Marathon County Board of Health

Meeting Date/Time: **Tuesday, December 14, 2021 at 7:45 AM**
Meeting Location: **Marathon County Courthouse**
Assembly Room
500 Forest Street
Wausau, WI 54403

The meeting site identified above will be open to the public beginning at 7:45 AM. Marathon County requests that appropriate COVID-19 safety measures, including adequate social distancing, be utilized by all in-person attendees. Persons wishing to attend the meeting by phone may call into the telephone conference beginning five (5) minutes prior to the start time indicated above using the following number. When you enter the telephone conference, put your phone on mute.

Dial +1 312 626 6799 US (Chicago)
Meeting ID: 851 2896 1112
Password: 882227

Committee Members: John Robinson, Chair; Craig McEwen, Vice-Chair; Kue Her, Secretary; Sandi Cihlar; Dean Danner; Tiffany Lee; Corrie Norrbom, Tara Draeger

Marathon County Mission Statement: Marathon County Government serves people by leading, coordinating, and providing county, regional, and statewide initiatives. It directly or in cooperation with other public and private partners provides services and creates opportunities that make Marathon County and the surrounding area a preferred place to live, work, visit, and do business. (Last updated: 12-20-05)

Marathon County Health Department Mission Statement: To advance a healthy Marathon County community by preventing disease, promoting health, and protecting the public from environmental hazards. (Last updated: 5-7-13)

1. **Call to Order**

2. **Public Comment Period (Limit to 15 Minutes)**

3. **Approval of the Minutes**
   A. **October 12, 2021 Board of Health Meeting**
   B. **November 9, 2021 Board of Health Meeting**

4. **Operational Functions Required by Statute, Ordinance, or Resolution**

5. **Policy Discussion and Possible Action**
   A. **Potential recommendation to schools in relation to Wisconsin Administrative Code 252.05 and 252.21**

6. **Educational Presentations/Outcome Monitoring Reports**
   A. Update on Northern Mobile Home Park and related actions taken to mitigate the human health hazards by Michael Puerner, Corporation Counsel
   B. COVID Status Review

C. Communicable Disease Overview by Eileen Eckardt, Family Health and Communicable Disease Director
D. Report from the Health & Human Services Committee meeting on policy issues impacting public health

7. Announcements

8. Next Meeting Date & Time, Location, Future Agenda Items:
A. Confirm January 11, 2021 meeting date and determine agenda topics

9. Adjourn

FAXED TO: Daily Herald, City Pages, Marshfield News, Mid-West Radio Group

Date _________ Time______________
By ______________________________

Signed______________________________

THIS NOTICE POSTED AT THE COURTHOUSE

Date_________ Time________________

Any person planning to attend this meeting who needs some type of special accommodation in order to participate should call the County Clerk's Office at 715-261-1500 or e-mail infomarathon@mail.co.marathon.wi.us one business day before the meeting.

Marathon County Board of Health

Meeting Date/Time:	**Tuesday, October 12, 2021 at 7:45 AM**
Meeting Location:	**Marathon County Courthouse Assembly Room 500 Forest Street Wausau, WI 54403**

Present - In Person:	John Robinson, Sandi Cihlar
Present - Via Zoom:	Kue Her, Craig McEwen, Corrie Norrbom
MCHD Staff:	Laura Scudiere, Dale Grosskurth, Eileen Eckardt, Rachel Klemp-North, Rebecca Mroczenski, Aaron Ruff (online), Jonathan Schmunk, Kim Wieloch
Others via Zoom:	Tim Buttke, Chris Dickinson

1. Call to Order

John Robinson called the meeting to order at 7:46 AM.

2. Public Comment Period (Limit to 15 Minutes)

No public comments were made.

3. Approval of the Minutes of the September 14, 2021 Board of Health Meeting

Motion to approve the minutes of the September 14, 2021 Board of Health meeting made by Sandi Cihlar. Second by Craig McEwen. Motion approved.

4. Operational Functions Required by Statute, Ordinance, or Resolution

A. None

5. Policy Discussion and Possible Action

A. COVID-19 Response and Recovery Funding for Local and Tribal Health Departments

Laura Scudiere shared that the intent of COVID funding is to build infrastructure to return to and/or continue doing 140-required activities and summarized the initial proposal for utilizing the funding. She stressed that this is a hybrid model that allows the Marathon County Health Department to flex staffing according to the response required by the level of disease activity. Corrie Norrbom requested intentionality with hiring as there is an opportunity here to diversify the workforce. Sandi Cihlar requested resuming the regular update of other communicable disease case numbers to support funding of MCHD.

Motion to advance proposal to appropriate committees for consideration made by Sandi Cihlar. Second by Kue Her. Motion approved.

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6. Educational Presentations/Outcome Monitoring Reports

A. Update on actions being taken to address human health hazards identified at the Northern Mobile Home Park

Dale Grosskurth shared that the North Central Community Action Program has been doing outreach to residents: packets have been provided to all residences that appear to be occupied, and the organization has worked directly with 10 households so far to move homes to another park. They will continue to do outreach to connect with as many residents as possible, as the park must be unoccupied by November 8, 2021. The understanding is that the City of Schofield will work with Everest Metro Police to enforce the vacancy order. Due to the outdated resident listing that was provided by the owner, the exact demographics of the current residents are unknown.

B. COVID Dashboard

Laura Scudiere provided an overview of a COVID dashboard in the Board packet and indicated that current information can be found on the Marathon County Health Department website. There was a discussion about challenges to testing (availability, high wait times) in the area and early plans to partner with health care providers and the National Guard to offer testing options. There was further discussion about barriers to testing (literacy, language, culture) and how these barriers highlight health inequities. John Robinson requested an update at the next meeting on testing as well as an update on DHS reporting parameters for COVID funding.

C. Topics for Upcoming Board Training

Group discussed topics for a Board retreat/meeting/training to be scheduled. Topics of interest include health equity; the Board of Health's relationship to the Health and Human Services committee and clarity about the reporting structure; understanding of authority of the Health Officer and the Board of Health from a state statute standpoint; the Wisconsin Association of Local Health Departments and Boards (WALHDB) and its relationship with other national organizations. Laura and John will plan this training and bring it back to board for approval.

D. Report from the Health & Human Services Committee meeting on policy issues impacting public health

Tim Buttke reported on the elevated child support grant from Marathon County Department of Social Services, which is a partnership between Kenosha, Racine, Wood, and Marathon Counties and whose goal is improving relationships between non-custodial parents and their children. The results indicated significant success, with 170 total enrollees and 85 active participants, as well as approved grant funding of a position to start in October.

The Committee also received a request from Mount View Care Center requesting approval for a decrease in number of licensed beds from 183 to 154. There were concerns raised and

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objections to the proposal brought forward, so MVCC representatives will bring back the proposal with requested clarifications to a future meeting.

7. Announcements

None.

8. Next Meeting Date & Time, Location, Future Agenda Items:

A. Confirm November 9, 2021 meeting date and determine agenda topics
   i. There will be no update from Healthy Marathon County.
   ii. Start Right update and discussion about evaluation results from UniverCity.

9. Adjourn

Motion to adjourn made by Craig McEwen, second by Kue Her. Meeting adjourned at 8:28 AM.

Respectfully submitted,

Kue Her, Secretary Kim
Wieloch, Recorder

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Marathon County Board of Health

Meeting Date/Time: **Tuesday, November 9, 2021, at 7:45 AM**
Meeting Location: **Marathon County Courthouse**
Assembly Room
500 Forest Street
Wausau, WI 54403

Present - In Person: John Robinson, Tara Draeger

Present - Via Zoom: Kue Her, Craig McEwen, Corrie Norrbom, Sandi Cihlar, Dean Danner

MCHD Staff: Laura Scudiere, Dale Grosskurth (online), Eileen Eckardt, Rachel Klemp-North, Rebecca Mroczenski, Aaron Ruff (online), Kang Chu Yang, Kim Wieloch

Others via Zoom: Tim Buttke, Casey Wilson

1. Call to Order

John Robinson called the meeting to order at 7:53 AM.

2. Welcome of new member, Tara Draeger

John Robinson formally welcomed Tara Draeger as a new Board of Health member. Tara Draeger shared her background in public health as the System Director of Community Health Improvement at Aspirus and current interim Executive Director of the Aspirus Health Foundation.

3. Public Comment Period (Limit to 15 Minutes)

No public comments were made.

4. Approval of the Minutes of the September 14, 2021, Board of Health Meeting

The minutes of the October board meeting included in the packet. The agenda stated approval of the September minutes. Chair postponed the approval of minutes until the agenda date reflects the minutes.

5. Operational Functions Required by Statute, Ordinance, or Resolution

A. None

6. Policy Discussion and Possible Action

A. Communication to school districts regarding communicable disease statutory responsibilities

Laura Scudiere shared that COVID transmission remains an issue in schools. 20% of the positive cases within the county is school related. Most schools are not meeting

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communicable disease state statue 252. Schools are interested in collaborating in vaccine efforts but have not been consistently participating in masking and mitigation recommendations. Best practices in reducing risks in schools and adding layers of mitigation were shared.

The board also discussed possible school district board actions for the future, including, but not limited to reducing masking and quarantine for schools currently providing these strategies. Board members discussed past and current factors affecting school contact tracing efforts. Question was asked what we have learned from the pandemic and whether steps are being taken to re-strategize MCHD emergency preparedness plan Laura stated that there are many lessons to be learned and that state discussions have been factoring in what recovery will look like.

7. Educational Presentations/Outcome Monitoring Reports

A. Update on actions being taken to address human health hazards identified at the Northern Mobile Home Park

Dale Grosskurth shared that more households have engaged with NCCAP to get housing. Many individuals that did not seek NCCAP have relocated to a different park. There has been notification that the park owner is currently addressing some of the issues previously noted by MCHD, however, recent visits to the park indicate the health hazards persist. No additional inspection and or contact has been made between the owner and MCHD.

After several weeks of petition, legal actions are being considered. Board members suggested that given the nature of the situation, a citation would be in order. Dale Grosskurth will reach out to Mike to discuss his recommendations.

As of 11/08/2021, there is no data on the number of residents remaining on the property. MCHD has not specifically reach out to squatters, but NCCAP has been offered to all within the park including squatters and families with children. Specifics of programs offered by NCCAP to family with children is unknown. Details of program would be better explained by NCCAP. There is also no data on the count of children on the park property. NCCAP has done a great deal of outreach, but some individuals have chosen not to use NCCAP services. Group agreed that although resources for these individuals are needed, the main concern should be aim at the environmental health hazards that remain present.

B. COVID Status Review

Laura Scudiere provided an overview of the COVID dashboard and where to locate the most current information.

Laura Scudiere also indicated that COVID numbers continue to climb, and more people are choosing not to get tested when symptomatic. MCHD continues to work with the Wisconsin National Guard to set up and conduct community testing sites. Community testing is currently offered at East gate hall, Marathon Park, Thursday-Saturday, 9-5pm. The city hall in Abbotsford, WI will soon be available for testing as well. Dates and time are currently being determined. All sites are free of charge, conducting PCR testing and offers walk-ins. Rapid testing is also available at the UW. The following school districts have also taken on

testing: DC Everest, Wausau, Spencer, Marathon, and Athens.

The group voiced concerns regarding testing dates and its accessibility for the community. Although testing is free, the limitation in dates can be difficult for individuals and accentuate health equities. Laura Scudiere shared that test dates are dependent of the availability of the Wisconsin National Guard. Requests to transfer the event dates have been made.

Laura Scudiere also shared that the FDA, CDC, and DHS have approved Pfizer COVID vaccines for children ages 5-11 years old. Vaccines are available at the AMI site starting Nov. 9. Aspirus and other local providers are awaiting their vaccine shipment and are working on coordinating this effort.

Regarding mandates for vaccination at employers with over 100 employees, MCHD's role will be to strategize and assist health providers to provide these services. Public health will not be expected to enforce this mandate nor be a direct service provider for vaccinations or testing.

C. Review of New Environmental Health Tracking Program Data

Dale Grosskurth gave an overview of the DHS resource.

- The resource summarizes and links environmental factors to health issues.
- Provides a profile snapshot of the number of factors released a year, such as Motor Accidents, COPD, and climate change.
- Contains multiple data sources.
- Has profiles developed for all counties.
- Helps link and give comparable data.
- Provides individuals with the knowledge to act.

The group discuss the following data from the DHS resource, Radon data/testing and installations information, current lead testing programs for children and education opportunities for lead service line issues. Dale Grosskurth also shared that if a child is on Medicaid, they are tested at 1-2 years and at 3-5 years. Anyone not on Medicaid is tested by their physician. Homeowners with buildings built in 1940 or earlier are recommended to test their children.
This resource can help public health anticipate the next health crisis and assist in addressing the determinants of environmental health. The group agreed to review the resource to assist future Board of Health goals.

D. Start Right Evaluation Update
Laura Scudiere shared the preliminary highlights of the Start Right program evaluation. A formative evaluation will be shared with the board along with the recommendations of the evaluator at a future meeting. The evaluator stated that the program itself was a strong and an effective program but lacked longitudinal data/evidence. A return-on-investment calculation was not conducted as the evaluator was not able to do so without the longitudinal data required to do so. Laura reminded the board that the county budget was set and Start Right was included in that budget. Changes to programming and potential

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resources required would need to be reviewed for the upcoming 2023 budget cycle. Laura Scudiere anticipates to present program changes to the Board of health in January 2022 and to the Human Services Committee in February 2022.

E. Report from the Health & Human Services Committee meeting on policy issues impacting public health

Tim Buttke shared that Mount View Care Center 4th proposal was postponed to November. The plan is to reduce the bed counts and put the beds in reserve.

The group also discussed staffing issues in the nursing homes. Tim Buttke shared that the operations executive indicated that “they are in trouble and cannot and are struggling to staff their facilities.”

8. Announcements

A. Sandi Cihlar thanked Laura Scudiere for including the communicable disease report. Sandi shared that having this information is great for the board to see. It gives them a look at the other issues that are occurring besides COVID. Board expressed desire to have more information on other communicable disease work within the county.

9. Next Meeting Date & Time, Location, Future Agenda Items:

A. Confirm December 14, 2021, meeting date and determine agenda topics

10. Adjourn

Motion to adjourn made by John Robinson, second by Craig McEwen. Meeting adjourned at 9:09 AM.

Respectfully submitted,

Kue Her, Secretary
Kang Chu Yang, Recorder

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Health Officer Notes

December 2021

A. Call to Order

B. Public Comment Period (Limit to 15 Minutes)

C. Approval of the Minutes

D. Operational Functions Required by Statute, Ordinance, or Resolution

   A. None

E. Policy Discussion and Possible Action

   A. **Potential recommendation to schools in relation to Wisconsin Administrative Code 252.05 and 252.21**
      i. **Board of Health members will have the opportunity to discuss communication to schools relative to the statutory requirements set forth in Wisconsin Administrative Code 252.05 and 252.21. A copy of 252 has been provided in the amended board packet.**

F. Educational Presentations/Outcome Monitoring Reports

   A. Update on actions being taken to address human health hazards identified at the Northern Mobile Home Park
      i. Mike Puerner, Corporation Counsel, will discuss the progress of current legal actions taken to mitigate the human health hazard identified at Northern Mobile Home Park.
   B. COVID Status Review
      i. A COVID dashboard has been provided in the packet. Please be aware that this is a snapshot in time, taken on submission of the board packet information. Updated data is also found on our web site at https://www.co.marathon.wi.us/Departments/HealthDepartment/COVID19/Dashboard.aspx
      ii. COVID response programmatic updates will be provided.
   C. Communicable Disease Overview
      i. Eileen Eckardt, Family Health and Communicable Disease Director, will provide an overview of current communicable disease work being conducted at the Marathon County Health Department.
   D. Report from the Health & Human Services Committee meeting on policy issues impacting public health

G. Announcements

   A. Marathon County Health Department applied for a Wisconsin DHS grant opportunity, Mobilizing Communities for a Just Response. The grant application request was $100,000 to support COVID outreach and health equity work in 2022.

Marathon County COVID-19 Dashboard

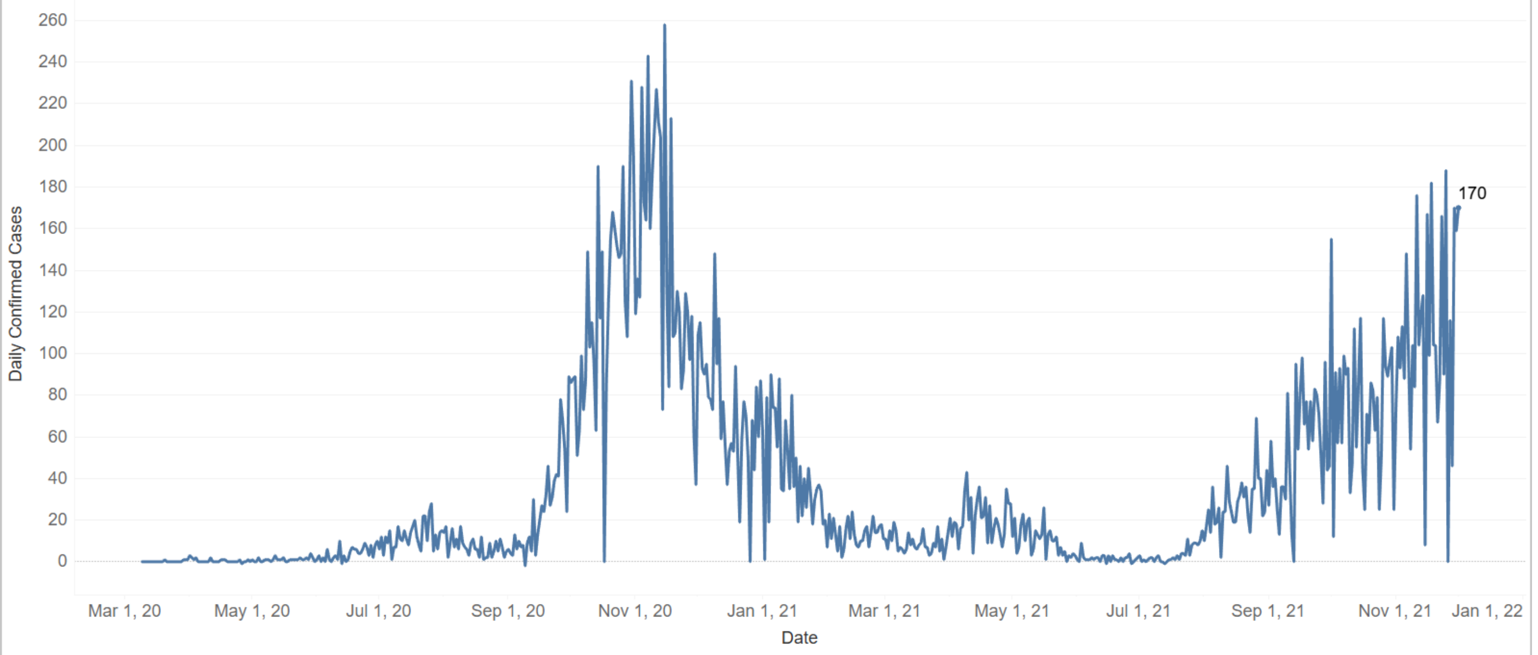
View online: https://www.co.marathon.wi.us/Departments/HealthDepartment/COVID19/Dashboard.aspx

Marathon County COVID-19 Case Data

This data is compiled by the Wisconsin Department of Health Services. Case data will be updated daily, Monday through Friday. Weekend data will be added on Monday. To see more detailed data, hover over the graphic. For weekend numbers, visit https://www.dhs.wisconsin.gov/covid-19/county.htm Last updated: **12/1/2021**

New Daily Confirmed Cases	170
Total Confirmed Cases	23,164
Recovered	19,818
Confirmed Deaths	281

7-Day Average (Confirmed & Probable)	114
Percent Recovered	838.3%
Ever Hospitalized	1,209
Percent Ever Hospitalized	51.1%



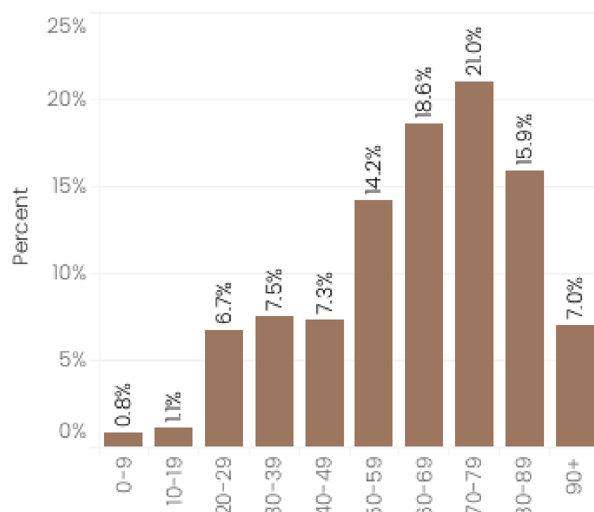
Marathon County COVID-19 Dashboard

COVID-19 Hospitalizations

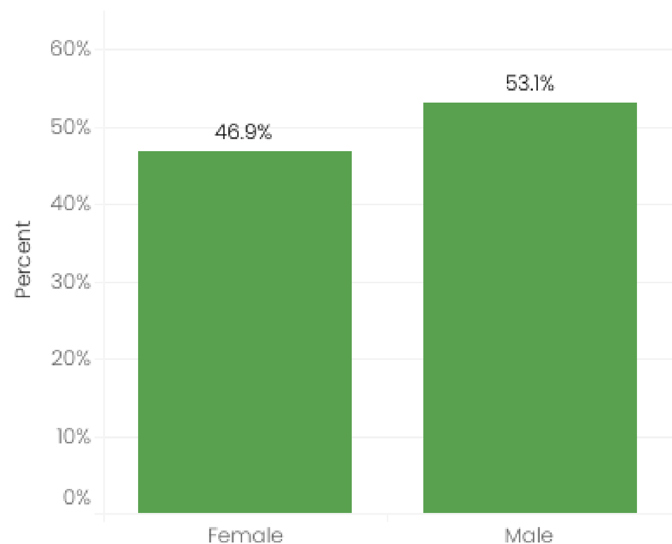
This data is compiled by the Wisconsin Department of Health Services weekly.
To see more detailed data, hover over the graphic. Last updated: **11/29/2021**

