

Menu of Suggested Provisions for State Tuberculosis Prevention and Control Laws



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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**MENU OF SUGGESTED PROVISIONS FOR STATE TUBERCULOSIS
PREVENTION AND CONTROL LAWS**

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**Assisted by a panel of tuberculosis and legal experts convened at a workshop in Atlanta,
Georgia on February 4-5, 2010**

**Endorsed by:
National Tuberculosis Controllers Association
Advisory Council for the Elimination of Tuberculosis**

Disclaimer: *The information contained in this document does not constitute legal advice and does not represent the legal views of the Department of Health and Human Services. Use of any provision herein should be contemplated only in conjunction with advice from legal counsel. Provisions may need to be modified, supplemented, or replaced to ensure appropriate citation to or compliance with relevant laws or to otherwise address the needs or requirements of a specific jurisdiction.*

Acknowledgements

We would like to extend our thanks to the participants of the workshop entitled “*Developing a Menu of Suggested Provisions for State Tuberculosis Prevention and Control Laws*,” held in Atlanta, Georgia on February 4-5, 2010, for their valuable input and contributions. Workshop participants included state TB controllers, state and local TB program staff, legal counsel to state and local TB programs, representatives from partner organizations (National Tuberculosis Controllers Association, Association of State and Territorial Health Officials, and National Association of County and City Health Officials), U.S. Department of Justice staff, and CDC staff in the following offices and programs: Division of Tuberculosis Elimination; Public Health Law Program; Office of the General Counsel; National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; and National Center for Emerging and Zoonotic Infectious Diseases. We also extend our thanks to the Advisory Council for the Elimination of Tuberculosis and the Association of Public Health Laboratories for their valuable comments, and to the American Bar Association for their contributions to the workshop.

Introduction

Tuberculosis (TB) laws provide authority for state and local TB programs to prevent and control TB, an airborne infectious disease that sickens approximately 11,000 to 12,000 people each year in the United States. Prompted by an initial request of the Advisory Council for the Elimination of Tuberculosis (ACET) for a model TB control act, and with support from the National Tuberculosis Controllers Association (NTCA), CDC's Division of Tuberculosis Elimination and Public Health Law Program commenced work on a "Menu of Suggested Provisions for State Tuberculosis Prevention and Control Laws"¹ during the summer of 2009. We researched, reviewed, and categorized the TB prevention and control statutes and regulations of all 50 states (plus the District of Columbia and New York City) based on ACET recommendations and on the framework used in the article "Tuberculosis control laws—United States, 1993: recommendations of the Advisory Council for the Elimination of Tuberculosis (ACET)," published in the *Morbidity and Mortality Weekly Report*.² We re-organized, modified, and condensed the Menu to provide a set of options within each section that are believed to be effective in the jurisdictions in which they are in place.

We then convened a workshop on February 4-5, 2010 comprising TB controllers, TB program staff, legal counsel to state and local TB programs, representatives from partner organizations (NTCA, Association of State and Territorial Health Officials, and National Association of County and City Health Officials), and federal public health attorneys and policy staff, with a wide range of TB prevention and control responsibility, experience, and expertise. Workshop participants reviewed and analyzed the draft Menu's provisions, and provided valuable input concerning retention, modification, deletion, or addition of provisions. ACET members also reviewed the draft Menu and added valuable perspective on recommended revisions. In addition, the Association of Public Health Laboratories (APHL) TB Steering Committee provided feedback and input on the laboratory provisions in the draft Menu. This document is the product of those efforts. We hope that the document will be of immediate practical value to public health officials and their legal counsel in the enactment, promulgation, amendment, or implementation of TB prevention and control laws in a variety of jurisdictions.

While this document is intended to provide impetus for consideration of TB-related legal issues, and to suggest possible approaches for addressing those issues, the suggested provisions obviously must be considered within the policy and legal frameworks of the jurisdiction contemplating adoption of the suggested provisions. For example, implementation of some of the provisions is dependent on the resources available to the jurisdiction. States will be mindful of their resources when contemplating actions or duties that will be required of public health officials (i.e., states may not want to adopt laws that result in "unfunded mandates"). The same holds true when imposing timeframes for reporting or laboratory testing.

¹ Although the title of the document and the descriptive notes refer to "states," the Menu's provisions are also available for consideration by tribes, territories, or localities.

² Centers for Disease Control and Prevention. Tuberculosis control laws—United States, 1993: recommendations of the Advisory Council for the Elimination of Tuberculosis (ACET). *MMWR* 1993;42(No. RR-15):[1-28].

Similarly, when deciding whether to adopt any of the provisions in the Menu, careful consideration should be given to whether a provision should appear in statute or regulation. States may wish to adopt broad or general statutes that confer discretion to the regulatory process, which can be more expeditiously exercised to make changes or updates. Regulations must be authorized by statute (i.e., there can be a statute without a regulation, but not a regulation without an authorizing statute). Some of the factors that go into this decision are: the timeframe in which the regulation may be promulgated by the authorized agency or the statute enacted by the legislature, how often changes might need to be made to the law, whether the subject matter of the legal provision is technical and regular updates are likely according to advances in technology or practice, and whether statutory authority exists to promulgate a regulation. Finally, some states do not have TB-specific laws (other than reporting laws). We do not intend to recommend that such states adopt TB-specific laws, as these states may have concluded that their general communicable disease control laws provide adequate legal authority to prevent and control TB. Indeed, some of the provisions in the Menu are taken from general communicable disease control codes and are not specific to TB. States using the Menu to assist in the development of TB prevention and control statutes or regulations should therefore carefully tailor those provisions to meet their specific needs.

Each section of the Menu commences with a brief note describing the purpose of provisions included within the section. Provisions in each section are in turn organized under sub-headings. Bulleted provisions within each section and under each sub-heading are mutually exclusive; i.e., a bulleted provision should be viewed as alternative to, rather than supplemental to, other provisions.

Based upon recommendations of workshop participants, ACET, APHL, or other reviewers within CDC, some provisions were substantively modified or revised. No legal citation is provided for these provisions. Legal citations are included where the exact language of the provision was retained with the following exceptions: 1) the term “quarantine” was either deleted or replaced with the term “isolation”; 2) public health official titles such as “Commissioner” or “Director” were consistently replaced with the generic term “health officer” or “public health official”; 3) names of state health departments (e.g., South Carolina Department of Health and Environmental Control) or components of a state health department (e.g., Division of Infectious Diseases) were replaced with the generic term “department”; 4) cited state code sections within the text of a law were deleted and replaced with a brief description of the cited law in brackets; 5) names of states were replaced with the generic term “state” in brackets; 6) at the recommendation of Workshop participants, bracketed terminology replaced terms such as “afflicted person,” “carrier,” and “tuberculous person”; 7) the term “*Mycobacterium tuberculosis*” was italicized; 8) for consistency purposes, sub-bullets are numbered in some instances, where the language in the existing law may have organized the text according to letters or roman numerals; and 9) in a few instances, bracketed terminology was added to an existing provision with a note specifying that the change was made and the purpose behind it.

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Menu of Suggested Provisions for State Tuberculosis Prevention and Control Laws

I. Definitions for Consideration

Descriptive Note: Defining TB, the measures for preventing and controlling it, and other relevant terms is a critical component of TB prevention and control statutes and regulations. As with state TB prevention and control laws in general, TB-related definitions found in statute or regulation vary considerably from state to state. Definitions listed in this section are not intended to define these terms appearing in other sections of the Menu; rather, they were selected from definitions currently found in some states' laws based on the view that they may be particularly useful to jurisdictions contemplating changes to their legal TB-related definitions.

- “Active tuberculosis” means a disease that is caused by *Mycobacterium tuberculosis* or other members of the *Mycobacterium tuberculosis* complex family in any part of the body and that is in an active state as determined by either:
 - 1) A smear or culture taken from any source in the person’s body tests positive for tuberculosis and the person has not completed the appropriate prescribed course of medication for active tuberculosis disease.
 - 2) Radiographic, current clinical, or laboratory evidence is sufficient to support a medical diagnosis of tuberculosis for which treatment is indicated.
- “Case management” means the coordination of the necessary medical, nursing, outreach, and social service systems which ensure that all persons with confirmed [or] clinically suspected tuberculosis are started on appropriate therapy, and that all persons with confirmed tuberculosis complete an appropriate and effective course of treatment. 105 MASS. CODE REGS. 365.200 (2010). [NOTE: “Or” in brackets replaced the word “and,” and the legal citation was retained].
- “Case management services” can include, but are not limited to:
 - Patient education regarding the transmission of TB, how to prevent it, and the importance of keeping appointments for clinical assessments and completing treatment;
 - Facilitating the continuity of care for a patient with suspected or confirmed TB until treatment completion by scheduling diagnostic evaluations in a timely manner, monitoring adherence to prescribed therapy, and intervening as appropriate and necessary to address non-adherence;
 - Assessing adherence to community infection control precautions and intervening as appropriate and necessary to address non-adherence;
 - Coordination of TB care with the care of co-existing medical conditions among multiple medical providers;
 - Assessing the quality of care provided by both public and private health care providers with intervention as necessary;
 - Identification of psychosocial barriers to adherence and treatment completion, including, but not limited to: housing, food, transportation, communication, child care, parenting, incarceration, substance abuse and mental illness and intervention as necessary to promote the continuity of treatment;

- Coordination of contact or source case investigation and care, including identification, evaluation and appropriate treatment of all identified contacts;
 - Coordination of investigations for all Class B1 and B2 referrals (defined as referrals from the CDC’s Division of Global Migration and Quarantine, which informs the Department of persons who are refugees, parolees, asylees, or recent legal immigrants to the United States, and who were screened overseas and classified as either B1 meaning TB, clinically active, not infectious or B2 meaning TB, not clinically active, not infectious) including location, evaluation, and initiation of appropriate treatment;
 - Coordination of all field services, including provision of directly observed therapy (DOT) as prescribed by a health care provider; and
 - Building and maintaining effective working relationships with infection control professionals at hospitals and private health care providers that identify and report tuberculosis in the designated coverage area.
- “Communicable disease” means an illness caused by an infectious agent or its toxins that occurs through the direct or indirect transmission of the infectious agent or its products from an infected individual or via an animal, vector or the inanimate environment to a susceptible animal or human host. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.01 (2010).
 - “Confinement” means the restriction of an individual with TB to a specified place, including, but not limited to, a health facility or other public or private premises, in order to prevent transmission of the disease to others, to prevent the development of drug-resistance, or to ensure that the individual receives a complete course of treatment.
 - “Contact” means a person identified by the public health department who has had exposure to a patient with suspected or confirmed infectious or potentially infectious TB sufficient in both duration and proximity to make him or her at increased risk for recent transmission of latent TB infection. N.J. ADMIN. CODE § 8:57-5.3 (2009).
 - “Cure” means a medically successful complete course of antituberculosis treatment. ARIZ. REV. STAT. § 36-711 (LexisNexis 2009).
 - NOTE: “Medically successful complete course of antituberculosis treatment” means that a [person who has or who based upon reasonable grounds is suspected of having active tuberculosis] has successfully completed a prescribed course of antituberculosis treatment and has been medically discharged from further medical treatment for tuberculosis by a licensed physician. ARIZ. REV. STAT. § 36-711 (LexisNexis 2009).
 - “Cure” or “treatment to cure” means the completion of a course of antituberculosis treatment. FLA. STAT. ANN. § 392.52 (LexisNexis 2009).
 - “Directly observed therapy” means a course of treatment, or preventive treatment, for a contagious disease in which the prescribed medication is administered to the person or taken by the person under direct observation as specified by the Department. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.01 (2010).
 - “Examination” for tuberculosis infection or disease means conducting tests, including, but not limited to, Mantoux tuberculin skin tests, interferon gamma release assays or other tests for tuberculosis infection approved by the U.S. Food and Drug Administration, laboratory examination, and X-rays, as recommended by any of the following: 1) the local health officer, 2) the most recent guidelines of the state department, 3) the most

recent guidelines of the Centers for Disease Control and Prevention, or 4) the most recent guidelines of the American Thoracic Society.

