PUBLIC HEALTH PREPAREDNESS

HHS Should Assess Jurisdictional Planning for Isolation and Quarantine

Report to Congressional Committees

July 2024
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GAO Highlights

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Highlights of GAO-24-106705, a report to congressional committees
July 2024

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Why GAO Did This Study

As of June 2024, over 1.1 million people in the United States have died from COVID-19, according to CDC. State and territorial (jurisdictional) governments have primary responsibility for leading the preparation for and response to public health emergencies, with federal support through guidance and funding awards. When jurisdictions' capabilities are insufficient, HHS is charged with leading the federal public health and medical response. GAO added HHS leadership of public health emergencies to its High-Risk List in 2022.

The Consolidated Appropriations Act, 2023 included a provision for GAO to review selected jurisdictions' isolation and quarantine planning. Regarding isolation and quarantine, this report examines (1) selected jurisdictions' COVID-19 actions, (2) their planning, (3) federal agencies' support to jurisdictions, and (4) CDC's efforts to assess jurisdictional planning. GAO reviewed documentation and interviewed officials from seven jurisdictions selected for geographic variation and representatives from five national public health associations. GAO also reviewed documentation and interviewed officials from HHS and the Federal Emergency Management Agency.

What GAO Recommends

GAO is making two recommendations to CDC to (1) document its intentions to share finalized isolation and quarantine guidance with jurisdictions before publication; and (2) assess jurisdictional planning for isolation and quarantine. HHS agreed with the recommendations.

What GAO Found

When a new disease presents a public health emergency, isolation and quarantine are among the first measures available to limit disease spread. All seven selected jurisdictions (states and territories) GAO reviewed used isolation and quarantine for the COVID-19 pandemic. Officials from these jurisdictions identified considerations for implementing such measures for COVID-19, including difficulty with enforcement and isolation and quarantine facility logistics.

Examples of Selected Jurisdictions' COVID-19 Isolation and Quarantine Actions

Isolation or quarantine action	Number of selected jurisdictions (of seven)
Guidance: Shared guidance about isolation and quarantine with the public and stakeholders, such as on websites or through contact tracing.	7
Isolation or quarantine facilities: Offered facilities for individuals or family members to isolate or quarantine when unable to do so at home.	7
Enforced isolation or quarantine: Enforced isolation or quarantine orders through fines or jail time.	1

Source: Selected jurisdictions including Alabama, American Samoa, Hawaii, New Jersey, Rhode Island, South Dakota, and Texas (information); GAO (icons). | GAO-24-106705

The selected jurisdictions carried out some isolation and quarantine planning before the COVID-19 pandemic. Four had detailed plans based on past experiences with diseases such as H1N1 influenza, while the remaining three had high-level provisions within emergency plans. In response to COVID-19 experiences, the selected jurisdictions have taken steps to strengthen their isolation and quarantine planning, such as updating plans to identify potential facilities for isolation and quarantine.

Federal agencies—primarily the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC)—provided guidance and awarded funding to jurisdictions during the COVID-19 pandemic that could be used to support isolation and quarantine efforts. However, CDC did not provide advance notice of isolation and quarantine guidance to jurisdictions before publication, which slowed jurisdictions' implementation of these measures. CDC has a new process for developing and sharing guidance, and officials told GAO the agency intends to provide advance notice to jurisdictions when possible. However, CDC has not documented its intentions to provide advance notice. Doing so will help ensure CDC implements its approach as planned and thereby help jurisdictions prepare for and effectively implement isolation and quarantine when needed.

Additionally, CDC has not assessed jurisdictions' planning for isolation and quarantine. As a result, CDC is missing information to identify and address gaps in jurisdictions' planning, including the absence of such plans. The National Biodefense Strategy directs CDC to determine any gaps in disease mitigation preparedness, including for isolation and quarantine. By assessing jurisdictions' planning, CDC could better fulfill this responsibility and identify and help address any gaps in jurisdictional planning for future disease outbreaks.

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Abbreviations

ASPR	Administration for Strategic Preparedness and Response
CDC	Centers for Disease Control and Prevention
FEMA	Federal Emergency Management Agency
HHS	Department of Health and Human Services
PanCAP Adapted	Pandemic Crisis Action Plan Adapted: U.S. Government COVID-19 Response Plan
PHEP	Public Health Emergency Preparedness

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GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

July 25, 2024

The Honorable Bernard Sanders
Chair
The Honorable Bill Cassidy
Ranking Member
Committee on Heath, Education, Labor and Pensions
United States Senate
The Honorable Cathy McMorris Rodgers
Chair
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

As of June 2024, over 1.1 million people in the United States had died from COVID-19, according to the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC). State and territorial governments—jurisdictions—have primary responsibility for leading the preparation for and response to public health threats and emergencies, including those caused by an infectious disease like COVID-19.[1] HHS awards funds and provides guidance to jurisdictions to prepare for infectious disease threats and support jurisdictions' response in times of emergency.

When a new disease presents a public health emergency, isolation, quarantine, and other non-pharmaceutical interventions, such as handwashing and social distancing, are the first public health countermeasures that are readily available to respond to that new disease, according to CDC and the World Health Organization.[2] Isolation—separating sick people with an infectious disease from people who are not sick—and quarantine—restricting the movement of people who were exposed to an infectious disease—are methods for containing and mitigating the spread of infectious diseases like COVID-19 during the public health emergency, according to CDC.

States and territories are responsible for enforcing isolation and quarantine within their borders. They also are responsible for developing plans to prepare for emergencies, such as those needing isolation and quarantine. Such plans are not required to include isolation and quarantine measures. CDC—the agency within HHS responsible for protecting the nation's health—is authorized to take measures to prevent the introduction, transmission, or spread of infectious diseases from foreign countries into the U.S. and between states.[3] These measures include taking federal actions for isolation and quarantine. CDC also assists jurisdictions in the

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[1]We refer to states, territories, and the District of Columbia as jurisdictions for the purposes of this report. According to CDC, Tribes enforce isolation and quarantine law within tribal lands, if such laws exist. Tribes were outside the scope of this review.

[2]The Secretary of Health and Human Services may declare a public health emergency upon a determination that a) a disease or disorder presents a public health emergency; or b) a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. 42 U.S.C. § 247d(a).

[3]42 U.S.C. § 264(a).

prevention and suppression of infectious diseases. This support can include cooperating with and aiding jurisdictions in the enforcement of their quarantine regulations.[4] Generally, if jurisdictions' response capabilities are exceeded, they may seek support from the federal government.

The Consolidated Appropriations Act, 2023 included a provision for us to review selected jurisdictions' isolation and quarantine planning and related federal assistance.[5] This report is also part of our body of work on HHS's leadership of public health emergencies, which we identified as an area of high risk.[6] We added this topic to our High-Risk List in 2022, citing the critical need for the nation to be prepared for, and effectively respond to, future public health threats and emergencies.

This report

1. describes the isolation and quarantine actions selected jurisdictions took in response to the COVID-19 pandemic;

2. describes selected jurisdictions' planning for isolation and quarantine;

3. examines the federal support provided for jurisdictions' isolation and quarantine efforts; and

4. evaluates the extent to which CDC assesses jurisdictions' planning for isolation and quarantine.

For three of the objectives, we reviewed documentation and interviewed health department officials from a nongeneralizable sample of seven of 56 jurisdictions (states, territories, and the District of Columbia) and representatives from five national associations representing state, territorial, local, and tribal public health officials. We selected six states and one territory—which we refer to as selected jurisdictions—to obtain variation in the following characteristics: geographic location, health department governance structure (i.e., the relationship between state and local health agencies), population size and rurality, duration of imposed travel restrictions for COVID-19, federal funding awarded to jurisdictions that could have been used for isolation or quarantine activities, and extent of homeless population.[7] We selected and interviewed health department officials from the following jurisdictions: American Samoa, Alabama, Hawaii, New Jersey, Rhode Island, South Dakota, and Texas. (See fig. 1.) Information from selected jurisdictions is not generalizable to other jurisdictions. Additionally, we selected three national associations that represent all state, territorial, or local

[4] 42 U.S.C. § 243(a).

[5] Pub. L. No. 117-328, § 2114, 136 Stat. 4459, 5726 (2022).

[6] See GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203 (Washington, D.C.: Apr. 20, 2023) and GAO, *COVID-19: Significant Improvements Are Needed for Overseeing Relief Funds and Leading Responses to Public Health Emergencies*, GAO-22-105291 (Washington, D.C.: Jan. 27, 2022).

[7] We used the following data sources to select a diverse group of jurisdictions: U.S. Census Bureau 2020 Census, CDC governance health structures listing, CDC COVID-19 Crisis Response Cooperative Agreement Funding Data, Department of Homeland Security Public Assistance Grants Manager, and Department of Housing and Urban Development 2020 Annual Homelessness Assessment Report. We assessed the reliability of these data by reviewing related documentation. Based on this assessment, we determined that these data were sufficiently reliable for the purposes of selecting jurisdictions.

health department officials; one association that represents all tribal health officials; and one association that represents all state and territorial political leaders.[8]

[8]We interviewed representatives from the following national associations: Association of State and Territorial Health Officials, National Association of County and City Health Officials, Council of State and Territorial Epidemiologists, National Indian Health Board, and National Governors Association.

Figure 1: Characteristics of Selected Jurisdictions

South Dakota
Largely centralized
886,667
43% rural

New Jersey
Decentralized
9,288,994
6% rural

Rhode Island
Centralized
1,097,379
9% rural

Texas
Largely decentralized
29,145,505
16% rural

Alabama
Largely centralized
5,024,279
42% rural

American Samoa
N/A
49,710
24% rural

Hawaii
Centralized
1,455,271
14% rural

Public health governance structure[a]
Population size, 2020 (percent rural)

Source: GAO analysis of U.S. Census Bureau, Centers for Disease Control and Prevention (CDC) data (data); GAO (icons); MapResource (United States mainland); bonilla1879/stock.adobe.com (Hawaii); lesniewski/stock.adobe.com (American Samoa). | GAO-24-106705

Note: We refer to states and territories as jurisdictions for the purposes of this review.

[a]Public health governance structure indicates the relationship between state health departments and local public health units, according to CDC. Centralized or largely centralized governance indicates that local health units are primarily led by employees of the state. Decentralized or largely decentralized governance indicates that local health units are primarily led by employees of local governments.

To describe the isolation and quarantine actions selected jurisdictions took in response to the COVID-19 pandemic, we reviewed documentation and interviewed health department officials from the selected

jurisdictions for information on actions from January 2020 through May 2023—the beginning and end of the public health emergency declaration for COVID-19. We reviewed documentation of actions taken, such as guidance, planning documents, and other support. For the purposes of this review, we included actions jurisdictional governments took to promote isolation or quarantine, including issuing guidance, offering facilities, offering wraparound services, issuing orders, or enforcing isolation or quarantine.[9] Jurisdictions can use other community mitigation measures in conjunction with isolation and quarantine, such as travel restrictions or social distancing. We interviewed jurisdictional health department officials about isolation and quarantine actions taken for COVID-19 and the challenges or other considerations that influenced their actions. We also interviewed representatives from the five national associations to gain a broader perspective on jurisdictions'—including state, territorial, tribal, and city or county jurisdictions—isolation and quarantine experiences.

To describe the selected jurisdictions' planning for isolation and quarantine, we reviewed their isolation and quarantine planning documents developed before and in response to the COVID-19 pandemic.[10] We also interviewed officials from the selected jurisdictional health departments and representatives from national associations to gain further perspective on jurisdictional preparedness planning efforts. Additionally, to describe isolation and quarantine planning informed by COVID-19 experiences across all state and territorial jurisdictions, we reviewed work plans submitted by 50 states, five territories, and the District of Columbia describing how they would use funding from CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement program for the 2022-2023 budget period.[11]

To examine the federal support provided for jurisdictions' isolation and quarantine efforts, we reviewed documentation and interviewed officials from the Administration for Strategic Preparedness and Response (ASPR) and CDC within HHS, and the Federal Emergency Management Agency (FEMA) within the Department of Homeland Security. This included documentation and interviews about technical assistance and funding awards that the agencies provided to help jurisdictions implement isolation and quarantine during the COVID-19 public health emergency, as well as CDC's plans to provide support in the future. We reviewed CDC and FEMA COVID-19 award data and associated documentation to determine which jurisdictions used awards for isolation and quarantine purposes.[12] We assessed the reliability of these award data by reviewing

[9]Wraparound services refer to supportive services such as delivery of food, medicine, or transportation to individuals in isolation or quarantine. We limited our review to actions for the general public isolating or quarantining at home or in facilities specifically for isolation or quarantine purposes, rather than at other types of institutions such as schools or health care facilities. Repatriation of individuals from abroad at the outset of the COVID-19 pandemic is outside the scope of this review. For more information on federal repatriation for COVID-19 see *COVID-19: HHS Should Clarify Agency Roles for Emergency Return of U.S. Citizens during a Pandemic*, GAO-21-334 (Washington, D.C.: Apr. 19, 2021). For information on COVID-19 response at other healthcare facilities, see for example *COVID-19 in Nursing Homes: Outbreak Duration Averaged 4 Weeks and Was Strongly Associated with Community Spread*, GAO-23-104291 (Washington, D.C.: Dec. 15, 2022).