New Weekly Hospitalizations

Hospitalizations by Age



Hospitalizations by Gender



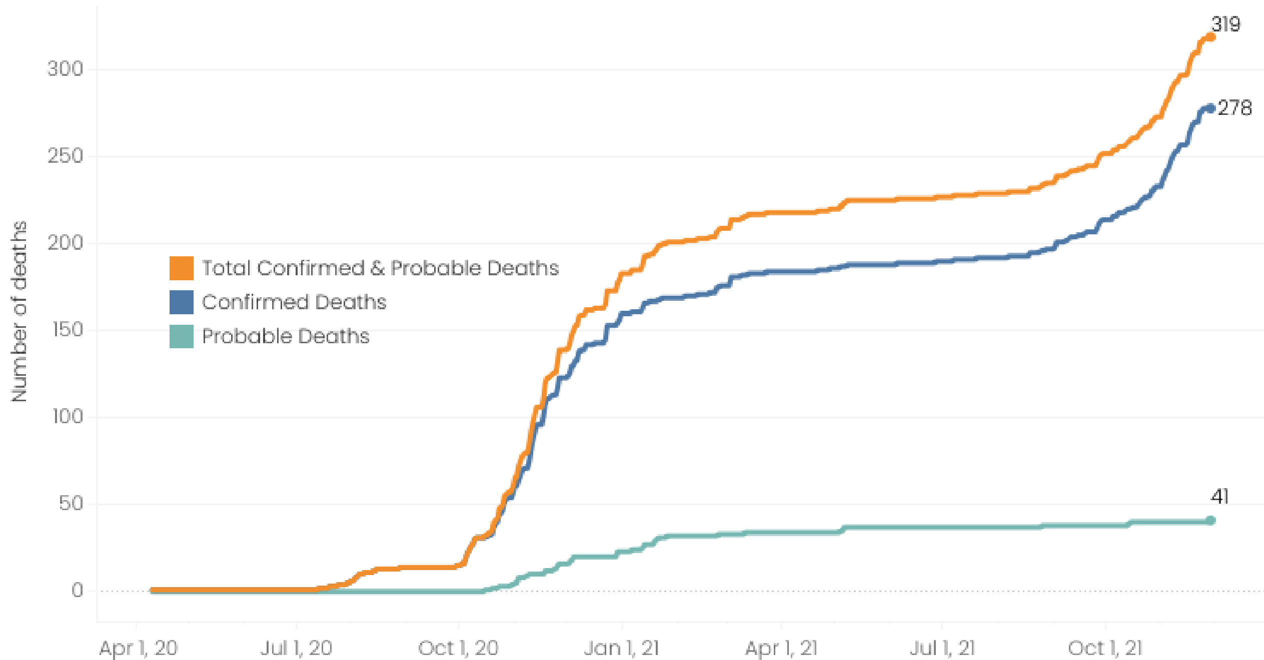
Marathon County COVID-19 Dashboard

COVID-19 Deaths

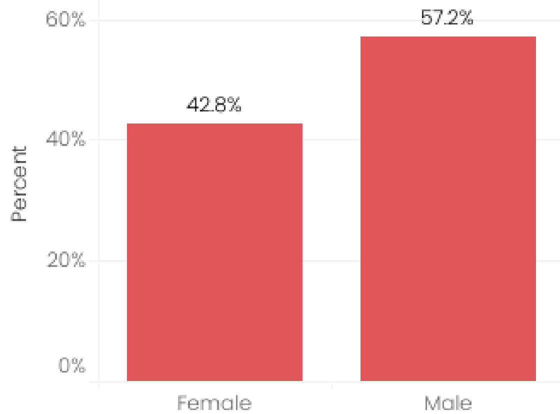
This data is compiled by the Wisconsin Department of Health Services. Death data will be updated weekly. To see more detailed data, hover over the graphic. Last updated: **11/29/2021**

Confirmed and Probable Deaths

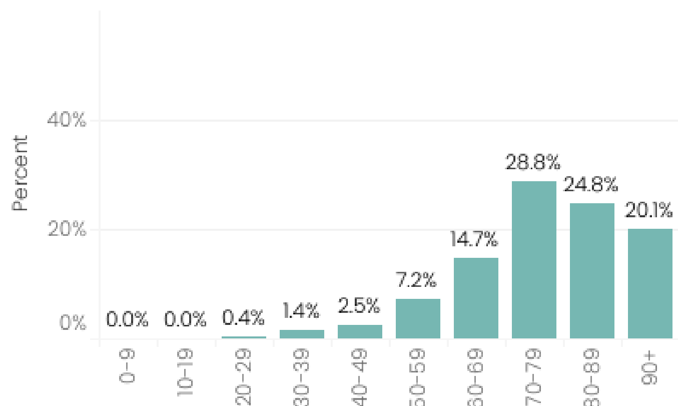
Deaths among probable cases are those that meet one of the following criteria:
- A probable case of COVID-19 is reported to have died from causes related to COVID-19.
- A death certificate that lists COVID-19 disease or SARS-CoV-2 as an underlying cause of death or a significant condition contributing to death is reported to DHS but WEDSS has no record of confirmatory laboratory evidence for SARS-CoV-2.



Deaths by Gender



Deaths by Age



Marathon County COVID-19 Dashboard

Total Daily COVID-19 Tests

The graphs show the daily totals for COVID-19 tests in Marathon County residents. Last updated: **12/1/2021**

Value: 700, 650, 600, 550, 500, 450, 400, 350, 300, 250, 200, 150, 100, 50, 0, -50

Total Tests
Positive Tests

298
170

May 1, 20 · Jul 1, 20 · Sep 1, 20 · Nov 1, 20 · Jan 1, 21 · Mar 1, 21 · May 1, 21 · Jul 1, 21 · Sep 1, 21 · Nov 1, 21

Day of Report Date

Marathon County COVID-19 Dashboard

As of November 30, 2021:

- 19,008 Marathon County residents have received a booster dose

The Wisconsin Department of Health Services is working on updating statewide vaccination data to include pediatric doses (ages 5-11) and booster doses for individuals age 18 and older.

COVID-19 Vaccines for Wisconsin residents

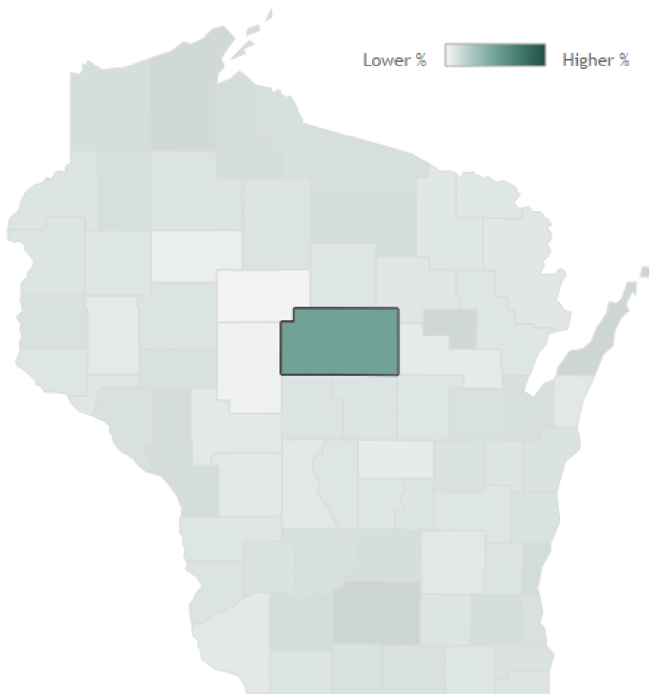
Updated: 11/30/2021

HERC region data

- Total population who have received at least one dose
- Total population who have completed the series
- Adults (18+) who have received at least one dose
- Adults (18+) who have completed series

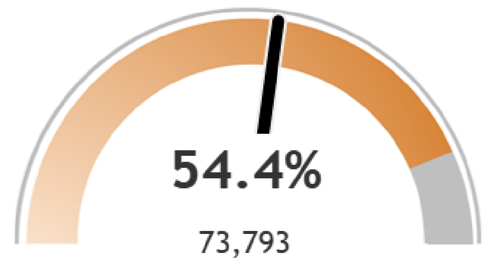
Percent of Wisconsin residents who have received at least one dose by county

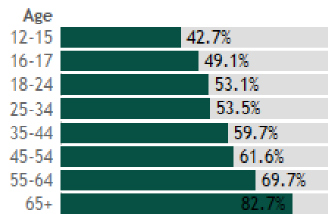
Click a county to filter data

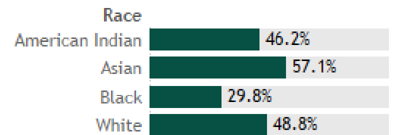


Percent of Marathon County residents who have received at least one dose

The orange represents the population for whom the vaccine is authorized. The gray indicates the population under 12 years of age for whom the vaccines are not authorized.







*8.4% of records reported a race of "Other".

*1.4% of records reported an unknown race

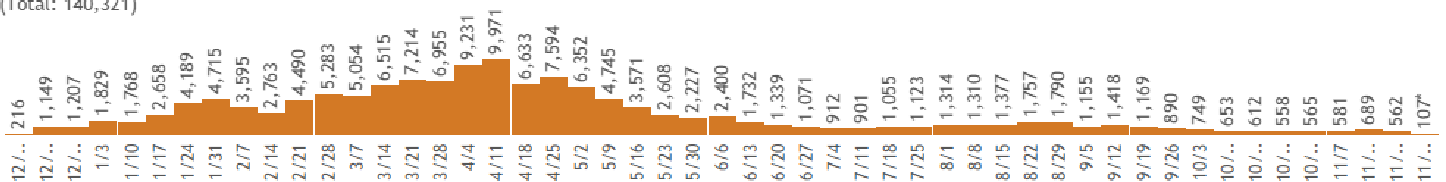
*0.1% of records were reported without sex.

*1.7% of records were reported without ethnicity.

View more data on racial and ethnic disparities in Wisconsin

Vaccine doses for Marathon County residents by week

(Total: 140,321)



*Current week may be incomplete.

MEDIA PACKET

2021-12-14

BOH MEETING

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Moderna boosters get OK as cases spike in nursing homes

Sarah Volpenhein
Milwaukee Journal Sentinel
USA TODAY NETWORK – WISCONSIN

Thousands of Wisconsin nursing home residents, most of whom initially received the Moderna vaccine, can now get a booster shot, just as nursing homes in the state report another uptick in COVID-19 cases.

The Centers for Disease Control and Prevention signed off on the Moderna booster Thursday, following the recommendation of a panel of experts that found the shots were safe and effective at boosting protection against the coronavirus. Previously, only the Pfizer shot had been approved as a

See BOOSTERS, Page 5A

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Boosters

Continued from Page 1A

booster.

That clears the way for many nursing home residents in the state to get the shots, most of whom received the Moderna vaccine when it was initially offered to them beginning last December through a federal program to distribute the vaccine to nursing homes.

Nursing home officials are anxious to get boosters to residents, said John Sauer, president and CEO of LeadingAge Wisconsin, a statewide association of nursing homes and other long-term care providers.

Some studies have shown that nursing home residents lose some protection from the vaccine over time, likely due to waning immunity and the rise of the highly contagious delta variant.

"We are ready to go with the institutional pharmacies to roll out the boosters," Sauer said. "Now is the time ... so we can continue to keep residents safe."

COVID infections have been on the rise in Wisconsin nursing homes

Nursing homes in the state have reported double the number of COVID-19 infections in residents in the last four weeks for which there is data, compared to the four weeks prior. From Sept. 13 to Oct. 10, about 253 residents tested positive for COVID-19, compared to 137 in the four weeks prior, according to the latest data from the CDC's National Healthcare Safety Network.

In that same period, 31 residents with COVID-19 died, compared to 12 in the four weeks prior.

Since September, several nursing homes have had outbreaks where between eight and 17 residents have become infected. While there have been breakthrough cases, officials at some nursing homes with large outbreaks have said most residents had mild or no symptoms and credited the vaccine with preventing serious illness.

The case numbers are still much lower than at the height of the pandemic last year, when in November alone, more than 2,700 residents tested positive for the virus and hundreds died.

90% of all nursing home residents in Wisconsin are fully vaccinated

Rick Abrams, president and CEO of the Wisconsin Health Care Association, said the nursing homes in his association will work closely with local pharmacies and long-term care pharmacies to make sure residents who want a booster can get one. Nearly 90% of nursing home residents in Wisconsin are fully vaccinated against the coronavirus.

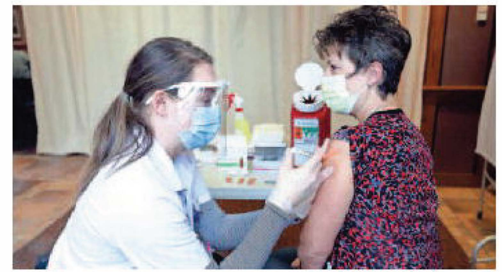
But he hopes the boosters don't distract from efforts to vaccinate people who haven't gotten a single dose.

"What's really important is that we get as many staff — and for that matter the 10% of our residents that are unvaccinated — we get them to the initial vaccination," he said. "We can't lose sight of what needs to be the continuing priority, and that is ... getting folks that are currently unvaccinated vaccinated."

Many nursing home workers haven't received COVID-19 vaccine

Many nursing home workers are still reluctant to get the vaccine. The percentage who have gotten the vaccine has slowly crept up in the last several months, but more than 30% have still not been fully vaccinated, according to the CDC. Vaccination rates also vary widely from nursing home to nursing home. At some Wisconsin facilities, less than a third of workers have gotten the vaccine.

In August, President Joe Biden announced his administration would issue a rule requiring vaccinations for all staff working in nursing homes, as a condition of those facilities receiving federal Medicare and Medicaid funding. Federal regulators have yet to issue the rule. The August announcement was met by an outcry from nursing home groups, who worried the requirement would exacerbate existing staffing shortages and criticized it for singling out nursing homes and not other health care providers. Then in September, the administration announced it would expand the requirement to include hospitals, home health agencies and other Medicare and Medicaid certified facilities.



Walgreens pharmacist Erika Medlock, left, administers a COVID-19 vaccine to nurse Celeste Klaus on Jan. 11. MIKE DE SISTI/MILWAUKEE JOURNAL SENTINEL

Sauer said the fastest way out of the pandemic is to get more people vaccinated.

"No one can rest on their laurels or let their guard down, but what really has made a difference is the vaccine," he said, pointing to the difference between case numbers in November and now. "Mandate or no mandate, the best thing that everyone can do is roll up their sleeve and receive the vaccine because it's a game-changer."

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Four in 10 state health officers have left since March 2020

Madeline Heim
USA TODAY NETWORK – WISCONSIN

Nearly 40% of local health department leaders in Wisconsin have left their jobs since March 2020, mirroring a national exodus during a difficult and divisive pandemic.

In data provided to the USA TODAY NETWORK-Wisconsin, the state association of local health departments and boards listed 33 agencies out of 86 that had lost their top official since the pandemic began. That includes the Wisconsin Department of Health Services, which has cycled through three while managing the state's response to the crisis.

That's more than twice the number that had left by the end of last year, previous reporting shows.

"There's always some turnover, but 40% is a little bit out of this world," said Darren Rausch, health officer for the City of Greenfield in Milwaukee County and co-president of the Wisconsin Association of Local Health Departments and Boards.

In a typical year, they might see a handful of people retiring or leaving for other jobs, Rausch said. The stress of managing COVID-19 outbreaks amid vitriol over stay-at-home orders, mask mandates and vaccination campaigns may have pushed more out sooner.

Nationwide, more than 300 public health leaders have resigned or retired during the pandemic, according to an ongoing investigation from The Associated Press and Kaiser Health News.

Many health officials have seen tightened limits on what they can do to control disease transmission — at least 26 states in the past year have

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Health officers

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passed laws weakening government authority to protect public health, Kaiser Health News found.

Wisconsin's top court has ruled against Democratic Gov. Tony Evers' pandemic actions several times: Striking down his stay-at-home order, ruling that he didn't have the authority to issue multiple health emergency orders, saying he should have sought to limit bar and restaurant capacity through the Legislature instead of on his own and overturning the state's mask mandate.

Lawmakers in the state Assembly also proposed limiting local health officers' power to close businesses or implement capacity restrictions, though that proposal did not gain traction in the Senate.

Workforce challenges aren't limited to department leaders, Rausch added. On a recent call with members of the National Association of County and City Health Officials, he said people mentioned struggling to fill environmental health, nursing and contact tracing roles, too.

In Wisconsin, it's hard to tell how many retirements happened early because of pandemic-related exhaustion, Rausch said. Some health officers — such as the City of Appleton's Kurt Eggebrecht, who left the job in June — postponed retirements to keep overseeing their community's crisis response.

Among those who've departed for other jobs, Rausch said some may have left to find positions that didn't feel as politically charged.

A few former officials spoke directly to that challenge as they left, including the former Sauk County health officer, who in his resignation letter decried the county board's attitude toward his department's actions, and the former Milwaukee health officer, who said GOP lawmakers and the state Supreme Court had tied health officials' hands.

Though most positions have been filled by at least an interim health officer, Rausch said it's difficult to recruit under the current climate.

In a 2020 survey of Wisconsin's city, county and tribal health departments by the Milwaukee Journal Sentinel, many reported harassment, including verbal assaults and threats of physical violence.

"People have seen what we've gone through. People have heard what we've gone through," Rausch said. "We're all kind of feeling that pressure."

Today, data from the association of local health departments and boards show that 69% of health officers in Wisconsin are newer to the job, with five years or less of experience, compared with 20% who have 10 years or more of experience, Rausch said.

That balance, too, makes it more important to ensure people stick around, he said. Each time a new health officer comes in, they have to rebuild relationships with their local schools, businesses, government partners and community members. That takes time, he said, and isn't easily done while simultaneously trying to control a pandemic.

"Wisconsin has lost a lot of very talented leaders with a lot of experience," Rausch said.

Jurisdictions where a health officer has left since March 2020: *Iowa County, Ashland County, Sheboygan County, Outagamie County, City of Cudahy, Polk County, Shawano and Menominee counties, Lafayette County, City of Wauwatosa, Langlade County, Columbia County, Vernon County, Burnett County, Monroe County, Sauk County, City of Milwaukee, Manitowoc County, Rock County, Rusk County, City of Menasha, Green Lake County, Buffalo County, Forest County, La Crosse County, Marathon County, Racine County, Wisconsin Department of Health Services, City of Greendale, Crawford County, Adams County, City of Appleton, North Shore Health Department, Washington and Ozaukee counties.*

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When, how children may be able to get the vaccine

Wisconsin health, hospital officials awaiting final approval

Rory Linnane and Amy Schwabe
Milwaukee Journal Sentinel
USA TODAY NETWORK – WISCONSIN

With the possibility of vaccines being approved for children ages 5 to 11 as early as this week, many families are eager to get shots that can offer relief, more normalcy in daily life, and a break from the disruptions of quarantines.

"Many primary care offices, including those in Children's Wisconsin, are gearing up and getting ready to distribute," Children's Wisconsin pediatrician Dr. Michael Gutzeit said.

Those ages 12 to 15 became eligible for vaccines in May.

Here's what we know about when and how younger children may be able to get the vaccine, and what it can mean for them.

When can children under 12 get vaccinated?

Health and hospital officials are awaiting final sign-offs in the coming days from two federal agencies — the Food and Drug Administration and the Centers for Disease Control and Prevention — to start providing the Pfizer vaccine to children ages 5 to 11.

An advisory committee for the FDA recommended the approval Tuesday. A CDC committee is scheduled to meet

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Lizzie Amidzich, 15, a freshman at Greendale High School, received her first dose of the COVID-19 vaccine on May 13. There is a possibility of vaccines being approved for children ages 5 to 11 as early as this week.
PROVIDED

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Vaccine

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Tuesday and Wednesday. Then, if CDC Director Rochelle Walensky approves, shots can begin as soon as vaccines can be distributed. The two-shot vaccine is one-third of the dosage that adults and adolescents received and comes with a different color cap to differentiate it. The shots will be administered three weeks apart. Gutzeit said Wednesday he expected vaccinators would be able to start giving shots the week of Nov. 8 or Nov. 15. President Joe Biden has said the country has enough vaccines for all 28 million children in the U.S. ages 5 to 11. Moderna has said its vaccine is safe for children ages 6 to 11 but the company has not yet applied for FDA authorization.

Where can children get vaccinated?

Shots will be available for no cost at pharmacies, doctors' offices and sites operated by public health departments — which could include pop-up clinics in schools. To find an appointment, health officials encourage families to start with their primary care doctor if they have one. Families can also find appointments at vaccines.gov by entering a ZIP code and choosing Pfizer, the only vaccine currently available for children under 12. The state health department also offers a multilingual hotline to help residents find appointments: 844-684-1064.

Do you need insurance or an ID?

Vaccination sites may ask you for an ID or insurance card, but you are not required to present either.

Vaccination sites are not supposed to turn away anyone who is unable or unwilling to provide an ID. They're not supposed to turn away anyone on the basis of immigration status or documentation.

The vaccine is free. While vaccination sites may bill your health insurance if you have it, individuals should not be asked to pay anything themselves by the vaccinator or their insurance provider.

Is the vaccine safe?

Before the FDA committee recommended approval, Pfizer presented the results of several studies it has conducted among about 5,000 5- to 11-year-olds.

No severe side effects were reported. Typical side effects were sore arms, fatigue, headaches, muscle pain, chills and low-grade fevers. No dangerous allergic reactions were reported, and there were no cases of myocarditis — a swelling of the heart muscle that has been seen following COVID-19 shots in a small number of adolescents and young adults. Health experts said they expect to see cases of myocarditis once the vaccine is rolled out to more children, but no one has died of myocarditis after the COVID-19 vaccine, and it generally responds quickly to treatment.