- Extensively Drug-Resistant TB (XDR TB): TB that is resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of the three injectable second-line drugs. CDC definition (<http://www.cdc.gov/tb/topic/drtb/default.htm>).
- “Immediate or imminent public health risk” means a patient with suspected or confirmed infectious or potentially infectious TB disease and who does any of the following: 1) Threatens to leave an acute care facility against medical advice, 2) Leaves an acute care facility against medical advice, 3) States he or she will not adhere to infection control measures, 4) Does not adhere to infection control measures, 5) Refuses to take anti-tuberculosis medication as prescribed, or 6) Threatens to travel on a public conveyance. N.J. ADMIN. CODE § 8:57-5.3 (2009).
- “Isolates” means a population of *Mycobacterium tuberculosis* observed in cultures obtained from clinical specimens of persons with active tuberculosis. KY. REV. STAT. ANN. § 215.511 (LexisNexis 2009).
- “Isolation” means the separation of ill persons who have a communicable disease from those who are healthy, and the restriction of their movement to stop the spread of that disease or illness.
- “Latent TB infection” (LTBI) means the presence of *Mycobacterium tuberculosis* bacteria in the body as evidenced by a significant reaction to a Mantoux tuberculin skin test or positive interferon gamma release assay. A person with latent TB infection does not have an illness nor is he or she infectious. N.J. ADMIN. CODE § 8:57-5.3 (2009).
- “Least restrictive environment or manner” means the intervention that limits the patient's activities the least while providing protection for the public against the likelihood of TB transmission. N.J. ADMIN. CODE § 8:57-5.3 (2009).
- “Multidrug-Resistant Tuberculosis” (MDR TB) means TB that is resistant to at least isoniazid and rifampin. CDC definition (<http://www.cdc.gov/tb/topic/drtb/default.htm>).
- “*Mycobacterium tuberculosis* complex”: *Mycobacterium tuberculosis*, *Mycobacterium bovis*, or *Mycobacterium africanum*. (NOTE: This definition was suggested by the APHL TB Steering Committee for the purposes of the Menu. There are actually seven organisms, but these are the three that are by far most clinically important).
- “Suspected or confirmed infectious or potentially infectious TB disease” means any of the following: 1) A patient with a smear positive for AFB and/or nucleic acid amplification test positive for *M.tb* and/or a culture positive for *M.tb* or *M.tb* complex (this applies only to specimens from sputum, bronchioalveolar lavage, gastric aspirate, lung tissue or other tissue of the respiratory tract such as the larynx or epiglottis); 2) A patient with a chest radiograph, computed tomography scan, or clinical findings indicative of pulmonary tuberculosis sufficient to warrant treatment with anti-tuberculosis medications; 3) A patient whose chest radiograph or respiratory symptoms improve while taking anti-tuberculosis medication; or 4) A patient with respiratory symptoms indicative of pulmonary tuberculosis until a diagnostic evaluation is completed to rule out TB as a cause of these symptoms.
- “Suspected or confirmed TB disease” means one or more of the following: 1) A patient meeting the definition of suspected or confirmed infectious or potentially infectious TB disease; 2) A patient with a smear positive for AFB and/or nucleic acid amplification test positive for *M. tuberculosis* and/or a culture positive for *M. tuberculosis* or *M.*

tuberculosis complex from a location outside the respiratory tract; 3) A patient with extra-pulmonary clinical findings indicative of tuberculosis sufficient to prescribe treatment with anti-tuberculosis medications; 4) A patient whose extra-pulmonary symptoms improve on anti-tuberculosis medications; or 5) A patient with symptoms indicative of extra-pulmonary tuberculosis until a diagnostic evaluation is completed to rule out TB as the cause of these symptoms. N.J. ADMIN. CODE § 8:57-5.3 (2009).

- “Threat to the public health” means that a person has active tuberculosis and: 1) Is not taking medications as prescribed, 2) Is not following the recommendations of the treating physician, 3) Is not seeking treatment for signs and symptoms compatible with tuberculosis, or 4) Evidences a disregard for the health of the public.
- “Treatment” means medication or medical therapy prescribed by a licensed physician to cure a person of active tuberculosis. ARIZ. REV. STAT. § 36-711 (LexisNexis 2009).
- “Tuberculosis” means a disease caused by *Mycobacterium tuberculosis*, *Mycobacterium bovis*, or *Mycobacterium africanum*. FLA. STAT. ANN. § 392.52 (LexisNexis 2009).
- “Tuberculosis”, as demonstrated by:
 - 1) Positive culture for *Mycobacterium tuberculosis* complex; or
 - 2) Positive DNA probe, polymerase chain reaction (PCR), or other technique for identifying *Mycobacterium tuberculosis* from a clinical or pathology specimen; or
 - 3) Positive smear for acid-fast bacillus, with final culture results pending or not available, on either a microbiology or a pathology specimen; or
 - 4) Clinically suspected pulmonary or extrapulmonary (meningeal, bone, kidney, etc.) tuberculosis, such that the physician or other health care professional attending the case has initiated or intends to initiate isolation or treatment for tuberculosis, or to continue or resume treatment for previously incompletely treated disease, or, if the patient is not available, that the physician or other health care professional would initiate isolation or treatment if the patient were available; or
 - 5) Biopsy, pathology, or autopsy findings in lung, lymph nodes or other tissue specimens, consistent with active tuberculosis disease including, but not limited to presence of acid-fast bacilli, caseating and non-caseating granulomas, caseous matter, tubercles and fibro-caseous lesions.

II. Legislative Intent

Descriptive Note: Some states choose to include statements of purpose, or “legislative intent” in their TB prevention and control laws. These provisions are often intended to “set the stage” for the statutory or regulatory provisions following them but are generally not enforceable in and of themselves. Provisions of this type are sometimes designed to generally educate or to emphasize the importance of TB prevention and control to the general public, public health officials, attorneys, judges, and patients.

- Tuberculosis has been and continues to be a threat to the public's health in [State]. While it is important to respect the rights of individuals, the legitimate public interest in protecting the public health and welfare from the spread of a deadly infectious disease outweighs incidental curtailment of individual rights that may occur in implementing effective testing, treatment, and infection control strategies. To protect the public's

health, it is the intent of the legislature that local health officials provide culturally sensitive and medically appropriate early diagnosis, treatment, education, and follow-up to prevent tuberculosis. Further, it is imperative that public health officials and their staff have the necessary authority and discretion to take actions as are necessary to protect the health and welfare of the public, subject to the constitutional protection required under the federal and state constitutions. Nothing in this chapter shall be construed as in any way limiting the broad powers of health officials to act as necessary to protect the public health. WASH. REV. CODE ANN. § 70.28.005 (LexisNexis 2009).

- It is hereby declared that tuberculosis is an infectious and communicable disease, that it endangers the population of this state, and that the treatment and control of such disease is a state and local responsibility. It is further declared that the emergence of multidrug-resistant tuberculosis requires that this threat be addressed with a coherent and consistent strategy in order to protect the public health. To the end that tuberculosis may be brought better under control and multidrug-resistant tuberculosis prevented, it is further declared that the department and local public health agencies shall, within available resources, cooperatively promote control and treatment of persons suffering from tuberculosis. COLO. REV. STAT. ANN. § 25-4-501 (West 2009).
- It is the public policy of the state to:
 - 1) protect persons from the danger of tuberculosis;
 - 2) provide and maintain a comprehensive program for the prevention, abatement, and adequate control working toward eradication of the disease;
 - 3) cooperate with other state agencies and the federal government in carrying out these objectives. MONT. CODE ANN. § 50-17-101 (2009).

III. Enabling Statutes and Rulemaking Provisions

Descriptive Note: Enabling statutes create authority for administrative agencies to promulgate regulations or rules. This authority may be express – e.g., “the health department shall promulgate rules necessary to enforce this act” or implied – e.g., “the department shall conduct the following communicable disease control activities to protect the public’s health: investigation, enforcement of isolation and detention...” The first and second bullets below are examples of enabling statutes that grant implied authority for departments of health to promulgate TB prevention and control regulations. Regulations have been promulgated pursuant to this authority in New Jersey and New Hampshire, respectively. The New Jersey statute contains language that is not relevant to TB (e.g., quarantine, disinfection of articles), but is excerpted verbatim to demonstrate how a state has used its statutory authority to promulgate a wide range of TB prevention and control regulatory provisions. The third and fourth bullets provide express authority for the departments of health in those states to promulgate regulations for TB prevention and control, and the final bullet is an example of a general rulemaking provision.

- In order to prevent the spread of disease affecting humans, the department and the local boards of health within their respective jurisdictions and subject to the State sanitary code, shall have power to:
 - Declare what diseases are communicable.
 - Declare when any communicable disease has become epidemic.

- Require the reporting of communicable diseases.
- Maintain and enforce proper and sufficient quarantine, wherever deemed necessary.
- Remove any person infected with a communicable disease to a suitable place, if in its judgment removal is necessary and can be accomplished without any undue risk to the person infected.
- Disinfect any premises when deemed necessary.
- Remove to a proper place to be designated by it all articles within its jurisdiction, which, in its opinion, shall be infected with any matter likely to communicate disease and to destroy such articles, when in its opinion the safety of the public health requires it.

In the event the Governor declares a public health emergency, the department shall oversee the uniform exercise of these powers in the State and the local board of health shall be subject to the department's exercise of authority under this section. N.J. STAT. ANN. § 26:4-2 (West 2009).

- The department shall:
 - Identify, investigate, and test for communicable diseases posing a threat to the citizens of the state and its visitors.
 - Educate the general public, persons who provide health services to the public, and those persons responsible for the health and well-being of other persons relative to measures that will prevent the contraction of communicable disease, minimize its effects, and impede its spread.
 - Coordinate such medical, municipal, and other services as may be necessary to control, and, when possible, eradicate communicable diseases when they occur. N.H. REV. STAT. ANN. § 141-C:3 (2009).
- The department shall by rule:
 - Specify reportable diseases;
 - Identify those categories of persons who must report reportable diseases and the circumstances under which the reports must be made;
 - Prescribe the procedures and forms for making such reports and transmitting the reports to the department; and
 - Prescribe measures and methods for investigating the source and controlling reportable diseases. OR. REV. STAT. ANN. § 433.004 (West 2010).
- The director shall adopt rules to:
 - Prescribe reasonable and necessary measures for the submission of tuberculosis reports and statistics from counties.
 - Prescribe reasonable and necessary measures regarding standards of medical care to be used by health care providers, agencies and institutions caring for [persons who have or who based upon reasonable grounds are suspected of having active tuberculosis].
 - Prescribe necessary and reasonable measures not in conflict with law for the enforcement of the provisions of this article.
 - To enforce this article as necessary. ARIZ. REV. STAT. § 36-721 (LexisNexis 2009).

