

# Comments on CDC Plan for Quarantine Station Expansion

Guthrie Birkhead MD MPH

New York State Department of Health

Representing the

Association of State and Territorial  
Health Officials (ASTHO)

IOM Committee

January 20, 2005

# Quarantine and State Public Health: Historical Perspective

- Both tied to the history of public health in US
- Both at the forefront of responding to bioterrorism and emerging infectious diseases such as SARS, Flu, etc.
- Both have primary police powers:
  - DGMQ: ports of entry, interstate
  - State/local health: within their borders
- Key conclusion: need to strengthen coordination and communication;

# Coordination and Communication in One State: New York

- Kennedy Airport Quarantine station;
- Major shipping ports of entry;
- 3 major border crossings with Canada;  
(SARS: proximity to Toronto).
- New York is a major international destination for tourists and immigrants
- New York has been a terrorist target in the past

# Kennedy Airport Quarantine Station

- New York City Dept of Health has major role:
  - Plague in 1994 (also Port of Albany),
  - Ebola in 1995,
  - Suspect H5N1 flu in 1997,
  - Cruise ship outbreaks – chickenpox,
  - SARS in 2002,
  - Designation of communicable disease hospitals and protocols for triage and transport of suspect patients.
- Biologics – botulinum antitoxin

# Needs identified for improved coordination and communication.

- Better education and coordination with customs/immigration,
- Better protocols and drills for suspect smallpox, ebola, on a flight,
- Cruise ship issues,
- Potential for Biowatch detectors in airports,
- Better protocols for working with airlines re: tracking contacts (NJ Lassa case, 8/04), measles, meningococcal cases).

# Other Border Crossings

- During SARS:
  - Distribute informational fliers
  - Potential role in screening for illness
  - Referral to local hospitals for medical evaluation
  - Local concerns about transferring patients from Toronto to NY hospitals.

# Immigrant/Migrant Issues

- Immigrants
  - TB
  - Lead poisoning
- Adoptees
  - SARS

# ASTHO: Informal Survey of Impacted States

- Past State HD experience with Q-stations:
  - Limited interactions – antitoxin, sick travelers
  - Not much interaction around preparedness activities.
- State involvement with expansion plan:
  - Limited knowledge and involvement so far.
  - Details of plan and direct discussions have not yet taken place

# ASTHO: Informal Survey of Impacted States

- State view of “new partner” vision and function:
  - States supportive in general
  - See value of medical epidemiologists, public health advisors, veterinarians, and information technologists at Q-stations to interact with.
  - As with any new partnership, need to explore and agree upon respective roles and responsibilities before implementation.

# ASTHO Survey

## Conclusions:

- States have limited (or no) info on proposal.
- Critical to begin detailed discussions early in the planning process.
  - Different issues in each state/locality
  - Include local health agencies
  - Work out roles, coordination, communication (including crisis communications plan).
  - Need to clarify boundary/jurisdictional issues.
  - Need for state-specific MOUs(?)

# ASTHO Survey Conclusions

- Integrate into state/local public health and preparedness planning efforts:
  - Joint preparedness training/planning.
  - Develop, and drill, joint protocols
  - Communication plan for good coordination
  - Q-stations surge capacity plan needs to rely in the first instance on Federal assets.
  - In a wide-scale emergency (e.g SARS), state and local assets will be occupied elsewhere (possible liaison at each others op-centers)

# ASTHO Survey Conclusions

- Funding:
  - State BT/preparedness funding is now beginning to be reduced.
  - Expanded State responsibilities that carry a price tag need to have increased state funding.
  - State/local funding needs to be preserved
  - Q-station funding (not at state expense)