Major health systems have strongly encouraged children to get vaccinated upon approval.

"With expected approval for the Pfizer vaccine by the FDA and CDC, the vaccines now mean this is a preventable disease for all children ages 5 and up," Advocate Aurora Health said in a statement. "We encourage parents to get their children vaccinated as soon as possible."

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Wausau Daily Herald

NEWS

Here's why some Wisconsin schools scaled back contact tracing and are skipping quarantines

AnnMarie Hilton USA TODAY NETWORK-Wisconsin

Published 6:01 a.m. CT Nov. 3, 2021 | **Updated 9:03 a.m. CT Nov. 3, 2021**

Parents in the Wausau School District have taken on a new role this school year: contact tracers.

In a private Facebook group, parents, grandparents and community members are posting whatever they know about COVID-19 cases in Wausau schools.

One parent, Norah Brown, said the group really buckled down on the second day of school this fall. That was when they realized Wausau schools wouldn't be doing in-house contact tracing.

The district updates an online dashboard daily with the number of cases at each school, but families aren't told if their child was exposed to an infected child or staff member — with the exception of elementary students' families, who are sent a letter when their child was in the same classroom as an infected person. Families of middle and high school students are just encouraged to check the dashboard.

Contact tracing has been used for more than a century to control communicable diseases, said Patrick Remington, a physician and professor emeritus at the University of Wisconsin School of Medicine and Public Health. Public health officials were contact tracing every day, long before the COVID-19 pandemic even started, to track diseases such as measles, hepatitis, tuberculosis and sexually transmitted diseases.

Next to vaccination, identifying people who have been exposed, or potentially exposed, can be one of the best ways to get ahead of a virus, said Remington, who spent six years as an epidemiologist for the CDC.

But in a school setting, identifying those close contacts can be "very challenging," he said, because of all the places a student may visit in a given day: art class, gym class, recess, buses, friends' houses after school and so on.

"The potential contacts are overwhelming," Remington said.

Federal health officials continue to update their advice about how schools should handle contact tracing and quarantines for students who've been in contact with infected people. But while the latest guidelines from the Centers for Disease Control and Prevention still suggest that schools and health departments should try to track down close contacts, notify their families, and put them in quarantine if they haven't been fully vaccinated, many Wisconsin school districts have scaled back those efforts this year.

School districts in Wisconsin are not required by the state to follow any COVID-19 protocols. Decisions around masking, contact tracing and quarantines have been left to administrators and school boards.

Scaled-back procedures veer from the traditional public health response, but many districts are adapting their approaches both because they have limited resources and because of concerns about negative effects of depriving kids of an in-person education.

Said Remington: “Society is weighing the benefits of what is a textbook public health response with the cost."

RELATED: Wisconsin parents suing school boards over lack of COVID-19 protocols face an 'uphill battle.' Here's why.

Health departments can help, but only if schools cooperate

A Wausau School District spokesperson said the district's director of pupil services was not available for an interview with the USA TODAY NETWORK-Wisconsin and sent a link to this year’s COVID-19 protocols, which include the option for students and staff to wear masks, daily cleaning and social distancing.

The Wausau school district’s website says people who test positive are required to isolate, and to reach out to the Marathon County Health Department with any questions on contact tracing and quarantines.

Marathon County Health Officer Laura Scudiere said some of the county's schools were very actively involved in contact tracing last year. This year, Scudiere wrote in an email to the USA

TODAY NETWORK-Wisconsin, the schools said it was dropped was "extremely time intensive and not sustainable."

Some schools are still providing the health department with detailed lists of students and staff who may have been exposed, but others have said it would be difficult to know that information, since students are moving around so much within the school. Few, she said, provide seating charts.

Scudiere said her department believes in the COVID-19 strategies suggested by the CDC and the state's health and education departments, yet many schools in the county have "chosen not to take that approach."

"The difficulty is that health departments are unable to be fully effective unless we have cooperation from local school leadership on mitigation," she wrote.

Parents are refusing to provide information, too, Scudiere said. Many won't say which school their child attends, and a growing number have stopped taking calls from the health department.

Is best practice always the best option?

According to the state Department of Health Services, identifying students who test positive or come in contact with someone else who has and then placing them in isolation or quarantine should be the primary strategy for reducing transmission of COVID-19 in a school setting.

The CDC says schools or health departments should let students and their families know "as soon as possible" if they've been exposed to an infected person.

Fully vaccinated students don't need to quarantine, the CDC says, though they should get tested 5-7 days later and wear a mask indoors for at least 14 days or until they test negative.

Those who aren't fully vaccinated should stay home after exposure, the CDC says, though it says students can consult their local health department or school officials about ways to shorten the quarantine from the recommended 14 days to as few as seven (with a negative test).

Having public health guidance can be helpful, but school districts also have to consider feedback from families and how to best serve their students' educational needs.

Last year, the School District of Omro had a more stringent quarantine policy than it does this year. Karen Carley, the district's director of health and nursing services, said students would cry in her office because they had to leave school — not because they were sick, but because a sibling was.

Keeping kids in school is important not only academically, but also for students' emotional wellbeing, she said.

Carley said the district understands there's a risk to keeping those kids in school, but they're outweighed by the benefits of in-person learning.

"We need those kids in person," she said.

Standardized test scores — which went down for both English and math last spring — underscore the negative effects of school shutdowns, online learning and large-scale quarantines. There were fewer students who even took those tests and midway through last year, administrators reported that many more kids than usual were failing classes.

RELATED: Fewer Wisconsin students took last year's standardized tests. Those who did take them fared worse than usual.

RELATED: We asked Wisconsin high schools how many students failed a class during first semester. It's not pretty.

Districts across the state also reported last year that hundreds of students were in quarantine and unable to participate normally in in-person classes. In May, the School District of Waukesha loosened its quarantine requirements after having quarantined more than 8,300 students — 2% of whom ultimately tested positive for COVID-19, a school board member told the Milwaukee Journal Sentinel.

School nurses have not been immune to the burdens brought on by the pandemic. Carley said she's always been busy during the nine years she's worked as a school nurse, but even more responsibilities have been placed on her since the pandemic began in spring 2020.

Omro's decision to go with its current quarantine policy, Carley said, was made after the nursing staff and administrators brought data to the school board showing how much time was missed by close contacts and how few of them actually went on to test positive.

Rather than giving up completely on its infection-fighting policy, Omro decided to loosen quarantines but stick with diligent contact tracing. Whenever there is a positive COVID-19 case reported in an Omro school, there is an immediate chain reaction of nurses, teachers,

parents and administrators working together to find anyone who has been exposed, Carley said.

It starts with either Carley or the other nurse interviewing the student's parents about when symptoms started. From there, the school principal and secretary are brought in to provide attendance information about which days the student was in school and which classes they attended. Then, teachers are asked which students were seated within 3 feet of the student. The clerical staff finds contact information for any family that needs to be informed.

All of that can happen within just a couple hours of finding out about a positive case. Carley said she likes to call families, and the nursing staff follows up with an email with information about how to monitor for symptoms.

But nowhere in that information will a parent see something that says their child has to stay home and quarantine. Only students who share a household with an infected person are excluded from school, she said. Otherwise, students who are exposed to a sick person at school are free to keep attending, unless they develop symptoms.

In-house data are ending quarantines, but are they reliable?

Little Chute Area School District wants to see students in school as much as possible and control COVID-19, so it meets with the Outagamie County Public Health once or twice a week, said Heidi Schmidt, district administrator.

They still contact trace using seating charts and conversations with teachers and coaches to identify all students and staff who have been within 6 feet of a positive case for 15 minutes, going back two days before symptom onset, said Samantha Busko, school nurse. In younger grades, entire classes are often deemed close contacts, because it's hard to say whether students were in their seats the whole time.

But like Omro, Little Chute isn't requiring close contacts to quarantine, so long as they don't have symptoms, and as long as the exposure wasn't out in the community, where the district can't ensure its mitigation strategies were in place.

The decision to change the quarantine policy for asymptomatic close contacts was based on data Little Chute collected that showed only 1% of in-school close contacts last year went on to test positive, Busko said.

From an epidemiology standpoint, Dr. Laura Cassidy, a professor and director of epidemiology at Medical College of Wisconsin, said such observations can miss important

considerations that are part of more formal research such as controlled studies. For example, some COVID tests can miss asymptomatic cases. Health officials are constantly learning about how people who don't show symptoms may spread the virus.

"I would err with caution," she said. "And stick with what the scientists say."

Schmidt said people have asked why the district uses last year's data in light of the twice-as-contagious delta variant and cases peaking at the start of this school year, but she said they've closely monitored it, and haven't found a reason to change their practice.

Other districts across the state have eliminated quarantines for unvaccinated, asymptomatic close contacts, including the Fond du Lac School District, Elmbrook Schools and Kettle Moraine School District.

'We all just want to protect our kids'

Most public health departments and school districts don't have the resources it would take to identify every single contact. Because of that, Remington said, there needs to be a balance between what's ideal and what's feasible.

It may not be possible to call every single student who would technically be a close contact, but as a parent, Remington said, he would want to know at least if there was a positive case in his child's classroom. From there, families can monitor for symptoms and make adjustment as they see fit.

Contact tracing isn't just taxing on personnel at schools and public health departments, but there can be a cost to students' education. Typically, some form of quarantine or isolation follows contact tracing, which carries its own costs.

Especially when children are involved, Cassidy said, the pandemic is stressful and emotional. Given that the coronavirus was a new virus, there has been a lot of "evolution of understanding," over the past almost two years, she said.

It can be frustrating and polarizing when the rules change and parents feel the emotions associated with wanting what's best for one's child. She sympathizes with parents who want to bring the world back to "normal" for their kids and also with those who feel they are helpless in protecting their child's health.

"Either way, we all just want to protect our kids," said Cassidy, who is also a mother to grown children.

In Wausau, two of Brown's four kids in the Wausau schools are attending in-person and the other two, who are elementary age, are doing virtual learning. She said she would prefer if they could all be in school, butshe is thankful there is a virtual option because she doesn’t feel comfortable sending her unvaccinated children.

Brown said she wishes the district would go adopt a policy more like that in Omro. Even if the district didn't enforce quarantines for every close contact, parents could get more information and decide for themselves how to proceed.

Last year was frustrating because people didn’t really know what to do, Brown said, but now the science is there and “we’re choosing not to do it.”

Correction: The Green Bay Area Public School District requires unvaccinated students to quarantine if they've been exposed to somebody infected with COVID-19. This story previously stated otherwise.

USA TODAY NETWORK-Wisconsin reporters Allison Garfield, Alec Johnson, Rory Linnane and Natalija Mileusnic contributed to this story.

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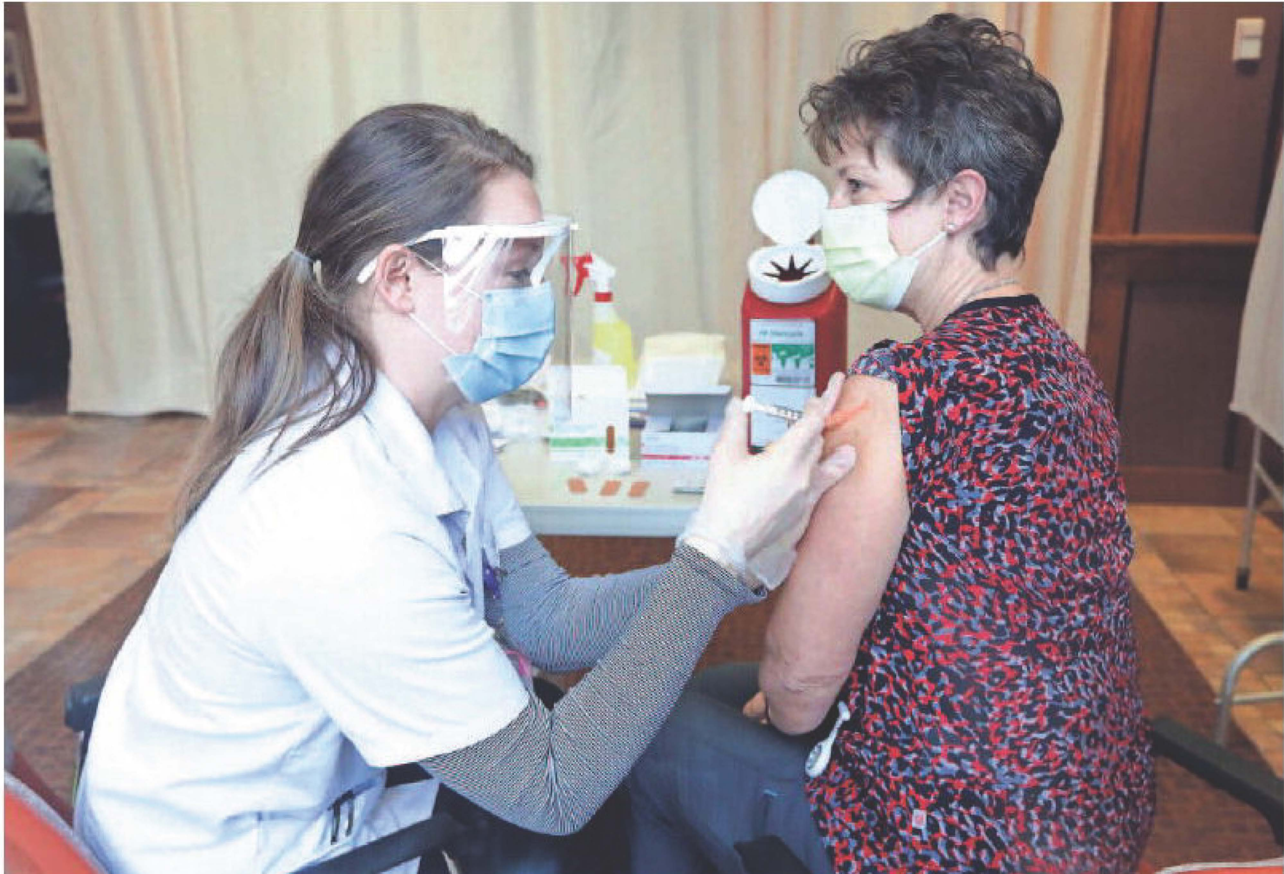
Expanding the mandate



Walgreens pharmacist Erika Medlock, left, administers a COVID-19 vaccine to nurse Celeste Klaus as Shorehaven's nursing home residents and staff received their first dose of the Moderna vaccine at the facility in Oconomowoc Monday.
MIKE DE SISTI/MILWAUKEE JOURNAL SENTINEL

Nursing home workers have until Jan. 4 to get COVID-19 vaccine

Sarah Volpenhein Milwaukee Journal Sentinel | USA TODAY NETWORK – Wisconsin

Nursing home workers will be required to be fully vaccinated against COVID-19 by Jan. 4, under a federal rule that took effect Friday, though federal regulators say the rule doesn't apply to assisted living facilities. • The rule requires nursing home workers, as well as workers in other health care settings, such as hospitals and home health agencies, to be fully vaccinated with either two doses of the Pfizer or Moderna vaccine, or one dose of the Johnson & Johnson vaccine by Jan. 4. • Under the rule, nursing home workers will not have the option of undergoing regular testing in lieu of vaccination. • John Sauer, president and CEO of LeadingAge Wisconsin, a statewide association of nursing homes and other long-term care providers, said it would be a challenge to get everyone vaccinated by Jan. 4, calling the time frame "more than ambitious."

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Mandate

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"I support the idea ... that everyone should be vaccinated, whether they work in long-term care or not, but our desire to have people vaccinated doesn't create a magic wand," he said. "We're still a long way from achieving 100% vaccination rate."

The rule was issued more than two months after President Joe Biden announced in August that his administration would require the vaccine for all nursing home workers. The Biden administration then decided in September to expand the mandate to hospitals and other facilities that take payments from Medicare and Medicaid, effectively delaying the release of the rule.

In Wisconsin, nursing home vaccination rates have improved only slightly in the last few months and have remained stubbornly low in certain facilities. Meanwhile, more nursing homes have reported outbreaks of COVID-19 and new cases have ticked up, though case counts have stayed well below levels seen last November at the pandemic's peak.

About 69 nursing home residents in Wisconsin have died with COVID-19 in the last three months reported to the federal government, according to data that the nursing homes are required to submit weekly.

Most nursing home residents - nearly 89% - have been fully vaccinated, but they remain vulnerable to breakthrough infections because so many are older and have underlying medical conditions.

Overall, about 70% of Wisconsin nursing home workers have been fully vaccinated, an improvement of about 8 percentage points from three months ago. However, that percentage obscures large disparities between facilities and between types of workers in nursing homes.

Federal data show that aides, who provide the most direct care to residents, are the least likely of nursing home workers to be fully vaccinated, according to health service researchers and other academics.

In the Wisconsin nursing homes that reported detailed staff vaccination data in the latest week for which the data was available, only about 55% of aides had been fully vaccinated, compared to nearly 70% of nurses and 75% of therapists.

Vaccination rates also vary widely from nursing home to nursing home. In some facilities, as few as a third of workers have been fully vaccinated, ultimately increasing the risk of an outbreak.

At Riverdale Health Care Center in Muscoda, where only about 35% of the workers were fully vaccinated, 14 residents tested positive for COVID-19 in the first few weeks of October. Five of those who had COVID-19 died in a two-week span, making it the deadliest outbreak in a Wisconsin nursing home in months, according to the federal data.

Ashley Kohls, chief director of operations for Bedrock Healthcare facilities in Wisconsin, including Riverdale, said Friday that the outbreak is over, and residents are no longer under quarantine.

She did not answer how the outbreak started. Federal data show a staff member tested positive for COVID-19 the week before residents started getting sick. She did not answer Friday whether the staff member had been vaccinated.

Kohls said nursing home officials would continue to educate staff about the COVID-19 vaccines, and expressed confidence that the facility would be able to comply with the federal requirement by Jan. 4.

Nursing homes that don't comply with the rule could face fines, penalties or, in more serious cases, loss of Medicare and Medicaid funding. State inspectors will largely be responsible for inspecting the facilities and ensuring they comply with the vaccination requirement. Facilities that don't meet the vaccine mandate will be given multiple chances to improve vaccination compliance, officials have said.

The federal rule allows exemptions for medical reasons and sincerely held religious beliefs.

Sauer, of LeadingAge Wisconsin, said that at this point, it is unclear how much time facilities will be given to come into compliance if they don't meet 100% vaccination by Jan. 4 or how stringent the penalties for noncompliance will be.

"I'm hoping that as we go through this, we're going to find that there is more time before the heavy hand of enforcement takes over and the line in the sand is drawn and we're going to have to terminate employees," he said.

Mandate doesn't apply to assisted living

Nursing home groups had called for the mandate to apply evenly across health care sectors.

"The fact that it does not apply to assisted living facilities ... in the state creates a tremendous hole in what the administration is attempting to accomplish," said Rick Abrams, president and CEO of the Wisconsin Health Care Association, which represents many nursing homes and assisted living facilities in the state.

He worries that nursing home workers who decline the vaccine could simply switch to jobs in assisted living, further exacerbating staffing shortages at nursing homes.

The federal government does not have much leverage over assisted living facilities, which - unlike nursing homes - do not heavily rely on Medicaid and Medicare funds, said R. Tamara Konetzka, a health sciences professor at the University of Chicago.

"There's no scientific reason that these mandates should not include assisted living," she said, adding that nursing home and assisted living residents are at a similarly high risk of severe illness from COVID-19. "The difference is completely in what authority and leverage the federal government has."

It is unclear how many assisted living workers in Wisconsin have gotten the vaccine. Those facilities are regulated by the state and are not subject to the same reporting requirements that nursing homes are.

In emails to the Wisconsin Department of Health Services, spokespeople did not answer questions about vaccination rates at assisted living facilities in the state.

Some assisted living facilities could still be covered by another federal vaccine requirement for businesses with 100 or more employees. However, those workers have the option to undergo regular testing in lieu of getting the vaccine. Even before that regulation was issued, some assisted living operators, including Brookdale Senior Living, chose to impose vaccine requirements on their own.

Some states, including Massachusetts and Washington, have chosen to require the vaccine of assisted living workers.

Sarah Volpenhein is a Report for America corps reporter who focuses on news of value to underserved communities for the Milwaukee Journal Sentinel. Email her at svolpenhei@gannett.com. Please consider supporting journalism that informs our democracy with a tax-deductible gift to this reporting effort at JSOnline.com/RFA.

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State COVID-19 levels are rising again after a barely-there reprieve

Madeline Heim
USA TODAY NETWORK – WISCONSIN

Climbing COVID-19 cases are worrying Wisconsin health care workers as the holidays approach, with leaders fearing that their exhausted workforce can't run much faster and that spare beds will be even harder to come by.

After the more contagious delta variant caused cases to spike in late summer to levels not seen since before the arrival of vaccines, they started to drop at the end of September. Hospitalizations dipped a few weeks later,

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Cases

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from a high of close to 1,200 Wisconsinites in hospitals with the disease on Oct. 11 to fewer than 900 at the end of that month.

But what some viewed hopefully as the tapering off of delta's run turned out to only be a blip on its radar.

Cases took off again at the end of October and have been rising steadily since then. Wisconsin is now averaging more than 3,100 new cases per day, according to data from the Wisconsin Department of Health Services.

New hospitalizations tend to lag new cases by a few weeks, but they, too, are back up. About 1,230 residents were hospitalized with the virus on Monday, a record high in 2021.

The monthlong decline wasn't enough for health care workers to catch their breath, their bosses say.

"There was about a week there when we were all having small sighs of relief thinking delta might be over for us," said Dr. Jeff Pothof, chief quality officer at UW Health in Madison.

He said he worries COVID admissions will continue to rise before they go down, and that more people could be hospitalized with the flu, which is already circulating at higher levels than at this time last year.

His hospital is so full and busy now that that scenario could strain an already "exceedingly difficult environment."

Pothof isn't alone. More than 600 days into the pandemic, Wisconsin hospitals are bracing for busier and busier facilities as people gather for deer hunting and the holidays, creating opportunities for the virus to jump from person to person — and it'll happen amid a nationwide shortage of health care workers.

