officer and other necessary officers;

~~(c) employ qualified staff;~~

~~(d)~~(c) adopt bylaws to govern meetings;

~~(e)~~(d) hold regular meetings at least quarterly and hold special meetings as necessary;

~~(f)~~(e) identify, assess, prevent, and ameliorate conditions of public health importance through:

(i) epidemiological tracking and investigation;

(ii) screening and testing;

(iii) isolation and quarantine measures;

(iv) diagnosis, treatment, and case management;

(v) abatement of public health nuisances;

(vi) inspections;

(vii) collecting and maintaining health information;

(viii) education and training of health professionals; or

(ix) other public health measures as allowed by law;

~~(g)~~(f) protect the public from the introduction and spread of communicable disease or other conditions of public health importance, including through actions to ensure the removal of filth or other contaminants that might cause disease or adversely affect public health;

~~(h)~~(g) supervise or make inspections for conditions of public health importance and issue written orders for compliance or for correction, destruction, or removal of the conditions;

~~(i)~~(h) bring and pursue actions and issue orders necessary to abate, restrain, or prosecute the violation of public health laws, rules, and local regulations;

~~(j)~~(i) identify to the department an administrative liaison for public health. The liaison must be the local health officer in jurisdictions that employ a full-time local health officer. In jurisdictions that do not employ a full-time local health officer, the liaison must be the highest ranking public health professional employed by the jurisdiction.

~~(k)~~(j) subject to the provisions of 50-2-130, ~~adopt~~ propose for adoption by the local governing body necessary regulations that are not less stringent than state standards for the control and disposal of sewage from private and public buildings and facilities that are not regulated by Title 75, chapter 6, or Title 76, chapter 4. The regulations must describe standards for granting variances from

the minimum requirements that are identical to standards promulgated by the board of environmental review and must provide for appeal of variance decisions to the department as required by 75-5-305. If the local board of health regulates or permits water well drilling, the regulations must prohibit the drilling of a well if the well isolation zone, as defined in 76-4-102, encroaches onto adjacent private property without the authorization of the private property owner.

~~(2)~~(3) Local boards of health may:

(a) accept and spend funds received from a federal agency, the state, a school district, or other persons or entities;

(b) ~~adopt~~ propose for adoption by the local governing body necessary fees to administer regulations for the control and disposal of sewage from private and public buildings and facilities;

(c) ~~adopt~~ propose for adoption by the local governing body regulations that do not conflict with 50-50-126 [non-profit food establishments and wild game] or rules adopted by the department:

(i) for the control of communicable diseases;

(ii) for the removal of filth that might cause disease or adversely affect public health;

(iii) subject to the provisions of 50-2-130, for sanitation in public and private buildings and facilities that affects public health and for the maintenance of sewage treatment systems that do not discharge effluent directly into state water and that are not required to have an operating permit as required by rules adopted under 75-5-401;

(iv) subject to the provisions of 50-2-130 and Title 50, chapter 48, for tattooing and body-piercing establishments and that are not less stringent than state standards for tattooing and body-piercing establishments;

(v) for the establishment of institutional controls that have been selected or approved by the:

(A) United States environmental protection agency as part of a remedy for a facility under the federal Comprehensive Environmental Response, Compensation, and Liability Act of 1980, 42 U.S.C. 9601, et seq.; or

(B) department of environmental quality as part of a remedy for a facility under the Montana Comprehensive Environmental Cleanup and Responsibility Act, Title 75, chapter 10, part 7; and

(vi) to implement the public health laws;

(d) adopt rules necessary to implement and enforce regulations adopted by the local governing body; and

~~(d)~~(e) promote cooperation and formal collaborative agreements between the local board of health and tribes, tribal organizations, and the Indian health service regarding public health planning, priority setting, information and data sharing, reporting, resource allocation, service delivery, jurisdiction, and other matters addressed in this title.

~~(3)~~(4) A local board of health may provide, implement, facilitate, or encourage other public health services and functions as considered reasonable and necessary.

(5) A directive, mandate, or order issued by a local board of health in response to a declaration of emergency or disaster by the governor as allowed in 10-3-302 and 10-3-303 or by the principal executive officer of a political subdivision as allowed in 10-3-402 and 10-3-403:

(a) remains in effect only during the declared state of emergency or disaster or until the governing body holds a public meeting and

allows public comment and the majority of the governing body moves to amend, rescind, or otherwise change the directive, mandate, or order; and

(b) may not interfere with or otherwise limit, modify, or abridge a person's physical attendance at or operation of a religious facility, church, synagogue, or other place of worship."