[10]We define planning prior to the COVID-19 pandemic as any plans or procedures created before COVID-19 was declared a public health emergency on January 31, 2020. Isolation and quarantine planning developed in response to the COVID-19 pandemic includes COVID-19-specific documents and plans and procedures developed since the public health emergency through April 2024.

[11]Through the PHEP program, CDC provides annual awards to states and other jurisdictions to aid capacity building and preparedness for "all hazard" public health threats, including infectious diseases, extreme weather events, or terrorist threats. For more information on PHEP funding, see *Public Health Preparedness: Building and Maintaining Infrastructure beyond the COVID-19 Pandemic*, GAO-24-105891 (Washington, D.C.: Nov. 7, 2023).

[12]We examined agency data on CDC Public Health Crisis Response cooperative agreement funding for 2020 and FEMA Public Assistance grant funding as of June 2023 to identify recipients that reported using the award for isolation or quarantine purposes. We did not examine or verify reported award amounts.

documentation and discussing them with agency officials. Based on this assessment, we determined that these data were sufficiently reliable for determining which jurisdictions used the awards, but not how much funding each jurisdiction received.

Further, to examine federal support, we compared a new process CDC instituted in August 2023 for developing public health guidance, including for isolation and quarantine, against its responsibilities outlined in federal strategies for emergency response. These strategies included the Pandemic Crisis Action Plan Adapted: U.S. Government COVID-19 Response Plan (PanCAP Adapted) and the National Response Framework.[13] We also assessed CDC's new public health guidance development process against selected federal internal control standards for control environment, implementing control activities, communicating quality information, and monitoring.[14] Additionally, we interviewed selected jurisdictional health department officials about their experiences with federal agencies' support for isolation and quarantine, including the technical assistance and awards they received and any challenges they encountered. We also interviewed representatives from the five selected national associations to gain a broader perspective on jurisdictions' experiences.

To evaluate the extent to which CDC assesses jurisdictions' planning for isolation and quarantine, we reviewed CDC documentation on jurisdictional preparedness and response assessments, including CDC's guidance on what jurisdictions should submit for these assessments in 2019 through 2024, and interviewed officials. We compared CDC's efforts to assess jurisdictional isolation and quarantine planning against its responsibilities outlined in the National Biodefense Strategy, which directs CDC to determine gaps in preparedness and response for community mitigation measures (i.e., nonpharmaceutical interventions).[15]

To help ensure the accuracy of the facts and statements presented from our interviews, we provided relevant excerpts of the draft report to the jurisdictions we interviewed. We incorporated, as appropriate, their technical comments. The views of the jurisdictions and national associations interviewed are not generalizable beyond those entities.

We conducted this performance audit from March 2023 to July 2024 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[13]See Department of Health and Human Services, *PanCAP Adapted: U.S. Government COVID-19 Response Plan* (Mar. 13, 2020); and Department of Homeland Security, *National Response Framework, Fourth Edition* (Oct. 28, 2019).

[14]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). We also reviewed CDC's Public Health Guidance Development Framework against selected federal internal control standards that our prior work has identified and applied to federal agencies' guidance processes. See *Regulatory Guidance Processes: Selected Departments Could Strengthen Internal Control and Dissemination Practices*, GAO-15-368 (Washington, D.C.: Apr. 16, 2015).

[15]The White House, *National Biodefense Strategy and Implementation Plan for Countering Biological Threats, Enhancing Pandemic Preparedness, and Achieving Global Health Security* (Washington, D.C.: October 2022).

Background

State and territorial governments—jurisdictions—have primary responsibility for leading the preparation for and response to public health threats and emergencies. Jurisdictional health departments also assist local health departments and providers in responding to emergencies. When jurisdictions' capabilities are insufficient, they may seek additional support from the federal government. With respect to biological threats specifically, the National Biodefense Strategy explains how the U.S. government will manage its activities to more effectively assess, prevent, prepare for, respond to, and recover from biological threats. The federal government does so by coordinating its biodefense efforts with those of state, local, tribal, territorial, and international partners, industry, academia, nongovernmental entities, and the private sector.

CDC Public Health Emergency Preparedness Cooperative Agreement

HHS components award funding to jurisdictions to prepare for infectious disease and other public health threats through several programs, one of which includes PHEP cooperative agreements.

CDC administers the PHEP cooperative agreements, established in 2002, to jurisdictions with the goal of developing effective public health emergency management and response programs nationwide.[16] Through PHEP cooperative agreements, CDC provides annual awards to jurisdictions to aid capacity building and preparedness for "all-hazard" public health threats, including infectious disease outbreaks, extreme weather events, or terrorist threats. As a condition of receiving a PHEP award, jurisdictions must have an "All-Hazards Preparedness and Response Plan." While PHEP recipients are required to address nonpharmaceutical interventions in these all-hazard plans, according to CDC, there is no requirement for them to address isolation or quarantine specifically.[17]

As part of PHEP, CDC established public health preparedness capability standards in 2011 and updated them in 2018. The *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health* describe standards for 15 capabilities designed to help jurisdictions prepare for emergencies.[18] Isolation and quarantine activities are embedded in capability 11: nonpharmaceutical interventions. CDC defines nonpharmaceutical interventions as actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. Nonpharmaceutical interventions, also referred to as community mitigation measures, can include isolation, quarantine, restrictions on movement, social distancing, external decontamination, hygiene, or precautionary protective behaviors, according to CDC.

[16]The PHEP cooperative agreement program provides awards to 62 jurisdictions (50 states, four localities, and eight U.S. territories and freely associated states).

[17]See 42 U.S.C. § 247d-3a(b)(2)(A).

[18]Specifically, CDC designed the capability standards to advance the emergency preparedness and response capacity of jurisdictional public health systems. CDC, *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health* (Atlanta, Ga.: Oct. 2018). See CDC, "Public Health Emergency Preparedness and Response Capabilities," https://www.cdc.gov/readiness/php/capabilities/index.html, accessed June 27, 2024. Beginning in 2024, CDC will use a new Public Health Response Readiness Framework that will focus on 10 priority areas that are essential to our ability to prepare for, respond to, and recover from health threats, according to CDC's website.

CDC requires PHEP award recipients to develop and implement work plans outlining how they will use PHEP awards. Jurisdictional PHEP recipients must use their PHEP awards to build and sustain their public health preparedness and response capacity, according to PHEP program documentation. Recipients develop work plans for each budget period within a 5-year PHEP performance period, the most recent of which covered 2019-2024.

Federal Public Health Emergency Response and the COVID-19 Pandemic

If an emergency is severe enough that jurisdictional response capabilities are insufficient, jurisdictional governments may seek support from the federal government. The PanCAP Adapted describes the structure and authorities for the federal government to lead and coordinate the COVID-19 response.[19]

HHS is required to lead the federal public health and medical response to public health emergencies and incidents covered by the National Response Framework, which guides the nation's response on disasters and emergencies.[20]

Within HHS, the following components are involved in such a response.

- **ASPR.** ASPR serves as the principal advisor to the Secretary of Health and Human Services on all matters related to federal public health and medical preparedness and response to public health emergencies.
- **CDC.** CDC has a lead role in addressing public health emergency preparedness and response, including detecting and responding to new and emerging disease threats. CDC is authorized to issue quarantine orders to prevent the spread of infectious diseases from foreign countries into the United States and between states.[21] CDC also assists states and localities in the prevention and suppression of infectious diseases, including cooperating with and aiding states and localities in the enforcement of their quarantine regulations.[22]

While HHS is the lead for the public health and medical response, FEMA, an agency within the Department of Homeland Security, coordinates the overall federal response during Presidentially-declared disasters and

[19]The Biological Incident Annex to the Response and Recovery Federal Interagency Operational Plan provides strategic guidance for interagency coordination during a response to a biological incident. Department of Homeland Security, *Biological Incident Annex to the Response and Recovery Federal Interagency Operational Plan*, May 2023. The PanCAP, approved in 2018, operationalizes the Biological Incident Annex with a focus on potential viral pandemic pathogens and the PanCAP Adapted adapts federal response actions for COVID-19. Specifically, the PanCAP Adapted outlines key federal decisions, federal actions, and interagency coordination structures that may be used during the COVID-19 response. Department of Health and Human Services, *PanCAP Adapted: U.S. Government COVID-19 Response Plan* (Mar. 13, 2020).

[20]42 U.S.C. § 300hh(a). Department of Homeland Security, *National Response Framework, Fourth Edition* (Oct. 28, 2019). The National Response Framework establishes an all-hazards response structure to coordinate federal resources during emergencies and disasters and is divided into 15 emergency support functions, which are functional areas that are most frequently needed during a national response. HHS, through ASPR, is the lead agency for Emergency Support Function #8: Public Health and Medical Services Response.

[21]Under 42 U.S.C. § 264, the Secretary of Health and Human Services may make and enforce regulations necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States and between the states.

[22]See 42 U.S.C. § 243(a).

emergencies. HHS and FEMA can also make certain awards available to jurisdictions to respond to emergencies and disasters.

Under section 319 of the Public Health Service Act, the Secretary of Health and Human Services may issue a public health emergency declaration.[23] Such a declaration triggers the availability of certain authorities under federal law that may allow the federal government to increase support to and reduce administrative burdens on jurisdictions. On January 30, 2020, the Secretary of Health and Human Services declared a public health emergency for COVID-19, which expired on May 11, 2023.

In addition, on March 13, 2020, the President declared COVID-19 a nationwide emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.[24] The President also approved major disaster declarations under the Stafford Act for all 50 states, the District of Columbia, five territories, and certain Tribes. These declarations made available additional authorities to assist jurisdictions. The Stafford Act incident period terminated on May 11, 2023.

Selected Jurisdictions Took a Range of Isolation and Quarantine Actions for COVID-19

Selected Jurisdictions’ COVID-19 Isolation and Quarantine Actions

The seven selected jurisdictions (states and territories) took a range of actions to promote isolation and quarantine and limit the spread of disease during the public health emergency for COVID-19. Specifically, isolation and quarantine actions jurisdictional officials reported taking ranged from issuing public guidance to offering facilities for isolation and quarantine; providing wraparound services—such as food delivery services—to encourage compliance; requiring individuals to isolate or quarantine; and enforcing isolation or quarantine. (See fig. 2.)

[23] 42 U.S.C. § 247d.

[24] 42 U.S.C. § 5191.

Figure 2: Examples of Selected Jurisdictions' COVID-19 Isolation and Quarantine Actions, 2020 to 2023

Isolation or quarantine action	Number of jurisdictions (of seven)
Guidance Shared guidance about isolation and quarantine with the public and stakeholders, such as on websites or through contact tracing—calls or texts to identify and notify those who test positive for or are exposed to COVID-19.	7
Isolation or quarantine facilities Contracted with hotels or others to offer facilities for individuals or family members to isolate or quarantine when unable to do so at home.	7
Wraparound services Provided supportive or "wraparound" services such as delivery of food, medicine, or transportation to individuals isolating or quarantining at facilities or at home.	7
Isolation or quarantine orders Issued one or more official isolation or quarantine orders to individuals.	6
Enforced isolation or quarantine[a] Enforced isolation or quarantine orders through fines or jail time.	1

Source: Selected jurisdictions (information); GAO (icons). | GAO-24-106705

Note: GAO reviewed documentation and interviewed health department officials from seven selected jurisdictions: American Samoa, Alabama, Hawaii, New Jersey, Rhode Island, South Dakota, and Texas.

[a]For the purposes of this report we define enforcement to include fines or jail time. Jurisdictions also monitored compliance of individuals in isolation or quarantine such as by placing phone calls to or conducting home or facility visits, but without imposing fines or jail time.

Guidance. All seven selected jurisdictions shared guidance about home isolation and quarantine with the public and stakeholders such as local health officials. Isolation and quarantine guidance generally recommended when to isolate or quarantine and for how long. For example, New Jersey's guidance as of September 2022 instructed individuals to isolate for 5 days after testing positive for COVID-19, which aligned with CDC guidance at the time. The selected jurisdictions used various means to share isolation and quarantine guidance, such as website updates, public service announcements, social media posts, and communication with community sources. Six of the selected jurisdictions translated the guidance into other languages.

Examples of COVID-19 Isolation and Quarantine Facilities

Some jurisdictions, including all those we interviewed, offered facilities for individuals or family members to isolate or quarantine in when unable to do so at home. The types of facilities, number of facilities, and time frames differed across the selected jurisdictions. Examples of selected jurisdictions' COVID-19 isolation and quarantine facility arrangements include the following:

- Rhode Island's centralized health department managed five facilities at various times between 2020 and 2023, including facilities for individuals and families. The health department used one state-owned facility, contracted with two hotels, and worked with other departments and charitable organizations to operate some of the facilities and provide wraparound services.
- Hawaii's centralized state health department contracted with hotels to provide facilities in every county from 2020 through 2021. Anyone without housing or unable to isolate safely at home was eligible. The health department also contracted for wraparound services such as food and used case managers to offer care coordination and behavioral health care.