COVID-19 patients are also joined by people who've put off care during the pandemic and now need more urgent attention for their ailments, stretching hospitals even thinner. Dr. Michael Stadler, chief medical officer at Froedtert Hospital in the Milwaukee area, said even as the hospital's COVID census has stayed relatively stable in recent months, that pent-up demand is showing in his facility, from fuller emergency departments to more surgeries like hip or knee replacements.

At Marshfield Clinic, whose hospitals stretch across much of northern and western Wisconsin, the number of COVID patients has doubled from 45 to 90 over the past two weeks, director of communications John Gardner said in an email. Intensive care units have "exceeded or are near capacity," he wrote.

Tammy Simon, who leads the health system's pandemic planning, said she's reviewing open bed space on almost an hour-by-hour basis. Patients who come to emergency rooms often have to wait longer for a bed to free up elsewhere in the hospital, she said.

It's a similar scenario at Bellin Hospital in Green Bay. Jason Perry, director of COVID operations, said the emergency department is running at 105 to 120% of capacity every day.

Tammy Simon, who leads the health system's pandemic planning, said she's reviewing open bed space on almost an hour-by-hour basis.

They're limiting elective procedures to free up space and sending patients home as soon as they safely can, even if it's at night.

"In the old days, if someone wanted to stay the night, we'd say sure," Perry said. "Now we don't have the ability to do that. If you meet discharge criteria, we get you home because there's someone in the emergency department who needs that bed."

Both Perry and Simon said it's difficult to discharge patients who need rehab to nursing homes because those facilities are also full to the brim — another nationwide problem.

Slide south to the Fox Valley and health care officials are just as concerned. During a Nov. 19 conversation with community leaders, ThedaCare senior innovation executive Frank Mellon described an "aggressive" rise in cases and hospitalizations in the region.

As has been the case since delta emerged, middle-aged people are appearing more and more often in COVID wards, Mellon said. (Seniors, who were among the most vulnerable to the disease, are now highly protected by vaccines — more than 87% of people 65 and older in Wisconsin have gotten the shot.)

Middle-aged and younger people often have the stamina to fight complications from the disease that older patients may not survive, but they sometimes require 20 to 30-day hospital stays. While it's a win when they beat it, he said, those long stays mean beds and other resources don't free up for others who may need them.

On Tuesday, there were 108 COVID-19 patients hospitalized in the Fox Valley region, according to Wisconsin Hospital Association data, an increase of 18 patients in the past week. Mellon said he expects the census to continue upward.

Dr. Imran Andrabi, president and CEO of ThedaCare, asked those who have refused vaccination to consider the impact their choices are having.

"The answer can't be that we are at a 50% vaccination rate," Andrabi said. "If we stay at that level, we will have surge number four, and surge number five, and surge number six. And all of those things are going to have consequences to our community."

Stadler, at Froedtert, says it's the stress on his staff that keeps him up at night. Though difficult, they've learned how to care for COVID patients and to maximize space in the hospital. But he fears the point when employees will reach a limit.

"Those who have been in the trenches — I worry about them, their ability to maintain resilience," Stadler said. "It's not like we have a deep bench, being able to rotate people on and off."

A spokesperson for Advocate Aurora Health declined an interview but said in an email statement the system's inpatient hospitalizations are on the rise, and high numbers of positive tests are a concern. There were 256 COVID patients in Aurora's Wisconsin hospitals Tuesday, the statement said, the vast majority unvaccinated.

Last year, many chose to gather in smaller groups for the holidays or declined to gather altogether. This year, with at least half of the state's population vaccinated, people are hoping to make up for the celebrations the pandemic took from them.

Simon, at Marshfield Clinic, said she hopes people recognize that as much as they'd like the pandemic to be over, it's not over for those who pass through her hospital's doors, be they patients, family members or employees — and that the next month of holiday gatherings is all but certain to put strain on an already battered system.

She's asking for people to wear their masks, wash their hands, stay home if they're sick and get tested. The pillars of the pandemic response still work, but she feels they've been left behind.

"I think people are forgetting," Simon said.

Contact reporter Madeline Heim at 920-996-7266 or mheim@gannett.com. Follow her on Twitter at @madeline_heim.

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Hospital beds scarce as COVID ramps up

Delta variant is to blame

Hospital beds in central Wisconsin are getting scarce as the COVID-19 pandemic roars back.

With Marathon County recording 575 new coronavirus cases within the past week, spokesmen for the two large, local health care systems, Aspirus and Marshfield Clinic, acknowledged that hospital beds are at a premium. They said local patients with other ailments sometimes are routed to alternative providers within their systems.

Jeff Stark, a spokesman for the Marshfield Clinic Health System, said the Marshfield Medical Center hospital has seen a "significant surge" in COVID-19 patients that has resulted in a recent shortage of beds. He said a patient count of around 50 patients in October "completely filled" the hospital's Intensive Care Unit (ICU) and required conversion of an entire hospital floor into a COVID-19 unit.

Stark said Marshfield Medical Clinic Health System is able to send patients to any of its nine hospitals, if needed.

"If we do need to transfer prior to hospital admission due to a shortage in bed space, we do

Hospital beds

Continued from page 1

our best to keep patients in the health system to ensure a seamless transition of care," he said.

Andrew Kraus, spokesman for Aspirus, said his health care system had 81 hospitalized coronavirus patients as of last Thursday, including 18 at the Aspirus Wausau Hospital. He said this patient level represented a slight drop from Oct. 13, when the system had 91 patients.

"Still, we are pretty full," he said.

Aspirus Systems executive physician Dr. Susan Schneider said this newest wave of COVID-19 patients is putting pressure on ICUs because the disease's Delta variant is affecting a younger group of patients. The average age of a COVID-19 patient within the Aspirus System has dropped from age 62 to 50.

"The ICU is essentially one of the areas in our hospitals that take care of the sickest of the sick," she said. "We're seeing with this most recent surge with the Delta variant that patients are somewhat younger than they have been in the past and needing a much higher level of care."

As of Oct. 26, 32 of the Aspirus Systems coronavirus patients were being treated in an ICU.

Schneider said the lion's share of new coronavirus cases are among those who have not been vaccinated.

"Over 80 percent of our patients right now that are admitted with COVID-infections are unvaccinated,"she said.

Aaron Ruff, spokesman for the Marathon County Health Department, said the county has not seen this level of COVID-19 cases since December 2020, one month after case levels hit their peak.

He said county health officials had hoped that the newest surge in cases would plateau and, possibly, decline. Instead, cases have continued to grow slowly over the last two months.

"November 2020 was our worst month," he said. "We are concerned about what is going to happen this month."

Ruff said county health officials meet weekly with Aspirus and Marshfield Clinic representatives. He said that these health care providers have reported large numbers of patients.

"Their beds are full and this impacts other patients," he said. "When hospitals are burdened like this, it impacts all of us."

Time to get vaccinated

November is looking scary. Marathon County recorded 575 confirmed cases of COVID-19 this past week and, after a summer where deaths had plateaued, we are now seeing a surge of fatalities.

Twenty-eight people in the county died from the coronavirus this past month. Hospitalizations are spiking up to 35 a week and, as we report in this week's issue, it's tough to find an empty hospital bed at either the Marshfield Medical Center hospital or at the Aspirus Wausau Hospital.

Both institutions report that the situation is short of a crisis and, even when beds are full, they can find care for patients at other hospitals within their respective systems. Still, patients with non-coronavirus ailments are being told to find alternative care given the influx of COVID-19 patients.

This is not good.

We plead with our readers to do the thing that will best protect themselves from the coronavirus and also best protect the community. Get vaccinated.

Vaccines are safe and, while not perfect, are effective in protecting people from COVID-19. Marathon county data for September reported by the Wisconsin Department of Health Services proves the value of coronavirus vaccines. The death rate due to COVID-19 among the unvaccinated per 100,000 people was 19.8, but only 4.9 for vaccinated people.

Younger people have thought they did not need to get vaccinated because COVID-19 only threatened senior citizens with death. That's changing with the Delta variant. The average age of a COVID-19 patient at the Aspirus Wausau Hospital has dropped dramatically from 62 to 50.

Only barely half of the Marathon County population is fully vaccinated. This low rate enables the virus to spread. We can do better. We must do better.

Go to vaccines.gov. The website lists 24 places within 25 miles of our area that are vaccinating people. The vaccines are free. Make an appointment.

Share the love, not the virus.

Hospital beds full in Marshfield, Wausau

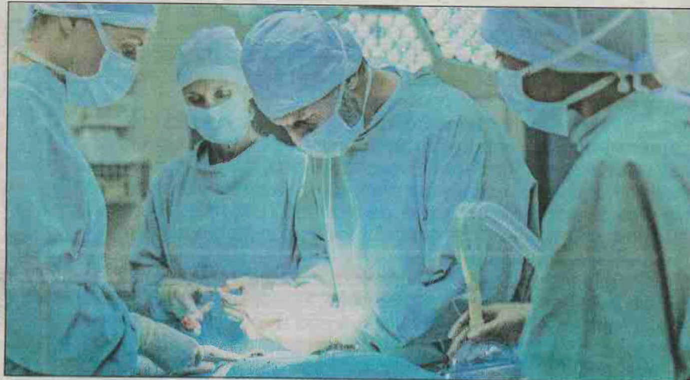
COVID-19 surge in November has overwhelmed providers

A spokesman for the Marathon County Health Department on Thursday said hospital beds across the state, including in central Wisconsin, are full due to a late fall surge in COVID-19 cases.

Aaron Ruff, department public information officer, said both hospital Intensive Care Units (ICUs) and other hospital departments are near maximum capacity, affecting care for both coronavirus patients and all others with serious illnesses.

"The care for patients of any kind is affected, whether they are in a car accident, have diabetes or suffer a heart attack," he said. "We have ICUs at 96 percent capacity statewide. Other hospital beds are at 99 percent capacity."

See **HOSPITALS ARE FULL/** page 5



Hospitals are full

Continued from page 1

Ruff said hospitals lack both physical beds to place patients, but also staff to care for the extraordinary number of patients showing up for care.

"It's both," he said. "It's a combination of not having brick and mortar space, but also health care workers. With burnout, staffing is an issue."

As of Friday, the health department reported Marathon County was seeing 106 new COVID-19 cases each day with 37 people being hospitalized for the disease each week. Thirty-seven people died from COVID-19 in the county between Oct. 16 and Nov. 16.

Ruff said the current surge seems to be repeating this area's experience last winter when cases peaked in December.

"Our hospitalizations are not as high as last year, but we are seeing parallels from what we experienced last October, November and December," he said. "People will get sick and die. We have seen this before."

Ruff said the seasonal spike in COVID-19 cases comes when barely half of county residents, 69,605, are fully vaccinated against COVID-19.

He said state and local hospitals were largely being filled up by people who are not vaccinated.

"The vast majority of hospitalized individuals are not fully vaccinated," he said. "They are the main driver."

Ruff said unvaccinated people in Marathon County were 16 times more likely to get COVID-19 and 18 times more likely to be hospitalized.

The spokesman repeated Department of Health Services recommendations that people get vaccinated and that people, especially those over age 65, get booster shots.

Ruff said the "good news" is that health care providers are becoming more skilled in treating COVID-19, using monoclodal antibodies, but, on the other hand, the coronavirus is becoming a more serious threat to people who are not old or have compromised immune systems.

"We are seeing hospitalizations of people in their thirties, forties or fifties," he said.

Spokesmen for both Aspirus Health and Marshfield Clinic Health System on Thursday confirmed that their hospitals were at capacity trying to take care of COVID-19 patients.

"It's extremely important that the public is aware that COVID-19 is surging across Wisconsin and many Wisconsin hospitals, including the hospitals in our health system are either at or near capacity," said John Gardner, Marshfield Clinic director of communications. "The Marshfield Health System has more than 90 COVID-19 patients occupying a hospital bed, and ICUs have exceeded or are near capacity, as is our COVID-19 unit in Marshfield."

Gardner said Marshfield Clinic is transporting patients to different care centers within its system to meet the needs of patients.

"We're leveraging all of the hospital beds in the system as much as we can," he said. " With demand exceeding capacity, there could be a delay in transferring Emergency Department patients out of the ED to a nursing unit. Despite this, we have not transferred patients to hospitals outside of our health system unless they need specialized care not available at one of our hospitals. I will also say we get requests daily from other health systems wanting to transfer their patients to us due to them exceeding their capacity."

At Aspirus, Andrew Kraus said hospital beds are now at a premium. "COVID-19 ICU bed capacity is tight and we adapt as needed," he said.

Kraus said local residents can help this problem by getting vaccinated. He reported Aspirus had 106 patients hospitalized for COVID-19 throughout its system on Nov. 17. Of these, 76 percent were not fully vaccinated and 29 required ICU-level care.

Dr. Susan Schneider, Aspirus system senior physician executive of primary care, said people need to better understand how COVID-19 was causing a local health care crisis.

"I really think there's a disconnect with what's happening in the perception out in the community versus what's happening within our health system as well as actually the rest of the health systems across the state," she said. "This pandemic has been going on for a long time and people are tired of it and really want to get back to normal life, but that's not really what we're seeing in the health care system."

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Wisconsin Department of Health Services
Division of Public Health
PHAVR - WEDSS

YTD Disease Incidents by Episode Date

Incidents for MMWR Weeks 1 - 46 (Through week of Nov. 28, 2021)

Jurisdiction: Marathon County

	2021				
Disease Group	Week 43	Week 44	Week 45	Week 46	Total
Arboviral Disease	0	0	0	0	1
Babesiosis	0	0	0	0	9
Blastomycosis	0	0	0	0	4
Campylobacteriosis (Campylobacter Infection)	0	0	0	1	29
Carbon Monoxide Poisoning	0	0	0	0	8
Chlamydia Trachomatis Infection	6	4	9	3	323
Coccidioidomycosis	0	0	0	0	2
Coronavirus	646	724	821	795	10765
Cryptosporidiosis	0	0	0	0	12
Ehrlichiosis / Anaplasmosis	0	0	0	0	48
Giardiasis	0	0	0	0	28
Gonorrhea	1	2	5	1	85
Haemophilus Influenzae Invasive Disease	1	0	0	0	4
Hepatitis B	0	0	0	0	2
Hepatitis C	0	0	0	0	20
Histoplasmosis	0	0	0	0	1
Influenza	0	1	0	0	1
Invasive Streptococcal Disease (Groups A And B)	0	0	0	0	17
Legionellosis	0	0	0	0	1
Listeriosis	0	0	0	0	2
Lyme Disease	0	0	0	0	42
Meningitis, Other Bacterial	0	0	0	0	2
Meningococcal Disease	0	0	0	0	1
Mycobacterial Disease (Nontuberculous)	0	0	1	0	11
Pathogenic E.coli	1	1	0	0	11
Salmonellosis	1	1	0	0	24
Shigellosis	0	0	0	0	2
Streptococcus Pneumoniae Invasive Disease	0	1	0	0	3
Syphilis	0	0	0	1	4
Toxoplasmosis	0	0	0	0	1
Tuberculosis	0	0	0	0	3
Tuberculosis, Latent Infection (LTBI)	0	0	0	0	15
Varicella (Chickenpox)	0	0	0	0	3
	656	734	836	801	11486

CHAPTER 252

COMMUNICABLE DISEASES

252.01 Definitions.
252.02 Powers and duties of department.
252.03 Duties of local health officers.
252.04 Immunization program.
252.041 Compulsory vaccination during a state of emergency.
252.05 Reports of cases.
252.06 Isolation and quarantine.
252.07 Tuberculosis.
252.09 Meningococcal disease and hepatitis B.
252.10 Public health dispensaries.
252.11 Sexually transmitted disease.
252.12 HIV and related infections, including hepatitis C virus infections; services and prevention.
252.13 HIV tests.
252.133 HIV testing for anatomical gifts.
252.14 Discrimination related to acquired immunodeficiency syndrome.
252.15 Restrictions on use of an HIV test.
252.16 Health insurance premium subsidies.
252.17 Medical leave premium subsidies.
252.185 Communicable disease control and prevention.
252.19 Communicable diseases; suspected cases; protection of public.
252.21 Communicable diseases; schools; duties of teachers, parents, officers.
252.25 Violation of law relating to health.

Cross−reference: See definitions in s. 250.01.

252.01 Definitions. In this chapter:

(1c) "Advanced practice nurse prescriber" means an advanced practice nurse who is certified under s. 441.16 (2) to issue prescription orders.

(1g) "Emergency medical responder" has the meaning given in s. 256.01 (4p).

(1m) "HIV" means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

(2) "HIV infection" means the pathological state produced by a human body in response to the presence of HIV.

(2m) "HIV test" means a test for the presence of HIV or an antibody to HIV.

(3) "Municipality" means any city, village or town.

(4) "Peace officer" has the meaning given in s. 939.22 (22).

(5) "Physician assistant" has the meaning given in s. 448.01 (6).

NOTE: Sub. (5) is repealed eff. 4−1−22 by 2021 Wis. Act 23.

(6) "State epidemiologist" means the individual appointed by the state health officer under s. 250.02 (1) as the state epidemiologist for acute and communicable diseases.

(7) "State patrol officer" means an officer of the state traffic patrol under s. 110.07 (1) (a).

(8) "Validated HIV test result" means a result of an HIV test that meets the validation requirements determined to be necessary by the state epidemiologist.

History: 1993 a. 27 ss. 281, 283, 320, 338, 339, 341; 1993 a. 252; 2005 a. 187; 2009 a. 209; 2011 a. 161; 2017 a. 12; 2021 a. 23.

252.02 Powers and duties of department. **(1)** The department may establish systems of disease surveillance and inspection to ascertain the presence of any communicable disease. Any agent of the department may, with a special inspection warrant issued under s. 66.0119, enter any building, vessel or conveyance to inspect the same and remove therefrom any person affected by a communicable disease. For this purpose, the agent may require the person in charge of the vessel or conveyance, other than a railway car, to stop the same at any place and may require the conductor of any railway train to stop the train at any station or upon any sidetrack, for such time as may be necessary.

(2) In an emergency, the department may provide those sick with a communicable disease with medical aid and temporary hospital accommodation.

(3) The department may close schools and forbid public gatherings in schools, churches, and other places to control outbreaks and epidemics.

(4) Except as provided in ss. 93.07 (24) (e) and 97.59, the department may promulgate and enforce rules or issue orders for guarding against the introduction of any communicable disease into the state, for the control and suppression of communicable diseases, for the quarantine and disinfection of persons, localities and things infected or suspected of being infected by a communicable disease and for the sanitary care of jails, state prisons, mental health institutions, schools, and public buildings and connected premises. Any rule or order may be made applicable to the whole or any specified part of the state, or to any vessel or other conveyance. The department may issue orders for any city, village or county by service upon the local health officer. Rules that are promulgated and orders that are issued under this subsection supersede conflicting or less stringent local regulations, orders or ordinances.

(5) If any public officer or employee or any person in charge of any building, vessel, conveyance, jail, state prison, mental health institution or school fails to comply with a rule promulgated or order issued under sub. (4), the department may appoint an agent to execute its rules or orders. Expenses that an agent incurs shall be paid by the unit of government that employs the person or of which the public officer is a member. If the building, vessel, conveyance, mental health institution or school is privately owned the state shall pay the expenses that the agent incurs.

(6) The department may authorize and implement all emergency measures necessary to control communicable diseases.

(7) The department shall promulgate rules that specify medical conditions treatable by prescriptions or nonprescription drug products for which pharmacists and pharmacies must report under s. 450.145 (1).

History: 1981 c. 291; 1993 a. 27 s. 284; Stats. 1993 s. 252.02; 1999 a. 150 s. 672; 2001 a. 109; 2005 a. 198; 2015 a. 55.

Cross−reference: See also ch. DHS 145, Wis. adm. code.

An order issued by the Department of Health Services confining all people to their homes, forbidding travel, and closing businesses exceeded the statutory authority of this section. Wisconsin Legislature v. Palm, 2020 WI 42, 391 Wis. 2d 497, 942 N.W.2d 900, 20−0765.

252.03 Duties of local health officers. **(1)** Every local health officer, upon the appearance of any communicable disease in his or her territory, shall immediately investigate all the circumstances and make a full report to the appropriate governing body and also to the department. The local health officer shall promptly take all measures necessary to prevent, suppress and control communicable diseases, and shall report to the appropriate governing body the progress of the communicable diseases and the measures used against them, as needed to keep the appropriate governing body fully informed, or at such intervals as the secretary may direct. The local health officer may inspect schools and other public buildings within his or her jurisdiction as needed to determine whether the buildings are kept in a sanitary condition.

(2) Local health officers may do what is reasonable and necessary for the prevention and suppression of disease; may forbid public gatherings when deemed necessary to control outbreaks or epidemics and shall advise the department of measures taken.

(3) If the local authorities fail to enforce the communicable disease statutes and rules, the department shall take charge, and expenses thus incurred shall be paid by the county or municipality.

(4) No person may interfere with the investigation under this chapter of any place or its occupants by local health officers or their assistants.

History: 1981 c. 291; 1993 a. 27 s. 285; Stats. 1993 s. 252.03.

Although the Wisconsin Supreme Court's decision in *Palm*, 2020 WI 42, is not directly controlling on powers of local health officers under this section, it is advisable to limit enforcement under this section to ordinances or administrative enforcement. Also, local authorities should ensure that any measures that direct people to stay at home, forbid certain travel, or close certain businesses speak specifically to the local authority's statutory power under subs. (1) and (2) to "prevent, suppress and control communicable diseases" and "forbid public gatherings when deemed necessary to control outbreaks or epidemics." OAG 3−20.

252.04 Immunization program. (1) The department shall carry out a statewide immunization program to eliminate mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough), poliomyelitis and other diseases that the department specifies by rule, and to protect against tetanus. Any person who immunizes an individual under this section shall maintain records identifying the manufacturer and lot number of the vaccine used, the date of immunization and the name and title of the person who immunized the individual. These records shall be available to the individual or, if the individual is a minor, to his or her parent, guardian or legal custodian upon request.