Boards of health are administrative boards, administrative boards make decisions about policy, rules/regulations, and financial management, they are not advisory boards that make recommendations only. Boards of health have some mandatory duties, "shall", and some permissive duties, "may", under the law. The board of health recommends the appointment of a local health officer. That appointment must be approved by the local governing body or bodies. Additional duties are the creation and amendment of bylaws, election of officers, and holding regular (at least quarterly) and special meetings as needed. This health board voted in late 2020 to have monthly meetings through the pandemic. A board may no longer "employ" staff, but they still set policy which directs the actions of the health officer who must carry out the "measures as adopted by the local board of health"[11]. The local health officer and Department of Health staff have been employed by the county since, at least, the 2012 City County Compact, for which the City pays a percentage[12] of the salaries which are in the "Sanitarian" budget[13]. This division of pay from oversight is similar to the Library Director who is employed/payed by the City but directed by the Library Board, and for whom the County pays a percentage.

A critical, mandatory, and unreviewable non-emergency duty of the health board, (particularly during an outbreak or pandemic) is to, "(e) identify, assess, prevent, and ameliorate conditions of public health importance through:

(i) epidemiological tracking and investigation;
(ii) screening and testing;
(iii) isolation and quarantine measures;
(iv) diagnosis, treatment, and case management;
(v) abatement of public health nuisances;
(vi) inspections;

[11] Section 50-2-118(4) MCA

[12] Compact says 17%

[13]

1000.000.022.440120.111	49	BAUKUS, ALEXANDER J	HEALTH DEPT DIRECTOR	0.5
1000.000.022.440120.111	50	DESNICK, LAUREL	HEALTH OFFICER	0.02
1000.000.022.440120.111	51	PEARSON, KALEB S	SANITARIAN	1
1000.000.022.440120.111	52	BECKNER, BRIAN	SANITARIAN	1
1000.000.022.440120.111	54	FIEVET, PATRICIA A	HEALTH DEPT ADMIN ASST	0.25

(vii) collecting and maintaining health information;
(viii) education and training of health professionals; or
(ix) other public health measures as allowed by law;"[14]

This requirement for a board of health to set the rules/policy for the tracking, investigation, quarantine, and collection of health information, etc., is the basis upon which the "local health officers or their authorized representatives shall: * * * ~~(4)~~(d) establish and maintain quarantine and isolation measures ***as adopted by the local board of health***;"[15] Emphasis supplied.

Under the board of health's permissive duties, it may propose rules and regulations that may be enforced by the local health officer. That rulemaking authority as it is relevant to the control of disease and infections, and "in order to carry out the purposes of the public health system, in collaboration with federal, state, and local partners" states that:

(3) Local boards of health may:
(a) accept and spend funds received from a federal agency, the state, a school district, or other persons or entities; * * *
(c) ~~adopt~~ propose for adoption by the local governing body regulations that do not conflict with 50-50-126 [non-profit food establishments and wild game] or rules adopted by the department:
(i) for the control of communicable diseases;
* * *; and
(vi) to implement the public health laws;

Any regulations proposed by the board of health are reviewable by the local governing body or bodies and are limited under the statute to the particular purposes stated in the statute. Conversely, a local governing body may create rules or regulations under its emergency or non-emergency powers and the local board of health may, "(d) adopt rules necessary to implement and enforce regulations adopted by the local governing body;"[16] This is, again, one of the ways that a board of health is expected to carry out the purposes of the public health system, in collaboration with federal, state, and local partners.

Either the County Attorney[17] or the Health Officer[18] may enforce the rules enacted by the board of health or the department (DPHHS). The 2021 legislature amended the penalty provision by making the violation of a local board regulation a civil penalty rather than a misdemeanor crime.[19] Local board regulations can be enforced by a local health officer, with the

[14] Section 50-2-116(2)(e)
[15] Section 50-2-118 (1)(d) MCA
[16] Section 50-2-118 (3)(d)
[17] Section 50-2-124 (4) MCA
[18] Section 50-2-118(1)(e) MCA
[19] HB 121 Section 4 and 50-2-124 MCA

appropriate court[20], who may also request the assistance of a peace officer[21]. Violations of DPHHS regulations continue to be misdemeanors. Violations of DPHHS regulations are to be prosecuted by the County Attorney. [22]

Local Health Officers have the same obligation as boards of health to collaborate with federal, state, and local partners, but have only mandatory, not permissive, duties under Section 50-2-118 MCA. Local health officers have emergency authority that is reviewable by the local governing bodies. Local health officers have non-emergency authority to report communicable disease under the rules provided by DPHHS and to establish and maintain isolation and quarantine measures as adopted by a local board of health. HB 121 amended Section 50-2-118 MCA to read: (underlined sections are additions deletions are noted with strikethroughs).