Source: Hawaii Department of Health, Rhode Island Department of Health. | GAO-24-106705

Additionally, all of our selected jurisdictions conducted some contact tracing or helped local health departments conduct contact tracing—telephone calls or letters to people that tested positive for COVID-19 and their close contacts to inform them of isolation and quarantine guidance. Officials from two jurisdictions noted they conducted contact tracing as resources allowed and staff could keep up with cases.

Isolation or quarantine facilities. All selected jurisdictions offered facilities for individuals or family members to isolate or quarantine when unable to do so at home. Jurisdictions often offered these facilities for certain vulnerable populations such as unhoused individuals, students, or health care workers. For example, three of the seven jurisdictions provided facilities mainly for individuals experiencing homelessness. In the two island jurisdictions, the government made facilities available to anyone who could not safely isolate or quarantine at home. The type and number of facilities and time frames for offering facilities varied by selected jurisdiction. (See sidebar.) In some jurisdictions, the state-level public health department supported isolation and quarantine facilities offered by local (e.g., city or county-level) health departments. Representatives from national associations representing state, territorial, local, and tribal public health officials also noted use of facilities at each of these levels of government.

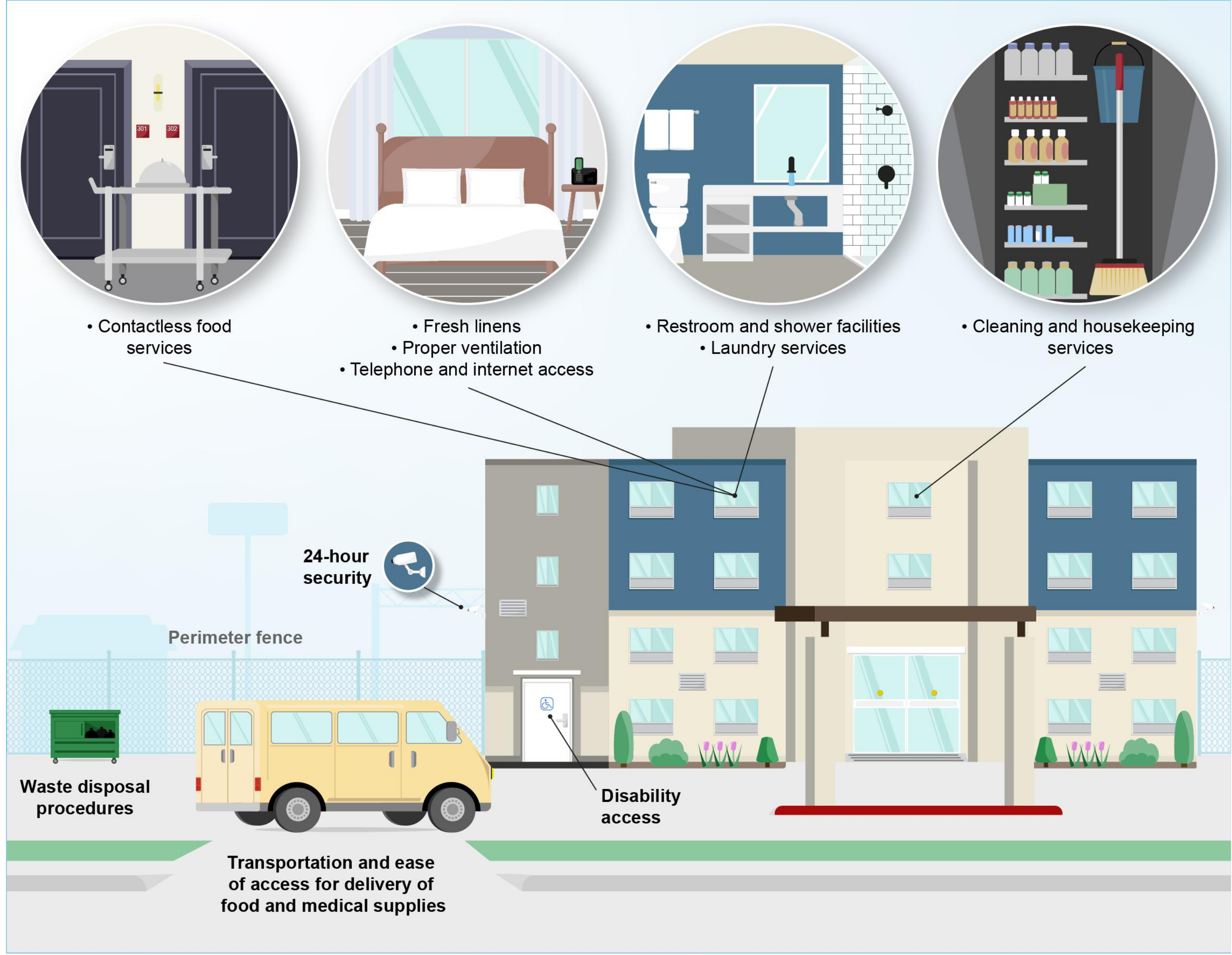
Wraparound services. All selected jurisdictions provided supportive or "wraparound" services such as delivery of food, laundry, medicine, mental health care, religious services, entertainment, or transportation to

individuals isolating or quarantining at facilities or at home. In some places, health officials we interviewed noted the value of offering wraparound services to promote compliance with isolation and quarantine guidance. Jurisdictions delivered the services in various ways, such as contracting with vendors (Alabama, Rhode Island, and Texas) or using their Medical Reserve Corps volunteers (Hawaii).[25] Additionally, Rhode Island provided state-funded cash assistance to individuals in isolation or quarantine who met certain criteria to promote compliance, according to health officials. Representatives from national associations representing local and tribal public health officials also noted local and tribal governments offered wraparound services to their residents. For example, certain Tribes offered food delivery, medication, and other services, and for one Tribe, a traditional healer to people in isolation, according to representatives from a national association.

Jurisdictions identified some characteristics and wraparound services as valuable to include in isolation and quarantine facilities, according to planning documents. (See fig. 3.)

[25]The Medical Reserve Corps consists of health care volunteers—medical and public health professionals—as well as others who donate their time to help strengthen a response to public health emergencies by augmenting federal, state, and local capabilities and building community resilience. See generally 42 U.S.C. § 300hh-15. For more information on the use of Medical Reserve Corps volunteers, see *Public Health Preparedness: Information on the Use of Medical Reserve Corps Volunteers during Emergencies*, GAO-20-630 (Washington, D.C.: Sept. 14, 2020).

Figure 3: Examples of Characteristics and Wraparound Services for Isolation and Quarantine Facilities Identified by Selected Jurisdictions



Source: GAO analysis of jurisdiction preparedness plans (information); GAO (illustration). | GAO-24-106705

Note: GAO reviewed documentation from seven selected jurisdictions: American Samoa, Alabama, Hawaii, New Jersey, Rhode Island, South Dakota, and Texas.

Isolation or quarantine orders. Six selected jurisdictions (American Samoa, Alabama, Hawaii, Rhode Island, South Dakota, and Texas) issued official isolation or quarantine orders to individuals, though health officials in all but one jurisdiction said they used orders rarely.[26] One of the jurisdictions—Alabama—issued quarantine orders for every individual who tested positive for COVID-19 through late 2022, which was very resource intensive for the health department, according to officials. The island jurisdictions—American Samoa and

[26]An isolation or quarantine order requires an individual to isolate or quarantine for a certain amount of time or until they are able to confirm their status through testing, according to the National Conference of State Legislatures.

Hawaii—had more widespread quarantine requirements, though they did not issue quarantine orders for all individuals. For example, American Samoa required American Samoans seeking to repatriate to the island to first quarantine for 7 days in Hawaii then for another 14 days upon arrival in American Samoa.

Enforcement of isolation or quarantine. One of the selected jurisdictions—Hawaii—engaged law enforcement to enforce isolation or quarantine orders through fines for certain individuals. Specifically, in limited cases Hawaii imposed fines on travelers and Hawaiian residents who were repeatedly noncompliant with isolation or quarantine orders. Additionally, health officials from both island jurisdictions explained that they worked with public safety and other departments to monitor compliance with isolation or quarantine requirements during some of the response.

Considerations for Implementing Isolation and Quarantine

Selected jurisdictional officials and national public health association representatives identified considerations for, or challenges with, taking isolation and quarantine actions for COVID-19.

Enforcement of isolation and quarantine. Officials from five selected jurisdictions and representatives from two national associations identified enforcing isolation or quarantine orders or requirements as a challenge. Officials cited time frames for pursuing legal enforcement before an individual's isolation or quarantine period had ended and the reluctance of law enforcement to pursue the issue as reasons for difficulty with enforcement.

For example, officials from three jurisdictions noted the need to see a judge to enforce isolation or quarantine. Officials from one of these jurisdictions said it would have required dozens of lawyers to enforce quarantine orders. Moreover, courts in the jurisdiction would have a month to hold a hearing once a petition was filed to enforce an isolation and quarantine order, by which time the individual's isolation or quarantine period may have ended before enforcement could occur, according to officials.

Law enforcement reluctance was another consideration according to officials in one jurisdiction. These officials said some local sheriffs refused to deliver isolation and quarantine orders. Representatives from two national associations confirmed this concern, stating that some states experienced challenges obtaining buy-in from law enforcement in enforcing orders, for example, because law enforcement officers might place themselves at risk of getting COVID-19 during enforcement.

Rather than enforce isolation and quarantine, some selected jurisdictions generally sought to promote voluntary compliance such as by offering facilities and culturally relevant wraparound services, according to jurisdictional officials. For example, by providing needed services and home comforts, people were more likely to remain at home or a facility, officials told us.

Logistics of offering quarantine facilities. Health officials from four selected jurisdictions and representatives from three national associations identified the logistics of offering isolation and quarantine facilities—such as identifying hotels willing to house sick people or providing wraparound services—as an impediment to quickly opening or operating such facilities. For example, officials from three jurisdictions and representatives from three national associations noted that many hotels initially did not want to participate because of concerns about contaminating rooms or becoming known as a "COVID-19 hotel." According to officials from a jurisdiction and a national association, some selected jurisdictions used government or other

facilities in addition to hotels to house people in isolation or quarantine, which officials told us also proved difficult.

With respect to offering wraparound services, officials from two jurisdictions noted the unexpected need for and difficulty identifying transportation services to transport sick individuals to and from isolation and quarantine facilities. Again, some of the difficulty was due to commercial transportation services, such as public buses or ride-hailing applications, being disinclined to serve sick individuals, officials from one jurisdiction said. The jurisdictions contracted with ambulance companies to provide transportation, which was very expensive, according to officials from one jurisdiction.

Contracting for hotel rooms and wraparound services was another difficulty cited by jurisdictional officials. Specifically, officials from two jurisdictions said the process of contracting for hotel rooms and wraparound services was difficult due to state procurement procedures.

Financial and staffing strain on jurisdictions. Officials from four selected jurisdictions and representatives from two national associations said financial and staffing resources to implement isolation and quarantine actions were challenges during the pandemic. Standing up and maintaining facilities as well as offering wraparound services were costly for jurisdictional governments, according to representatives from two national associations.

Another challenge for jurisdictions was the strain it put on their human resources. Officials from a jurisdiction and representatives from two national associations noted that jurisdictions had few health department staff to maintain isolation and quarantine facilities or conduct contact tracing, which in some cases limited the services the jurisdiction could provide. For example, one jurisdiction did not have enough contact tracers, which resulted in a lag between when people needed health department support and when the department became of aware of that need. Generally, health departments often did not have the resources to hire new staff and therefore had to reassign existing staff to the COVID-19 response, causing burnout, according to representatives from two national associations.

To offset staffing limitations, in one jurisdiction, the behavioral health office took over management of the isolation and quarantine facility program and employed case managers to manage it and volunteer health workers to deliver wraparound services, according to officials.

Communication with public. Isolation and quarantine only work to limit disease spread if people listen and comply, according to representatives from one national association. Officials from four jurisdictions and representatives from four national associations said countering misinformation or providing clear communication about isolation and quarantine was a challenge they faced in encouraging compliance with isolation and quarantine during the COVID-19 pandemic. At the same time, media and social media spread misinformation about public health interventions, according to officials from one jurisdiction and representatives from two national associations. Officials in one jurisdiction also said the COVID-19 experience had eroded public trust and health departments' ability to implement isolation and quarantine in the future.

To combat difficulty communicating about isolation and quarantine, jurisdictional public health officials we interviewed said they took various actions, such as dedicating resources to communication, employing new communication methods—such as robust social media or website development—and leveraging community groups. For example, officials in three jurisdictions told us that partnering with trusted community leaders—such as village leaders, church leaders, and professional organizations—helped to effectively communicate the

importance of isolation and quarantine. Officials from two jurisdictions also noted the importance of translating guidance and materials into culturally relevant languages to improve communication.