(2) Any student admitted to any elementary, middle, junior, or senior high school or into any child care center or nursery school shall, within 30 school days after the date on which the student is admitted, present written evidence to the school, child care center, or nursery school of having completed the first immunization for each vaccine required for the student's grade and being on schedule for the remainder of the basic and recall (booster) immunization series for mumps, measles, rubella (German measles), diphtheria, pertussis (whooping cough), poliomyelitis, tetanus, and other diseases that the department specifies by rule or shall present a written waiver under sub. (3).

(3) The immunization requirement is waived if the student, if an adult, or the student's parent, guardian, or legal custodian submits a written statement to the school, child care center, or nursery school objecting to the immunization for reasons of health, religion, or personal conviction. At the time any school, child care center, or nursery school notifies a student, parent, guardian, or legal custodian of the immunization requirements, it shall inform the person in writing of the person's right to a waiver under this subsection.

(3m) Any government entity; public or private elementary, middle, junior high, or senior high school; childcare center or nursery school; or health care provider, as defined in s. 146.81 (1), that sends a piece of mail containing information that could disclose another person's immunization status, including immunization reminders sent by U.S. mail, shall ensure that any information that could disclose a person's immunization status or otherwise allow someone to infer a person's immunization status is enclosed and sealed within the piece of mail and that no such information is visible on the outside of the piece of mail.

(4) The student, if an adult, or the student's parent, guardian, or legal custodian shall keep the school, child care center, or nursery school informed of the student's compliance with the immunization schedule.

(5) (a) By the 15th and the 25th school day after the date on which the student is admitted to a school, child care center, or nursery school, the school, child care center, or nursery school shall notify in writing any adult student or the parent, guardian, or legal custodian of any minor student who has not met the immunization or waiver requirements of this section. The notices shall cite the terms of those requirements and shall state that court action and forfeiture penalty could result due to noncompliance. The notices shall also explain the reasons for the immunization requirements and include information on how and where to obtain the required immunizations.

(b) 1. A school, child care center, or nursery school may exclude from the school, child care center, or nursery school any student who fails to satisfy the requirements of sub. (2).

2. Beginning on July 1, 1993, if the department determines that fewer than 98 percent of the students in a child care center, nursery school, or school district who are subject to the requirements of sub. (2) have complied with sub. (2), the child care center or nursery school shall exclude any child who fails to satisfy the requirements of sub. (2) and the school district shall exclude any student enrolled in grades kindergarten to 6 who fails to satisfy the requirements of sub. (2).

3. Beginning on July 1, 1995, if the department determines that fewer than 99 percent of the students in a child care center, nursery school, or school district who are subject to the requirements of sub. (2) have complied with sub. (2), the child care center or nursery school shall exclude any child who fails to satisfy the requirements of sub. (2) and the school district shall exclude any student enrolled in grades kindergarten to 6 who fails to satisfy the requirements of sub. (2).

4. No student may be excluded from public school under this paragraph for more than 10 consecutive school days unless, prior to the 11th consecutive school day of exclusion, the school board provides the student and the student's parent, guardian or legal custodian with an additional notice, a hearing and the opportunity to appeal the exclusion, as provided under s. 120.13 (1) (c) 3.

(6) The school, child care center, or nursery school shall notify the district attorney of the county in which the student resides of any minor student who fails to present written evidence of completed immunizations or a written waiver under sub. (3) within 60 school days after being admitted to the school, child care center, or nursery school. The district attorney shall petition the court exercising jurisdiction under chs. 48 and 938 for an order directing that the student be in compliance with the requirements of this section. If the court grants the petition, the court may specify the date by which a written waiver shall be submitted under sub. (3) or may specify the terms of the immunization schedule. The court may require an adult student or the parent, guardian, or legal custodian of a minor student who refuses to submit a written waiver by the specified date or meet the terms of the immunization schedule to forfeit not more than $25 per day of violation.

(7) If an emergency arises, consisting of a substantial outbreak as determined by the department by rule of one of the diseases specified in sub. (2) at a school or in the municipality in which the school is located, the department may order the school to exclude students who are not immunized until the outbreak subsides.

(8) The department shall provide the vaccines without charge, if federal or state funds are available for the vaccines, upon request of a school district or a local health department. The department shall provide the necessary professional consultant services to carry out an immunization program, under the requirements of sub. (9), in the jurisdiction of the requesting local health department. Persons immunized may not be charged for vaccines furnished by the department.

(9) (a) An immunization program under sub. (8) shall be supervised by a physician, selected by the school district or local health department, who shall issue written orders for the administration of immunizations that are in accordance with written protocols issued by the department.

(b) If the physician under par. (a) is not an employee of the county, city, village or school district, receives no compensation for his or her services under par. (a) and acts under par. (a) in accordance with written protocols issued by the department, he or she is a state agent of the department for the purposes of ss. 165.25 (6), 893.82 (3) and 895.46.

(c) The department may disapprove the selection made under par. (a) or may require the removal of a physician selected.

(9m) A pharmacist or pharmacy that administers a vaccine under this section to a person 6 to 18 years of age shall update the

Wisconsin Immunization Registry established by the department within 7 days of administering the vaccine.

(10) The department shall, by rule, prescribe the mechanisms for implementing and monitoring compliance with this section. The department shall prescribe, by rule, the form that any person immunizing a student shall provide to the student under sub. (1).

(11) Annually, by July 1, the department shall submit a report to the legislature under s. 13.172 (3) on the success of the statewide immunization program under this section.

History: 1993 a. 27 ss. 181, 470; 1995 a. 32, 77, 222; 2009 a. 185; 2015 a. 55; 2021 a. 81.

Cross−reference: See also chs. DHS 144 and 146, Wis. adm. code.

252.041 Compulsory vaccination during a state of emergency. **(1)** Except as provided in sub. (2), during the period under which the department is designated as the lead state agency, as specified in s. 250.042 (2), the department, as the public health authority, may do all of the following as necessary to address a public health emergency:

(a) Order any individual to receive a vaccination unless the vaccination is reasonably likely to lead to serious harm to the individual or unless the individual, for reasons of religion or conscience, refuses to obtain the vaccination.

(b) Isolate or quarantine, under s. 252.06, any individual who is unable or unwilling for reasons specified under sub. (1) to receive vaccination under par. (a).

(2) The department shall promulgate rules that specify circumstances, if any, under which vaccination may not be performed on an individual.

History: 2001 a. 109.

252.05 Reports of cases. **(1)** Any health care provider, as defined in s. 146.81 (1) (a) to (p), who knows or has reason to believe that a person treated or visited by him or her has a communicable disease, or having a communicable disease, has died, shall report the appearance of the communicable disease or the death to the local health officer. The health agency of a federally recognized American Indian tribe or band may report this information to the local health officer. The local health officer shall report this information to the department or shall direct the person reporting to report to the department. Any person directed to report shall submit this information to the department.

(2) Each laboratory shall report as prescribed by the department those specimen results that indicate that an individual providing the specimen has a communicable disease, or having a communicable disease, has died, or that the department finds necessary for the surveillance, control, diagnosis, and prevention of communicable diseases.

(3) Anyone having knowledge or reason to believe that any person has a communicable disease shall report the facts to the local health officer or to the department.

(4) Reports under subs. (1) and (2) shall state so far as known the name, sex, age, and residence of the person, the communicable disease and other facts the department or local health officer requires. Report forms, including forms appropriate for reporting under s. 95.22, may be furnished by the department and distributed by the local health officer.

(5) All reports shall be made within 24 hours, unless otherwise specified by the department, by telephone, telegraph, mail or electronic means or by deposit at the office of the local health officer.

(6) Any local health officer, upon receiving a report, shall cause a permanent record of the report to be made and upon demand of the department transmit the original or a copy to the department, together with other information the department requires. The department may store these records as paper or electronic records and shall treat them as patient health care records under ss. 146.81 to 146.835.

(7) When an outbreak or epidemic occurs, the local health officer shall immediately report to the department, and shall at all times keep the department informed of the prevalence of the communicable diseases in the locality in the manner and with the facts the department requires.

(8) The department shall print and distribute, without charge, to all local health departments and, upon request, to health care providers and facilities a chart that provides information about communicable diseases.

(9) Any person licensed, permitted, registered or certified under ch. 441 or 448 shall use ordinary skill in determining the presence of communicable diseases. If there is a dispute regarding disease determination, if the disease may have potential public health significance or if more extensive laboratory tests will aid in the investigation, the local health officer shall order the tests made by the state laboratory of hygiene or by a laboratory certified under 42 USC 263a.

(11) If a violation of this section is reported to a district attorney by a local health officer or by the department, the district attorney shall forthwith prosecute the proper action, and upon request of the department, the attorney general shall assist.

History: 1971 c. 164 s. 91; 1981 c. 291; 1993 a. 16; 1993 a. 27 ss. 286 to 291, 293, 294, 471; Stats. 1993 s. 252.05; 1993 a. 183; 2001 a. 109; 2005 a. 198; 2007 a. 97; 2009 a. 28.

252.06 Isolation and quarantine. **(1)** The department or the local health officer acting on behalf of the department may require isolation of a patient or of an individual under s. 252.041 (1) (b), quarantine of contacts, concurrent and terminal disinfection, or modified forms of these procedures as may be necessary and as are determined by the department by rule.

(3) If a local health officer suspects or is informed of the existence of any communicable disease, the officer shall at once investigate and make or cause such examinations to be made as are necessary. The diagnostic report of a physician, the notification or confirmatory report of a parent or caretaker of the patient, or a reasonable belief in the existence of a communicable disease shall require the local health officer immediately to quarantine, isolate, require restrictions or take other communicable disease control measures in the manner, upon the persons and for the time specified in rules promulgated by the department. If the local health officer is not a physician, he or she shall consult a physician as speedily as possible where there is reasonable doubt or disagreement in diagnosis and where advice is needed. The local health officer shall investigate evasion of the laws and rules concerning communicable disease and shall act to protect the public.

(4) (a) If deemed necessary by the department or a local health officer for a particular communicable disease, all persons except the local health officer, his or her representative, attending physicians and nurses, members of the clergy, the members of the immediate family and any other person having a special written permit from the local health officer are forbidden to be in direct contact with the patient.

(b) If s. 250.042 (1) applies, all of the following apply:

1. No person, other than a person authorized by the public health authority or agent of the public health authority, may enter an isolation or quarantine premises.

2. A violation of subd. 1. is subject to a fine not to exceed $10,000 or imprisonment not to exceed 9 months, or both.

3. Any person, whether authorized under subd. 1. or not, who enters an isolation or quarantine premises may be subject to isolation or quarantine under this section.

(5) The local health officer shall employ as many persons as are necessary to execute his or her orders and properly guard any place if quarantine or other restrictions on communicable disease are violated or intent to violate is manifested. These persons shall be sworn in as quarantine guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or the orders and rules of the department or any local health officer.

(6) (a) When the local health officer deems it necessary that a person be quarantined or otherwise restricted in a separate place, the officer shall remove the person, if it can be done without danger to the person's health, to this place.

(b) When a person confined in a jail, state prison, mental health institute or other public place of detention has a disease which the local health officer or the director of health at the institution deems dangerous to the health of other residents or the neighborhood, the local health officer or the director of health at the institution shall order in writing the removal of the person to a hospital or other place of safety, there to be provided for and securely kept. Upon recovery the person shall be returned; and if the person was committed by a court or under process the removal order or a copy shall be returned by the local health officer to the committing court officer.

(10) (a) Expenses for necessary medical care, food and other articles needed for the care of the infected person shall be charged against the person or whoever is liable for the person's support.

(b) The county or municipality in which a person with a communicable disease resides is liable for the following costs accruing under this section, unless the costs are payable through 3rd−party liability or through any benefit system:

1. The expense of employing guards under sub. (5).

2. The expense of maintaining quarantine and enforcing isolation of the quarantined area.

3. The expense of conducting examinations and tests for disease carriers made under the direction of the local health officer.

4. The expense of care provided under par. (a) to any dependent person, as defined in s. 49.01 (2).

(c) All expenses incurred by a local health department, or by an entity designated as a local health department by a federally recognized American Indian tribe or band in this state, in quarantining a person outside his or her home during a state of emergency related to public health declared by the governor under s. 323.10 and not reimbursed from federal funds shall be paid for under either of the following, as appropriate:

1. If the governor designates the department as the lead state agency under s. 323.10, from the appropriation under s. 20.435 (1) (c).

2. If the governor does not designate the department as the lead state agency under s. 323.10, from the appropriation under s. 20.465 (3) (e).

History: 1981 c. 291; 1983 a. 189 s. 329 (19); 1993 a. 27 s. 295; Stats. 1993 s. 252.06; 2001 a. 109; 2003 a. 186; 2009 a. 42.

NOTE: 2003 Wis. Act 186, which affected this section, contains extensive explanatory notes.

Cross−reference: See also ch. DHS 145, Wis. adm. code.

Due Process in the Time of Coronavirus. Killoran & Wittenberg. Wis. Law. Apr. 2020.

252.07 Tuberculosis. (1g) In this section:

(a) "Infectious tuberculosis" means tuberculosis disease of the respiratory tract, capable of producing infection or disease in others as demonstrated by the presence of acid−fast bacilli in the sputum or bronchial secretions or by chest radiograph and clinical findings.

(b) "Isolate" means a population of mycobacterium tuberculosis bacteria that has been obtained in pure culture medium.

(c) "Isolation" means the separation from other persons of a person with infectious tuberculosis in a place and under conditions that prevent the transmission of the infection.

(d) "Suspect tuberculosis" means an illness marked by symptoms and laboratory tests that may be indicative of tuberculosis, such as a prolonged cough, prolonged fever, hemoptysis, compatible roentgenographic findings or other appropriate medical imaging findings.

(1m) Infectious tuberculosis and suspect tuberculosis are subject to the reporting requirements specified in s. 252.05. Any laboratory that receives a specimen for tuberculosis testing shall report all positive results obtained by any appropriate procedure, including a procedure performed by an out−of−state laboratory, to the local health officer and to the department.

(1p) Any laboratory that performs primary culture for mycobacteria shall also perform organism identification for mycobacterium tuberculosis complex using an approved rapid testing procedure specified by the department by rule.

(1t) Any laboratory that identifies mycobacterium tuberculosis shall ensure that antimicrobial drug susceptibility tests are performed on the initial isolate. The laboratory shall report the results of these tests to the local health officer and the department.

(2) The department shall identify groups at risk for contracting or transmitting mycobacterium tuberculosis and shall recommend the protocol for screening members of those groups.

(5) Upon report of any person under sub. (1m) or (1t), the local health officer shall at once investigate and make and enforce the necessary orders. If any person does not voluntarily comply with any order made by the local health officer with respect to that person, the local health officer or the department may order a medical evaluation, directly observed therapy or home isolation of that person.

(8) (a) The department or a local health officer may order the confinement to a facility of an individual who has a confirmed diagnosis of infectious tuberculosis or suspect tuberculosis if all of the following conditions are met:

1. The department or local health officer notifies a court in writing of the confinement.

2. The department or local health officer provides to the court a written statement from a physician, physician assistant, or advanced practice nurse prescriber that the individual has infectious tuberculosis or suspect tuberculosis.

3. The department or local health officer provides to the court evidence that the individual has refused to follow a prescribed treatment regimen or, in the case of an individual with suspect tuberculosis, has refused to undergo a medical examination to confirm whether the individual has infectious tuberculosis.

4. In the case of an individual with a confirmed diagnosis of infectious tuberculosis, the department or local health officer determines that the individual poses an imminent and substantial threat to himself or herself or to the public health. The department or local health officer shall provide to the court a written statement of that determination.

(b) If the department or local health officer orders the confinement of an individual under this subsection, a law enforcement officer, or other person authorized by the local public health officer, shall transport the individual, if necessary, to a facility that the department or local health officer determines will meet the individual's need for medical evaluation, isolation and treatment.

(c) No individual may be confined under this subsection for more than 72 hours, excluding Saturdays, Sundays and legal holidays, without a court hearing under sub. (9) to determine whether the confinement should continue.

(9) (a) The department or a local health officer may petition any court for a hearing to determine whether an individual with infectious or suspect tuberculosis should be confined for longer than 72 hours in a facility where proper care and treatment will be provided and spread of the disease will be prevented. The department or local health officer shall include in the petition documentation that demonstrates all of the following:

1. That the individual named in the petition has infectious tuberculosis; that the individual has noninfectious tuberculosis but is at high risk of developing infectious tuberculosis; or that the individual has suspect tuberculosis.

2. That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under sub. (11); or that the disease is resistant to the medication prescribed to the individual.

3. That all other reasonable means of achieving voluntary compliance with treatment have been exhausted and no less restrictive alternative exists; or that no other medication to treat the resistant disease is available.

4. That the individual poses an imminent and substantial threat to himself or herself or to the public health.

(b) The department or local health officer shall give the individual written notice of a hearing at least 48 hours before a scheduled hearing is to be held. Notice of the hearing shall include all of the following information:

1. The date, time and place of the hearing.

2. The grounds, and underlying facts, upon which confinement of the individual is being sought.

3. An explanation of the individual's rights specified under par. (d).

4. The proposed actions to be taken and the reasons for each action.

(c) If the court orders confinement of an individual under this subsection, the individual shall remain confined until the department or local health officer, with the concurrence of a treating physician, physician assistant, or advanced practice nurse prescriber, determines that treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health. If the individual is to be confined for more than 6 months, the court shall review the confinement every 6 months.

(d) An individual who is the subject of a petition for a hearing under this subsection has the right to appear at the hearing, the right to present evidence and cross−examine witnesses and the right to be represented by adversary counsel. At the time of the filing of the petition the court shall assure that the individual who is the subject of the petition is represented by adversary counsel. If the individual claims or appears to be indigent, the court shall refer the individual to the authority for indigency determinations specified under s. 977.07 (1). If the individual is a child, the court shall refer that child to the state public defender who shall appoint counsel for the child without a determination of indigency, as provided in s. 48.23 (4). Unless good cause is shown, a hearing under this subsection may be conducted by telephone or live audiovisual means, if available.

(e) An order issued by the court under this subsection may be appealed as a matter of right. An appeal shall be heard within 30 days after the appeal is filed. An appeal does not stay the order.

(10) Inpatient care for isolated pulmonary tuberculosis patients, and inpatient care exceeding 30 days for other pulmonary tuberculosis patients, who are not eligible for federal medicare benefits, for medical assistance under subch. IV of ch. 49 or for health care services funded by a relief block grant under subch. II of ch. 49 may be reimbursed if provided by a facility contracted by the department. If the patient has private health insurance, the state shall pay the difference between health insurance payments and total charges.

(11) The department may promulgate any rules necessary for the administration and enforcement of this section, including, if necessary to prevent or control the transmission of mycobacterium tuberculosis, rules that require screening of members of specific groups that are at risk for contracting or transmitting mycobacterium tuberculosis.

(12) From the appropriation account under s. 20.435 (1) (e), the department may expend not more than $81,100 annually to fund targeted prevention activities for populations at high risk for tuberculosis infection.

History: 1971 c. 158; 1975 c. 383 s. 4; 1975 c. 421; 1981 c. 291; 1993 a. 27 s. 296, 472; Stats. 1993 s. 252.07; 1993 a. 490; 1999 a. 9 ss. 2400rg to 2400rp, 2400ru; 2005 a. 187; 2009 a. 28; 2011 a. 161.

The commonly accepted meanings of "facility" and "confined" indicate that the legislature intended jail to be a permissible placement option under sub. (9) (a) for persons with noninfectious tuberculosis who are noncompliant with a prescribed treatment regimen, provided that no less restrictive alternative exists. If conditions at a particular jail are such that proper care and treatment would be unavailable, or contrary to the prevention of the spread of the disease, jail is not authorized under sub. (9) (a). Whether a facility meets these requirements is a fact−intensive question addressed to the circuit court's discretion. City of Milwaukee v. Washington, 2007 WI 104, 304 Wis. 2d 98, 735 N.W.2d 111, 05−3141.

The "no less restrictive alternative" requirement under sub. (9) (a) 3. applies to the place of confinement as well as the fact of confinement. A court must determine that the place of confinement is a facility where proper care and treatment will be provided, spread of the disease will be prevented, and no less restrictive alternative to the proposed placement exists. If after this analysis two or more placement options remain, a court may consider cost as a factor in making its determination. City of Milwaukee v. Washington, 2007 WI 104, 304 Wis. 2d 98, 735 N.W.2d 111, 05−3141.

252.09 Meningococcal disease and hepatitis B. (1) Each private college and university in this state shall do all of the following:

(a) Annually, provide detailed information on the risks associated with meningococcal disease and hepatitis B and the availability and effectiveness of vaccines against the diseases to each enrolled student, if he or she is at least 18 years old, or to the student's parent or guardian, if the student is a minor.

(b) Require a student who resides in a dormitory or residence hall, or the student's parent or guardian if the student is a minor, to affirm that the student received the information under par. (a).

(c) Require a student who resides in a dormitory or residence hall to affirm whether he or she has received the vaccination against meningococcal disease and to provide the date of the vaccination, if any.

(d) Require a student who resides in a dormitory or residence hall to affirm whether he or she received the vaccination against hepatitis B and to provide the date of the vaccination, if any.

(e) Maintain a confidential record of the affirmations and the dates of the vaccinations of each student under pars. (c) and (d).

(2) Nothing in this section requires a college or university to provide or pay for vaccinations against meningococcal disease or hepatitis B.

History: 2003 a. 61.

252.10 Public health dispensaries. (1) A local health department may request from the department certification to establish and maintain a public health dispensary for the diagnosis and treatment of persons suffering from or suspected of having tuberculosis. Two or more local health departments may jointly establish, operate and maintain public health dispensaries. The department shall certify a local health department to establish and maintain a public health dispensary if the local health department meets the standards established by the department by rule. The department of health services may withhold, suspend or revoke a certification if the local health department fails to comply with any rules promulgated by the department. The department shall provide the local health department with reasonable notice of the decision to withhold, suspend or revoke certification. The department shall offer the local health department an opportunity to comply with the rules and an opportunity for a fair hearing. Certified local health departments may contract for public health dispensary services. If the provider of those services fails to comply, the department may suspend or revoke the local health department's certification. The department may establish, operate and maintain public health dispensaries and branches in areas of the state where local authorities have not provided public health dispensaries.