- The department shall enforce this [tuberculosis control or communicable disease control code] and shall from time to time promulgate any additional forms and regulations that are necessary for this purpose. DEL. CODE ANN. tit. 16, § 1233 (West 2010).

IV. Case Identification

A. Mandated Reporting

1. Required Reporters of Communicable Disease

Descriptive Note: Workshop participants (See Introduction, page 3) recommended a timeframe of 24 hours to report suspected or confirmed cases of TB. The general requirement below that “anyone having knowledge” of a disease shall report to authorities is intended to supplement laws requiring specific persons or entities to report TB. Two alternate provisions are included requiring healthcare providers to report; the provision on administrators is intended to encompass a wide range of persons or entities that states would generally require to report TB. The provision on federal or tribal entities is an excerpt from an existing Arizona regulatory provision, but no legal citation is included because it has been summarized. The provision has reportedly been effective in fostering a working relationship between local health departments in the state and federal entities and tribes. The clause “to the extent permitted by law” may alleviate concerns regarding enforceability and federalism.

Timeframe for Reporting

- Any reporter of a suspected or confirmed case of tuberculosis shall report to the designated department or official within twenty-four (24) hours.

General Reporting

- 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. WIS. STAT. § 252.05 (2009).

Listing of Specific Persons or Entities Required to Report

Healthcare Providers:

- Any healthcare provider (defined as any doctor of medicine, of osteopathy, or of dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under [state licensure code], or an intern, or a resident, fellow, or medical officer licensed under [state licensure code], or a hospital, clinic or nursing home and its agents and employees, or a public hospital and its agents and employees) laboratory, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of confirmed tuberculosis or clinically suspected tuberculosis, shall notify the [TB Program] in the Department within 24 hours...Upon receipt of such notice, the [TB Program] shall notify the local board of health in the community where the case resides within 24 hours. 105 MASS. CODE REGS. 300.180 (2010).

- Physicians, pharmacists, nurses, hospital administrators, medical examiners, morticians, laboratory administrators and others who provide health care services to persons with tuberculosis or suspected tuberculosis shall report suspected and confirmed cases of tuberculosis to the department within twenty-four (24) hours.

Laboratories:

- Any person who is in charge of a clinical laboratory in which a laboratory examination of any specimen derived from the human body yields microscopical, cultural, immunological, serological, or other evidence of disease or illness as the Department may specify, shall promptly notify the official local health department or the state health department of such findings. Each notification shall give the date and result of the test performed, the name and the date of birth of the person from whom the specimen was obtained, and the name and address of the physician for whom such examination or test was performed.
- The laboratory director must report to the state or local health department the identification of, or laboratory findings suggestive of, the presence of the microbiologic organisms, diseases, or conditions listed in these rules.

Administrators:

- Every administrator [defined as the person having control or supervision over a health care facility, correctional facility, school, youth camp, child care center, preschool, or institution of higher education] shall report any person who is ill or infected with any disease listed in [reportable disease regulation] within the required timeframe, and shall make a report as set forth in [regulation specifying the method of reporting and content of reports]. Administrators may delegate these reporting requirements to a member of the staff, but this delegation does not relieve the health care provider or administrator of the ultimate reporting responsibility.

Federal or Tribal Entities:

- To the extent permitted by law, a federal or tribal entity shall comply with the reporting requirements in this Article. Examples:
 - If the federal or tribal entity is participating in the diagnosis or treatment of an individual, the federal or tribal entity shall comply with the reporting requirements for a health care provider;
 - If the federal or tribal entity is operating a facility that provides health care services, the federal or tribal entity shall comply with the reporting requirements for an administrator of a health care institution;
 - For the purposes of this Section, "federal or tribal entity" means a person operating within this state, whether on federal or tribal land or otherwise, under the authority of an agency or other administrative subdivision of the federal government or a tribal nation and who is (for example):
 - Licensed as a doctor of allopathic, naturopathic, osteopathic, or homeopathic medicine under the laws of this or another state;
 - Operating a facility that provides health care services.

Other persons or entities:

- Infection surveillance staff
- Public health officials
- Coroners
- Administrators of congregate settings
- Emergency medical service personnel, law enforcement officers, firefighters
- Persons in charge of food establishments.

Local – State Reporting

- Each local board of health shall report to the Department the occurrence or suspected occurrence of any disease reported to the board of health, pursuant to [regulation describing diseases reportable to local boards of health]. When available, the case's name, date of birth, age, sex, address and disease must be included for each report. The report shall be in a form or manner deemed acceptable by the Department. Each case shall be reported, immediately, but no later than 24 hours after receipt by the local board of health. 105 MASS. CODE REGS. 300.110 (2010).

2. Information/Data to be Reported

Descriptive Note: If states choose to adopt detailed provisions on information/data to be reported, consideration should be given to whether the provisions should be in statute or regulation (usually, promulgation of regulations would be the appropriate vehicle due to agency expertise and because regulations generally may be amended or updated more expeditiously than statutes). The first bullet below is an example of a regulation that requires reporters to complete and submit all information on the jurisdiction's form rather than listing in the statute all of the detailed information that is required to be reported. States adopting this sort of provision may choose to incorporate the form by reference. The second bullet is an example of a more detailed provision; no citation is listed because it is a combination of two existing state regulatory provisions. The third bullet is an excerpt from a California statutory provision and was specifically included in this section because it has reportedly been effective in incentivizing health facilities in the state to report individuals with suspected or confirmed TB. Few states have laws requiring reporting of latent tuberculosis infection (LTBI), but two alternate provisions are included for states considering adoption of such provisions. Where resources permit, adoption of LTBI reporting laws may facilitate surveillance and enable TB programs to identify patients who should be started on preventive treatment. Finally, four examples of laboratory reporting provisions are included, ranging from general to detailed (the third bullet relates to genotyping). No citations are included because language was changed or deleted at the recommendation of the APHL TB Steering Committee (e.g., deletion of language not relevant to TB).

- All individuals or entities reporting suspected or confirmed cases of tuberculosis shall complete and submit reports required by this rule using forms and formats approved for use by the department. A reporter using a reporting system or systems, to the extent approved by the department, is deemed to comply with the reporting requirements of this rule until such use is no longer considered active by the department.

- A report shall be submitted to the department within twenty-four (24) hours of a diagnosis of tuberculosis or upon suspicion that a person has tuberculosis. This report shall contain the following information concerning the patient diagnosed with tuberculosis or suspected of having tuberculosis:
 - Patient's name, address and county and whether the patient is homeless;
 - Telephone number;
 - Sex and date of birth;
 - Race and ethnic origin;
 - Country of origin and the month and year the patient arrived in the United States;
 - Occupation;
 - Site of the disease;
 - Chest X-ray date and its results;
 - Specimen source, smear, nucleic acid amplification, culture and drug susceptibility test results;
 - Tuberculin skin test history;
 - HIV status;
 - Whether the patient is a resident of a correctional facility;
 - Whether the patient is a resident of a long-term care facility;
 - Alcohol or drug use history;
 - Initial drug regimen;
 - Drug toxicity and monitoring records, and a listing of other patient medications to evaluate the potential for drug-drug interactions;
 - Signature of the person submitting the report; and
 - Date the report is submitted.

Updates of patients' progress or lack of progress shall be submitted to the department including, but not limited to, the latest microbiology results of cultures, any development of drug resistance, the most recent chest X-ray results, clinical symptoms and treatment. The health care provider shall report any screening of contacts, with the names and addresses and results of the screening tests of the contacts, to the local health department. Also, the health care provider shall report to the local health department the names of persons who were contacts to cases and did not return for follow-up.

- A health facility, local detention facility, or state correctional institution shall not discharge or release 1) a person known to have active tuberculosis disease, or 2) a person who the medical staff of the health facility or of the penal institution has reasonable grounds to believe has active tuberculosis disease, unless: ...notification and a written treatment plan pursuant to [statutory provision requiring disease notification report to local health officer, including an individual treatment plan] has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer. CAL. [HEALTH & SAFETY] CODE § 121361 (Deering 2009).

Latent Tuberculosis Infection (LTBI):

- Latent Tuberculosis Infection shall be reported to the local health authority or the Department of Health within three (3) calendar days of first knowledge or suspicion. MO. CODE REGS. tit. 19, § 20-20.020 (2009).

- Any health care provider, board of health or administrator of a city, state or private institution or hospital who has knowledge of a case of latent tuberculosis infection (LTBI), as diagnosed by a tuberculin skin test performed with purified protein derivative (PPD) antigen by the Mantoux method, or by any other diagnostic test approved for this purpose by the federal Food and Drug Administration, that results in a reaction that represents a positive test according to the most recently published guidelines of the U.S. Centers for Disease Control and Prevention, shall notify the [TB Program] in the Department in a written or electronic format as designated by the Department, with information regarding the name and address of the individual, date of birth, gender, size of the positive skin test or alternative test result, treatment initiated and, as requested by the Department, information about risk of exposure to tuberculosis. 105 MASS. CODE REGS. 300.180 (2010).

Laboratory Results:

- 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.
- Laboratories are required to report the following to the department:
 - Results of smears that are positive for acid-fast bacilli.
 - Results of cultures positive for any member of the *M. tuberculosis* complex (i.e., *M. tuberculosis*, *M. bovis*, *M. africanum*) or any other mycobacteria.
 - Results of rapid methodologies, including nucleic acid amplification, which are indicative of *M. tuberculosis* complex.
- Special reporting requirements for Tuberculosis:
 - Test results must also be submitted by laboratories to the state TB program [address and phone number may be added here].
 - The genotype must be reported. If genotyping is not available, the isolate must be submitted to the state public health laboratory [address and phone number may be added here]. The Department will provide the mailing materials and pay mailing costs.
- The director of a clinical laboratory conducting an examination of a specimen submitted for analysis shall report to the Department, within 24 hours of obtaining results, all positive or reactive laboratory findings which indicate the presumptive or confirmed presence of *M. tuberculosis* complex, and also any laboratory findings which are otherwise required to be reported pursuant to this section or this Article; provided that findings indicating the presumptive or confirmed presence of *M. tuberculosis* complex, as well as outbreaks or suspected outbreaks, shall also be reported to the Department immediately. A clinical laboratory which refers a specimen to another laboratory for examination shall provide to the testing laboratory all of the information the testing laboratory will need to fully comply with the reporting requirements set forth in this Code.
 - Reports shall contain all of the information and data elements required by the reporting forms or electronic reporting format approved by the Department, including but not limited to: 1) the full name, date of birth and address of the person from whom the specimen was taken; the race, ethnicity and gender of such person, if known; the date the specimen was collected; and the type of specimen;

- 2) the medical record number, if known, identification number or code assigned to the person, if any, and other personal identifiers as may be required by the Department; 3) the name, address and telephone number of the physician or other authorized health care practitioner who submitted the specimen, the health care facility, if any, that submitted the specimen, and the clinical laboratory that referred the specimen, if any; 4) the name and address of the clinical laboratory which performed the test; 5) the date the test or tests results were first available, 6) the name(s) of test or tests performed; 7) the positive or reactive results; 8) the drug susceptibility test results for *Mycobacterium tuberculosis* complex. This requirement includes traditional broth, agar and newer automated methods of drug susceptibility testing, as well as molecular-based methods that assay for molecular determinants of drug resistance.
- Reports shall also include all laboratory findings which indicate presumptive presence of tuberculosis, the results of smears found positive for acid-fast bacilli (AFB), all results including negatives and species identification on samples which had positive smears, and all drug susceptibility testing results. Such reports shall specify the laboratory methodology used and shall state whether the specimen was susceptible or resistant to each anti-tuberculosis drug at each concentration tested.
 - Reports required pursuant to this article shall be made in a manner and form prescribed by the department.