Mental and financial strain on individuals and families. Isolation and quarantine place restrictions on people's movement and their ability to work, go to school, or access normal activities. Jurisdictional public health officials with responsibility for implementing isolation and quarantine must consider the trade-offs of limiting disease spread and the effect on these activities.[27] Officials from four jurisdictions and representatives from two national associations acknowledged the social, emotional, or financial consequences of isolation and quarantine on populations, including children. As officials from one jurisdiction elaborated, the general public was unprepared for teleworking and distance learning, and isolation and quarantine policies were generally disruptive.

Selected jurisdictions took action to defray the negative consequences of isolation and quarantine by offering various supports to people, such as mental health care, entertainment, or cash assistance. For example, two jurisdictions made technology services available to connect people in quarantine with family and friends or behavioral health providers to decrease feelings of loneliness.

Nature of COVID-19 transmission. Additionally, officials from two jurisdictions and representatives from one national association noted that isolation and quarantine is generally a good tool for containing and mitigating spread of diseases such as Ebola virus disease or tuberculosis. By contrast, the potentially asymptomatic and fast spread of COVID-19 reduced the effectiveness of isolation and quarantine as a mitigation method for this disease, they noted. This became particularly true as COVID-19 spread widely in communities. Moreover, officials from these two jurisdictions and representatives from two national associations identified testing capacity or delayed test results, particularly at the beginning of the pandemic, as limiting jurisdictions' ability to conduct timely contact tracing.

Selected Jurisdictions Did Some Isolation and Quarantine Planning Before the COVID-19 Pandemic and Are Revising Planning for Future Threats

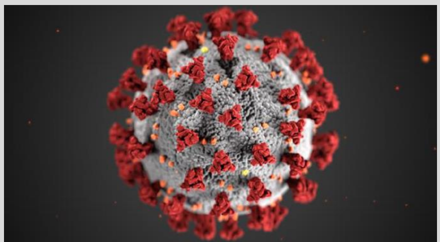
Selected Jurisdictions' Isolation and Quarantine Planning Before the COVID-19 Pandemic

Prior to the COVID-19 pandemic, four of the seven selected jurisdictions had operational isolation and quarantine plans that could be applied to infectious diseases generally, while three did not have such plans, according to documents we reviewed from the selected jurisdictions. CDC defines operational plans as describing roles and responsibilities, tasks, integration, and actions required of a jurisdiction during emergencies. The documentation we reviewed showed that the three jurisdictions without operational plans that could be applied to infectious diseases generally had high-level isolation and quarantine provisions as part of emergency plans. For the purposes of this review, high level provisions are those which mention isolation

[27]GAO has also reported that the health and economic effects of the COVID-19 pandemic have intensified concerns about the increasing numbers of people affected by behavioral health conditions and in need of treatment. See *Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers*, GAO-23-105250 (Washington, D.C.: Oct. 27, 2022).

and quarantine as possible nonpharmaceutical interventions but do not detail practical considerations for implementation. As a condition of receiving a PHEP award, jurisdictions must have an "All-Hazards Preparedness and Response Plan"; however, there is no requirement for these plans to address isolation or quarantine specifically.

List of Quarantinable Diseases



Isolation and quarantine help protect the public by preventing exposure to people who have or may have a contagious disease, such as COVID-19, according to CDC. CDC maintains a list of quarantinable diseases for which the Secretary of Health and Human Services can authorize isolation and quarantine, including:

- Cholera
- Infectious tuberculosis
- Diphtheria
- Plague
- Smallpox
- Yellow fever
- Viral hemorrhagic fevers, such as Ebola virus disease
- Severe Acute Respiratory Syndromes, such as COVID-19
- Flu that can cause pandemic
- Measles

Source: Centers for Disease Control and Prevention (CDC) (information), CDC, Alissa Eckert, Dan Higgins (image). | GAO-24-10670

Operational isolation and quarantine plans. Prior to the COVID-19 pandemic, four selected jurisdictions—American Samoa, Hawaii, New Jersey, and South Dakota—had detailed, operational isolation and quarantine plans that could be applied to infectious diseases generally. For example, American Samoa's health department officials told us they used their Isolation and Quarantine Plan, last updated in January 2020, to respond to other quarantinable infectious diseases prior to the COVID-19 pandemic, including H1N1 influenza, measles, and chikungunya virus. Hawaii officials said that the health department used its 2008 Pandemic Influenza Preparedness and Response Plan to respond to the H1N1 pandemic. Hawaii, New Jersey, South Dakota, and American Samoa's operational plans delineated health department responsibilities and described isolation and quarantine implementation in detail, among other considerations, such as:

- **Isolation and quarantine facilities.** For example, New Jersey's 2003 Severe Acute Respiratory Syndrome Preparedness and Response Plan acknowledged that a widespread infectious disease threat may require isolation and quarantine outside of hospital or healthcare settings.

Additionally, Hawaii's plan indicated that homes or other facilities—such as hotels—may serve as isolation facilities for individuals unable to isolate at home or when hospital isolation beds reached capacity. New Jersey and Hawaii's plans established site selection criteria for isolation and quarantine facilities such as food and laundry service, telephone and internet access, bathroom facilities, and controlled entry.

- **Authorities.** Hawaii's plan documented the health department's authorities relating to isolation and quarantine, noting the health department's ability to require isolation and quarantine, implement its pandemic plan, and advise and inform the governor on the progression of the disease threat. New Jersey, South Dakota, and American Samoa's plans similarly noted the jurisdictional health departments' legal authorities to require individuals to isolate or quarantine.
- **Wraparound services.** American Samoa's plan, for example, charged the health department with providing for isolated or quarantined individuals' needs through services such as meal preparation, mental and behavioral health support, transportation, and childcare. Hawaii's plan similarly instructed the health department to provide wraparound services to individuals in quarantine to promote physical and mental health. Specifically, under the plan, the health department maintained a memorandum of agreement with the local American Red Cross chapter to provide basic necessities and mental health support.
- **Enforcement and compliance.** For example, Hawaii's health department planned to call quarantined individuals twice daily at random times to ensure compliance with quarantine orders. If quarantined individuals did not answer such calls, then the plan charged a health department representative with visiting the quarantined individual to ensure compliance or confirm non-compliance with quarantine orders. In the event of non-compliance, the plan outlined law enforcement's authority to locate and confine individuals in violation of the quarantine order. South Dakota's 2006 Pandemic Influenza Plan established that the health department maintain protocols for monitoring individuals in isolation and quarantine and work with law enforcement and the Attorney General's office to enforce movement restrictions. Additionally, American Samoa planned to require individuals placed in isolation or quarantine to sign a document indicating agreement to comply with isolation and quarantine requirements. It also charged the health department's medical director with determining the scope of monitoring necessary for individuals in isolation or quarantine.

High-level isolation and quarantine provisions in emergency plans. Three selected jurisdictions mentioned isolation and quarantine at a high level in their public health emergency preparedness plans prior to the COVID-19 pandemic. However, they did not have detailed operational isolation and quarantine plans that could be applied to infectious diseases generally. For example, one jurisdiction's Pandemic Influenza Plan mentioned isolation as a possible consideration for the general public in the event of an infectious disease threat but did not provide further detail.

Another jurisdiction used its 2015 Respiratory Viruses Having Pandemic Potential Plan to respond to communicable diseases requiring isolation such as tuberculosis and H1N1 influenza, according to jurisdictional officials. This plan detailed operations for pandemic response such as surveillance activities, communication procedures, and incident command structures but did not include isolation and quarantine procedures.

Selected Jurisdictions Are Revising Isolation and Quarantine Planning Based on COVID-19 Experience

Operationalizing Isolation and Quarantine during the COVID-19 Pandemic

The Rhode Island Department of Health developed several documents to operationalize isolation and quarantine procedures during the COVID-19 pandemic. For example:

Quarantine and Isolation Support Plan guided officials in determining isolation and quarantine thresholds, assessing the need for various services, and discerning roles and responsibilities.

Food Delivery Protocol established protocols for meeting urgent food needs for those in isolation.

Case Investigation, Data Management, & Operations guided support staff in managing data, conducting case investigations, and understanding case management operations for those in isolation and quarantine.

First COVID-19 Case Protocol established isolation and quarantine procedures for the first confirmed case of COVID-19 in Rhode Island.

Quarantine and Isolation Cash Assistance Procedures outlined procedures for providing cash assistance to low-income individuals in isolation and quarantine to promote compliance.

Source: Rhode Island Department of Health documents. | GAO-24-106705

In response to their COVID-19 experiences with implementing isolation and quarantine, six selected jurisdictions planned for isolation and quarantine by documenting isolation and quarantine processes in new plans, documenting procedures within plans, or both. Additionally, officials from four selected jurisdictions, including the remaining jurisdiction that had not yet documented isolation and quarantine procedures or updated plans, told us they are planning to further update their isolation and quarantine plans to respond to future threats.

Efforts to strengthen isolation and quarantine planning. The selected jurisdictions engaged in efforts to strengthen their isolation and quarantine planning during their COVID-19 response, including by documenting COVID-19 procedures or updating already existing preparedness plans (see fig. 4).

Figure 4: Examples of Selected Jurisdictions' Documented Isolation and Quarantine Planning During the COVID-19 Response

Type of planning for isolation and quarantine	Number of jurisdictions (of seven)	Example
Describing ideal facility characteristics	2	American Samoa's 2021 plan documented procedures for prioritizing isolation and quarantine facilities with perimeter fencing, 24-hour security, disability access, ease of access for food and medical supply delivery, and proper ventilation.
Defining contact tracing procedures[a]	3	Alabama's 2020 plan documented the health department's protocols for contact tracing, including that health department staff gather information on symptoms, provide isolation and quarantine recommendations, and investigate symptomatic contacts.
Planning for wraparound services[b]	4	Rhode Island's 2020 plan identified and documented stakeholders across the state to provide services such as food, routine medical care, behavioral health support, pet needs, employment services, and educational support to those in isolation or quarantine.
Delineating enforcement mechanisms or authorities[c]	5	Texas's 2020 plan documented protocol for staff at isolation and quarantine facilities to engage law enforcement if individuals are noncompliant with isolation and quarantine requirements.
Identifying possible isolation and quarantine facilities	5	South Dakota's 2020 plan documented the health department's partnership with hotels willing to provide isolation and quarantine services to areas of the state without local isolation and quarantine facilities.

Source: GAO analysis of selected jurisdictions' preparedness plans (information); GAO (icons). | GAO-24-106705

Note: Some selected jurisdictions' preparedness plans specifically referenced the COVID-19 pandemic, while others were more general. All plans included in this analysis were developed or updated by jurisdictions during the COVID-19 response based on their COVID-19 experiences. That is, the plans were updated in 2020 or later.

[a]Contact tracing is telephone calls or letters to people that tested positive for COVID-19 and their close contacts to inform them of isolation and quarantine guidance. Jurisdictions documented public health officials responsible for conducting contact tracing.

[b]Jurisdictions planned to provide supportive or "wraparound" services such as food, medicine, or transportation to individuals isolating or quarantining at home or in a facility.

[c]Three jurisdictions planned to engage law enforcement if individuals were found to be noncompliant with isolation and quarantine protocols. The remaining jurisdictions' plans discussed protocols for monitoring compliance of individuals in isolation and quarantine.

- **Documented COVID-19 procedures.** During the COVID-19 public health emergency from January 2020 through May 2023, five selected jurisdictions—Alabama, Hawaii, Rhode Island, South Dakota, and Texas—developed and documented COVID-19 isolation and quarantine procedures, such as isolation and quarantine facility operations and protocols for providing wraparound services.[28] For example, Texas's state health department developed an Isolation and Quarantine Facility Project Manual to describe operational procedures for facilities stood up during the COVID-19 pandemic. Texas regional health departments used the centralized planning document while operating isolation and quarantine facilities in the field, rather than developing their own operations, according to officials.

[28]For the purposes of this review, we define documenting COVID-19 procedures as memorializing such procedures or processes in planning documents.

Selected jurisdictions also revised existing preparedness and response plans to meet their needs for the COVID-19 response, according to officials. For example, health department officials from three jurisdictions—Alabama, New Jersey, and Rhode Island—told us they referred to existing Ebola virus disease-specific plans with isolation and quarantine procedures when responding to the COVID-19 pandemic. Our review of these plans showed that they did not include considerations for larger-scale isolation and quarantine implementation, as was needed for the COVID-19 response. As such, Ebola virus disease-specific isolation and quarantine procedures were not fully applicable to the COVID-19 response.