(6) (a) The state shall credit or reimburse each dispensary on an annual or quarterly basis for the operation of public health dispensaries established and maintained in accordance with this section and rules promulgated by the department.

(b) The department shall determine by rule the reimbursement rate under par. (a) for services.

(g) The reimbursement by the state under pars. (a) and (b) shall apply only to funds that the department allocates for the reimbursement under the appropriation account under s. 20.435 (1) (e).

(7) Drugs necessary for the treatment of mycobacterium tuberculosis shall be purchased by the department from the appropriation account under s. 20.435 (1) (e) and dispensed to patients through the public health dispensaries, local health departments, physicians or advanced practice nurse prescribers.

(9) Public health dispensaries shall maintain such records as are required by the department to enable them to carry out their responsibilities designated in this section and in rules promulgated by the department. Records may be audited by the department.

(10) All public health dispensaries and branches thereof shall maintain records of costs and receipts which may be audited by the department of health services.

History: 1971 c. 81; 1971 c. 211 s. 124; 1973 c. 90; 1975 c. 39, 198, 224; 1975 c. 413 ss. 2, 18; Stats. 1975 s. 149.06; 1977 c. 29; 1981 c. 20 ss. 1446, 2202 (20) (c); 1983 a. 27; 1985 a. 29; 1991 a. 39, 160; 1993 a. 27 ss. 406, 407, 409, 411 to 414; Stats. 1993 s. 252.10, 1993 a. 443; 1995 a. 27 ss. 6318, 9126 (19), 9145 (1); 1997 a. 27, 75, 156, 175, 252; 1999 a. 9, 32, 186; 2007 a. 20 s. 9121 (6) (a); 2009 a. 28.

Cross−reference: See also ch. DHS 145, Wis. adm. code.

252.11 Sexually transmitted disease. **(1)** In this section, "sexually transmitted disease" means syphilis, gonorrhea, chlamydia and other diseases the department includes by rule.

(1m) A physician or other health care professional called to attend a person infected with any form of sexually transmitted disease, as specified in rules promulgated by the department, shall report the disease to the local health officer and to the department in the manner directed by the department in writing on forms furnished by the department. A physician may treat a minor infected with a sexually transmitted disease or examine and diagnose a minor for the presence of such a disease without obtaining the consent of the minor's parents or guardian. The physician shall incur no civil liability solely by reason of the lack of consent of the minor's parents or guardian.

(2) An officer of the department or a local health officer having knowledge of any reported or reasonably suspected case or contact of a sexually transmitted disease for which no appropriate treatment is being administered, or of an actual contact of a reported case or potential contact of a reasonably suspected case, shall investigate or cause the case or contact to be investigated as necessary. If, following a request of an officer of the department or a local health officer, a person reasonably suspected of being infected with a sexually transmitted disease refuses or neglects examination by a physician, physician assistant, or advanced practice nurse prescriber or treatment, an officer of the department or a local health officer may proceed to have the person committed under sub. (5) to an institution or system of care for examination, treatment, or observation.

(4) If a person infected with a sexually transmitted disease ceases or refuses treatment before reaching what in a physician's, physician assistant's, or advanced practice nurse prescriber's opinion is the noncommunicable stage, the physician, physician assistant, or advanced practice nurse prescriber shall notify the department. The department shall without delay take the necessary steps to have the person committed for treatment or observation under sub. (5), or shall notify the local health officer to take these steps.

(5) Any court of record may commit a person infected with a sexually transmitted disease to any institution or may require the person to undergo a system of care for examination, treatment, or observation if the person ceases or refuses examination, treatment, or observation under the supervision of a physician, physician assistant, or advanced practice nurse prescriber. The court shall summon the person to appear on a date at least 48 hours, but not more than 96 hours, after service if an officer of the department or a local health officer petitions the court and states the facts authorizing commitment. If the person fails to appear or fails to accept commitment without reasonable cause, the court may cite the person for contempt. The court may issue a warrant and may direct the sheriff, any constable, or any police officer of the county immediately to arrest the person and bring the person to court if the court finds that a summons will be ineffectual. The court shall hear the matter of commitment summarily. Commitment under this subsection continues until the disease is no longer communicable or until other provisions are made for treatment that satisfy the department. The certificate of the petitioning officer is prima facie evidence that the disease is no longer communicable or that satisfactory provisions for treatment have been made.

(5m) A health care professional, as defined in s. 968.38 (1) (a), acting under an order of a court under s. 938.296 (4) or 968.38 (4) may, without first obtaining informed consent to the testing, subject an individual to a test or a series of tests to ascertain whether that individual is infected with a sexually transmitted disease. No sample used for performance of a test under this subsection may disclose the name of the test subject.

(7) Reports, examinations and inspections and all records concerning sexually transmitted diseases are confidential and not open to public inspection, and may not be divulged except as may be necessary for the preservation of the public health, in the course of commitment proceedings under sub. (5), or as provided under s. 938.296 (4) or 968.38 (4). If a physician, physician assistant, or advanced practice nurse prescriber has reported a case of sexually transmitted disease to the department under sub. (4), information regarding the presence of the disease and treatment is not privileged when the patient, physician, physician assistant, or advanced practice nurse prescriber is called upon to testify to the facts before any court of record.

(9) The department shall prepare for free distribution upon request to state residents, information and instructions concerning sexually transmitted diseases.

(10) The state laboratory of hygiene shall examine specimens for the diagnosis of sexually transmitted diseases for any physician, physician assistant, advanced practice nurse prescriber, or local health officer in the state, and shall report the positive results of the examinations to the local health officer and to the department. All laboratories performing tests for sexually transmitted diseases shall report all positive results to the local health officer and to the department, with the name of the physician, physician assistant, or advanced practice nurse prescriber to whom reported.

(11) In each county with an incidence of gonorrhea, antibiotic resistant gonorrhea, chlamydia or syphilis that exceeds the statewide average, a program to diagnose and treat sexually transmitted diseases at no cost to the patient is required. The county board of supervisors is responsible for ensuring that the program exists, but is required to establish its own program only if no other public or private program is operating. The department shall compile statistics indicating the incidence of gonorrhea, antibiotic resistant gonorrhea, chlamydia and syphilis for each county in the state.

History: 1971 c. 42, 125; 1973 c. 90; 1975 c. 6; 1975 c. 383 s. 4; 1975 c. 421; 1981 c. 291; 1991 a. 269; 1993 a. 27 s. 297; Stats. 1993 s. 252.11; 1993 a. 32; 1995 a. 77; 1999 a. 188; 2005 a. 187; 2009 a. 209; 2011 a. 161.

Cross−reference: See also ch. DHS 145, Wis. adm. code.

252.12 HIV and related infections, including hepatitis C virus infections; services and prevention. **(1)** DEFINITIONS. In this section:

(b) "AIDS service organizations" means nonprofit corporations or public agencies that provide, or arrange for the provision of, comprehensive services to prevent HIV infection and comprehensive health and social services for persons who have HIV infection, and that are designated as such by the department under sub. (4).

(c) "Nonprofit corporation" means a nonstock corporation organized under ch. 181 that is a nonprofit corporation, as defined in s. 181.0103 (17).

(d) "Organization" means a nonprofit corporation or a public agency which proposes to provide services to individuals with acquired immunodeficiency syndrome.

(e) "Public agency" means a county, city, village, town or school district or an agency of this state or of a county, city, village, town or school district.

(2) DISTRIBUTION OF FUNDS. (a) *HIV and related infections, including hepatitis C virus infections; services.* From the appropriation accounts under s. 20.435 (1) (a) and (am), the department

shall distribute funds for the provision of services to individuals with or at risk of contracting HIV infection, as follows:

1. 'Partner referral and notification.' The department shall contact an individual known to have received an HIV infection and encourage him or her to refer for counseling, HIV testing, and, if appropriate, testing for hepatitis C virus infection any person with whom the individual has had sexual relations or has shared intravenous equipment.

2. 'Grants to local projects.' The department shall make grants to applying organizations for the provision of HIV and related infection prevention information, the establishment of counseling support groups and the provision of direct care to persons with HIV infection, including those persons with hepatitis C virus infection.

3. 'Statewide public education campaign.' The department shall promote public awareness of the risk of contracting HIV and related infections and measures for HIV and related infections protection by development and distribution of information through clinics providing family planning services, as defined in s. 253.07 (1) (b), offices of physicians and clinics for sexually transmitted diseases and by newsletters, public presentations or other releases of information to newspapers, periodicals, radio and television stations and other public information resources. The information shall be targeted at individuals whose behavior puts them at risk of contracting HIV and related infections and shall encompass the following topics:

a. HIV infection and related infections.

b. Means of identifying whether or not individuals may be at risk of contracting HIV and related infections.

c. Measures individuals may take to protect themselves from contracting HIV and related infections.

d. Locations for procuring additional information or obtaining HIV testing services.

4. 'Information network.' The department shall establish a network to provide information to local health officers and other public officials who are responsible for HIV infection and related infection prevention and training.

5. 'HIV seroprevalence studies.' The department shall perform HIV tests and, if appropriate, tests for the presence of related infections and shall conduct behavioral surveys among population groups determined by the department to be highly at risk of becoming infected with or transmitting HIV and related infections. Information obtained shall be used to develop targeted HIV infection and related infection prevention efforts for these groups and to evaluate the state's prevention strategies.

6. 'Grants for targeted populations and intervention services.' The department shall make grants to those applying organizations that the department determines are best able to contact individuals who are determined to be highly at risk of contracting HIV for the provision of HIV and related infection information and intervention services.

7. 'Contracts for counseling and laboratory testing services.' The department shall distribute funding in each fiscal year to contract with organizations to provide, at alternate testing sites, anonymous or confidential counseling services for HIV, laboratory HIV testing services, and, if appropriate, laboratory testing services for the presence of related viruses.

8. 'Mike Johnson life care and early intervention services grants.' The department shall award not more than $4,000,000 in each fiscal year in grants to applying organizations for the provision of needs assessments; assistance in procuring financial, medical, legal, social and pastoral services; counseling and therapy; homecare services and supplies; advocacy; and case management services. These services shall include early intervention services. The department shall also award not more than $74,000 in each year from the appropriation account under s. 20.435 (5) (md) for the services under this subdivision. The state share of payment for case management services that are provided under s. 49.45 (25) (be) to recipients of medical assistance shall be paid from the appropriation account under s. 20.435 (1) (am). All of the following apply to grants awarded under this subdivision:

a. None of the funds awarded may be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual.

b. None of the funds awarded may be used for political purposes.

c. Funds awarded shall be used to provide medical care and support services for individuals with HIV.

9. 'Grant for family resource center.' The department shall award a grant to develop and implement an African−American family resource center in the city of Milwaukee that targets activities toward the prevention and treatment of HIV infection and related infections, including hepatitis C virus infection, of minority group members, as defined in s. 16.287 (1) (f).

(c) *HIV prevention grants.* 1. From the appropriation account under s. 20.435 (1) (md), the department shall award to applying nonprofit corporations or public agencies up to $75,000 in each fiscal year, on a competitive basis, as grants for services to prevent HIV. Criteria for award of the grants shall include all of the following:

a. The scope of proposed services, including the proposed targeted population and numbers of persons proposed to be served.

b. The proposed methodology for the prevention services, including distribution and delivery of information and appropriateness of the message provided.

c. The qualifications of the applicant nonprofit corporation or public agency and its staff.

d. The proposed allocation of grant funds to the nonprofit corporation or public agency staff and services.

e. The proposed method by which the applicant would evaluate the impact of the grant funds awarded.

2. From the appropriation account under s. 20.435 (1) (am), the department shall award $75,000 in each fiscal year as grants for services to prevent HIV infection and related infections, including hepatitis C virus infection. Criteria for award of the grants shall include the criteria specified under subd. 1. The department shall award 60 percent of the funding to applying organizations that receive funding under par. (a) 8. and 40 percent of the funding to applying community−based organizations that are operated by minority group members, as defined in s. 16.287 (1) (f).

3. From the appropriation account under s. 20.435 (1) (am), the department shall award to the African American AIDS task force of the Black Health Coalition of Wisconsin, Inc., $25,000 in each fiscal year as grants for services to prevent HIV infection and related infections, including hepatitis C infection.

(3) CONFIDENTIALITY OF INFORMATION. The results of any test performed under sub. (2) (a) 5. are confidential and may be disclosed only to the individual who receives a test or to other persons with the informed consent of the test subject. Information other than that released to the test subject, if released under sub. (2) (a) 5., may not identify the test subject.

(4) DESIGNATION OF AIDS SERVICE ORGANIZATIONS. The department shall designate AIDS service organizations and specify the geographical area of the state in which they are designated to provide services.

History: 1987 a. 27, 70, 399; 1989 a. 31, 201, 336; 1991 a. 39, 80; 1993 a. 16; 1993 a. 27 ss. 318, 319, 321, 323; Stats. 1993 s. 252.12; 1995 a. 27; 1997 a. 27, 79; 1999 a. 9; 2001 a. 16; 2005 a. 25; 2007 a. 20; 2009 a. 28, 209, 221; 2011 a. 32; 2013 a. 20; 2015 a. 55; 2017 a. 59.

252.13 HIV tests. (1) In this section, "autologous transfusion" means the receipt by an individual, by transfusion, of whole blood, blood plasma, a blood product or a blood derivative, which the individual has previously had withdrawn from himself or herself for his or her own use.

(1m) Except as provided under sub. (3), any blood bank, blood center or plasma center in this state that purchases or

receives whole blood, blood plasma, a blood product or a blood derivative shall, prior to its distribution or use and in accordance with the conditions under s. 252.15 (2m) (a), subject that blood, plasma, product or derivative to an HIV test. This subsection does not apply to a blood bank that purchases or receives whole blood, blood plasma, a blood product or a blood derivative from a blood bank, blood center or plasma center in this state if the whole blood, blood plasma, blood product or blood derivative has previously been subjected to an HIV test.

(1r) For the purposes of this section, the state epidemiologist shall make separate findings of medical significance and sufficient reliability for an HIV test or a series of HIV tests for each of the following purposes:

(a) Subjecting whole blood, blood plasma, a blood product or a blood derivative to a test prior to distribution or use of the whole blood, blood plasma, blood product or blood derivative.

(b) Providing disclosure of test results to the subject of the test.

(2) If performance of a test under sub. (1m) yields a validated test result positive for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV, the whole blood, blood plasma, blood product or blood derivative so tested with this result may not be distributed or used except for purposes of research or as provided under sub. (5).

(3) If a medical emergency, including a threat to the preservation of life of a potential donee, exists under which whole blood, blood plasma, a blood product, or a blood derivative that has been subjected to HIV testing under sub. (1m) is unavailable, the requirement of sub. (1m) shall not apply.

(4) Subsections (1m) and (2) do not apply to the extent that federal law or regulations require that a blood bank, blood center, or plasma center administer an HIV test to whole blood, blood plasma, a blood product, or a blood derivative.

(5) Whole blood, blood plasma, a blood product, or a blood derivative described under sub. (2) that is voluntarily donated solely for the purpose of an autologous transfusion may be distributed to or used by the person who has donated the whole blood, blood plasma, blood product, or blood derivative. No person other than the person who has donated the whole blood, blood plasma, blood product, or blood derivative may receive or use the whole blood, blood plasma, blood product, or blood derivative unless it has been subjected to an HIV test under sub. (1m) and performance of the test has yielded a negative, validated HIV test result.

History: 1985 a. 73; 1987 a. 70; 1989 a. 201 ss. 9, 36; 1993 a. 27 ss. 325, 473; Stats. 1993 s. 252.13; 2009 a. 209.

252.133 HIV testing for anatomical gifts. (1) Except as provided in sub. (2), a health care provider, as defined in s. 252.15 (1) (ar), who procures, processes, distributes, or uses a human body part or human tissue that is the subject of an anatomical gift under s. 157.06 shall have an HIV test performed on the donor of the body part or tissue in order to assure medical acceptability of the gift for the purpose intended. The health care provider shall use an HIV test that yields a validated HIV test result. If the validated HIV test result of the donor is positive, the human body part or human tissue donated for use or proposed for donation may not be used.

(2) If, as determined by the attending physician of a potential donee of a human body part or human tissue, a medical emergency exists under which a human body part or human tissue that has been subjected to testing under sub. (1) is unavailable, including a threat to the preservation of the life of the potential donee, the requirement of sub. (1) does not apply.

History: 2009 a. 209 ss. 30, 45, 46; 2013 a. 166 s. 77.

252.14 Discrimination related to acquired immunodeficiency syndrome. (1) In this section:

(ad) "Correctional officer" has the meaning given in s. 301.28 (1).

(am) "Fire fighter" has the meaning given in s. 102.475 (8) (b).

(ar) "Health care provider" means any of the following:

1. A nurse licensed under ch. 441.

2. A chiropractor licensed under ch. 446.

3. A dentist licensed under ch. 447.

4. A physician licensed under subch. II of ch. 448.

4c. A perfusionist licensed under subch. II of ch. 448.

4e. A physical therapist or physical therapist assistant who is licensed under subch. III of ch. 448 or who holds a compact privilege under subch. X of ch. 448.

NOTE: Subd. 4e. is shown as affected eff. 4−1−22 by 2021 Wis. Act 23. Prior to 4−1−22 it reads:

4e. A physical therapist or physical therapist assistant who is licensed under subch. III of ch. 448 or who holds a compact privilege under subch. IX of ch. 448.

4g. A podiatrist licensed under subch. IV of ch. 448.

4m. A dietitian certified under subch. V of ch. 448.

4p. An occupational therapist or occupational therapy assistant licensed under subch. VII of ch. 448.

4q. An athletic trainer licensed under subch. VI of ch. 448.

5. An optometrist licensed under ch. 449.

6. A psychologist licensed under ch. 455.

7. A social worker, marriage and family therapist, or professional counselor certified or licensed under ch. 457.

8. A speech−language pathologist or audiologist licensed under subch. II of ch. 459 or a speech and language pathologist licensed by the department of public instruction.

9. An employee or agent of any provider specified under subds. 1. to 8.

10. A partnership of any provider specified under subds. 1. to 8.

11. A corporation of any provider specified under subds. 1. to 8. that provides health care services.

12. A cooperative health care association organized under s. 185.981 that directly provides services through salaried employees in its own facility.

13. An emergency medical services practitioner licensed under s. 256.15 (5).

14. A physician assistant.

15. An emergency medical responder.

(c) "Home health agency" has the meaning specified in s. 50.49 (1) (a).

(d) "Inpatient health care facility" means a hospital, nursing home, community−based residential facility, county home, county mental health complex or other place licensed or approved by the department under s. 49.70, 49.71, 49.72, 50.02, 50.03, 50.35, 51.08 or 51.09 or a facility under s. 45.50, 48.62, 51.05, 51.06, 233.40, 233.41, 233.42 or 252.10.

(2) No health care provider, peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, home health agency, inpatient health care facility, or person who has access to a validated HIV test result may do any of the following with respect to an individual who has acquired immunodeficiency syndrome or has a positive, validated HIV test result, solely because the individual has HIV infection or an illness or medical condition that is caused by, arises from, or is related to HIV infection:

(a) Refuse to treat the individual, if his or her condition is within the scope of licensure or certification of the health care provider, home health agency or inpatient health care facility.

(am) If a peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, refuse to provide services to the individual.

(b) Provide care to the individual at a standard that is lower than that provided other individuals with like medical needs.

(bm) If a peace officer, fire fighter, correctional officer, state patrol officer, jailer or keeper of a jail or person designated with custodial authority by the jailer or keeper, provide services to the

individual at a standard that is lower than that provided other individuals with like service needs.

(c) Isolate the individual unless medically necessary.

(d) Subject the individual to indignity, including humiliating, degrading or abusive treatment.

(2m) If a person declines to be subjected to an HIV test, a health care provider may not use the fact that the person declined an HIV test as a basis for denying services or treatment, other than an HIV test, to the person.

(3) A health care provider, home health agency, or inpatient health care facility that treats an individual who has an HIV infection or acquired immunodeficiency syndrome shall develop and follow procedures that shall ensure continuity of care for the individual in the event that his or her condition exceeds the scope of licensure or certification of the provider, agency, or facility.

(4) Any person violating sub. (2) is liable to the patient for actual damages and costs, plus exemplary damages of up to $10,000 for an intentional violation. In determining the amount of exemplary damages, a court shall consider the ability of a health care provider who is an individual to pay exemplary damages.

History: 1989 a. 201; 1991 a. 32, 39, 160, 189, 269, 315; 1993 a. 27 ss. 326 to 331; Stats. 1993 s. 252.14; 1993 a. 105, 190, 252, 443; 1993 a. 490 s. 143; 1993 a. 491, 495; 1995 a. 27 ss. 6322, 9145 (1); 1997 a. 27, 35, 67, 75, 175; 1999 a. 9, 32, 180; 2001 a. 70, 80, 89; 2005 a. 22; 2007 a. 130; 2009 a. 165, 209; 2011 a. 161; 2017 a. 12; 2019 a. 100; 2021 a. 23 s. 71.

252.15 Restrictions on use of an HIV test. **(1)** Definitions. In this section:

(ac) "Authorized representative" means any of the following:

1. A health care agent, as defined under s. 155.01 (4), acting in accordance with a power of attorney for health care that is in effect under s. 155.05 (2).

2. A person named by the court under ch. 48 or 54 or ch. 880, 2003 stats., having the duty and authority of guardianship.

3. A parent or legal custodian of a person who is under 14 years of age.

4. For a person who is unable to communicate due to a medical condition, the person's closest living relative or another individual with whom the person has a meaningful social and emotional relationship.

(ad) "Correctional officer" has the meaning given in s. 301.28 (1).

(af) "Emergency medical services practitioner" has the meaning given in s. 256.01 (5).

(aj) "Fire fighter" has the meaning given in s. 102.475 (8) (b).

(am) "Health care professional" means a physician or physician assistant who is licensed under ch. 448 or a registered nurse or licensed practical nurse who is licensed under ch. 441.