> "**50-2-118. Powers and duties of local health officers.** (1) In order to carry out the purpose of the public health system, in collaboration with federal, state, and local partners, local health officers or their authorized representatives shall:
>
> ~~(1)~~(a) make inspections for conditions of public health importance and issue written orders for compliance or for correction, destruction, or removal of the condition;
>
> ~~(2)~~(b) take steps to limit contact between people in order to protect the public health from imminent threats, including but not limited to ordering the closure of buildings or facilities where people congregate and canceling events;
>
> ~~(3)~~(c) report communicable diseases to the department as required by rule;
>
> ~~(4)~~(d) establish and maintain quarantine and isolation measures as adopted by the local board of health; and
>
> ~~(5)~~(e) pursue action with the appropriate court if this chapter or rules adopted by the local board or department under this chapter are violated.
>
> (2) A directive, mandate, or order issued by a local health officer in response to a declaration of emergency or disaster by the governor as allowed in 10-3-302 and 10-3-303 or by the principal executive officer of a political subdivision as allowed in 10-3-402 and 10-3-403:
>
> (a) remains in effect only during the declared state of emergency or disaster or until the governing body holds a public meeting and allows public comment and the majority of the governing body moves to amend, rescind, or otherwise change the directive, mandate, or order; and
>
> (b) may not interfere with or otherwise limit, modify, or abridge a person's physical attendance at or operation of a religious facility, church, synagogue, or other place of worship."

[20] Section 50-2-118(e) MCA
[21] Section 50-2-120
[22] Section 50-50-107 and

With regard to communicable disease, the non-emergency powers of the local health officer must be guided by the department rules for reporting of communicable diseases, and the local health officer must follow the direction of the local health board which must set standards, rules, and policy to:

> (e) identify, assess, prevent, and ameliorate conditions of public health importance through:
> (i) epidemiological tracking and investigation;
> (ii) screening and testing;
> (iii) isolation and quarantine measures;
> (iv) diagnosis, treatment, and case management;
> (v) abatement of public health nuisances;
> (vi) inspections;
> (vii) collecting and maintaining health information;
> (viii) education and training of health professionals; or
> (ix) other public health measures as allowed by law;

Much like the requirements for notice and the right to be heard, any use of legislative or regulatory authority requires due process, and because the separation of powers is a constitutional limitation on the overreach of agencies or officials, a local health officer cannot exercise powers that they have not been given by either the legislature, the department, or a local board of health. Those powers are, and must be, specifically delegated by the legislature to an administrative official or an administrative agency or board with reasonable clarity, and such powers must not be overly broad, or the delegation of power is void. The Montana Supreme Court has reiterated this holding recently in *Montana Indep. Living Project v. Dep't of Transportation,* 2019 MT 298, ¶¶ 18-19, 398 Mont. 204, 216–18, 454 P.3d 1216, 1222–24, which stated in relevant part:

> Article III, Section 1, of the Montana Constitution details the separation of powers, providing that "No person or persons charged with the exercise of power properly belonging to one branch shall exercise any power properly belonging to either of the others, except as in this constitution expressly directed or permitted." This Court has held that "The Montana Constitution is not a grant but a limitation on legislative power, so that the Legislature may enact any law not expressly or inferentially prohibited by the Constitution." *Plath v. Hi-Ball Contractors*, 139 Mont. 263, 267, 362 P.2d 1021, 1023 (1961) (citations omitted).
>
> The Legislature's law-making power may not be granted to an administrative body to be exercised under the guise of administrative discretion. *Petition to Transfer Territory*, 2000 MT 342, ¶ 15, 303 Mont. 204, 15 P.3d 447
> (citing *Bacus v. Lake County*, 138 Mont. 69, 78, 354 P.2d 1056, 1061 (1960)). Accordingly, when delegating powers to an administrative body, the Legislature must prescribe a policy, standard, or rule for their guidance and must not vest them with an arbitrary and uncontrolled

> discretion. *Bacus*, 138 Mont. at 78, 354 P.2d at 1061; *State v. Mathis*, 2003 MT 112, ¶ 15, 315 Mont. 378, 68 P.3d 756. If the Legislature does not prescribe with reasonable clarity the limits of this *217 power, or if the limits are overly broad, its attempt to delegate is void. *Bacus*, 138 Mont. at 78, 354 P.2d at 1061. Conversely, a statute completely and validly delegates administrative authority when nothing with respect to a determination of what is the law is left to the administrative agency, and its provisions are sufficiently clear, definite, and certain to enable the agency to know its rights and obligations. *Mathis*, ¶ 15.