- **Updating preparedness plans.** During the COVID-19 response, two selected jurisdictions—American Samoa and Hawaii—developed or revised operational preparedness plans to codify isolation and quarantine procedures. Officials from another four selected jurisdictions told us they intended to update their preparedness plans to reflect COVID-19 experiences and to prepare for future emergencies. For example, health department officials from one jurisdiction told us they planned to draft broad guidelines for isolation and quarantine that can be customized as needed based on the disease. Officials from the remaining selected jurisdiction told us that while they intended to update their preparedness plans to reflect experiences from the COVID-19 pandemic generally, they are not changing isolation and quarantine planning. Additionally, representatives from a national association suggested jurisdictions could develop and maintain relationships with governmental and non-governmental organizations, such as hotels or food banks, and consider contract and payment mechanisms. Jurisdictions could document such updates in their preparedness plans.

Other considerations for isolation and quarantine planning. Jurisdictional health department officials also identified factors that could affect future isolation and quarantine planning, such as the availability of federal funds to support planning efforts and potential changes to jurisdictional health department authorities.

- **Leveraging PHEP funds for isolation and quarantine planning.** Our review of PHEP work plans for 50 states, five territories, and the District of Columbia for the 2022-2023 budget period showed that 24 of 56 jurisdictions planned to use PHEP funds for isolation or quarantine preparedness activities.[29] Nineteen of these 24 jurisdictions intended to update their isolation and quarantine plans using PHEP funds. Jurisdictions proposed using PHEP awards to support various strategies for updating their isolation and quarantine plans. For example, one state's health department planned to incorporate feedback from local, state, and tribal partners, as well as lessons learned from its COVID-19 After Action Review, according to its PHEP work plan from the 2022-2023 budget period. Other examples of jurisdictions' planned activities using PHEP funds included identifying isolation and quarantine facilities and developing isolation and quarantine plans for special populations.
- **Planning for potential changes to authorities.** According to representatives we interviewed from two national public health associations, some jurisdictional legislatures have limited health departments' isolation and quarantine authorities such that they may not have the same authority to implement isolation and quarantine as they did during the COVID-19 response.[30] This may have implications for isolation and

[29]Jurisdictions receiving PHEP funds submit annual work plans to CDC to document how they plan to use their PHEP awards in accordance with CDC's 15 capabilities for public health emergency management and response. Our review of PHEP work plans included the 50 states, the five territories, and Washington, D.C. We excluded cities that received PHEP funding for the 2022-2023 PHEP budget period because our review focused on the state and territorial level of government.
[30]For example, see M. Davis, et al., "Emergency Powers and the Pandemic: Reflecting on Legislative Reforms and the Future of Public Health Response," *Journal of Emergency Management,* vol. 21, no. 7 (2023): 19–35.

quarantine planning as public health preparedness capability standards instruct jurisdictions to consider legal authorities in preparedness planning.

Federal Agencies Supported Jurisdictions’ COVID-19 Isolation and Quarantine Efforts In Several Ways; CDC Has a New Process for Developing and Communicating Guidance

Federal agencies’ support of jurisdictions’ use of isolation and quarantine during the COVID-19 pandemic included providing technical assistance, such as by publishing guidance on isolation and quarantine recommendations, and awarding funding. However, selected jurisdictional officials and national association representatives noted challenges with CDC’s isolation and quarantine guidance development and communication. CDC has created a new process for developing and issuing public health guidance, but the agency has not documented its intention to communicate guidance to jurisdictions in advance of publication when feasible.

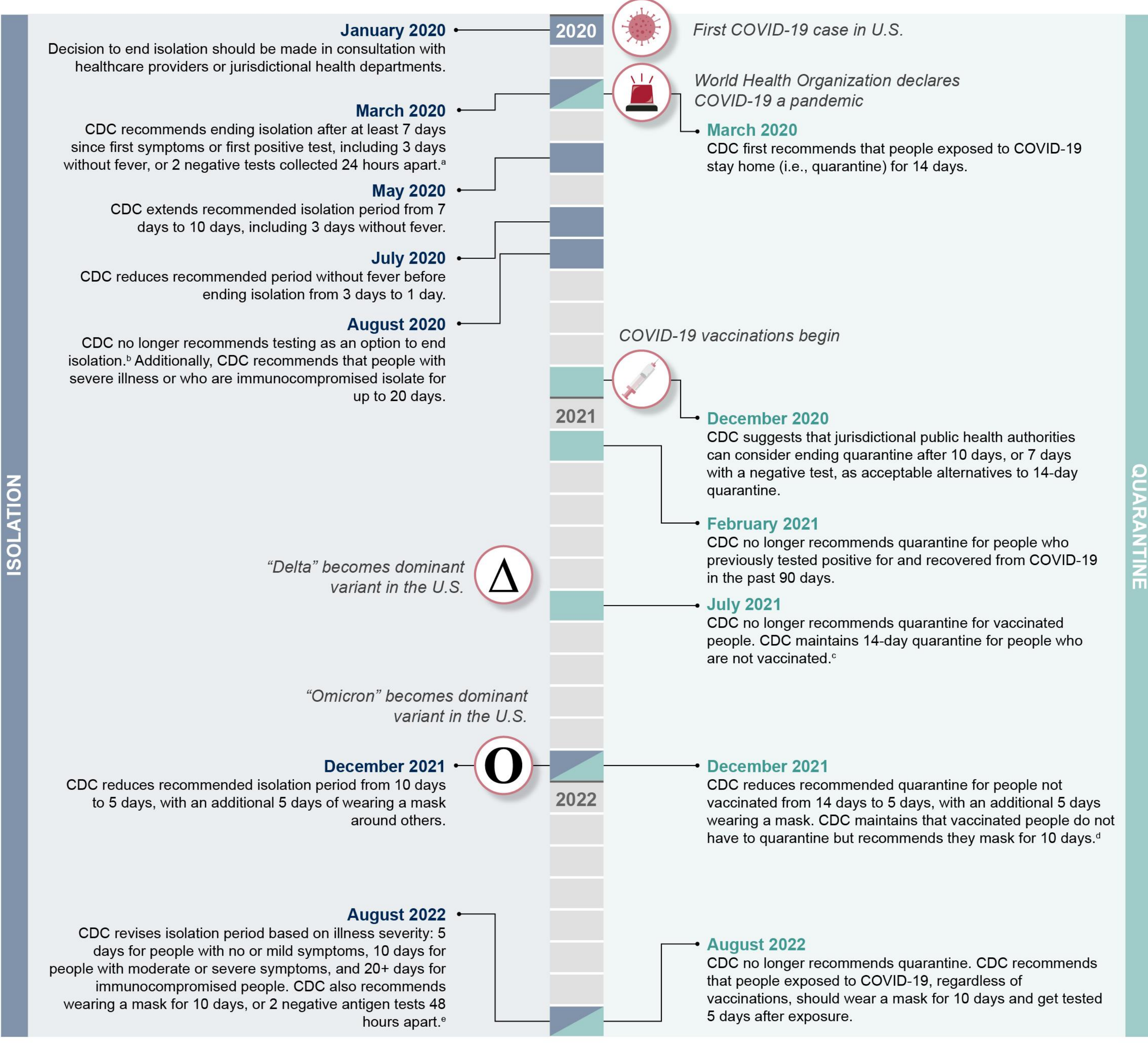
ASPR, CDC, and FEMA Provided Technical Assistance and Awarded Funding to Jurisdictions for COVID-19 Isolation and Quarantine; Selected Jurisdictions Identified Some Challenges

ASPR, CDC, and FEMA supported jurisdictions’ use of isolation and quarantine by providing technical assistance and awarding funding during the COVID-19 pandemic. Officials from our selected jurisdictions and national association representatives identified some challenges associated with this federal support.

Technical assistance. ASPR, CDC, and FEMA provided technical assistance on COVID-19 isolation and quarantine by issuing guidance, answering inquiries, convening partners, and to a lesser extent, deploying federal staff to support jurisdictions.

- **Publishing guidance.** CDC provided written COVID-19 isolation and quarantine guidance on its website and frequently updated guidance as new science emerged. (See fig. 5.)

Figure 5: Selected Changes to CDC Guidance on Isolation and Quarantine for COVID-19, 2020-2022



Source: GAO analysis of Centers for Disease Control and Prevention (CDC) documents; GAO (icons). | GAO-24-106705

Note: Isolation separates sick people with COVID-19 from people who are not sick, and quarantine restricts the movement of people who were exposed to COVID-19. We included only selected changes to CDC guidance on isolation and quarantine, such as changes to duration, in this figure. CDC updated COVID-19 isolation and quarantine guidance based on emerging science and its understanding of the novel virus and new variants, according to CDC officials.

On March 1, 2024, CDC revised its COVID-19 guidance to align with guidance for other respiratory viruses, such as influenza. As of June 2024, CDC recommended that people with respiratory virus symptoms stay home and away from others until at least 24 hours after their overall symptoms are getting better and they have not had a fever. CDC recommended that people take additional precautions, such as additional steps for cleaner air,

hygiene, masks, physical distancing, or testing, for 5 days after resuming normal activities. See CDC, "Preventing Spread of Respiratory Viruses When You're Sick," https://www.cdc.gov/respiratory-viruses/prevention/precautions-when-sick.html, accessed June 7, 2024.

[a]Specifically, in March 2020, CDC recommended discontinuing isolation after at least (a) 72 hours since recovery (i.e., resolution of fever and improvement in symptoms) and 7 days since first symptoms; (b) resolution of fever, improvement in symptoms, and two negative tests collected over 24 hours apart; or (c) 7 days after first positive test, for individuals without symptoms.

[b]CDC recommended that most people with COVID-19 end isolation 10 days after first symptoms or first positive test, although testing to end isolation may be considered in some instances.

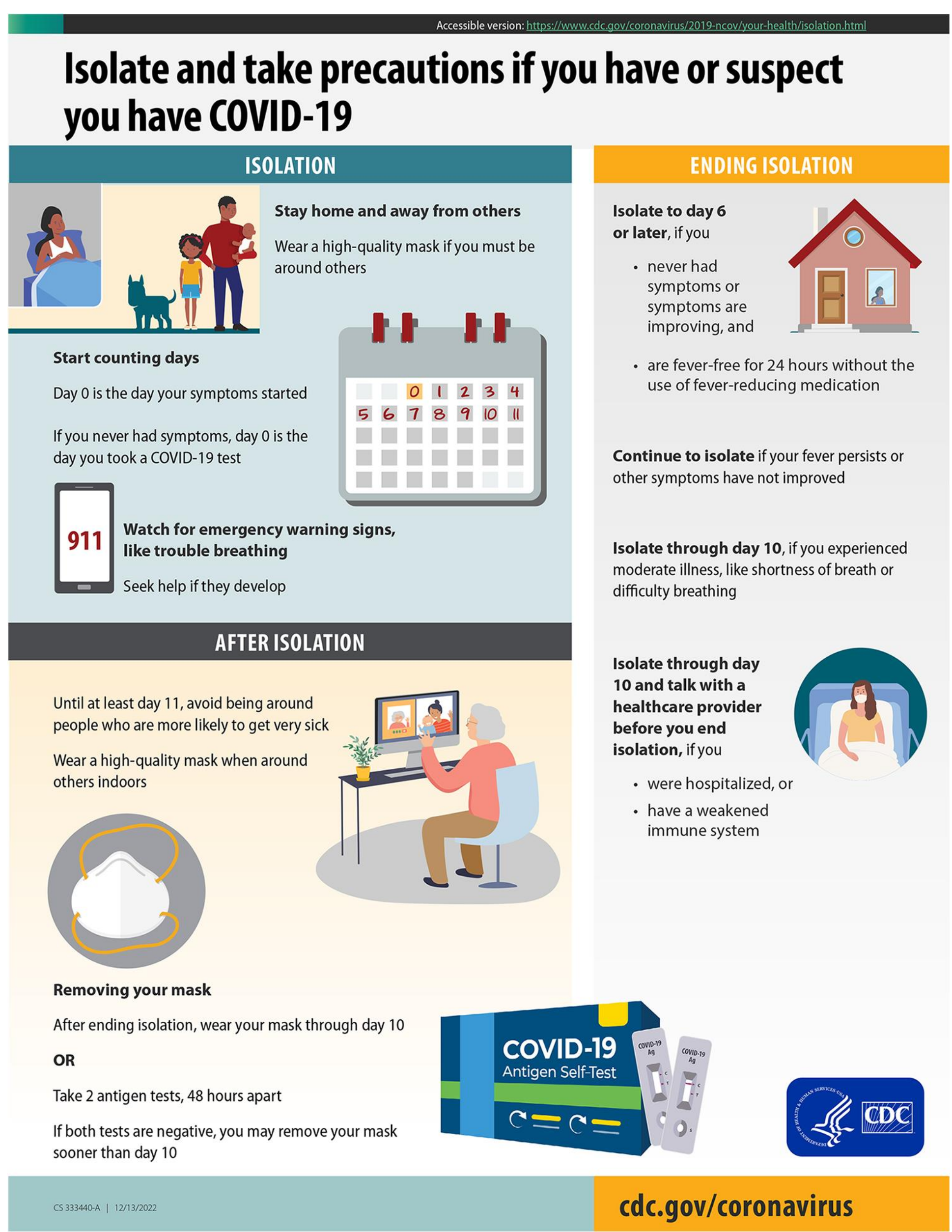
[c]At the time of this guidance, CDC counted individuals as being fully vaccinated if they received two doses on different days (regardless of time interval) of the two-dose vaccines or received one dose of a single-dose vaccine.