(ar) "Health care provider" means any of the following:

1. A person or entity that is specified in s. 146.81 (1) (a) to (hm) and (i) to (p).

2. A home health agency.

3. An employee of the Mendota Mental Health Institute or the Winnebago Mental Health Institute.

(cm) "Home health agency" has the meaning given in s. 50.49 (1) (a).

(eg) "Relative" means a spouse, parent, grandparent, stepparent, brother, sister, first cousin, nephew or niece; or uncle or aunt within the 3rd degree of kinship as computed under s. 990.001 (16). This relationship may be by blood, marriage or adoption.

(em) "Significant exposure" means contact that carries a potential for a transmission of HIV, by one or more of the following:

1. Transmission, into a body orifice or onto mucous membrane, of blood; semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

2. Exchange, during the accidental or intentional infliction of a penetrating wound, including a needle puncture, of blood; semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

3. Exchange, into an eye, an open wound, an oozing lesion, or where a significant breakdown in the epidermal barrier has occurred, of blood; semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial or amniotic fluid; or other body fluid that is visibly contaminated with blood.

6. Other routes of exposure, defined as significant in rules promulgated by the department. The department in promulgating the rules shall consider all potential routes of transmission of HIV identified by the centers for disease control of the federal public health service.

(er) "Social worker" means an individual who is certified or licensed as a social worker, advanced practice social worker, independent social worker, or clinical social worker under ch. 457.

(fm) "Standard precautions" means measures that a health care provider, an employee of a health care provider or other individual takes in accordance with recommendations of the federal centers for disease control for the health care provider, employee or other individual for prevention of HIV transmission in health−care settings.

(2m) Consent for HIV testing. (a) Except as provided in par. (b), and subject to par. (c), a health care provider, blood bank, blood center, or plasma center may not subject a person to an HIV test unless all of the following conditions are satisfied:

1. The health care provider, blood bank, blood center, or plasma center notifies the person or the person's authorized representative that the person will be subjected to an HIV test unless the person or the person's authorized representative declines the test.

2. The health care provider, blood bank, blood center, or plasma center offers the person or the person's authorized representative a brief oral or written explanation or description of HIV infection; HIV test results; requirements under subs. (7) (b) and (7m) for reporting HIV test results; treatment options for a person who has a positive HIV test result; and services provided by AIDS service organizations, as defined in s. 252.12 (1) (b), and other community−based organizations for persons who have a positive HIV test result.

3. If a health care provider offers to perform an HIV test, the health care provider notifies the person or the person's authorized representative that the person or the person's authorized representative may decline the HIV test and that, if the person or the person's authorized representative declines the HIV test, the health care provider may not use the fact that the person declined an HIV test as a basis for denying services or treatment, other than an HIV test, to the person.

4. The health care provider, blood bank, blood center, or plasma center provides the person or the person's authorized representative an opportunity to ask questions and to decline the HIV test.

5. After complying with applicable conditions under subds. 1. to 4., the health care provider, blood bank, blood center, or plasma center verifies that the person or the person's authorized representative understands that an HIV test will be performed on the person and that the decision of the person or the person's authorized representative regarding whether to have an HIV test performed is not coerced or involuntary.

(b) Paragraph (a) does not apply to any of the following:

1. HIV testing of any body fluid or tissue that is performed by the department, a laboratory certified under 42 USC 263a, or a health care provider, blood bank, blood center, or plasma center for the purpose of research, if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher.

2. HIV testing of a resident or patient of a center for the developmentally disabled, as defined in s. 51.01 (3), or a mental health institute, as defined in s. 51.01 (12), if the medical director of the center or institute determines that the conduct of the resident or

patient poses a significant risk of transmitting HIV to another resident or patient of the center or institute and if the medical director provides the resident or patient, or the resident's or patient's guardian, an explanation of the HIV test result.

3. HIV testing by a health care professional acting under an order of the court under sub. (5j) or s. 938.296 (4) or (5) or 968.38 (4) or (5). No sample used for laboratory test purposes under this subdivision may disclose the name of the HIV test subject, and the HIV test results may not be made part of the individual's permanent medical record.

4. HIV testing in cases of significant exposure, as provided under sub. (5g) or (5j).

5. HIV testing of a donor of a human body part or human tissue that is required under s. 252.133.

(c) If the subject of an HIV test is a minor who is 14 years of age or older, a health care provider, blood bank, blood center, or plasma center shall provide the notifications and offer the information under par. (a) 1. to 4. to the minor or his or her authorized representative, and only the minor or his or authorized representative may consent to or decline an HIV test under par. (a).

(2r) PROHIBITION AGAINST CONDITIONING HIV TESTING ON DISCLOSURE. A health care provider may not require a person to authorize disclosure of HIV test results as a condition of administering an HIV test to the person.

(3m) CONFIDENTIALITY AND DISCLOSURE OF HIV TEST RESULTS. (a) The subject of an HIV test or the subject's authorized representative may disclose the results of the subject's test to anyone.

(b) Except as provided under par. (d) or (e), a person who is neither the subject of the HIV test nor the subject's authorized representative may not disclose the subject's HIV test results unless the subject of the HIV test or his or her authorized representative has signed authorization for the disclosure that contains all of the following:

1. The name of the subject of the HIV test.

2. Specification of the information that may be disclosed.

3. The name of the person authorized to make the disclosure.

4. The name of the person to whom the disclosure is authorized.

5. The signature of the subject of the HIV test or the signature of the subject's authorized representative.

6. The date the authorization is signed as provided under subd. 5.

7. The time period during which the authorization for disclosure is effective.

(c) If the subject of an HIV test is a minor who is 14 years of age or older, only the minor or his or her authorized representative may exercise the test subject's authority to disclose HIV test results under par. (a) or to authorize disclosure of HIV test results under par. (b).

(d) Except as provided under par. (f), a person who is neither the subject of an HIV test nor the subject's authorized representative may without written authorization from the test subject or authorized representative under par. (b) disclose the subject's HIV test results to the following persons under the following circumstances:

1. To the subject of the HIV test and the subject's authorized representative.

2. To a health care provider who provides care to the subject of the HIV test, including those instances in which a health care provider provides emergency care to the subject.

3. To an agent or employee of a health care provider under subd. 2. who prepares or stores patient health care records, as defined in s. 146.81 (4), for the purposes of preparation or storage of those records; provides patient care; or handles or processes specimens of body fluids or tissues.

4. To a blood bank, blood center, or plasma center that subjected the test subject to an HIV test for any of the following purposes:

a. Determining the medical acceptability of blood or plasma secured from the subject of the HIV test.

b. Notifying the subject of the HIV test of the test results.

c. Investigating HIV infections in blood or plasma.

5. To a health care provider who procures, processes, distributes or uses a human body part that is the subject of an anatomical gift under s. 157.06, for the purpose of assuring medical acceptability of the gift for the purpose intended.

6. To the state epidemiologist or his or her designee, or to a local health officer or his or her designees, for the purpose of providing epidemiologic surveillance or investigation or control of communicable disease.

7. To a funeral director, as defined under s. 445.01 (5) (a) 1. or 2. or (c) or to other persons who prepare the body of the subject of the HIV test for burial or other disposition or to a person who performs an autopsy, or assists in performing an autopsy, on the subject of the HIV test.

8. To health care facility staff committees or accreditation or health care services review organizations for the purposes of conducting program monitoring and evaluation and health care services reviews.

9. Under a lawful order of a court of record except as provided under s. 901.05.

10. Except as provided under par. (g), to a person who conducts research, for the purpose of research, if the researcher:

a. Is affiliated with a health care provider under subd. 2.

b. Has obtained permission to perform the research from an institutional review board.

c. Provides written assurance to the person disclosing the HIV test results that use of the information requested is only for the purpose under which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final research product will not reveal information that may identify the test subject unless the researcher has first received informed consent for disclosure from the test subject.

11. To a coroner, medical examiner, or an appointed assistant to a coroner or medical examiner, if one or more of the following applies:

a. The coroner, medical examiner, or an appointed assistant is investigating the cause of death of the subject of the HIV test and possible HIV−infected status is relevant to the cause of death.

b. The coroner, medical examiner, or appointed assistant is investigating the cause of death of the subject of the HIV test and has contact with the body fluid of the subject of the HIV test that constitutes a significant exposure, if a physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the coroner, medical examiner, or appointed assistant has had a contact that constitutes a significant exposure and if the certification accompanies the request for disclosure.

12. To a sheriff, jailer or keeper of a prison, jail, or house of correction or a person designated with custodial authority by the sheriff, jailer, or keeper, for whom disclosure is necessitated in order to permit the assigning of a private cell to a prisoner who has a positive HIV test result.

13. If the subject of the HIV test has a positive HIV test result and is deceased, by the subject's attending physician, physician assistant, or advanced practice nurse prescriber, to persons, if known to the physician, physician assistant, or advanced practice nurse prescriber, with whom the subject had sexual contact or shared intravenous drug use paraphernalia.

14. To a person under s. 938.296 (4) (a) to (e) as specified in s. 938.296 (4); to a person under s. 938.296 (5) (a) to (e) as speci-

fied in s. 938.296 (5); to a person under s. 968.38 (4) (a) to (c) as specified in s. 968.38 (4); or to a person under s. 968.38 (5) (a) to (c) as specified in s. 968.38 (5).

15. If the subject of the HIV test is a child who has been placed in a foster home, group home, residential care center for children and youth, or juvenile correctional facility, as defined in s. 938.02 (10p), or in a supervised independent living arrangement, including a placement under s. 48.205, 48.21, 938.205, or 938.21, or for whom placement in a foster home, group home, residential care center for children and youth, or juvenile correctional facility or in a supervised independent living arrangement is recommended under s. 48.33 (4), 48.425 (1) (g), 48.837 (4) (c), or 938.33 (3) or (4), to an agency directed by a court to prepare a court report under s. 48.33 (1), 48.424 (4) (b), 48.425 (3), 48.831 (2), 48.837 (4) (c), or 938.33 (1), to an agency responsible for preparing a court report under s. 48.365 (2g), 48.425 (1), 48.831 (2), 48.837 (4) (c), or 938.365 (2g), to an agency responsible for preparing a permanency plan under s. 48.355 (2e), 48.38, 48.43 (1) (c) or (5) (c), 48.63 (4) or (5) (c), 48.831 (4) (e), 938.355 (2e), or 938.38 regarding the child, or to an agency that placed the child or arranged for the placement of the child in any of those placements and, by any of those agencies, to any other of those agencies and, by the agency that placed the child or arranged for the placement of the child in any of those placements, to the child's foster parent or the operator of the group home, residential care center for children and youth, or juvenile correctional facility in which the child is placed, as provided in s. 48.371 or 938.371.

16. If the subject of the HIV test is a prisoner, to the prisoner's health care provider, the medical staff of a prison or jail in which a prisoner is confined, the receiving institution intake staff at a prison or jail to which a prisoner is being transferred or a person designated by a jailer to maintain prisoner medical records, if the disclosure is made with respect to the prisoner's patient health care records under s. 302.388, to the medical staff of a jail to whom the HIV results are disclosed under s. 302.388 (2) (c) or (d), to the medical staff of a jail to which a prisoner is being transferred, if the results are provided to the medical staff by the department of corrections as part of the prisoner's medical file, to a health care provider to whom the results are disclosed under s. 302.388 (2) (c) or (f) or the department of corrections if the disclosure is made with respect to a prisoner's patient health care records under s. 302.388 (4).

17. If the subject of the HIV test is a prisoner, by a person specified in subd. 16. to a correctional officer of the department of corrections who has custody of or is responsible for the supervision of the test subject, to a person designated by a jailer to have custodial authority over the test subject, or to a law enforcement officer or other person who is responsible for transferring the test subject to or from a prison or jail, if the HIV test result is positive and disclosure of that information is necessary for the health and safety of the test subject or of other prisoners, of the person to whom the information is disclosed, or of any employee of the prison or jail.

(e) The health care professional who performs an HIV test under sub. (5g) or (5j) on behalf of a person who has contact with body fluids of the test subject that constitutes a significant exposure shall disclose the HIV test results to the person and the person's physician, physician assistant, or nurse.

(f) The results of an HIV test of an individual that is performed under sub. (5g) or (5j) may be disclosed only to the following:

1. The subject of the test.

2. Anyone authorized by the subject of the test.

3. The person who was certified to have had contact that constitutes a significant exposure and to that person's physician, physician assistant, or nurse.

(g) A person who was certified to have had contact with body fluid of an individual that constitutes a significant exposure and has the individual's blood subjected to an HIV test under sub. (5g) or (5j) may not disclose the identity of the test subject to any other person except for the purpose of having the HIV test performed.

(h) A private pay patient may prohibit disclosure of his or her HIV test results under par. (d) 10. if he or she annually submits to the maintainer of his or her HIV test results under sub. (4) (c) a signed, written request that disclosure be prohibited.

(4) RECORD MAINTENANCE. A health care provider, blood bank, blood center, or plasma center that obtains a specimen of body fluids or tissues from a person for the purpose of an HIV test, or offers to subject a person to an HIV test, shall maintain in the person's health care record all of the following:

(b) A record of whether the person or his or her authorized representative consented to or declined the HIV test under sub. (2m) (a).

(bm) A record of any authorization for disclosure of HIV test results that the person or his or her authorized representative has made as provided under sub. (3m) (b).

(c) A record of the results of an HIV test administered to the person, except that results of an HIV test administered under sub. (5g) or (5j) or s. 938.296 (4) or (5) or 968.38 (4) or (5) that include the identity of the test subject may not be maintained without the consent of the test subject.

(5g) SIGNIFICANT EXPOSURE. A person who has contact with body fluid of an individual that constitutes a significant exposure may cause the individual to be subjected to HIV testing and receive the results of the HIV test under sub. (3m) (e) if all of the following apply:

(a) The contact occurred under one of the following circumstances:

1. The person is an emergency medical services practitioner; emergency medical responder; fire fighter; peace officer; correctional officer; person who is employed at a juvenile correctional facility, as defined in s. 938.02 (10p), or a secured residential care center for children and youth, as defined in s. 938.02 (15g); state patrol officer; jailer, keeper of a jail, or person designated with custodial authority by the jailer or keeper and the contact occurred during the course of the person providing care or services to the individual.

2. The person is a peace officer, correctional officer, state patrol officer, jailer, or keeper of a jail, or person designated with custodial authority by the jailer or keeper and the contact occurred while the person was searching or arresting the individual or while controlling or transferring the individual in custody.

3. The person is a health care provider or an employee of a health care provider and the contact occurred during the course of the person providing care or treatment to the individual or handling or processing specimens of body fluids or tissues of the individual.

4. The person is a staff member of a state crime laboratory and the contact occurred during the course of the person handling or processing specimens of body fluids or tissues of the individual.

5. The person is a social worker or an employee of a school district, cooperative educational service agency, charter school, private school, tribal school, as defined in s. 115.001 (15m), the Wisconsin Educational Services Program for the Deaf and Hard of Hearing, or the Wisconsin Center for the Blind and Visually Impaired and the contact occurred while the person was performing employment duties involving the individual.

6. While the person rendered emergency care at the scene of an emergency or accident, if the person is immune from civil liability for rendering the care under s. 895.48 or 895.4802 (2).

(b) If the contact occurs as provided under par. (a) 1. to 5., the entity that employs or contracts with the person to provide the services described under par. (a) 1. to 5. requires, as a general policy, that standard precautions against significant exposure be taken during provision of the services, except in those emergency cir-

cumstances in which the time necessary for use of the standard precautions would endanger the life of the individual.

(c) A physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the person has had contact that constitutes a significant exposure. The certification shall accompany the request for HIV testing and disclosure. If the person is a physician, physician assistant, or advanced practice nurse prescriber, he or she may not make this determination or certification. The information that is provided to a physician, physician assistant, or advanced practice nurse prescriber to document the occurrence of the contact that constitutes a significant exposure and the physician's, physician assistant's, or advanced practice nurse prescriber's certification that the person has had contact that constitutes a significant exposure, shall be provided on a report form that is developed by the department of safety and professional services under s. 101.02 (19) (a) or on a report form that the department of safety and professional services determines, under s. 101.02 (19) (b), is substantially equivalent to the report form that is developed under s. 101.02 (19) (a).

(d) The person submits to an HIV test as soon as feasible or within a time period established by the department after consulting guidelines of the centers for disease control of the federal public health service, whichever is earlier.

(e) Except as provided in sub. (5j), the HIV test is performed on blood of the individual that is drawn for a purpose other than HIV testing.

(f) The individual has been given an opportunity to be subjected to an HIV test in accordance with the conditions under sub. (2m) (a) and has declined.

(g) The individual has been informed of all of the following:

1. That an HIV test may be performed on his or her blood.

2. That the HIV test results may be disclosed to the person and the person's physician, physician assistant, or nurse.

3. That, except as provided in subd. 2., the HIV test may not be disclosed to any person.

4. That, if the person knows the identity of the individual, the person may not disclose the identity to any other person except for the purpose of having the HIV test performed.

5. That a record may be kept of the HIV test results only if the record does not reveal the individual's identity.

(5j) COURT ORDER FOR HIV TESTING. (a) A person who may cause an individual to be subjected to HIV testing under sub. (5g) may request the district attorney to apply to the circuit court for his or her county to order the individual to submit to an HIV test if no blood of the individual that was drawn for a purpose other than HIV testing is available for HIV testing. A person making a request to a district attorney under this paragraph shall provide the district attorney the certification under sub. (5g) (c).

(b) Upon receipt of a request and certification under par. (a), a district attorney shall, as soon as possible so as to enable the court to provide timely notice, apply to the circuit court for his or her county to order the individual to submit to an HIV test administered by a health care professional.

(c) The court shall set a time for a hearing on the matter under this subsection within 20 days after receipt of a request under par. (b). The court shall give the district attorney and the individual from whom an HIV test is sought notice of the hearing at least 72 hours prior to the hearing. The individual may have counsel at the hearing, and counsel may examine and cross−examine witnesses. If the court finds probable cause to believe that the person who requested a court order for testing has had contact with body fluid of the individual that constitutes a significant exposure, the court shall, except as provided in par. (d), order the individual to submit to an HIV test. No sample used for laboratory test purposes under this paragraph may disclose the name of the HIV test subject.

(d) The court is not required to order an individual to submit to an HIV test under par. (c) if the court finds substantial reason relating to the life or health of the individual not to do so and states the reason on the record.

(5m) AUTOPSIES; HIV TESTING OF CERTAIN CORPSES. (d) Notwithstanding s. 157.05, a corpse may be subjected to an HIV test and the test results disclosed to a person who has contact that constitutes a significant exposure with body fluid of the corpse or an individual who subsequently dies, if all of the following apply:

1. The contact occurs under any of the following circumstances:

a. While the person, including a person exempted from civil liability under the conditions specified under s. 895.48 or 895.4802 (2) renders emergency care to an emergency or accident victim and the victim subsequently dies prior to performance of an HIV test on the victim.

b. The person is a funeral director, coroner, medical examiner, or appointed assistant to a coroner or medical examiner and the contact occurs while the person prepares the corpse for burial or other disposition or while the person performs an autopsy or assists in performing an autopsy on the corpse.

c. The person is a health care provider or an agent or employee of a health care provider and the person has contact with body fluid of the corpse, or of a patient who dies subsequent to the contact and prior to performance of an HIV test on the patient.

2. A physician, physician assistant, or advanced practice nurse prescriber, based on information provided to the physician, physician assistant, or advanced practice nurse prescriber, determines and certifies in writing that the contact under subd. 1. constitutes a significant exposure. A health care provider who has a contact under subd. 1. c. may not make the certification under this subdivision for himself or herself.

3. The certification under subd. 2. accompanies the request for performance of an HIV test and disclosure.

(e) If the conditions under par. (d) are satisfied, the following person shall order an HIV test of the corpse:

1. If the contact occurs as provided under par. (d) 1. a., the coroner, medical examiner, or physician who certifies the victim's cause of death under s. 69.18 (2) (b), (c), or (d).

2. If the contact occurs as provided under par. (d) 1. b., the attending physician, physician assistant, or advanced practice nurse prescriber of the funeral director, coroner, medical examiner, or appointed assistant.

3. If the contact occurs as provided under par. (d) 1. c., the physician, physician assistant, or advanced practice nurse prescriber who makes the certification under par. (d) 2.

(5r) SALE OF TESTS WITHOUT APPROVAL PROHIBITED. No person may sell or offer to sell in this state a test or test kit to detect the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV for self−use by an individual unless the test or test kit is first approved by the state epidemiologist. In reviewing a test or test kit under this subsection, the state epidemiologist shall consider and weigh the benefits, if any, to the public health of the test or test kit against the risks, if any, to the public health of the test or test kit.

(6) EXPANDED DISCLOSURE OF HIV TEST RESULTS PROHIBITED. No person to whom the results of an HIV test have been disclosed under sub. (3m) (a), (b), (d), or (e) or (5m) may disclose the test results except as authorized under sub. (3m) (a), (b), (d), or (e) or (5m).

(7) REPORTING OF POSITIVE HIV TEST RESULTS. (a) Notwithstanding ss. 227.01 (13) and 227.10 (1), for the purposes of this subsection, the state epidemiologist shall determine, based on the preponderance of available scientific evidence, the procedures necessary in this state to obtain a validated HIV test result and the secretary shall so declare under s. 250.04 (1) or (2) (a). The state epidemiologist shall revise this determination if, in his or her opin-

ion, changed available scientific evidence warrants a revision, and the secretary shall declare the revision under s. 250.04 (1) or (2) (a).

(b) If a positive, validated HIV test result is obtained from an HIV test subject, the health care provider, blood bank, blood center, or plasma center that maintains a record of the HIV test result under sub. (4) (c) shall report to the state epidemiologist the following information:

1. The name and address of the health care provider, blood bank, blood center or plasma center reporting.

2. The name and address of the subject's health care provider, if known.

3. The name, address, telephone number, age or date of birth, race and ethnicity, sex and county of residence of the test subject, if known.

4. The date on which the HIV test was performed.

5. The HIV test result.

5m. The mode of transmission of HIV to the test subject.