3. Penalties for Failure to Report TB

Descriptive Note: Failing to report suspected or confirmed TB cases can potentially result in detrimental health outcomes for the individual with TB and ongoing transmission. Some states impose a penalty for persons or entities failing to report as required by law. This section includes examples of several different types of legal penalties: licensure-related penalties, fines, and misdemeanor offenses. The first bullet is a provision that relates to California’s Citation and Fine Program, which has reportedly been effective in improving the level of communicable disease reporting by physicians in the state.

- Citations and Fines.
 - For purposes of this article, “board official” shall mean the chief, deputy chief or supervising investigator II of the enforcement program of the board or the chief of licensing of the board.
 - A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in [regulatory provision listing citable offenses].
 - [NOTE: The regulatory provision listing citable offenses includes a violation of the state Business and Professions Code, statutory provision on Unprofessional Conduct, for violations of the provisions relating to: the duty to report persons with any infectious, contagious, or communicable disease to the local health officer; failure to report persons with active TB; the duty to examine or refer for examination household contacts of

persons with active TB; and reporting requirements involving reportable diseases and conditions to local health officers. Source: CAL. CODE REGS. tit. 16, § 1364.11 (2009)].

- A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail. CAL. CODE REGS. tit. 16, § 1364.10 (2009).
- An individual who repeatedly fails to file any mandatory report specified in this chapter is subject to a report being made to the licensing board governing the professional activities of the individual. The department shall notify the individual each time that the department determines that the individual has failed to file a required report. The department shall inform the individual in the notification that the individual may provide information to the department to explain or dispute the failure to report. IOWA CODE § 139A.25 (2009).
- Any individual or entity, knowing of the existence of a reportable disease, who fails promptly to report the same in accordance with this section, shall be deemed guilty of a Class V misdemeanor for each offense.

4. Duty to Report Nonadherent Patients

Descriptive Note: States may consider adopting provisions requiring healthcare providers to inform public health officials when their patients with TB are nonadherent in order for public health officials to coordinate and implement any necessary public health action. Nonadherence may include leaving the hospital against medical advice, cessation of treatment, or failure to adhere to a treatment plan or other measures to prevent transmission of TB.

- When a tuberculosis patient leaves the hospital against medical advice, the administrator shall, within 24 hours thereafter, notify both the local health officer of the county responsible for the tuberculosis patient's hospital care and the local health officer of the jurisdiction to which the tuberculosis patient is believed to have gone. MICH. ADMIN. CODE r. 325.178 (2009).
- Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease. Situations in which the provider may conclude that the patient has ceased treatment include times when the patient fails to keep an appointment, relocates without transferring care, or discontinues care. CAL [HEALTH & SAFETY] CODE § 121362 (Deering 2009).
- The physician or his or her designee shall immediately report to the local health officer when a person with tuberculosis disease does any of the following:
 - Terminates treatment against medical advice.
 - Fails to comply with the medical treatment plan.
 - Fails to comply with measures to prevent transmission.

- Leaves the hospital against the advice of a physician. WIS. ADMIN. CODE [DHS] § 145.10 (2009).

5. TB Registries, Proper Disclosure/Use of TB Information, and Immunity of Reporters

Descriptive Note: States may consider having systems in place that maximize the reporting of new TB cases, minimize the reporting of duplicate suspected and confirmed TB cases, and protect the confidentiality of reports. Below are examples of provisions addressing TB registries, appropriate uses and disclosure of information contained in reports (including scientific and research use), and immunity of reporters. No citation is included for the last provision in this section because “in good faith” was added to the existing language of the state’s law.

- Each local health department shall maintain a register of all diagnosed or suspected cases of tuberculosis. In addition, each local health department shall also maintain a register of individuals to whom that health department is providing preventive therapy. Quarterly status reports on suspected and diagnosed cases shall be furnished to the department of health tuberculosis control program. WASH. ADMIN. CODE § 246-170-031 (2009).
- The [department] shall keep a register of each individual who has tuberculosis. The [department] shall have exclusive control of the register, and may not disclose information in the register about any individual to any person who is not authorized by law to have the information. MD. CODE ANN., HEALTH-GEN. § 18-322 (LexisNexis 2009).
- Reports required; confidentiality; limitations on use; immunity
 - In order to further the protection of public health, such reports and notifications may be disclosed by the department, the official local health department, and the person making such reports or notifications to the Centers for Disease Control and Prevention of the Public Health Service of the United States Department of Health and Human Services or its successor in such a manner as to ensure that the identity of any individual cannot be ascertained. To further protect the public health, the department, the official local health department, and the person making the report or notification may disclose to the official state and local health departments of other states, territories, and the District of Columbia such reports and notifications, including sufficient identification and information so as to ensure that such investigations as deemed necessary are made.
 - The appropriate board, health department, agency, or official may: 1) Publish analyses of such reports and information for scientific and public health purposes in such a manner as to ensure that the identity of any individual concerned cannot be ascertained; 2) discuss the report or notification with the attending physician; and 3) make such investigation as deemed necessary. NEB. REV. STAT. ANN. § 71-503.01 (LexisNexis 2009).
- Any information, data, and reports with respect to a case of tuberculosis that are furnished to, or procured by, a county or district tuberculosis control unit or the department of health shall be confidential and used only for statistical, scientific, and medical research for the purpose of controlling tuberculosis in this state. No physician, hospital, or other entity furnishing information, data, or reports pursuant to this chapter

shall by reason of such furnishing be deemed to have violated any confidential relationship, be held to answer for willful betrayal of a professional confidence, or be held liable in damages to any person. OHIO REV. CODE ANN. § 339.81 (LexisNexis 2009).

- Any medical practitioner, any official health department, the department, or any other person making such [tuberculosis] reports or notifications in good faith shall be immune from suit for slander or libel or breach of privileged communication based on any statements contained in such reports and notifications.

B. Screening

1. Express Legal Authority to Screen

Descriptive Note: Public health officials interrupt transmission of TB by preventing, identifying, and treating persons with TB. TB screening may include screening for latent TB infection, active TB, or both. Broad screening programs are an intervention of the past and scarce TB funds are now appropriately allocated to screening high-risk populations. This section contains examples of provisions that authorize public health officials to screen for TB.

- A health officer may conduct screening programs of populations that are at increased risk of developing tuberculosis or having latent tuberculosis infection and offer treatment as appropriate. Such screening programs may be implemented by a local health officer with the approval of the state chief medical officer. COLO. REV. STAT. § 25-4-506 (2009).
- Each local health department shall assure the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis. Services shall include: Prevention and screening, with emphasis on screening of high risk populations. WASH. ADMIN. CODE § 246-170-031 (2009).

2. Specific Individuals/Populations to be Screened

Descriptive Note: Workshop participants recommended that this section focus on innovative provisions on TB screening, rather than provisions that run the gamut of high-risk populations that may be screened. The first bullet was drafted by the APHL TB Steering Committee and relates to screening laboratory personnel for latent TB infection. Finally, the provisions below on screening students of postsecondary educational institutions have recently been enacted by the Kansas state legislature. States considering adoption of this type of TB screening law may consider defining “postsecondary educational institution” broadly to include all relevant institutions.

Laboratorians:

- Laboratory workers conducting tests on clinical specimens suspected to be positive for *Mycobacterium tuberculosis* complex (MTB) are deemed at risk for exposure to MTB. Accordingly, laboratorians should undergo baseline screening for MTB using the tuberculin skin test, interferon gamma release assay test, or other test for tuberculosis infection approved by the U.S. Food and Drug Administration upon commencement of employment. After baseline testing for MTB, the laboratorian should receive MTB

screening annually. Laboratorians who have a baseline positive or newly positive test result for MTB should receive a medical examination, a chest radiograph and other testing as needed to exclude TB disease.

Students of Postsecondary Educational Institutions:

- The [state public health official] is hereby authorized and directed to adopt rules and regulations establishing guidelines for a tuberculosis prevention and control plan for any postsecondary educational institution. The tuberculosis prevention and control plan shall be designed to reduce the risk of tuberculosis transmission and shall be based on the recommendations by the American Thoracic Society, the Centers for Disease Control and Prevention and the Infectious Diseases Society of America. These rules and regulations shall be in compliance with the best practice standards as recommended by the Division of Tuberculosis Elimination of the Centers for Disease Control and Prevention.
 - Each postsecondary educational institution shall develop and implement a tuberculosis prevention and control plan with assistance of the department of health and environment. Each postsecondary educational institution shall designate a person who is responsible for the oversight and implementation of the plan. Such person shall maintain the records created or collected in accordance with this section for at least five years and allow the department of health and environment to review and inspect the records upon request.
 - The [state public health official] is hereby authorized and directed to adopt rules and regulations establishing tuberculosis evaluation requirements for certain students entering classrooms of a postsecondary educational institution in [state] who are considered as high risk for tuberculosis as defined by the department of health and environment. These rules and regulations shall establish evaluation criteria in compliance with best practice standards as recommended by the Division of Tuberculosis Elimination of the Centers for Disease Control and Prevention.
 - Each postsecondary educational institution shall develop and implement tuberculosis evaluation requirements with assistance of the department of health and environment. Each postsecondary educational institution shall designate a person who is responsible for the oversight and implementation of the requirements. Such person shall maintain the record for at least five years and the department of health and environment shall have the right to review and inspect the records upon request. Such person shall report immediately the positive findings of tuberculosis infection or disease to the department of health and environment.
 - Each student entering classrooms of a postsecondary educational institution in [state] shall comply with the tuberculosis evaluation requirements implemented by such institution where the student is enrolled by providing requested information in accordance with a screening and evaluation through an enrollment process. Any student who is not in compliance with the requirements shall not be attending classes or eligible to enroll for a subsequent semester or term or to obtain an official academic transcript or diploma until the student is compliant with the requirements.

- Nothing in this section and section 1, and amendments thereto, shall be construed as applying to individuals who are not attending the classes regularly but participating in the continuing education programs or any other seminar or function at the postsecondary educational institution.
- “Postsecondary educational institution” used in this section and section 1, and amendments thereto, means any public or private university, municipal university, community college or technical college.
- All costs associated with the evaluation requirements of the prevention and control plan shall be the responsibility of the student.
- Any person found to be infected with tuberculosis infection or tuberculosis disease will be provided treatment and ongoing monitoring in accordance with [state TB prevention and control laws]. KAN. STAT. ANN. § 65-129e (2010).

C. Laboratory Testing

Descriptive Note: Most of the provisions in this section are excerpts from existing laboratory reporting regulations but may be characterized as laboratory testing laws. The first bullet below is an example of a provision that may be utilized, where resources permit, in states desiring to require specimens to be sent to the department’s public health laboratory for confirmation. The second bullet is an example of a provision that might be more appropriate for high incidence states or states with fewer resources that want isolates sent to the department’s public health laboratory, but do not want to require it to confirm identification or drug susceptibilities for all cases. The second bullet may also be utilized for genotyping purposes. The fourth bullet requiring rapid testing along with culture facilitates earlier detection of TB, positively impacting patient care. The APHL TB Steering Committee drafted the provision on nucleic acid amplification testing, which is designed to encourage use of such testing.