[d]Specifically, CDC recommended 5-day quarantine for people who were unvaccinated or more than 6 months out from their second two-dose vaccine (or more than 2 months out from their one-dose vaccine) and had not yet received a booster vaccine dose.

[e]Antigen tests, including self-tests or at-home tests, are rapid tests that usually produce results in 15-30 minutes.

CDC's guidance included recommendations for who should isolate or quarantine and for how long. Some guidance applied to the general public and other guidance was specific to certain settings, such as patients or providers in healthcare facilities. Officials from our selected jurisdictions told us that they used CDC's guidance to help establish their own guidance on isolation and quarantine. See figure 6 for an example of CDC guidance on isolation for COVID-19.

Figure 6: CDC Guidance on Isolation and Precautions for Individuals with COVID-19, December 2022



Source: Centers for Disease Control and Prevention. | GAO-24-106705

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- **Answering inquiries.** Federal officials answered jurisdictions’ questions on isolation and quarantine through consultation calls and emails. CDC received over 675 inquiries from states, territories, localities, and Tribes related to COVID-19 isolation and quarantine as of May 2023, according to officials; these included inquiries from all of the selected jurisdictions in our review. CDC

officials told us they resolved most of these requests by sharing and clarifying existing guidance. CDC officials also said that they received a large volume of questions from jurisdictions related to CDC's December 2021 guidance change, when it reduced the recommended isolation period from 10 days to 5 days (see fig. 5). ASPR also responded to technical assistance requests on isolation and quarantine, for example, by providing information on isolation and quarantine for people experiencing homelessness. Additionally, CDC, ASPR Regional Office, and FEMA Regional Office officials told us they answered jurisdictions' questions about applying for and using federal award funding for supporting isolation and quarantine.

- **Convening partners.** CDC and ASPR also convened jurisdictions and stakeholders in national and regional groups to facilitate sharing of information on isolation and quarantine, according to agency officials. For example, CDC officials told us they facilitated several national Community of Practice webinars where jurisdictions shared best practices on topics including isolation and quarantine. ASPR addressed isolation in a number of trainings, according to officials, including a webinar that discussed considerations for using hotels for COVID-19 isolation and quarantine. Additionally, two national public health associations facilitated calls with CDC officials and jurisdictions to share information and discuss challenges, according to association representatives. Selected jurisdictional officials cited information-sharing calls as particularly helpful. For example, officials from one jurisdiction said that they learned through CDC calls how other jurisdictions were contracting with hotels for isolation and quarantine.
- **Deploying staff.** CDC deployed teams of CDC staff to jurisdictions to serve multiple purposes during the COVID-19 pandemic, according to agency officials, but it did not specifically deploy staff to jurisdictions to assist with isolation and quarantine. Officials from four selected jurisdictions told us that federal staff deployed for other purposes did assist with isolation and quarantine. For example, CDC officials told us that their deployed staff helped one selected jurisdiction develop wraparound services for people in isolation and quarantine. Additionally, a few jurisdictions leveraged federally-supported staffing resources for isolation and quarantine. For example, officials in two jurisdictions told us that individuals in the Medical Reserve Corps—a volunteer program overseen by ASPR—assisted with isolation and quarantine.[31]

Awards. CDC and FEMA awarded funding to jurisdictions that could be used to support isolation and quarantine for COVID-19. Specifically, CDC awarded funding through the Cooperative Agreement for Emergency Response: Public Health Crisis Response and the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging and Infectious Diseases Cooperative Agreement, and FEMA awarded funding through the Public Assistance grant. These funding sources each permitted, but did not require, jurisdictions to use these funds to support isolation and quarantine for COVID-19.[32] (See table 1.) For example, 40 of 56 jurisdictions that received CDC's Cooperative Agreement for Emergency Response: Public Health Crisis Response funding in 2020, including five of our seven selected jurisdictions, requested to use their award for activities related to isolation and quarantine in their initial work plans, according to CDC documentation.[33] Additionally, FEMA's Public Assistance grant program awarded funding to eligible entities in

[31]ASPR oversees the Medical Reserve Corps program and supports the units by providing communications, grants and contract oversight, and information for communities to establish, implement, and maintain Medical Reserve Corps units, among other things.

[32]CDC and FEMA did not require award recipients to use their awards for isolation or quarantine activities or track expenditures for isolation and quarantine, according to officials. Officials from selected jurisdictions noted that they may have used other federal funding for isolation and quarantine as well.

[33]For the purposes of this review, jurisdictions included 50 states, five territories, and the District of Columbia.

all 56 jurisdictions to support projects involving isolation and quarantine as of June 2023, according to agency data.

Table 1: Examples of Federal Awards That Could be Used for COVID-19 Isolation and Quarantine

Award	Purpose	Examples of allowed use for isolation and quarantine during COVID-19 pandemic
CDC Cooperative Agreement for Emergency Response: Public Health Crisis Response	Supports surge needs of public health programs responding to a significant public health emergency.	Award could be used for identifying and securing safe housing for isolation and quarantine and providing lodging and wraparound services such as food, cleaning, waste management, and clinical care for individuals in isolation and quarantine.
CDC Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases Cooperative Agreement	Provides financial support and technical assistance to the nation's health departments to detect, prevent, and respond to emerging infectious diseases.	The Enhancing Detection Expansion COVID-19 supplemental award could be used for wraparound services such as hoteling, food, and mental health services. Recipients could also use some setting-specific awards to support isolation and quarantine, such as in homeless shelters.
FEMA Public Assistance Grant	Provides supplemental grants to jurisdictional governments and certain types of private non-profits so communities can quickly respond to and recover from major disasters or emergencies.	Award could be used for non-congregate sheltering for isolation and quarantine—locations where each individual or household has living space that offers some level of privacy. Grant could be used to support facilities, staff, and supplies, among other services.

Source: GAO analysis of documents from Centers for Disease Control and Prevention (CDC) and Federal Emergency Management Agency (FEMA). | GAO-24-106705

Note: These awards allowed recipients to fund a wide variety of other activities in addition to isolation and quarantine. CDC and FEMA did not require award recipients to use their awards for isolation and quarantine activities, according to officials. Our data were not sufficiently reliable to determine how much award funding recipients received or used to support isolation and quarantine.

Challenges identified by selected jurisdictions and national associations. Officials from six selected jurisdictions and representatives from the five national associations told us that they experienced one or more challenges with federal technical assistance—publishing guidance, answering inquiries, convening partners, or deploying federal staff—or federal award funding for COVID-19 isolation and quarantine. These challenges could have delayed jurisdictions' isolation and quarantine response. As our prior work has highlighted, rapid response during public health emergencies is essential.[34]

Isolation and quarantine guidance. Our selected jurisdictions experienced challenges implementing federal guidance on isolation and quarantine, according to jurisdictional health department officials. National association representatives said this was true for their members as well. For example:

- Officials from six jurisdictions and representatives from four national associations told us that jurisdictions experienced challenges understanding, communicating, and quickly implementing isolation and quarantine guidance because CDC did not share guidance changes with them in advance of issuing the guidance publicly. Instead, CDC communicated finalized guidance changes via its website,

[34]See for example GAO-23-106203 and *COVID-19: Pandemic Lessons Highlight Need for Public Health Situational Awareness Network*, GAO-22-104600 (Washington, D.C.: June 23, 2022).

emails, and calls to jurisdictions upon guidance publication, according to officials from CDC and selected jurisdictions. Officials from five jurisdictions and representatives from three national associations said that jurisdictions sometimes learned about new isolation and quarantine guidance through news media, rather than from CDC. Therefore, they learned about changes at the same time as the public.

Selected jurisdictional officials and national association representatives said that this situation affected jurisdictions' ability to effectively implement isolation and quarantine because it did not allow them enough time to prepare for implementation, for example, by informing and training staff, updating their websites, adapting communications, and preparing for questions from the public. For example, jurisdictions sometimes had to answer questions about changes to the guidance that they had not yet seen or had only very recently become aware of, according to officials from two jurisdictions and representatives from three national associations. Officials from five jurisdictions also told us that CDC's approach contributed to confusion and misinformation and decreased the public's trust in federal and jurisdictional health officials, which may have affected compliance with isolation and quarantine guidance.

- Officials from two jurisdictions and representatives from three national associations said that CDC did not consistently seek input or feedback from jurisdictions when developing isolation and quarantine guidance. As a result, guidance was not necessarily practical for jurisdictions to implement, according to representatives from two national associations. CDC officials told us that they generally collected input during guidance development from national associations representing jurisdictional entities, such as the Association of State and Territorial Health Officials, but not from jurisdictional health departments themselves. CDC officials told us that the agency did not share guidance with jurisdictions in advance of publication during the COVID-19 pandemic to avoid leaked information and public confusion.
- Officials from three jurisdictions and representatives from four national associations told us they experienced challenges getting linguistically (i.e., translated) and culturally relevant information on isolation and quarantine from the federal government to meet their populations' needs. For example, federal isolation and quarantine guidance did not always reflect cultural sensitivity for some tribal populations that tended to live in smaller, multigenerational homes, according to representatives from one national association.
- Officials from one jurisdiction and representatives from one national association noted challenges with inconsistent messaging across federal agencies' guidance on isolation and quarantine. For example, national association representatives said that jurisdictions experienced challenges reconciling CDC's setting-specific guidance with the HHS Health Resources and Services Administration's guidance for the health centers that it funds.

Awards. Our selected jurisdictions experienced challenges using federal awards for isolation and quarantine, according to jurisdictional officials; national association representatives echoed these concerns for their members. These challenges are similar to challenges identified in our prior work examining federal awards provided in response to public health emergencies, including the COVID-19 pandemic.[35] For example:

[35]See GAO-24-105891 and *COVID-19 Relief Funds: State Experiences Could Inform Future Federal Relief Funding*, GAO-24-106152 (Washington, D.C.: Nov. 15, 2023).

- Officials from six jurisdictions and representatives from four national associations told us that federal awards were not always flexible enough to allow use for isolation and quarantine. For example, officials from one jurisdiction said they were unable to use federal awards for certain wraparound services such as transportation and providing medications.
- Officials from five jurisdictions and representatives from three national associations cited the timing of federal awards as a challenge. For example, two jurisdictions said that they had already stood up isolation and quarantine activities by the time federal awards became available for this purpose.

CDC Created a Process to Improve Guidance Development and Communication, But It Has Not Documented Its Plans for Providing Advance Notice to Jurisdictions

CDC has developed a new process to standardize how the agency creates and disseminates public health guidance to the public, health care providers, and jurisdictional health departments. According to CDC, this new process will be used to develop and issue any future guidance on isolation and quarantine. CDC has documented this process in its Public Health Guidance Development Framework (the framework), instituted in August 2023 as part of the CDC Moving Forward modernization initiative, and in related implementation materials. The framework is designed to increase uptake of public health guidance that people and communities need to protect their health, prevent disease, and prepare for new health threats, according to CDC.[36]

The framework represents a five-step process, according to CDC documentation: forecast and document the rationale for new or updated guidance, plan external engagement, formulate the guidance, release and disseminate the guidance, and evaluate the guidance. The framework calls for ongoing external engagement with the public and key partners throughout the guidance development process and considers contextual factors that influence guidance implementation. National association representatives we spoke with said that this framework addresses some of their—and jurisdictions'—concerns about guidance communication. Specifically, the framework incorporates the following elements:

- **Partner engagement during guidance development.** The framework established processes to collect internal (e.g., CDC subject matter experts and policy staff) and external (e.g., jurisdictional health departments and national public health associations) input during guidance development as well as to collect feedback on published guidance to inform future revisions.[37] For example, for public health guidance that is likely to form the basis of national, state, or local policy—including isolation and quarantine guidance for the general public, according to officials—the framework recommends a public input process, such as by holding a public meeting or webinar.[38] Representatives from one national association we spoke to believed that CDC's new process sufficiently addressed concerns about

[36]Public health guidance includes any statement by CDC recommending action that an external entity (e.g., public health programs, employers, workers, healthcare providers, or the public) could take to prevent, control, or treat illness, disease, or injury, according to CDC.

[37]For more information on important considerations for federal agencies' guidance development processes, see GAO-15-368.

[38]The framework notes that CDC may not collect external input during the development of public health guidance that needs to be released quickly to protect health. When this is the case, the framework calls for CDC to engage with external groups as soon as practical after dissemination to refine and revise the guidance as appropriate. CDC officials also told us that, in non-emergency circumstances, CDC might issue isolation and quarantine guidance with various options that jurisdictions can consider, which could require less public comment.

collecting jurisdictional input during guidance development, and these representatives told us that they communicated extensively with CDC before the agency released new COVID-19 isolation guidance in March 2024.[39] CDC also received input on the March 2024 guidance from a small group of jurisdictional officials, according to agency officials and national association representatives.