Consequently, neither the health officer or a board of health can act outside of the limitations in the law, through a public process, and a local health officer must act according to the policies enacted by DPHHS (for reporting to the department) the health board, and the regulations of the health board, as adopted or rejected by the local governing bodies.

Dissemination of Public Health Care Information – State and Federal

The Code of Federal Regulations (CFR) includes the Health Insurance Privacy and Portability Act of 1996(HIPAA). It modernized the flow of healthcare information, stipulates how personally identifiable information maintained by the healthcare and healthcare insurance industries should be protected from fraud and theft, and addressed some limitations on healthcare insurance coverage. An individual who believes that the Privacy Rule is not being upheld can file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). It is a misconception that the Privacy Rule creates a right for any individual to refuse to disclose any health information (such as chronic conditions or immunization records) if requested by an employer or business[23]. This is particularly true for public health care information in the custody and control of a public health authority.[24] The applicable exception to HIPAA, which allows the disclosure of public health care information to other emergency or medical personnel, is in relevant part:

[23] *Federal HIPPA Privacy Rule permits a covered entity to disclose PHI of an individual to LWE, & First Responders~ US DPHHS, Office of Civil Rights. 45 CFR 164.512(a).* https://www.hhs.gov/sites/default/files/covid-19-hipaa-and-first-responders-508.pdf

[24] Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required**.**

A covered entity[25] may use[26] or disclose protected health information[27] without the written authorization of the individual, as described in § 164.508, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally. * * *

(j) ***Standard: Uses and disclosures to avert a serious threat to health or safety*** -

(1) ***Permitted disclosures.*** A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)

(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and *Emphasis supplied*

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in § 164.501.

(2) ***Use or disclosure not permitted.*** A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

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[25] A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

[26] Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

[27] Protected health information means individually identifiable health information:
(1) Except as provided in paragraph (2) of this definition, that is:
(i) Transmitted by electronic media;
(ii) Maintained in electronic media; or
(iii) Transmitted or maintained in any other form or medium.

> **(3) *Limit on information that may be disclosed.*** A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i)[28] of this section.
> **(4) *Presumption of good faith belief.*** A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

A corresponding Montana Statute that defines the confidentiality of government health care information has a similar exception to the federal exception listed above.

> **50-16-603. Confidentiality of health care information.** Health care information in the possession of the department, a local board, a local health officer, or the entity's authorized representatives may not be released except:
> (1) for statistical purposes, if no identification of individuals can be made from the information released;
> (2) when the health care information pertains to a person who has given written consent to the release and has specified the type of information to be released and the person or entity to whom it may be released;
> (3) to medical personnel in a medical emergency as necessary to protect the health, life, or well-being of the named person;
> (4) as allowed by Title 50, chapters 17 and 18;
> ***(5) to another state or local public health agency, including those in other states, whenever necessary to continue health services to the named person or to undertake public health efforts to prevent or interrupt the transmission of a communicable disease or to alleviate and prevent injury caused by the release of biological, chemical, or radiological agents capable of causing imminent disability, death, or infection;*** *Emphasis supplied.*
> (6) in the case of a minor, as required by **41-3-201** or pursuant to an investigation or a safety and risk assessment under **41-3-202** or if the health care information is to be presented as evidence in a court proceeding involving child abuse pursuant to Title 41, chapter 3. Documents containing the information must be sealed by the court upon conclusion of the proceedings.
> (7) to medical personnel, the department, a local health officer or board, or a district court when necessary to implement or enforce state statutes or state or local health rules concerning the prevention or control of diseases designated as reportable pursuant to **50-1-202**, if the release does not conflict with any other provision contained in this part.

[28] (f) (2) (i) (A) Name and address; (B) Date and place of birth; (C) Social security number; (D) ABO blood type and rh factor; (E) Type of injury; (F) Date and time of treatment; (G) Date and time of death, if applicable; and (H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

Additionally, there is no liability for the release of PHI[29] information as it is both, permitted by law and granted immunity for the legislative acts of the health board and the health officer under Section 2-9-111(2) MCA which states, "a governmental entity is immune from suit for a legislative act or omission by its legislative body, or any member or staff of the legislative body, engaged in legislative acts. The exceptions allow, if not require, the dissemination of a person's health information to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, to prevent or interrupt the transmission of a communicable disease or biological agent capable of causing imminent disability, death, or infection[30]. It is the policy of the state of Montana that the health of the public be protected and promoted to the extent practicable through the public health system while respecting individual rights to dignity, privacy, and nondiscrimination[31]. Additionally, Section 50-1-105 sets forth purpose of the public health system and states:

> (2) The purpose of Montana's public health system is to provide leadership and ***to protect and promote the public's health by***:
> (a) ***promoting conditions in which people can be healthy***;
> (b) providing or promoting the provision of public health services and functions, including:
> (i) monitoring health status to identify and recommend solutions to community health problems;
> (ii) investigating and diagnosing health problems and health hazards in the community;
> (iii) informing and educating individuals about health issues;
> (iv) ***coordinating public and private sector collaboration and action to identify and solve health problems***;
> (v) ***developing policies, plans, and programs that support individual and community health efforts***;
> (vi) implementing and enforcing laws and regulations that protect health and ensure safety;
> (vii) linking individuals to needed personal health services and assisting with needed health care when otherwise unavailable;
> (viii) to the extent practicable, providing a competent public health workforce;
> (ix) evaluating effectiveness, accessibility, and quality of personal and population-based health services; and
> (x) to the extent that resources are available, conducting research for new insights on and innovative solutions to health problems;
> (c) ***encouraging collaboration among public and private sector partners in the public health system***;

[29] protected health information
[30] Section 50-16-603(5)
[31] Section 50-1-105(1)

> (d) seeking adequate funding and other resources to provide public health services and functions or accomplish public health system goals through public or private sources;
> (e) striving to ensure that public health services and functions are provided and public health powers are used based upon the best available scientific evidence; and
> (f) implementing the role of public health services and functions, health promotion, and preventive health services within the state health care system. *Emphasis supplied.*

Furthermore, Montana DPHHS includes emergency medical personnel in its calculation of staffing as a scarce resource and requires the protection of scarce resources during a pandemic, particularly where there is a surge in cases. The relevant DPHHS documents state in relevant part:

> The Montana Department of Public Health and Human Services (DPHHS) is the assigned primary agency of Emergency Support Function 8 – Public Health & Medical Services (ESF-8). This assignment is based on the Montana Emergency Response Framework. The purpose of DPHHS is to protect, maintain, and improve the health of all Montanans. The Crisis Standards of Care (CSC) Framework—referred to as the "CSC Framework" or "the Framework"—addresses specific challenges of a pervasive or catastrophic public health event that warrant a change in standard of care, shifting focus from individual patients to the good of the community.[32]
>
> In the event of a large-scale disaster, either a no-notice event such as a natural disaster or a prolonged situation such as a pandemic, there is the potential for an overwhelming number of critically ill or injured patients. In these situations, certain medical resources may become scarce and prioritization of care may need to be considered. Medical surge is a complex multifactorial event, the response to which is equally complex. In an effort to better understand, measure, discuss best practices and manage medical surge, it is essential to have an overall guiding framework.
>
> In the Framework, and on the issue and continuum of surge capacity, crisis capacity is the most serious. Crisis Capacity is defined as: Adaptive spaces, staff, and supplies are not consistent with usual standards of care but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity 1 activation constitutes a significant adjustment to standards of care.[33]
>
> Trigger: A "decision point about adaptations to health care service delivery" that requires specific action. A trigger event dictates action is needed to adapt health care delivery and resources. Triggers can be scripted or non-scripted. Scripted

[32] Scarce Resource Management and Crisis Care Guidance - Front Matter (mt.gov)
[33] Scarce Resource Management & Crisis Care Guidance Overview & Materials (mt.gov)

> triggers are built into Standard Operating Procedures (SOPs) and are automatic. Id.
>
> Potential Indicators with associated local Trigger (threshold that 'triggers' specific action is specified in agency/facility plans):
> • Unable to answer all EMS calls;
> • More than 12 hours of wait time for emergency department visits;
> • Unable to maintain staffing in the Intensive Care Unit (ICU);
> • Fewer than 5 percent of hospital beds available, no beds available;
> • No ICU beds available in the healthcare organization; or a disaster declaration affects more than one area hospital;
> • Shortage of specific equipment (ventilators) or of medications that have no substitute 'if/then' actions. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff.[34]
>
> In the Framework there is a duty of public health to steward resources. Duty to steward resources means: healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives. *Id.* Staffing is a scarce resource. *Id.*

Consequently, the Montana policy that governs health boards, health officers, and departments of health, that "the health of the public be protected and promoted to the extent practicable through the public health system while respecting individual rights to dignity, privacy, and nondiscrimination", and the statutory mandate for public health entities "to collaborate with federal, state, and local partners", leads to only one logical conclusion: that public health entities must provide at least names and addresses to protect emergency responders during a pandemic.

[34] Scarce Resource Management and Crisis Care Guidance - Front Matter (mt.gov)