- A physician who diagnoses a case of tuberculosis must ensure that a specimen from the individual is sent to the department's public health laboratory, if the individual has pulmonary, laryngeal, or pleural tuberculosis and he/she is able to produce a sputum sample with or without induction. Whenever a clinical laboratory finds a specimen tests positive for *M. tuberculosis* complex or acid-fast bacilli, the laboratory must forward the specimen to the department's public health laboratory for confirmation of the results and drug susceptibility testing.
- A laboratory that initially receives any clinical specimen which yields *Mycobacterium tuberculosis* complex, or yields a preliminary result indicative of *Mycobacterium tuberculosis* complex, is responsible for ensuring that the following are submitted:
 - 1) All preliminary results and any interpretation of those results to the appropriate local health department.
 - 2) The first *Mycobacterium tuberculosis* complex isolate, or subculture thereof, from the patient being tested for tuberculosis, to the department.
 - 3) Any *Mycobacterium tuberculosis* complex isolate, or subculture thereof, from a follow-up specimen, collected 90 days or more after the collection of the first *Mycobacterium tuberculosis* complex positive specimen. MICH. ADMIN. CODE r. 325.179 (2009).

- In order to ensure susceptibility testing, laboratories shall submit a representative and viable sample of the initial culture positive for any member of the *M. tuberculosis* complex to the state laboratory or other laboratory designated by the board to receive such specimen.
- Any laboratory that performs primary culture for mycobacteria shall also perform bacterial identification for *Mycobacterium tuberculosis* complex using an approved rapid testing procedure specified by the department by rule or have access to rapid *M. tuberculosis* complex identification directly from the positive primary culture via a reference or public health laboratory. The results of the identification test shall be available within 24-72 hours of detection of the positive culture.
 - Laboratories that provide mycobacteriology services shall provide nucleic acid amplification testing (NAA) or equivalent testing upon request for the purpose of early detection of *M. tuberculosis* complex in clinical specimens. Laboratories that are unable to provide this service shall have a regular and efficient arrangement with a reference laboratory for prompt NAA testing. When a physician requests NAA testing for detection of *M. tuberculosis* complex in a patient specimen, results shall be available within 72 hours (whether testing is performed in-house or referred to a reference laboratory).
 - Any laboratory that identifies *Mycobacterium tuberculosis* complex 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.
 - Any laboratory that performs primary culture for mycobacteria shall perform mycobacterial identification using an approved rapid testing procedure specified in the “Assessing Your Laboratory” document by the Association of Public Health Laboratories, unless specified otherwise by the TB controller.

D. Examination

1. Examination of TB Suspects

Descriptive Note: Examination enables public health officials to identify TB cases, facilitating immediate initiation of an appropriate treatment regimen for individuals who are found to have TB disease. The first two bullets below are examples of state statutory provisions that authorize public health officials to issue an order for examination (the second provision also specifically imposes a duty upon the individual suspected of having communicable TB to submit to examination), and the third bullet is an example of a state law that authorizes public health officials to petition the court directly for an order for examination. The final bullet is an example of a regulatory provision that contains detailed requirements for diagnostic evaluations.

- Whenever a health officer determines on reasonable grounds that an examination of any person is necessary for the preservation and protection of the public health, the health officer shall issue a written order directing medical examination, setting forth the name of the person to be examined, the time and place of the examination, and such other terms and conditions as the health officer may deem necessary. A copy of such order shall be served upon the person. Such an examination may be made by a licensed physician or

advanced practice nurse of the person's own choice under such terms and conditions as the health officer shall specify. COLO. REV. STAT. ANN. § 25-4-506 (2009).

- When any health officer shall have reasonable grounds to believe that any person has tuberculosis in a communicable form and will not voluntarily seek a medical examination, it shall be the duty of such health officer to order such person, either orally or in writing, to undergo an examination by a physician qualified in chest diseases, or at some clinic or medical care facility qualified to make such examinations. It shall be the duty of such suspected person to present himself or herself for examination at such time and place as ordered by the health officer. The examination shall include an x-ray of the chest, examination of sputum, and such other forms and types of examinations as shall be approved by the [public health official]. KAN. STAT. ANN. § 65-116b (2009).
- Application to require examination or treatment for tuberculosis.
 - The department or a local board may apply for an order from the district court if a person is reasonably suspected to have or to have been exposed to tuberculosis, upon request of: a physician legally authorized to practice medicine in the state; the department; or a local health officer.
 - The application must request that the person be ordered to: submit to an examination for tuberculosis and, if the person is found to have tuberculosis, to complete an approved course of treatment; or enter or return to a treatment location to complete an approved course of treatment.
 - The application for an order [described above] must allege that the person: is suspected of having tuberculosis or has been exposed to tuberculosis and has refused to be examined for tuberculosis as required by rules adopted by the department; or has tuberculosis and has refused to be treated or to complete an approved course of treatment.
 - The application must state the names of witnesses by which facts alleged may be proved. At least one witness must be a physician. MONT. CODE ANN. § 50-17-105 (2009).
- Diagnostic evaluations
 - 1) The designated public health nurse case manager for the health jurisdiction of residence shall monitor and facilitate timely diagnostic evaluation of all patients with suspected or confirmed infectious or potentially infectious TB disease, identified contacts to these patients and Class B1 or B2 referrals, regardless of the type of health care provider.
 - [NOTE: “Class B1 or B2 referrals” means referrals from the CDC's Division of Global Migration and Quarantine, which informs the Department of persons who are refugees, parolees, asylees, or recent legal immigrants to the United States, and who were screened overseas and classified as either B1 meaning TB, clinically active, not infectious or B2 meaning TB, not clinically active, not infectious. These classifications are made within 12 months of immigration and these referrals require evaluation of their TB status within 30 days of arrival to prevent potential transmission. Source: N.J. ADMIN. CODE § 8:57-5.3 (2010)].
 - 2) Where a health care provider, based on direct observation or other written clinical and/or laboratory findings, believes that a patient has suspected or confirmed infectious or potentially infectious TB disease, the health care provider

shall schedule an appointment for a diagnostic evaluation in his or her office or by referral within five business days of such observation.

- 3) The public health nurse case manager shall schedule a diagnostic evaluation in the public health clinic within 10 working days after notification of discharge of a [state] resident with suspected or confirmed infectious or potentially infectious TB disease from a hospital or correctional facility inside or outside [State], if the patient will be managed by a public health TB clinic.
- 4) The public health nurse case manager shall schedule any contact or Class B1 or B2 referral identified or located during an investigation for a diagnostic evaluation in the public health clinic within 20 working days after identification or notification by the Department's TB Program of his or her residence in the public health nurse case manager's health jurisdiction.
- 5) A diagnostic evaluation for a person with suspected or confirmed infectious or potentially infectious TB shall consist of at least a physical examination including visual acuity testing, a chest x-ray, sputum collection or induction and laboratory testing.
 - The health care provider may utilize the Department's TB Standards of Care as a guideline for appropriate practice.
- 6) A diagnostic evaluation of a contact or Class B1 or B2 referral shall consist of at least a Mantoux tuberculin skin test or an interferon gamma release assay, and a chest x-ray if the skin test is considered significant or the interferon gamma release assay is positive.
 - If active TB disease is suspected based on the results of the diagnostic evaluation, the health care provider shall complete the requirements at [5] above.
 - The health care provider may utilize the Department's TB Standards of Care as a guideline for appropriate practice. N.J. ADMIN. CODE § 8:57-5.8 (2010).

2. Examination of Contacts

Descriptive Note: The provisions in this section are examples of state laws addressing examination of contacts to individuals with active TB, ranging from general requirements to specific.

- The local health officer or the department may order an examination of a contact to detect tuberculosis. Contacts shall be reexamined at times and in a manner as the local health officer may require. WIS. ADMIN. CODE [DHS] § 145.10 (2009).
- A physician who attends a case of active tuberculosis shall examine or cause all household contacts to be examined or shall refer them to the Department for examination. The physician shall promptly notify the Department of such referral. When required by the Department, non-household contacts and household contacts not examined by a physician shall submit to examination by the Department. An examination required by this section shall include such tests as may be necessary to diagnose the presence of tuberculosis, including but not limited to tuberculin tests, [blood] tests for tuberculosis infection, and where indicated, laboratory examinations, and x-rays. If any suspicious

abnormality is found, steps satisfactory to the Department shall be taken to refer the person promptly to a physician or appropriate medical facility for further investigation and, if necessary, treatment. Contacts shall be re-examined at such times and in such manner as the Department may require. When requested by the Department, a physician shall report the results of any examination of a contact. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009). [NOTE: the term “blood” in brackets replaced the term “serologic,” and the legal citation was retained].

- The health officer shall evaluate for tuberculosis infection any contact of a case having active tuberculosis. A tuberculosis screening test must be administered to a contact residing in the same household as the case or other similarly close contact. If the tuberculosis screening test is negative, the tuberculosis screening test must be repeated 8 to 10 weeks after the last date of exposure to the case having active tuberculosis. If the initial or second tuberculosis screening test is positive, the contact must be referred for a chest radiograph and medical evaluation for active tuberculosis. Any contact found to have active tuberculosis or tuberculosis infection must be advised to complete an effective course of treatment in accordance with the recommendations for the counseling of and effective treatment for a person having active tuberculosis or tuberculosis infection in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference.
 - A child or other high-risk contact whose initial tuberculosis screening test administered pursuant to [above] is negative must be advised to take preventive treatment, unless medically contraindicated. Preventive treatment may be discontinued if the second tuberculosis screening test administered pursuant to [above] is negative.
 - The health officer may issue an order for a medical examination to any contact who refuses to submit to a medical examination pursuant to [above], to determine if the contact has active tuberculosis or tuberculosis infection.
 - A contact of a case having tuberculosis or suspected case considered to have tuberculosis shall comply with all rules and regulations issued by the State Board of Health and shall submit to a medical evaluation to determine the presence of active tuberculosis or tuberculosis infection.
 - If the tuberculosis screening test administered pursuant to [above] is positive, or if there is radiological evidence of active tuberculosis in the lungs, the contact shall submit to further medical evaluation. An order to submit to a medical examination may be issued by the health officer if the contact fails to report for a medical evaluation when requested to do so by the health officer. NEV. ADMIN. CODE § 441A.355 (2009); NEV. ADMIN. CODE § 441A.365 (2009).

V. Case Management

A. Authority of Public Health Officials to Implement Disease Control Measures and Enforcement/Validation of Orders

1. Authority to Implement Disease Control Measures

Descriptive Note: The majority of states have enacted laws authorizing public health officials to issue administrative orders (usually called “health officer orders”) for certain disease control measures rather than requiring a court order to compel behavior. These states may prefer administrative mechanisms because they tend to be faster and more efficient than seeking a court order in the first instance. This section contains examples of existing provisions that describe roles and responsibilities of public health officials and authorize them to implement a variety of different disease control measures. Conversely, some states have enacted laws authorizing public health officials to petition the court for an order in the first instance. These states may prefer this approach because they have experienced problems with enforcement of administrative orders as compared to court orders.