- **Contextual considerations.** The framework also calls for CDC to consider context for guidance, such as its expected impact on health equity and human rights and any barriers to understandability, acceptability, and feasibility. For example, the framework includes actions such as developing guidance in multiple languages, using plain language, and avoiding stigmatizing language. It also calls for CDC to enhance the guidance's understandability by clearly indicating how it aligns with or departs from previous or current related guidance.
- **Communication of finalized guidance.** The framework calls for CDC to follow established agency procedures to communicate guidance to key audiences, for example, by holding an advance briefing with key public health partners before information is published. For isolation and quarantine guidance changes, CDC officials told us that this would involve briefing relevant national associations, such as the Association of State and Territorial Health Officials, but the agency would not brief jurisdictional officials directly in advance of guidance publication. CDC officials told us that they often brief jurisdictional officials on guidance after publication.

With respect to communicating finalized guidance, CDC officials told us that it is now their preferred practice to share information with jurisdictional officials in advance of publication whenever possible to allow them to prepare for implementation. For example, CDC shared its March 2024 isolation guidance, talking points, and answers to frequently asked questions with jurisdictional members of national associations approximately 4 hours prior to public release, according to agency officials and national association representatives. CDC officials acknowledged the need for jurisdictional officials to receive advance notice of guidance given their key role in implementing it, particularly for isolation and quarantine. CDC officials told us their goal is to share finalized guidance with jurisdictions at least 24 hours in advance, and representatives from a national association agreed that jurisdictions should receive at least 24-hour notice prior to public release.

However, CDC has not documented its intentions to share guidance with jurisdictions in advance of publication, despite officials recognizing the importance of this practice. As noted earlier in this report, selected jurisdictional officials and national association representatives told us that not receiving advance notice of CDC isolation and quarantine guidance during the COVID-19 pandemic adversely affected jurisdictions' ability to implement the guidance. Similarly, an internal HHS review conducted in 2022 as part of CDC Moving Forward—CDC's modernization initiative—echoed concerns about CDC's COVID-19 communications.[40] This review found that CDC's absence of regular communications and consistent channels or methods for sharing information affected its ability to effectively communicate internally and externally during the COVID-19 pandemic. To address this concern, HHS's review recommended that CDC formalize roll-out procedures and

[39]On March 1, 2024, CDC revised its COVID-19 guidance to align with guidance for other respiratory viruses, such as influenza. This guidance recommended that people with respiratory virus symptoms stay home and away from others until at least 24 hours after their overall symptoms are getting better and they have not had a fever. CDC also recommended that people take additional precautions, such as additional steps for cleaner air, hygiene, masks, physical distancing, or testing, for 5 days after resuming normal activities. See CDC, "Preventing Spread of Respiratory Viruses When You're Sick," https://www.cdc.gov/respiratory-viruses/prevention/precautions-when-sick.html, accessed June 7, 2024.

[40]See Centers for Disease Control and Prevention, *CDC Moving Forward Summary Report* (Atlanta, Ga.: Sept. 1, 2022). HHS conducted this review to identify ways to improve and institutionalize how CDC develops and deploys its science and gather feedback on agency processes to inform CDC's Moving Forward modernization initiative.

processes for guidance documents, including tailored pre-release materials for key external partners, in a "no surprises communication operating posture."

CDC officials told us that they have not documented their intentions to provide advance notice of forthcoming guidance to jurisdictions because strategies for sharing information ahead of publication can vary based on circumstances, such as the urgency of the release or the extent of prior engagement with jurisdictions. Additionally, CDC must sometimes coordinate the release of guidance with other federal partners, which could influence when and whether the agency can share guidance with jurisdictions ahead of publication, according to officials. We recognize that circumstances can vary. However, CDC can document its intended process in, for example, the framework or related implementation materials, and include provisions for various types of situations that allow for flexibility. For example, CDC could document intended dissemination methods, such as an email directly to jurisdictional officials or through national associations; document ideal time frames, such as providing 24-hour notice of forthcoming guidance under circumstances when this is possible; and document exceptions, such as circumstances that call for expedited release.

CDC could better accomplish the Moving Forward review recommendation that the agency adopt a "no surprises communication operating posture," by documenting its intentions to share isolation and quarantine guidance with jurisdictions in advance.[41] This would also align with HHS's communication responsibilities in the National Response Framework.[42] Additionally, these actions would align with CDC's responsibilities in the PanCAP Adapted, which charged CDC with providing guidance on COVID-19 mitigation strategies, such as isolation and quarantine, to jurisdictions and coordinating and refining these strategies with jurisdictions prior to implementation.[43] Moreover, documenting its intentions would be consistent with federal internal control standards that highlight the importance of documentation, such as maintaining written policies and procedures to establish and communicate processes as well as retain institutional knowledge.[44]

Documenting its intentions to share isolation and quarantine guidance with jurisdictions in advance of publication whenever possible will help CDC more consistently implement this action across the agency. Moreover, if documented, CDC would be positioned to maintain this practice even as CDC staff change positions or retire. In turn, receiving advance notice of guidance should help jurisdictions plan for—and effectively implement—isolation and quarantine guidance to address public health developments and emerging threats. This advance notice could also help eliminate confusion during an emergency, such as jurisdictions experienced during the COVID-19 pandemic, that could slow response efforts. Jurisdictions need to be able to quickly implement isolation and quarantine guidance and communicate that guidance to other key parties in

[41]*CDC Moving Forward Summary Report*.

[42]*National Response Framework, Fourth Edition.* The National Response Framework requires regular and clear communication between response partners, including governments at all levels, to ensure that accurate, accessible, and actionable information is available in response to emerging threats.

[43]The Biological Incident Annex to the Response and Recovery Federal Interagency Operational Plan provides strategic guidance for interagency coordination during response to a biological incident. The PanCAP, approved in 2018, operationalizes the Biological Incident Annex with a focus on potential viral pandemic pathogens, and the PanCAP Adapted adapts federal response actions for COVID-19.

[44]GAO-14-704G. While we identified this deficiency in internal control standards for documentation, we found that CDC's new framework incorporated other selected internal controls by establishing processes to collect internal and external input during guidance development as well as to collect feedback on published guidance to inform future revisions. For more information on internal controls' application to federal agencies' guidance development processes, see GAO-15-368.

their area, such as local health departments and health care providers, to slow the spread of future infectious disease threats.

CDC Has Not Assessed Jurisdictions' Isolation and Quarantine Planning

Our review found that CDC is missing key information on jurisdictions'—states' and territories'—isolation and quarantine planning. In particular, CDC is missing information on whether and which jurisdictions have sufficient planning to implement isolation and quarantine in response to widespread infectious diseases. This includes missing information on any gaps in planning that could impede jurisdictional use of such measures and potentially require assistance from the federal government. For example, CDC officials did not know how many or which jurisdictions had isolation and quarantine plans in place prior to the COVID-19 pandemic. Further, CDC officials did not have current information on such plans as of December 2023.

CDC is missing this information because the agency does not assess jurisdictions' planning for implementing isolation and quarantine. While CDC has assessed some aspects of jurisdictions' planning for public health threats through PHEP Operational Readiness Reviews, such as preparedness for a large-scale vaccination campaign, officials told us the agency has not included isolation and quarantine planning in its assessments as of 2024.[45] Further, a new PHEP evaluation strategy for 2024, which aligns with the agency's Public Health Response Readiness Framework, will also not assess isolation and quarantine planning, according to officials.[46]

[45]CDC, *PHEP Operational Readiness Review Guidance* (Atlanta, Ga.: March 2022). According to the guidance, the Operational Readiness Review includes three sections: (1) jurisdictional descriptive information; (2) an evaluation of jurisdictional plans aligned with the 15 capability standards; and (3) operational activities including drills, exercises, incidents, and events. According to CDC's Operational Readiness Review guidance, the information CDC evaluated for the 2019-2024 PHEP performance period changed from year to year. For example, in 2022, CDC used the Operational Readiness Review to evaluate jurisdictions' preparedness for a COVID-19 vaccination campaign, including the ability to transport and store vaccines, manage volunteers, and more.

[46]CDC's PHEP 5-year performance period beginning July 2024 is focused on the agency's new Public Health Response Readiness Framework. The framework includes a priority focus on threat-specific planning and PHEP recipients may elect to plan for isolation and quarantine within relevant threat areas, according to CDC officials.

CDC Operational Readiness Reviews

The Public Health Emergency Preparedness (PHEP) cooperative agreement program is CDC's primary mechanism for supporting jurisdictional preparedness for "all-hazard" public health threats. CDC provides jurisdictions with standards for preparedness planning, including for isolation and quarantine as well as other nonpharmaceutical interventions, through the PHEP program. Jurisdictions are not required to plan for isolation and quarantine as a condition of receiving PHEP funding, according to CDC.

CDC established the PHEP Operational Readiness Review process in 2012 and conducted its first national review in 2015-2016 to evaluate preparedness of jurisdictional public health agencies. These reviews evaluate jurisdictional preparedness efforts against CDC preparedness and response standards and identify gaps, strengths, promising practices, and opportunities for CDC technical assistance. CDC requires PHEP recipients to submit various deliverables to demonstrate their preparedness as part of this process.

The assessment has changed over time and was originally established to assess preparedness for distribution of medical countermeasures—products such as vaccines that may be used in the event of a potential public health emergency. In 2020, CDC expanded the PHEP Operational Readiness Review to evaluate planning and operational functions aligned with the agency's 15 preparedness and response standards. However, the COVID-19 pandemic disrupted CDC's plans to conduct a full assessment in alignment with this guidance, according to officials.

Source: Centers for Disease Control and Prevention (CDC). | GAO-24-106705

CDC officials told us the agency has not prioritized an assessment—as part of PHEP or otherwise—of isolation and quarantine planning because these measures are not technically difficult to implement. CDC officials told us they do not specifically review PHEP recipients' preparedness plans to determine whether they include planning for isolation and quarantine. Instead, CDC officials told us that they have a general understanding of jurisdictional preparedness for isolation and quarantine based on their close working relationships with jurisdictions. However, our review of documentation from selected jurisdictions found that three of the seven selected jurisdictions did not have operational isolation and quarantine plans that could be generally applied to infectious diseases prior to the COVID-19 pandemic. For example, two of these selected jurisdictions had isolation and quarantine plans for specific diseases that experienced more limited spread, but the plans did not account for isolating and quarantining individuals outside of healthcare settings, as was required for the COVID-19 response.

Additionally, CDC officials said that infrastructure for isolation and quarantine implementation, such as jurisdiction-owned isolation and quarantine facilities, is a costly and rarely used capability to maintain. However, jurisdictions can take other actions to plan for isolation and quarantine without purchasing facilities. For example, CDC's notice of funding opportunity for the PHEP cooperative agreement program recommends that jurisdictions document applicable jurisdictional, legal, and regulatory authorities to implement isolation and quarantine.[47]

The National Biodefense Strategy directs CDC to determine gaps in preparedness and response for community mitigation measures (i.e., nonpharmaceutical interventions), including isolation and quarantine. To meet this directive, CDC established a new Division of Readiness and Response Science in October 2023 that will research and improve the impact of community mitigation measures, according to officials.[48] However, CDC officials said at the time of our review this Division does not intend to assess jurisdictions' planning for or capacity to implement community mitigation measures such as isolation and quarantine.

By assessing jurisdictions' planning for implementing isolation and quarantine, such as identifying which jurisdictions have plans and whether those plans are sufficient to implement large-scale isolation and quarantine, CDC would be better able to understand what preparedness gaps, if any, jurisdictions have and which gaps CDC might need to help fill. CDC could accomplish such an assessment through its PHEP evaluation processes or through other means that CDC determines feasible, such as a survey or structured conversations with jurisdictional officials. To respond to any gaps CDC identifies as part of this assessment, the agency could develop updated planning guidance or resources to help jurisdictions better prepare to respond to future threats. Further, such an assessment would help CDC fulfill its responsibilities to determine gaps in preparedness and response for community mitigation measures in the National Biodefense Strategy.

We also learned from CDC officials in April 2024 that HHS and the Department of Homeland Security are developing an interagency plan to identify operational requirements, roles, and responsibilities for isolation and quarantine. CDC anticipates completing this plan by the end of 2024, according to officials. Our review suggests that a CDC assessment of jurisdictions' planning for implementing isolation and quarantine would likely complement development of this interagency plan. Together, these efforts would better prepare the nation to use isolation and quarantine, should they be needed to protect against future threats.

Conclusions

Isolation and quarantine are key strategies jurisdictional governments can use to contain and mitigate the spread of infectious disease, particularly for new diseases such as COVID-19. CDC played a crucial role in supporting jurisdictions' COVID-19 response, including through guidance, technical assistance, and awarding funding for isolation and quarantine actions. However, jurisdictional officials and an internal HHS review noted

[47]See CDC, *Public Health Emergency Preparedness (PHEP) Cooperative Agreement, CDC-RFA-TP19-1901*. See also capability standards outlined in CDC, *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health* (Atlanta, Ga.: October 2018). PHEP recipients are not required to "meet" these standards to receive funding, but they are required to use them as they plan, operationalize, and evaluate their ability to prepare for, respond to, and recover from public health emergencies, according to CDC officials. Capability 11 covers nonpharmaceutical interventions, including isolation and quarantine.