6. Any other medical or epidemiological information required by the state epidemiologist for the purpose of exercising surveillance, control and prevention of HIV infections.

(c) Except as provided in sub. (7m), a report made under par. (b) may not include any of the following:

1. Information with respect to the sexual orientation of the HIV test subject.

2. The identity of persons with whom the HIV test subject may have had sexual contact.

(d) This subsection does not apply to the reporting of information under s. 252.05 with respect to persons for whom a diagnosis of acquired immunodeficiency syndrome has been made.

(7m) REPORTING OF PERSONS SIGNIFICANTLY EXPOSED. If a positive, validated HIV test result is obtained from a test subject, the test subject's physician, physician assistant, or advanced practice nurse prescriber who maintains a record of the HIV test result under sub. (4) (c) may report to the state epidemiologist the name of any person known to the physician, physician assistant, or advanced practice nurse prescriber to have had contact with body fluid of the test subject that constitutes a significant exposure, only after the physician, physician assistant, or advanced practice nurse prescriber has done all of the following:

(a) Counseled the HIV test subject to inform any person who has had contact with body fluid of the test subject that constitutes a significant exposure.

(b) Notified the HIV test subject that the name of any person known to the physician, physician assistant, or advanced practice nurse prescriber to have had contact with body fluid of the test subject that constitutes a significant exposure will be reported to the state epidemiologist.

(7r) EXPLANATION OF HIV FOR TEST SUBJECTS. The department shall provide to health care providers, blood banks, blood centers, and plasma centers a brief explanation or description of all of the following that a health care provider, blood bank, blood center, or plasma center may provide prospective HIV test subjects under sub. (2m) (a) 2.:

(a) HIV infection.

(b) HIV test results.

(c) Requirements under subs. (7) (b) and (7m) for reporting HIV test results.

(d) Treatment options for a person who has a positive HIV test result.

(e) Services provided by AIDS service organizations, as defined in s. 252.12 (1) (b), and other community−based organizations for persons who have a positive HIV test result.

(8) CIVIL LIABILITY. (a) Any person violating sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c) is liable to the subject of the test for actual damages, costs and reasonable actual attorney fees, plus exemplary damages of up to $2,000 for a negligent violation and up to $50,000 for an intentional violation.

(b) The plaintiff in an action under par. (a) has the burden of proving by a preponderance of the evidence that a violation occurred under sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c). A conviction under sub. (2m), (3m) (b), (d), or (f), (5m), (6) or (7) (c) is not a condition precedent to bringing an action under par. (a).

(9) PENALTIES. Whoever intentionally discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m) and thereby causes bodily harm or psychological harm to the subject of the HIV test may be fined not more than $50,000 or imprisoned not more than 9 months or both. Whoever negligently discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m) is subject to a forfeiture of not more than $2,000 for each violation. Whoever intentionally discloses the results of an HIV test in violation of sub. (3m) (b) or (f) or (5m), knowing that the information is confidential, and discloses the information for pecuniary gain may be fined not more than $200,000 or imprisoned not more than 3 years and 6 months, or both.

(10) DISCIPLINE OF EMPLOYEES. Any employee of the state or a political subdivision of the state who violates this section may be discharged or suspended without pay.

History: 1985 a. 29, 73, 120; 1987 a. 70 ss. 13 to 27, 36; 1987 a. 403 ss. 136, 256; 1989 a. 200; 1989 a. 201 ss. 11 to 25, 36; 1989 a. 298, 359; 1991 a. 269; 1993 a. 16 s. 2567; 1993 a. 27 ss. 332, 334, 337, 340, 342; Stats. 1993 s. 252.15; 1993 a. 32, 183, 190, 252, 395, 491; 1995 a. 27 ss. 6323, 9116 (5), 9126 (19); 1995 a. 77, 275; 1997 a. 54, 80, 156, 188; 1999 a. 9, 32, 79, 151, 162, 188; 2001 a. 38, 59, 69, 74, 103, 105; 2003 a. 271; 2005 a. 155, 187, 266, 344, 387; 2007 a. 97, 106, 130; 2009 a. 28, 209, 302, 355; 2011 a. 32; 2011 a. 260 ss. 42 to 44, 81; 2013 a. 334; 2015 a. 197 s. 51; 2017 a. 12.

No claim for a violation of s. 146.025, 1987 stats., was stated when the defendants neither conducted HIV tests nor were authorized recipients of the test results. Hillman v. Columbia County, 164 Wis. 2d 376, 474 N.W.2d 913 (Ct. App. 1991).

This section does not prevent a court acting in equity from ordering an HIV test where this section does not apply. Syring v. Tucker, 174 Wis. 2d 787, 498 N.W.2d 370 (1993).

This section has no bearing on a case in which a letter from the plaintiff to the defendant pharmacy contained a reference to a drug used only to treat AIDS, but did not disclose the results of an HIV test or directly disclose that the defendant had AIDS. Doe v. American Stores, Co., 74 F. Supp. 2d 855 (1999).

Confidentiality of Medical Records. Meili. Wis. Law. Feb. 1995.

HIV Confidentiality: Who Has the Right to Know? Krimmer. Wis. Law. Feb. 2003.

New Federal Privacy Rule for Health Care Providers, Part II: Balancing Federal and Wisconsin Medical Privacy Laws. Hartin. Wis. Law. June 2003.

252.16 Health insurance premium subsidies. (1) DEFINITIONS. In this section:

(ar) "Dependent" means a spouse or domestic partner under ch. 770, an unmarried child under the age of 19 years, an unmarried child who is a full−time student under the age of 21 years and who is financially dependent upon the parent, or an unmarried child of any age who is medically certified as disabled and who is dependent upon the parent.

(b) "Group health plan" means an insurance policy or a partially or wholly uninsured plan or program, that provides hospital, medical or other health coverage to members of a group, whether or not dependents of the members are also covered. The term includes a medicare supplement policy, as defined in s. 600.03 (28r), but does not include a medicare replacement policy, as defined in s. 600.03 (28p), or a long−term care insurance policy, as defined in s. 600.03 (28g).

(c) "Individual health policy" means an insurance policy or a partially or wholly uninsured plan or program, that provides hospital, medical or other health coverage to an individual on an individual basis and not as a member of a group, whether or not dependents of the individual are also covered. The term includes a medicare supplement policy, as defined in s. 600.03 (28r), but does not include a medicare replacement policy, as defined in s. 600.03 (28p), or a long−term care insurance policy, as defined in s. 600.03 (28g).

(d) "Medicare" means coverage under part A, part B, or part D of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395hhh.

(e) "Residence" means the concurrence of physical presence with intent to remain in a place of fixed habitation. Physical presence is prima facie evidence of intent to remain.

(2) SUBSIDY PROGRAM. From the appropriation account under s. 20.435 (1) (am), the department shall distribute funding in each fiscal year to subsidize the premium costs under s. 252.17 (2) and, under this subsection, the premium costs for health insurance coverage available to an individual who has HIV infection and who is unable to continue his or her employment or must reduce his or her hours because of an illness or medical condition arising from or related to HIV infection.

(3) ELIGIBILITY. An individual is eligible to receive a subsidy in an amount determined under sub. (4), if the department determines that the individual meets all of the following criteria:

(a) Has residence in this state.

(b) Has a family income, as defined by rule under sub. (6), that does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(c) Has submitted to the department a certification from a physician, as defined in s. 448.01 (5), physician assistant, or advanced practice nurse prescriber of all of the following:

1. That the individual has an infection that is an HIV infection.

2. That the individual's employment has terminated or his or her hours have been reduced, because of an illness or medical condition arising from or related to the individual's HIV infection.

(dm) Has, or is eligible for, health insurance coverage under a group health plan or an individual health policy.

(e) Authorizes the department, in writing, to do all of the following:

1. Contact the individual's employer or former employer or health insurer to verify the individual's eligibility for coverage under the group health plan or individual health policy and the premium and any other conditions of coverage, to make premium payments as provided in sub. (4) and for other purposes related to the administration of this section.

1m. Contact the individual's employer or former employer to verify that the individual's employment has been terminated or that his or her hours have been reduced and for other purposes related to the administration of this section.

2. Make any necessary disclosure to the individual's employer or former employer or health insurer regarding the individual's HIV status.

(4) AMOUNT AND PERIOD OF SUBSIDY. (a) Except as provided in pars. (b) and (d), if an individual satisfies sub. (3), the department shall pay the full amount of each premium payment for the individual's health insurance coverage under the group health plan or individual health policy under sub. (3) (dm), on or after the date on which the individual becomes eligible for a subsidy under sub. (3). Except as provided in pars. (b) and (d), the department shall pay the full amount of each premium payment regardless of whether the individual's health insurance coverage under sub. (3) (dm) includes coverage of the individual's dependents. Except as provided in par. (b), the department shall terminate the payments under this section when the individual's health insurance coverage ceases or when the individual no longer satisfies sub. (3), whichever occurs first. The department may not make payments under this section for premiums for medicare, except for premiums for coverage for part D of Title XVIII of the federal Social Security Act, 42 USC 1395 to 1395hhh.

(b) The obligation of the department to make payments under this section is subject to the availability of funds in the appropriation account under s. 20.435 (1) (am).

(d) For an individual who satisfies sub. (3) and who has a family income, as defined by rule under sub. (6) (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family, the department shall pay a portion of the amount of each premium payment for the individual's health insurance coverage. The portion that the department pays shall be determined according to a schedule established by the department by rule under sub. (6) (c). The department shall pay the portion of the premium determined according to the schedule regardless of whether the individual's health insurance coverage under sub. (3) (dm) includes coverage of the individual's dependents.

(5) APPLICATION PROCESS. The department may establish, by rule, a procedure under which an individual who does not satisfy sub. (3) (b), (c) 2. or (dm) may submit to the department an application for a premium subsidy under this section that the department shall hold until the individual satisfies each requirement of sub. (3), if the department determines that the procedure will assist the department to make premium payments in a timely manner once the individual satisfies each requirement of sub. (3). If an application is submitted by an employed individual under a procedure established by rule under this subsection, the department may not contact the individual's employer or health insurer unless the individual authorizes the department, in writing, to make that contact and to make any necessary disclosure to the individual's employer or health insurer regarding the individual's HIV status.

(6) RULES. The department shall promulgate rules that do all of the following:

(a) Define family income for purposes of sub. (3) (b).

(b) Establish a procedure for making payments under this section that ensures that the payments are actually used to pay premiums for health insurance coverage available to individuals who satisfy sub. (3).

(c) Establish a premium contribution schedule for individuals who have a family income, as defined by rule under par. (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family. In establishing the schedule under this paragraph, the department shall take into consideration both income level and family size.

History: 1989 a. 336; 1991 a. 269; 1993 a. 16 ss. 2587, 2588; 1993 a. 27 ss. 386 to 389; Stats. 1993 s. 252.16; 1993 a. 491; 1995 a. 27; 1997 a. 27; 2001 a. 38; 2005 a. 187; 2007 a. 20; 2009 a. 28; 2011 a. 161.

Cross−reference: See also ch. DHS 138, Wis. adm. code.

252.17 Medical leave premium subsidies. (1) DEFINITIONS. In this section:

(a) "Group health plan" has the meaning given in s. 252.16 (1) (b).

(d) "Medical leave" means medical leave under s. 103.10.

(e) "Residence" has the meaning given in s. 252.16 (1) (e).

(2) SUBSIDY PROGRAM. The department shall establish and administer a program to subsidize, as provided in s. 252.16 (2), the premium costs for coverage under a group health plan that are paid by an individual who has HIV infection and who is on unpaid medical leave from his or her employment because of an illness or medical condition arising from or related to HIV infection.

(3) ELIGIBILITY. An individual is eligible to receive a subsidy in an amount determined under sub. (4), if the department determines that the individual meets all of the following criteria:

(a) Has residence in this state.

(b) Has a family income, as defined by rule under sub. (6), that does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family.

(c) Has submitted to the department a certification from a physician, as defined in s. 448.01 (5), physician assistant, or advanced practice nurse prescriber of all of the following:

1. That the individual has an infection that is an HIV infection.

2. That the individual is on unpaid medical leave from his or her employment because of an illness or medical condition arising from or related to the individual's HIV infection or because of medical treatment or supervision for such an illness or medical condition.

(d) Is covered under a group health plan through his or her employment and pays part or all of the premium for that coverage, including any premium for coverage of the individual's spouse or domestic partner under ch. 770 and dependents.

(e) Authorizes the department, in writing, to do all of the following:

1. Contact the individual's employer or the administrator of the group health plan under which the individual is covered, to verify the individual's medical leave, group health plan coverage and the premium and any other conditions of coverage, to make premium payments as provided in sub. (4) and for other purposes related to the administration of this section.

2. Make any necessary disclosure to the individual's employer or the administrator of the group health plan under which the individual is covered regarding the individual's HIV status.

(f) Is not covered by a group health plan other than any of the following:

1. The group health plan under par. (d).

2. A group health plan that offers a substantial reduction in covered health care services from the group health plan under subd. 1.

(g) Is not covered by an individual health insurance policy other than an individual health insurance policy that offers a substantial reduction in covered health care services from the group health plan under par. (d).

(h) Is not eligible for medicare under 42 USC 1395 to 1395zz.

(i) Does not have escrowed under s. 103.10 (9) (c) an amount sufficient to pay the individual's required contribution to his or her premium payments.

(4) AMOUNT AND PERIOD OF SUBSIDY. (a) Except as provided in pars. (b), (c), and (d), if an individual satisfies sub. (3), the department shall pay the amount of each premium payment for coverage under the group health plan under sub. (3) (d) that is due from the individual on or after the date on which the individual becomes eligible for a subsidy under sub. (3). The department may not refuse to pay the full amount of the individual's contribution to each premium payment because the coverage that is provided to the individual who satisfies sub. (3) includes coverage of the individual's spouse or domestic partner under ch. 770 and dependents. Except as provided in par. (b), the department shall terminate the payments under this section when the individual's unpaid medical leave ends, when the individual no longer satisfies sub. (3) or upon the expiration of 29 months after the unpaid medical leave began, whichever occurs first.

(b) The obligation of the department to make payments under this section is subject to the availability of funds in the appropriation account under s. 20.435 (1) (am).

(c) If an individual who satisfies sub. (3) has an amount escrowed under s. 103.10 (9) (c) that is insufficient to pay the individual's required contribution to his or her premium payments, the amount paid under par. (a) may not exceed the individual's required contribution for the duration of the payments under this section as determined under par. (a) minus the amount escrowed.

(d) For an individual who satisfies sub. (3) and who has a family income, as defined by rule under sub. (6) (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family, the department shall pay a portion of the amount of each premium payment for the individual's coverage under the group health plan under sub. (3) (d). The portion that the department pays shall be determined according to a schedule established by the department by rule under sub. (6) (c). The department shall pay the portion of the premium determined according to the schedule regardless of whether the individual's coverage under the group health plan under sub. (3) (d) includes coverage of the individual's spouse or domestic partner under ch. 770 and dependents.

(5) APPLICATION PROCESS. The department may establish, by rule, a procedure under which an individual who does not satisfy sub. (3) (b) or (c) 2. may submit to the department an application for a premium subsidy under this section that the department shall hold until the individual satisfies each requirement of sub. (3), if the department determines that the procedure will assist the department to make premium payments in a timely manner once the individual satisfies each requirement of sub. (3). If an application is submitted by an individual under a procedure established by rule under this subsection, the department may not contact the individual's employer or the administrator of the group health plan under which the individual is covered, unless the individual authorizes the department, in writing, to make that contact and to make any necessary disclosure to the individual's employer or the administrator of the group health plan under which the individual is covered regarding the individual's HIV status.

(6) RULES. The department shall promulgate rules that do all of the following:

(a) Define family income for purposes of sub. (3) (b).

(b) Establish a procedure for making payments under this section that ensures that the payments are actually used to pay premiums for group health plan coverage available to individuals who satisfy sub. (3).

(c) Establish a premium contribution schedule for individuals who have a family income, as defined by rule under par. (a), that exceeds 200 percent but does not exceed 300 percent of the federal poverty line, as defined under 42 USC 9902 (2), for a family the size of the individual's family. In establishing the schedule under this paragraph, the department shall take into consideration both income level and family size.

History: 1991 a. 269; 1993 a. 16 ss. 2589, 2590; 1993 a. 27 ss. 390 to 394; Stats. 1993 s. 252.17; 1993 a. 491; 1997 a. 27; 1999 a. 103; 2005 a. 187; 2009 a. 28; 2011 a. 161.

Cross−reference: See also ch. DHS 138, Wis. adm. code.

252.185 Communicable disease control and prevention. (1) From the appropriation under s. 20.435 (1) (cf), the department shall distribute moneys to local health departments to use for disease surveillance, contact tracing, staff development and training, improving communication among health care professionals, public education and outreach, and other infection control measures as required under this chapter. The department shall consider the following factors to establish an equitable allocation formula for the distribution of moneys under this section:

(a) Base allocation, including at least some base amount for each local health department.

(b) General population.

(c) Target populations.

(d) Risk factors.

(e) Geographic area, including consideration of the size of the service area or the density of population, or both.

(2) By January 1, 2019, and biennially thereafter, each local health department shall submit to the division of the department that addresses public health issues a financial statement of its use of funds under this section.

History: 2017 a. 59.

252.19 Communicable diseases; suspected cases; protection of public. No person who is knowingly infected with a communicable disease may willfully violate the recommendations of the local health officer or subject others to danger of contracting the disease. No person may knowingly and willfully take, aid in taking, advise or cause to be taken, a person who is infected or is suspected of being infected with a communicable disease into any public place or conveyance where the infected person would expose any other person to danger of contracting the disease.

History: 1981 c. 291; 1993 a. 27 s. 299; Stats. 1993 s. 252.19.

252.21 Communicable diseases; schools; duties of teachers, parents, officers. (1) If a teacher, school nurse, or

principal of any school or child care center knows or suspects that a communicable disease is present in the school or center, he or she shall at once notify the local health officer.

(6) Any teacher, school nurse or principal may send home pupils who are suspected of having a communicable disease or any other disease the department specifies by rule. Any teacher, school nurse or principal who sends a pupil home shall immediately notify the parents of the pupil of the action and the reasons for the action. A teacher who sends a pupil home shall also notify the principal of the action and the reasons for the action.

History: 1981 c. 291; 1993 a. 27 s. 301; Stats. 1993 s. 252.21; 2009 a. 185.

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

History: 1981 c. 291; 1993 a. 27 s. 300; Stats. 1993 s. 252.25.

This section requires that a departmental order be promulgated using the procedure established by the legislature for rulemaking if criminal penalties are to follow. Wisconsin Legislature v. Palm, 2020 WI 42, 391 Wis. 2d 497, 942 N.W.2d 900, 20−0765.

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12/14/21

DRAFT

Dear School Superintendents,

We, the Marathon County Board of Health, are reaching out to schools in effort to strongly encourage the consideration of layered COVID mitigation strategies and bring some key updates to your attention.

While COVID-19 case rates may be decreasing in parts of the state, Marathon County's COVID-19 cases remain high. Our seven-day average of COVID-19 cases is at 139 per day. The Center for Disease Control (CDC https://covid.cdc.gov/covid-data-tracker/#county-view) currently classifies Marathon County's case rate as "high," and the Wisconsin Department of Health Services (DHS https://www.dhs.wisconsin.gov/covid-19/local.htm) classifies Marathon's case activity as "critically high." The Marathon County Board of Health remains concerned with the spread of COVID-19 within our community and have particular concern with the levels of transmission happening in schools.

We continue to strongly advise schools to adopt the strategies outlined by the Department of Public Instruction as proven ways to prevent the spread of COVID in your schools. This includes masking, physical distancing, robust ventilation, hand hygiene, and encouraging kids and staff who are symptomatic to stay home. More information on these guidelines can be found here: https://www.dhs.wisconsin.gov/covid-19/schools.htm.

We also strongly advise that you actively encourage eligible students and staff to get vaccinated for COVID-19 at a local COVID vaccination clinic (vaccines.gov). ***Please remember that vaccinated close contacts do not need to quarantine***. COVID vaccines are safe, effective, readily available in Marathon County, and are offered free of charge. An Emergency Use Authorization was recently adopted by the FDA for use of the Pfizer vaccine for children aged 5-11. If you are interested in hosting a vaccination clinic in collaboration with the Marathon County Health Department, they would be happy to coordinate with you. Vaccine clinics can be organized without any cost or liability to the school and at no cost to parents and families. We want to recognize the contributions of the schools that have chosen to collaborate with the health department on vaccine distribution.

If you have not done so already, please consider providing COVID testing availability at your schools. We are happy to report that ***five*** of Marathon County's School Districts have begun

testing, and Marathon County Health Department Staff are happy to connect you with resources that would do this service at no cost to you or your school.

We want to remind school districts within Marathon County of their statutory responsibility, pursuant to Wisconsin Statute Sections 252.05 and 252.21, to report information related to COVID positive cases and close contacts of students and staff participating in school or school activities to the Marathon County Health Department. Wisconsin Statute Section 252.05(3) requires any person who has "knowledge or reason to believe that any person has a communicable disease" to "report the facts to the local health officer." Wisconsin Statute Section 252.21 imposes more specific obligations, requiring any "teacher, school nurse, or principal of any school or child care center [who] knows or suspects that a communicable disease is present in the school or center" to "at once notify the local health officer." These are not only legal requirements, but are also important from a public health perspective, as the Health Department needs this information to be able to provide the Marathon County Community with the guidance and notification required to stop the spread of COVID-19.

We understand that contact tracing done by schools last year was extremely time consuming. Please note that school districts are **not** required to perform contact tracing. By providing contact information to the Marathon County Health Department, you are providing the vital tools we need to mitigate further spread. The Marathon County Health Department is committed to sending notification to contacts when we receive the required information. Thank you to those schools who have been actively working with the health department and providing this necessary information so far.

Sincerely,

Marathon County Board of Health

John Robinson, Chair
Sandi Cihlar, Vice Chair
Dean Danner
Craig McEwen
Tara Draeger
Corrie Norrbom MD
Kue Her MSN, FNP-BC
Tiffany Lee

DRAFT