- Special diseases--Tuberculosis.
 - Health care providers diagnosing or caring for a person with tuberculosis, whether pulmonary or nonpulmonary, shall:
 - 1) Report the case to the local health officer or local health department in accordance with the provisions of this chapter, and
 - 2) Report patient status to the local health officer every three months or as requested.
 - The local health officer or local health department shall:
 - 1) Have primary responsibility for control of tuberculosis within the designated jurisdiction;
 - 2) Maintain a tuberculosis control program including:
 - Prophylaxis,
 - Treatment,
 - Surveillance,
 - Case finding,
 - Contact tracing, and
 - Other aspects of epidemiologic investigation;
 - 3) Maintain a tuberculosis register of all persons with tuberculosis, whether new or recurrent, within the local jurisdiction including information about:
 - Identification of patient,
 - Clinical condition,
 - Epidemiology of disease,
 - Frequency of examinations;
 - 4) Impose isolation of a person with tuberculosis in an infectious stage if that person does not observe precautions to prevent the spread of the infection;
 - 5) Designate the place of isolation when imposed;
 - 6) Release the person from isolation when appropriate;
 - 7) Maintain and provide outpatient tuberculosis diagnostic and treatment services as necessary, including public health nursing services and physician consultation; and
 - 8) Submit reports of all cases to the department in accordance with the provisions of this chapter.
 - When a person with tuberculosis requires hospitalization:

- 1) Hospital admission shall occur in accordance with procedures arranged by the local health officer and the medical director or administrator of the hospital, and
 - 2) The principal health care provider shall:
 - Maintain responsibility for deciding date of discharge, and
 - Notify the local health officer of intended discharge in order to assure appropriate outpatient arrangements. WASH. ADMIN. CODE § 246-100-211 (2009).
- Where the health officer determines that the public health or the health of any other person is endangered by a case of tuberculosis, or a suspected case of tuberculosis the health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of such orders. In any court proceeding for enforcement, the health officer shall demonstrate the particularized circumstances constituting the necessity for an order. In any court proceeding for enforcement, the health officer shall demonstrate the particularized circumstances constituting the necessity for an order. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009).
- The department may instruct a case or [person suspected of having TB] of a reportable disease regarding public health measures for preventing the spread of the disease and of the necessity for treatment until cured or free from the infection. If the department knows or has reason to believe, because of medical or epidemiological information, that a person has a reportable disease and is a health threat to others, it may issue a public health notice directing the person to take one or more of the following actions:
 - 1) To be examined or tested to determine whether the person has a reportable disease in an infectious stage;
 - 2) To report to a physician, health care worker, or authorized department representative for counseling on the reportable disease and for information on how to avoid infecting others;
 - 3) To receive treatment until cured or free from the infection and to follow measures for preventing reinfection;
 - 4) To cease from specified conduct which endangers the health of others; or
 - 5) To cooperate with the department in implementation of recommended public health measures.

The department may use restrictive public health measures only if other measures to protect the public health have failed, including efforts to obtain the voluntary cooperation of the person who may be the subject of such measures. The department shall apply public health measures as necessary to achieve the desired purpose of protecting the public health, using the least intrusive measures first. S.D. ADMIN. R. 44:20:03:04 (2009).

- Whenever the health officer shall determine that treatment or isolation in a particular case is necessary for the preservation and protection of the public health, he or she shall make an order to that effect in writing, setting forth the name of the person, the period of time during which the order shall remain effective, the place of treatment or isolation and such other terms and conditions as may be necessary to protect the public health.

- Upon the making of an examination, treatment, or isolation order as provided in this section, a copy of such order shall be served upon the person named in such order.
- Upon the receipt of information that any examination, treatment, or isolation order, made and served as herein provided, has been violated, the health officer shall advise the prosecuting attorney of the county in which such violation has occurred, in writing, and shall submit to such prosecuting attorney the information in his or her possession relating to the subject matter of such examination, treatment, or isolation order, and of such violation or violations thereof.
- Any and all orders authorized under this section shall be made by the health officer or his or her tuberculosis control officer. WASH. REV. CODE ANN. § 70-28-031 (LexisNexis 2009).

2. Enforcement/Validation of Orders

Descriptive Note: States may consider incorporating an enforcement mechanism in laws that authorize public health officials to issue administrative orders compelling behavior if the order is violated. This section contains examples of enforcement provisions.

- In addition to the proceedings set forth in [statutory provision on powers and duties of health officers], where a local health officer has reasonable cause to believe that an individual has tuberculosis as defined in the rules and regulations of the state board of health, and the individual refuses to obey the order of the local health officer to appear for an initial examination or a follow-up examination or an order for treatment, or isolation, the health officer may apply to the superior court for an order requiring the individual to comply with the order of the local health officer. WASH. REV. CODE ANN. § 70-28-035 (LexisNexis 2009).
- Upon the receipt of information that any order has been violated, the health officer shall advise the district attorney of the county in which the violation has occurred, in writing, and shall submit to the district attorney the information in his or her possession relating to the subject matter of the order, and of the violation or violations thereof. CAL. [HEALTH & SAFETY] CODE § 121365 (West 2009).

B. Investigation

1. Coordination of and Authority and Guidelines for Conducting Investigations

Descriptive Note: Investigation is a fundamental component of TB prevention and control. This section contains examples of provisions that provide: 1) authority for conducting investigations, 2) guidance on how investigations should be carried out and what they should entail, and 3) instruction concerning coordination of investigations.

- Each local health officer is hereby directed to use every available means to ascertain the existence of, and immediately investigate all reported or suspected cases of active tuberculosis disease in the jurisdiction, and to ascertain the sources of those infections. In carrying out the investigations, each local health officer shall follow applicable local rules and regulations and all general and special rules, regulations, and orders of the state department. CAL [HEALTH & SAFETY] CODE § 121365 (Deering 2009).
- The department shall conduct or oversee the investigation, control, and monitoring of suspected or confirmed tuberculosis infection and disease within the state. Local health departments shall investigate, control, and monitor suspected or confirmed tuberculosis infection and disease within their respective jurisdictions. UTAH CODE ANN. § 26-6-8 (LexisNexis 2009).
- Reportable diseases
 - The authority or local public health administrator may investigate a case of a reportable disease, disease outbreak or epidemic. The investigation may include, but is not limited to:
 - Interviews of: 1) The subject of a reportable disease report; 2) Controls; 3) Health care providers; or 4) Employees of a health care facility.
 - Requiring a health care provider, any public or private entity, or an individual who has information necessary for the investigation to: 1) Permit inspection of the information by the authority or local public health administrator; and 2) Release the information to the authority or local public health administrator.
 - The authority shall establish by rule the manner in which information may be requested and obtained under [provisions directly above].
 - Information requested may include, but is not limited to, individually identifiable health information related to: 1) The case; 2) An individual who may be the potential source of exposure or infection; 3) An individual who has been or may have been exposed to or affected by the disease; 4) Policies, practices, systems or structures that may have affected the likelihood of disease transmission; and 5) Factors that may influence an individual's susceptibility to the disease or likelihood of being diagnosed with the disease. OR. REV. STAT. ANN. § 433.004 (West 2009).
- Upon receipt of a disease report pursuant to this article, the department may investigate the circumstances surrounding the occurrence of the reportable disease or condition to determine the authenticity of the report and to determine what public health measures have been given or should be provided. The department's investigation and actions may include the following:
 - Confer and coordinate with the physician, hospital, laboratory, institution, or person making the report;
 - Inspect premises pursuant to [state isolation statute];
 - Recommend the collection of laboratory specimens that may be necessary to confirm the diagnosis of the disease or to determine the source of the infection or epidemic;
 - Conduct an epidemiological investigation and record the findings on a case, [suspect], or epidemic;

- Ascertain the source of the infectious agent, identify unreported cases, and evaluate contacts;
 - Recommend or implement public health measures;
 - Provide information concerning the reportable disease and its prevention to the case, [suspect], contact, or a responsible member of such a person's household or institution to prevent further spread of the disease; and
 - Forward a report regarding a person residing in another state to the respective state public health authority or to the national Centers for Disease Control and Prevention for the purpose of effective interstate communicable disease control. S.D. ADMIN. R. 44:20:02:07 (2009).
- A local health officer who conducts an investigation pursuant to this article shall immediately notify the tuberculosis control officer of the existence and nature of the disease and of the measures taken to control tuberculosis. The local health officer shall keep the tuberculosis control officer informed of the prevalence of the disease as prescribed by the department. ARIZ. REV. STAT. § 36-723 (LexisNexis 2009).
 - A health care provider and a public, private, or hospital clinical laboratory shall assist in a disease investigation conducted by the department, a local board, or local department. A health care provider and a clinical laboratory shall provide the department, local board, or local department with all information necessary to conduct the investigation, including but not limited to medical records; exposure histories; medical histories; contact information; and test results necessary to the investigation, including positive, pending, and negative test results. IOWA ADMIN. CODE r. 641-1.7(135,139A) (2009).

2. Contact Investigations

Descriptive Note: Public health officials investigate TB exposure and transmission and prevent future cases of TB through contact investigations. According to guidelines issued jointly by the National Tuberculosis Controllers Association (NTCA) and CDC, a contact investigation should be considered if the index patient has suspected or confirmed pulmonary, laryngeal, or pleural TB. The provisions in this section relate to contact investigations; the final bullet below is an Indiana regulatory provision that has reportedly been effective in focusing contact investigations. When choosing to incorporate specific documents by reference, such as the NTCA/CDC contact investigation guidelines, states may consider adding “as amended and supplemented” to include the most current version or supplement to the cited document.

- The department and its authorized agents may counsel and interview, or cause to be counseled and interviewed, any person who has active tuberculosis, who is reasonably suspected of having active tuberculosis, or who is reasonably suspected of having been exposed to active tuberculosis, in order to investigate the source and spread of the disease and in order to require such person to submit to examination and treatment to cure as necessary. All information gathered in the course of contact investigation is confidential, subject to the provisions of [tuberculosis confidentiality statute]. Such information is exempt from [inspection under the public records statute]. FLA. STAT. ANN. § 392.54 (LexisNexis 2009).
- The initial case assessment and contact investigation by the local board of health shall begin within three working days of notification of a potential case of tuberculosis.

Contacts to the case shall be identified and categorized for their risk of tuberculosis infection as determined by their level of exposure and the person's potential for generating air-borne tubercle bacilli (droplet nuclei). Contacts shall be investigated according to the ATS/CDC standards and the policies of the [state TB control program]. Contact investigation reports shall be prepared and given to the [regional TB nurse] for the region, according to the policies developed by the [state TB control program]. 105 MASS. CODE REGS. 365.200 (2009).

- For confirmed and suspected cases of pulmonary, laryngeal, or pleural tuberculosis, a contact investigation shall be performed, identifying both high and medium priority contacts. Prioritization of contacts is to be assigned in accordance with Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis. Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR; December 16, 2005; Vol. 54; No. RR-15. Priority is based on the likelihood of infection and the potential hazards to the individual contact infected.
 - Prioritization of contacts exposed to persons with acid-fast bacilli (AFB) sputum positive or cavitary tuberculosis (TB) cases is as follows:
 - High-priority contacts include the following: household contacts; Children less than five (5) years of age; persons with medical risk factors, including HIV; persons exposed during medical procedures; persons exposed in a congregate setting; persons that exceed duration of environment limits as determined on a case-by-case basis by the department TB control program.
 - Medium-priority contacts include the following: children five (5) to fifteen (15) years of age; persons that exceed duration of environment limits as determined on a case-by-case basis by the department TB control program.
 - Prioritization of contacts exposed to persons with AFB sputum negative TB cases with abnormal chest radiographs is as follows:
 - High-priority contacts include the following: children less than five (5) years of age; persons with medical risk factors, including HIV; persons exposed during medical procedures.
 - Medium-priority contacts include the following: household contacts; persons exposed in a congregate setting; persons that exceed duration of environment limits as determined on a case-by-case basis by the department TB control program. 410 IND. ADMIN. CODE 1-2.3-106 (2009).