[48]CDC's Division of Readiness and Response Science develops and implements the science of readiness and response; builds scientific expertise to address health disparities and community mitigation; evaluates state, tribal, local, and territorial readiness and response; and informs a broader framework for evaluating CDC's and partners' readiness status, according to CDC's website.

that CDC could improve its guidance communication to better enable jurisdictions to implement isolation and quarantine measures within their borders. CDC has instituted a new public health guidance development process that addresses some of these concerns, but the agency has not documented its intentions to share finalized isolation and quarantine guidance with jurisdictions prior to publication, when feasible, to allow them to prepare to implement such guidance. By documenting such intentions, CDC can be more consistent in its actions and retain institutional knowledge about these intentions. In turn, this should help jurisdictions quickly understand and implement new isolation and quarantine guidance, which is essential to slowing the spread of future disease threats.

As key implementers of isolation and quarantine, jurisdictions need to be prepared to respond to infectious disease threats, including by using nonpharmaceutical interventions such as isolation and quarantine. However, we found that not all selected jurisdictions had isolation and quarantine plans prior to or following the COVID-19 pandemic. CDC plays a key role in assisting jurisdictions in their use of isolation and quarantine by providing support to help them respond in times of emergency. Because CDC has not assessed jurisdictional planning for isolation and quarantine, it is missing information on which jurisdictions have sufficient planning to implement isolation and quarantine when another emergency arises. Assessing jurisdictional planning for isolation and quarantine and determining whether federal actions are needed to help jurisdictions close any gaps would allow CDC to better fulfill its responsibilities outlined in the National Biodefense Strategy to enhance preparedness for future emerging and deliberate biological threats facing the nation.

Recommendations for Executive Action

We are making two recommendations to CDC:

The Director of CDC should document the agency's intentions to share finalized isolation and quarantine guidance with jurisdictions in advance of publication to allow them to prepare to implement such guidance. (Recommendation 1)

The Director of CDC should assess jurisdictional planning for isolation and quarantine and determine whether federal actions are needed to help jurisdictions close any gaps. (Recommendation 2)

Agency Comments and Our Evaluation

We provided a draft of this report to HHS and the Department of Homeland Security for review and comment. In its written comments, reproduced in appendix I, HHS concurred with our recommendations and identified steps to implement them. Regarding our first recommendation, HHS stated CDC will add a statement in the next iteration of its Public Health Guidance Development Framework to document its intentions to share finalized isolation and quarantine guidance with jurisdictions in advance of publication.

For our second recommendation on assessing jurisdictional planning for isolation and quarantine, HHS said CDC plans to review and update its public health preparedness capability standards—including those related to nonpharmaceutical interventions like isolation and quarantine—based on COVID-19 and other recent responses. HHS believes this effort could potentially inform future assessments of jurisdictional planning for isolation and quarantine. HHS also noted several challenges and limitations to jurisdictions implementing isolation and quarantine including restrictions on jurisdictional public health authorities and workforce

challenges. Additionally, HHS noted that jurisdictions often need federal support to carry out large-scale isolation and quarantine. These challenges make it all the more important that CDC understand jurisdictional preparedness for isolation and quarantine and determine whether federal actions are needed to help jurisdictions close any gaps.

HHS and the Department of Homeland Security also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, the Secretary of Homeland Security, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or DeniganMacauleyM@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

Mary Denigan-Macauley
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

June 27, 2024

Mary Denigan-Macauley
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Denigan-Macauley:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, **"PUBLIC HEALTH PREPAREDNESS: HHS Should Assess Jurisdictional Planning for Isolation and Quarantine" (GAO-24-106705).**

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Melanie Anne Egorin

Melanie Anne Egorin, PhD
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT TITLED - PUBLIC HEALTH PREPAREDNESS: HHS SHOULD ASSESS JURISDICTIONAL PLANNING FOR ISOLATION AND QUARANTINE (GAO-24-106705)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

Recommendation 1
The Director of CDC should document the agency's intentions to share finalized isolation and quarantine guidance with jurisdictions in advance of publication to allow them to prepare to implement such guidance.

HHS Response
CDC concurs with the recommendation and will add a statement in the next iteration of the Public Health Guidance framework.

Recommendation 2
The Director of CDC should assess jurisdictional planning for isolation and quarantine and determine whether federal actions are needed to help jurisdictions close any gaps.

HHS Response
CDC concurs with the recommendation.

CDC plans to review and update its national capability standards based on COVID-19 and other recent responses. This includes Capability 11: Nonpharmaceutical Interventions (NPI). To inform this process, CDC will gather input from subject matter experts from CDC, ASPR and national partner organizations such as APHL, ASTHO, CSTE, and NACCHO. Updates to the NPI capability functions could potentially inform future assessments of jurisdictional planning for isolation and quarantine.

CDC also notes for GAO the following challenges and limitations:

- Isolation and quarantine strategies have been longstanding public health tools and will continue to be used. However, erosion of public health authorities has been occurring in some jurisdictions. This could significantly impact jurisdictions' ability to impose isolation and quarantine actions.
    - Per CDC's Public Health Law Program, there has been a major increase in bills introduced in state legislatures proposing to restrict public health powers; a select few of those that were enacted into law impact state and local isolation and quarantine authorities directly. More common are restrictions on declaration powers in general, which could impact isolation and quarantine capacities.
        - New York enacted a law empowering the legislature to terminate an emergency declaration by concurrent resolution. a5967 (nysenate.gov)
        - Montana enacted a law imposing a 21-day limit on a governor's emergency declaration, unless extended by a majority of members of both the state house and senate. To extend the declaration up to 45 days, the

        - secretary of state is authorized to poll the legislature. HB0230.pdf (mt.gov)
    - Most of the restrictions potentially impacting mass quarantine powers do so indirectly:
        - Protections for first amendment rights may prohibit orders if the quarantine order inhibits access to houses of worship or exercising the right to assemble.
        - Limitations on emergency declarations may inhibit some states from using applicable powers specific to emergencies. In some states where mass quarantine is expressly authorized, the use of that power is limited to a declared emergency. Those states that have limited the scope of emergency declarations and their length or have increased legislative oversight over their duration (e.g., eased legislative veto) may not be able to tap into the statutes providing mass quarantine authority.
        - Also, emergency declarations may provide key resources that make mass quarantine feasible. For example, if the state can only bear the cost of mass quarantine by declaring an emergency to access funds, or if the response needs force multipliers from the national guard or under the Emergency Management Assistance Compact EMAC, losing a declaration could be problematic. These emergency declaration limitations were the most common restrictions legislatures enacted in the past three years.
    - At least one state, Idaho, has made a change that directly impacts isolation and quarantine law, narrowing the definitions of quarantine and isolation, which may make issuing orders more difficult.

More information is available in the joint CDC-NGA-ASTHO publication, *Emergency powers and the pandemic: Reflecting on state legislative reforms and the future of public health response* PMC(nih.gov).

- Workforce challenges also impact isolation and quarantine actions. Without sufficient legal advice and expertise, the most robust statutory, political, and financial support are meaningless if states don't have the appropriate people to write public health orders. During the COVID-19 response, many governors resorted to broadly issued stay-at-home orders as the available attorneys couldn't keep up with issuing individual isolation and quarantine orders.
- STLT jurisdictions often need federal support to implement isolation and quarantine actions. They generally do not have the funding to support isolation and quarantine capabilities "as a warm base" that can be implemented in a response. It's not practical and at a larger scale, STLT jurisdictions have requested the federal government to fund and manage this, for example COVID-19 repatriation.
- It's important to note that there are differences between the need for more typical small-scale isolation and quarantine actions and the need for those actions on a larger scale similar to what occurred during the Ebola and COVID-19 responses. Those are two very different situations, and the latter instance is what requires federal assistance.
- Isolation and quarantine situations often require different approaches, and special biocontainment units, negative pressure hospital rooms, various types of congregate

facilities, or individual homes might be appropriate under different circumstances:
- Intensive care and high level of protection for health care workers (e.g., Ebola)
- Airborne precautions
- Isolation for mild illness
- Mass quarantine (e.g., Wuhan evacuation)
- Individual isolation or quarantine (e.g., MDR TB)

- CDC is in the final stages of updating the Social Distancing Law Assessment tool as the Prevention Measure Law Project.

Accessible Text for Appendix I: Comments from the Department of Health and Human Services

June 27, 2024

Mary Denigan-Macauley
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

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Sincerely,

Melanie Anne Egorin, PhD
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HHS Response

CDC concurs with the recommendation and will add a statement in the next iteration of the Public Health Guidance framework.

Recommendation 2

The Director of CDC should assess jurisdictional planning for isolation and quarantine and determine whether federal actions are needed to help jurisdictions close any gaps.

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CDC concurs with the recommendation.

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CDC also notes for GAO the following challenges and limitations:

- Isolation and quarantine strategies have been longstanding public health tools and will continue to be used. However, erosion of public health authorities has been occurring in some jurisdictions. This could significantly impact jurisdictions' ability to impose isolation and quarantine actions.
    - Per CDC's Public Health Law Program, there has been a major increase in bills introduced in state legislatures proposing to restrict public health powers; a select few of those that were enacted into law impact state and local isolation and quarantine authorities directly. More common are restrictions on declaration powers in general, which could impact isolation and quarantine capacities.
        - New York enacted a law empowering the legislature to terminate an emergency declaration by concurrent resolution. a5967 (nysenate.gov)
        - Montana enacted a law imposing a 21-day limit on a governor's emergency declaration, unless extended by a majority of members of both the state house and senate. To extend the declaration up to 45 days, the secretary of state is authorized to poll the legislature. HB0230.pdf (mt.gov)
    - Most of the restrictions potentially impacting mass quarantine powers do so indirectly:
        - Protections for first amendment rights may prohibit orders if the quarantine order inhibits access to houses of worship or exercising the right to assemble.
        - Limitations on emergency declarations may inhibit some states from using applicable powers specific to emergencies. In some states where mass quarantine is expressly authorized, the use of that power is limited to a declared emergency. Those states that have limited the scope of emergency declarations and their length or have increased legislative oversight over their duration (e.g., eased legislative veto) may not be able to tap into the statutes providing mass quarantine authority.
        - Also, emergency declarations may provide key resources that make mass quarantine feasible. For example, if the state can only bear the cost of mass quarantine by declaring

an emergency to access funds, or if the response needs force multipliers from the national guard or under the Emergency Management Assistance Compact EMAC, losing a declaration could be problematic. These emergency declaration limitations were the most common restrictions legislatures enacted in the past three years.

- At least one state, Idaho, has made a change that directly impacts isolation and quarantine law, narrowing the definitions of quarantine and isolation, which may make issuing orders more difficult.

More information is available in the joint CDC-NGA-ASTHO publication, Emergency powers and the pandemic: Reflecting on state legislative reforms and the future of public health response PMC(nih.gov).

- Workforce challenges also impact isolation and quarantine actions. Without sufficient legal advice and expertise, the most robust statutory, political, and financial support are meaningless if states don't have the appropriate people to write public health orders. During the COVID-19 response, many governors resorted to broadly issued stay-at-home orders as the available attorneys couldn't keep up with issuing individual isolation and quarantine orders.
- STLT jurisdictions often need federal support to implement isolation and quarantine actions. They generally do not have the funding to support isolation and quarantine capabilities "as a warm base" that can be implemented in a response. It's not practical and at a larger scale, STLT jurisdictions have requested the federal government to fund and manage this, for example COVID-19 repatriation.
- It's important to note that there are differences between the need for more typical small- scale isolation and quarantine actions and the need for those actions on a larger scale similar to what occurred during the Ebola and COVID-19 responses. Those are two very different situations, and the latter instance is what requires federal assistance.
- Isolation and quarantine situations often require different approaches, and special biocontainment units, negative pressure hospital rooms, various types of congregate facilities, or individual homes might be appropriate under different circumstances:
    - Intensive care and high level of protection for health care workers (e.g., Ebola)
    - Airborne precautions
    - Isolation for mild illness
    - Mass quarantine (e.g., Wuhan evacuation)
    - Individual isolation or quarantine (e.g., MDR TB)
- CDC is in the final stages of updating the Social Distancing Law Assessment tool as the Prevention Measure Law Project.

Appendix II: GAO Contact and Staff Acknowledgments

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In addition to the contact named above, Tom Conahan (Assistant Director), Rebecca Abela (Analyst-in-Charge), Alanna Miller, Jennifer Natoli, and Rachel Weingart made key contributions to this report. Kaitlin Farquharson, Monica Perez-Nelson, Roxanna Sun, and Cathy Hamann Whitmore also made important contributions.

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