C. Treatment

1. Case Management, Treatment Guidelines, and Required Treatment

a. Case Management and Treatment Plans

Descriptive Note: Case management is a critical part of TB programs' and healthcare providers' efforts toward ensuring that patients with TB are managed properly, rendered noninfectious, and cured of their disease. Patients with TB often face issues that complicate and can act as barriers

to treatment, such as substance abuse, homelessness, unemployment, and lack of healthcare access. Effective case management may obviate the need for legal interventions. Case management requirements may appear in the form of guidelines or policy manuals, but some states have chosen to include case management provisions in their statutes and regulations. The second and third bullets below are examples of such laws, and have reportedly been effective in Florida and Massachusetts. The fourth bullet relates to case management in that it ensures continuity of care for patients with TB who are discharged from a hospital or any other institution which provides health care to residents.

- The department shall have the power and authority, and it shall be the duty of such department, to consult with physicians, hospitals, institutions, and individuals engaged in diagnosing and treating [persons with tuberculosis], provide to such persons and institutions clinical information, and refer cases for diagnosis and treatment upon the request of attending physicians. S.D. CODIFIED LAWS § 34-22-13 (2009).
- The department, its authorized representatives, or a physician licensed under [state licensure laws] shall prescribe an individualized treatment plan for each person who has active tuberculosis. The goal of the treatment plan is to achieve treatment to cure by the least restrictive means. The department shall develop, by rule, a standard treatment plan form that must include, but is not limited to, a statement of available services for treatment, which includes the use of directly observed therapy; all findings in the evaluation and diagnostic process; measurable objectives for treatment progress; and time periods for achieving each objective. Each treatment plan must be implemented through a case management approach designed to advance the individual needs of the person who has active tuberculosis. The person's progress in achieving the objectives of the treatment plan must be periodically reviewed and revised as necessary, in consultation with the person. FLA. STAT. ANN. § 392.64 (LexisNexis 2009).
 - An individualized treatment plan shall be prescribed by providers licensed under [state licensure laws], for each person in their care who has suspected or confirmed active tuberculosis.
 - The treatment plan must be consistent with current standards of medical practice and include information regarding: 1) provisions for treatment to cure; 2) provisions for follow-up; 3) delivery of treatment, e.g., directly observed therapy if appropriate; 4) a case management approach as defined by department guidelines.
 - The treatment plan must be documented on [department form], incorporated by reference and available at [insert link here].
 - The county health department director, administrator or their designee shall document the case management approach as defined in department guidelines [name of department form], incorporated by reference, available at [link to website].
 - The county health department shall provide a complete explanation of tuberculosis, the medical risks associated with tuberculosis, the need to comply with the prescribed course of the treatment plan, and the consequences of non-compliance with the treatment plan to each patient suspected or proven to have tuberculosis, to the patient's legal guardian or to the patient's caregiver. The explanation shall be culturally, developmentally, educationally and linguistically

appropriate and tailored to the understanding of the patient, the patient's legal guardian or the patient's caregiver. FLA. ADMIN. CODE ANN. r. 64D-3.043 (2009).

- Case Management
 - Case management for tuberculosis is defined as the coordination of the necessary medical, nursing, outreach, and social service systems which ensure that all persons with confirmed [or] clinically suspected tuberculosis are started on appropriate therapy, and that all persons with confirmed tuberculosis complete an appropriate and effective course of treatment. [NOTE: "Or" in brackets replaced "and," and the legal citation was retained].
 - The [state TB program] shall assign [regional TB nurses], as necessary, to work cooperatively and in consultation with local board of health authorities and the nurse case manager, designated by the local board of health, to ensure that a case management system is in place for every confirmed or clinically suspected case of tuberculosis.
 - The following measures are a requirement of the case-management system:
 - 1) The case shall be reported to the [state TB program], as required by [state law].
 - 2) All persons with confirmed and clinically suspected tuberculosis shall have a nurse case manager designated by the local board of health who will work in consultation and cooperation with the [regional TB nurse], as necessary, to manage persons with confirmed or clinically suspected tuberculosis. This case management is required regardless of the source of health care (public or private) and the ability to pay for the services or medications.
 - 3) In consultation with the treating health care provider, the nurse case manager, designated by the local board of health, determines that a medical treatment plan is in place and is in accordance with the American Thoracic Society (ATS) and federal Centers for Disease Control and Prevention (CDC) standards for care.
 - 4) The initial case assessment and contact investigation by the local board of health shall begin within three working days of notification of a potential case of tuberculosis. Contacts to the case shall be identified and categorized for their risk of tuberculosis infection as determined by their level of exposure and the person's potential for generating air-borne tubercle bacilli (droplet nuclei). Contacts shall be investigated according to the ATS/CDC standards and the policies of the [state TB program]. Contact investigation reports shall be prepared and given to the [regional TB nurse] for the region, according to the policies developed by the [state TB program].
 - 5) Starting with the first visit to a potential case by the nurse designated by the local board of health, there shall also be an assessment of whether there are factors which affect adherence with therapy. This includes, but is not limited to: poor access to health care facilities; homelessness; work schedules; poverty; language barriers; cultural beliefs; substance abuse; mental health status; recent immigration; and medical conditions which may interfere with treatment.

verified as valid and stable, and had sputum smears initially positive for AFB.

- The patient must have three consecutive sputum smears negative for AFB collected at least eight hours apart;
 - The patient must have a nucleic acid amplification test negative for *M. tuberculosis*;
 - The patient must have at least one sputum culture negative for *M. tuberculosis* after initiation of appropriate anti-tuberculosis treatment; or
 - The Department's TB Program may grant an exception based upon clinical evidence and interview of the patient; or
- 4) The patient is a resident of a congregate living facility, is homeless or has reported a private residence that the public health department has not verified as valid and stable, and has no sputum smears positive for AFB, and has been on appropriate anti-TB medications for a period of at least two weeks and has no respiratory symptoms.
- The Department's [hospital licensing division] may investigate a hospital's discharge of a patient who does not meet one of the criteria set forth at [first sub-bullet under “Hospital Discharge”] above.
 - Any hospital that fails to discharge a patient in accordance with [first sub-bullet under “Hospital Discharge”] above may be subject to penalties for licensure violations as identified by the Department's Division of Health Facilities Evaluation and Licensure. N.J. ADMIN. CODE § 8:57-5.5 (2009).

b. Treatment Guidelines

Descriptive Note: This section contains examples of provisions relating to treatment guidelines; one is general and the other specifically incorporates current CDC/ATS guidelines. When choosing to incorporate specific documents by reference, states may consider adding “as amended and supplemented” to include the most current version or supplement of the cited document.

- A health care provider who treats an individual with suspected or confirmed tuberculosis shall treat the individual according to guidelines established by the department. UTAH CODE ANN. § 26-6-8 (LexisNexis 2009).
- Treatment and control.
 - The Department incorporates by reference the ATS/CDC treatment standards as described in the segment entitled “Centers for Disease Control and Prevention. Treatment of Tuberculosis, American Thoracic Society, CDC, and Infectious Diseases Society of America. MMWR 2003;52 (No. RR-11),” Centers for Disease Control and Prevention. Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society; CDC, and the Infectious Diseases Society of America. MMWR 2005; 54 (No. RR-12),” and “Centers for Disease Control and Prevention. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection. MMWR 2000; 49 (No. RR-6).” In treating

tuberculosis, health care providers must adhere to the standards listed in these documents.

- A health-care provider who treats an individual with tuberculosis disease shall use the ATS/CDC treatment standards as a reference for the development of a comprehensive treatment and follow-up plan for each individual. The plan shall be developed in cooperation with the individual and approved by the local health department or the Program. Health-care providers shall routinely document an individuals' adherence to prescribed therapy for tuberculosis infection and disease. If isolation is indicated, the plan for isolation shall be approved by the local health department or the Program. UTAH ADMIN. CODE r. 388-804-6 (2009).

c. Required Treatment

Descriptive Note: The provisions in this section are examples of laws that require individuals with TB to be treated; the first bullet grants authority to the health officer to issue an order requiring treatment, the second bullet authorizes health officials to petition the court for an order requiring treatment, and the third bullet requires the individual with TB to seek treatment. Language requiring “treatment to cure” may be considered for active TB treatment provisions. The final two bullets address treatment for latent tuberculosis infection (LTBI). Treatment of LTBI is generally initiated after the possibility of TB disease is excluded, and has been proven to greatly reduce the risk that individuals latently infected with TB will progress to TB disease.

- Where the health officer determines that the public health or the health of any other person is endangered by a case of tuberculosis or a suspect case of tuberculosis, the health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of such orders. In any court proceeding for enforcement, the health officer shall demonstrate the particularized circumstances constituting the necessity for an order. Such orders may include, but shall not be limited to:
 - An order requiring a person who has active tuberculosis to complete an appropriate prescribed course of medication for tuberculosis and, if necessary, to follow required contagion precautions for tuberculosis. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009).
- Physical Examination and Treatment
 - 1) Subject to the provisions of subsections 3) and 4), the department and its authorized representatives may petition the circuit court to examine or cause to be examined, or treat to cure or cause to be treated to cure, any person who has, or is reasonably suspected of having or having been exposed to, active tuberculosis.
 - 2) Subject to the provisions of subsections 3) and 4), a person who has active tuberculosis or is reasonably suspected of having or having been exposed to active tuberculosis shall report for complete examination or treatment to cure, as appropriate, on an outpatient basis to a physician licensed under [state licensure law], or shall submit to examination or treatment to cure, as appropriate, at a county health department or other public facility. When a person has been diagnosed as having active tuberculosis, he or she shall continue with the

prescribed treatment on an outpatient basis, which includes the use of directly observed therapy, until such time as the disease is determined to be cured.

- 3) A person may not be apprehended or examined on an outpatient basis for active tuberculosis without consent, except upon the presentation of a warrant duly authorized by a circuit court. In requesting the issuance of such a warrant, the department must show by a preponderance of evidence that a threat to the public health would exist unless such a warrant is issued and must show that all other reasonable means of obtaining compliance have been exhausted and that no other less restrictive alternative is available.
- 4) A warrant requiring a person to be apprehended or examined on an outpatient basis may not be issued unless:
 - A hearing has been held with respect to which the person has received at least 72 hours' prior written notification and has received a list of the proposed actions to be taken and the reasons for each such action. However, with the consent of the person or the person's counsel, a hearing may be held within less than 72 hours.
 - The person has the right to attend the hearing, to cross-examine witnesses, and to present evidence. After review and consultation by the court, counsel for the person may waive the client's presence or allow the client to appear by television monitor where available.
 - The court advises the person of the right to have legal counsel present. If the person is insolvent and unable to employ counsel, the court shall appoint legal counsel for the person pursuant to the indigence criteria in [determination of indigence law].
- 5) The circuit court, legal counsel, and local law enforcement officials, as appropriate, shall consult with the department concerning any necessary infection control procedures to be taken during any court hearing or detention. FLA. STAT. ANN. § 392.55 (LexisNexis 2009).
- If, upon examination, it shall be determined that such person has tuberculosis in an active stage or in a communicable form, then it shall be the duty of such [person with tuberculosis] to arrange for admission of himself or herself as a patient in some medical care facility qualified to treat persons with tuberculosis or when there is no danger to the public or to other individuals as determined by the health officer, such person may receive treatment on an outpatient basis. KAN. STAT. ANN. § 65-116b (2009).

Treatment for LTBI

- Before therapy is started, persons with a positive TB screening test result shall receive a diagnostic evaluation for TB disease...If there is no evidence of disease, persons with TB infection should be considered for preventive therapy. Preventive therapy shall be conducted in accordance with the [incorporated publication]... ILL. ADMIN. CODE tit. 77, § 696.150 (2009).
- The health officer shall: 1) Direct that testing for tuberculosis infection using a Centers for Disease Control and Prevention approved method be performed on contacts of cases of tuberculosis in a communicable stage. 2) Recommend appropriate treatment for latent tuberculosis infection; and 3) Provide for the supervised presumptive treatment of latent tuberculosis infection for a child younger than 4 years old identified as a close contact to

a confirmed case or suspected case of active pulmonary tuberculosis. MD. CODE REGS. 10.06.01.21 (2009).

2. Directly Observed Therapy (DOT)

Descriptive Note: Directly observed therapy (DOT) may be defined as a course of treatment, or preventive treatment, for TB in which the prescribed course of medication is administered to the person or taken by the person under direct observation by a trained healthcare worker. DOT increases cure rates among patients with TB, and is also effective in decreasing drug resistance, treatment failure, relapse, and mortality. The provisions below are examples of existing laws on DOT; no citation is included for the third bullet because “or administration” was added after “ingestion” to account for patients who are prescribed injectable medication. The fourth bullet is an example of a regulation on DOT that is used in a state in which health officers are not necessarily physicians, and the state prefers DOT to be ordered or discontinued only by healthcare providers. The final bullet is an example of a law on DOT for patients with latent tuberculosis infection who are on preventive treatment.

- Directly Observed Therapy (DOT) shall be the standard for treatment of persons determined to have active tuberculosis disease. Exceptions may be granted by the health officer when necessary and for cause. Tuberculosis treatment shall continue by DOT until a prescribed course of therapy has been completed. OKLA. ADMIN. CODE § 310:521-3-3 (2009).
- Where the health officer determines that the public health or the health of any other person is endangered by a case of tuberculosis or a suspect case of tuberculosis, the health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of such orders. In any court proceeding for enforcement, the health officer shall demonstrate the particularized circumstances constituting the necessity for an order. Such orders may include, but shall not be limited to:
 - An order requiring a person who has active tuberculosis and who is unable or unwilling otherwise to complete an appropriate prescribed course of medication for tuberculosis to follow a course of directly observed therapy. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009).
- A health care provider shall place individuals with tuberculosis and suspected tuberculosis on a tuberculosis treatment regimen that is in accordance with current national and state standards of care, and that provide for direct observation by a trained health care worker of ingestion or administration of each dose of medication.
- Directly Observed Therapy
 - 1) Health care providers may prescribe DOT as a method to monitor the adherence of a patient to his or her prescribed treatment for tuberculosis disease.
 - Health care providers may utilize the Department's TB Standards of Care as a guideline for appropriate utilization of DOT.
 - 2) Only the patient's health care provider shall have the authority to order or discontinue DOT.
 - If a health care provider discontinues an order for DOT: Any health officer requiring DOT shall be immediately rescinded; and the health officer who

- petitioned the Superior Court for court ordered DOT, shall request that the court order be rescinded.
- 3) The local health officer in the patient's health jurisdiction of residence shall ensure the provision of DOT as ordered by a health care provider by providing field services as established at [regulation describing health officer responsibilities].
 - The provision of DOT on a daily, twice weekly or three times weekly basis shall continue until discontinued by the health care provider.
 - 4) The designated public health nurse case manager or designee for the health jurisdiction of the patient's residence shall negotiate a time and place to provide DOT.
 - The patient may request a reasonable amendment to an established DOT schedule or location from the public health nurse case manager or designee.
 - The public health nurse case manager or designee shall consider the patient's needs and the availability of resources in determining whether to make any accommodation.
 - 5) The public health nurse case manager shall intervene pursuant to [regulation on managing nonadherent TB patients] if a patient is not at least 80 percent adherent to a prescribed DOT regimen over any one-month period throughout the duration of treatment. N.J. ADMIN. CODE § 8:57-5.9 (2009).

DOT for LTBI

- Directly Observed Preventive Therapy (DOPT). In settings where DOPT can be given by a responsible and trained employee or volunteer, twice-a-week DOPT should be considered. DOPT should especially be considered for persons who are at high-risk for TB disease, or at high-risk of nonadherence to preventive therapy. ILL. ADMIN. CODE tit. 77, § 696.150 (2009).

D. Isolation

Descriptive Note: Quarantine is a disease control measure that applies to individuals who have been exposed to a communicable disease but are not yet ill. Individuals who are latently infected with TB pose no risk of transmission; therefore, quarantine is not an appropriate disease control measure for TB. Isolation is the separation of ill persons who have a communicable disease from those who are healthy and restriction of their movement to stop the spread of that disease or illness. Public health officials generally may isolate individuals with TB disease if they pose a threat to the public's health. The second bullet below is an example of a provision that could be utilized for home isolation or isolation in a facility. The third bullet is a state regulatory provision that authorizes electronic monitoring if an individual is ordered by the court to be committed but the location of commitment is the individual's home. Isolation in the home with electronic monitoring is a less restrictive alternative to confinement in a facility. The fourth and fifth bullets are examples of state laws that authorize isolation (in the home or in a facility) if an individual ceases treatment against medical advice. Individuals who cease treatment may become infectious, or the period of infectiousness may be extended if currently infectious, and also are at

risk of developing drug resistance (or increased drug resistance). The final bullet is an example of a state regulatory provision that prescribes the minimum period of isolation.

- If the local health officer determines that the public health in general or the health of a particular person is endangered by exposure to a person who is known to have active tuberculosis disease, or to a person for whom there are reasonable grounds to believe has active tuberculosis disease, the health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of the orders...The orders may include, but shall not be limited to, any of the following:
 - An order for isolation of persons with infectious tuberculosis disease to their place of residence until the health officer has determined that they no longer have infectious tuberculosis disease. CAL. [HEALTH & SAFETY] CODE § 121365 (Deering 2009).
- Isolation order - enforcement - court review
 - Whenever a health officer determines that isolation of a person in a particular tuberculosis case is necessary for the preservation and protection of the public health, the health officer shall make an isolation order in writing.
 - When a health officer is determining whether to issue an isolation order for a person, the health officer shall consider, but is not limited to, the following factors:
 - 1) Whether the person has active tuberculosis;
 - 2) If the person is violating the rules promulgated by the board of health or the orders issued by the appropriate health officer to comply with rules or orders; and
 - 3) Whether the person presents a substantial risk of exposing other persons to an imminent danger of infection.
 - All isolation orders shall set forth the name of the person to be isolated and the initial period, not to exceed six months, during which the order shall remain effective, the place of isolation, and such other terms and conditions as may be immediately necessary to protect the public health. The isolation order shall advise the person being detained that he or she has the right to request release from detention by contacting a person designated in the order and that the detention shall not continue for more than five business days after the request for release, unless the detention is authorized by court order. The health officer shall serve a copy of the isolation order upon the person. The person shall be reexamined at the time the initial order expires to ascertain whether or not [he/she continues to be infectious]. When it has been medically determined that the person no longer has active tuberculosis, the person shall be relieved from all further liability or duty imposed by [statutory provisions on tuberculosis], and the health officer shall rescind the order.
 - A health officer may detain a person who is the subject of an isolation order issued pursuant [above] without a prior court order. The health officer may detain the person in a hospital or other appropriate place for examination or treatment. COLO. REV. STAT. § 25-4-507 (2009).

- If the location of commitment is a private residence, law enforcement may use an electronic device to monitor adherence to the commitment order. N.J. ADMIN. CODE § 8:57-5.11 (2009).
- In a case of a person with multidrug-resistant tuberculosis, the health officer may issue an isolation order to such person if it is determined that the person has ceased taking prescribed medications against medical advice. Such order may be issued even if the person is no longer contagious so long as the person has not completed an entire course of therapy. COLO. REV. STAT. § 25-4-507 (2009).
- A health officer may require an individual having tuberculosis in a noncommunicable stage to be under medical supervision, which may include physical isolation from others, if the individual refuses to receive adequate chemotherapy. MD. CODE REGS. 10.06.01.21 (2009).
- Minimum period of isolation of patient – pulmonary tuberculosis (also includes mediastinal, laryngeal, pleural, or miliary). Until bacteriologically negative based on three appropriately collected and processed sputum smears that are collected in eight – 24 hour intervals (one of which should be an early morning specimen), and/or until 14 days after the initiation of appropriate effective chemotherapy, provided therapy is continued as prescribed, and there is demonstration of clinical improvement (i.e., decreasing cough, reduced fever, resolving lung infiltrates, or AFB smears showing decreasing numbers of organisms). 105 MASS. CODE REGS. § 300.200 (2009).

E. Emergency Detention

Descriptive Note: Emergency detention laws provide public health officials with legal authority to swiftly take public health action to detain a person with TB who is reasonably believed to be a threat to the public’s health. A hearing is not required prior to issuance of the health officer order or court order, but is generally required within a reasonable amount of time after the initial detention either if the individual requests release or if automatically granted by state law. All of the provisions in this section are reported to be effective in the jurisdictions in which they have been enacted or promulgated. There is variation among the selected provisions as to who is granted authority to implement or request assistance for emergency detention and whether the detention order is by health officer order or court order. The third bullet is a Florida statutory provision and the original wording of the law applies only to physicians. “Physician” was changed to “healthcare worker” below at the recommendation of Florida legal counsel to broaden the scope of the law, and the legal citation was retained. The final bullet pertains to MDR or XDR TB specifically.

- The local health officer may detain in a hospital or other appropriate place for examination or treatment, a person who is the subject of an order of detention issued pursuant to [statutory provision authorizing an order for the removal to, detention in, or admission into, a health facility or other treatment facility for examination or purpose of detention] without a prior court order except that when a person detained pursuant to [statutory provision authorizing an order for the removal to, detention in, or admission into, a health facility or other treatment facility for examination or purpose of detention] has requested release, the local health officer shall make an application for a court order authorizing the continued detention within 72 hours after the request or, if the 72-hour

period ends on a Saturday, Sunday, or legal holiday, by the end of the first business day following the Saturday, Sunday, or legal holiday, which application shall include a request for an expedited hearing. After the request for release, detention shall not continue for more than five business days in the absence of a court order authorizing detention. However, in no event shall any person be detained for more than 60 days without a court order authorizing the detention. The local health officer shall seek further court review of the detention within 90 days following the initial court order authorizing detention and thereafter within 90 days of each subsequent court review. In any court proceeding to enforce a local health officer's order for the removal or detention of a person, the local health officer shall prove the particularized circumstances constituting the necessity for the detention by clear and convincing evidence. Any person who is subject to a detention order shall have the right to be represented by counsel and upon the request of the person, counsel shall be provided. CAL. [HEALTH & SAFETY] CODE § 121366 (Deering 2009).

- Emergency Hold
 - 1) The department may file a petition before a circuit court requesting that an emergency hold order be issued for a person if the department has evidence that:
 - The person has or is reasonably suspected of having active tuberculosis;
 - The person poses a threat to the public health;
 - The person who has active tuberculosis is not likely to appear at a hearing scheduled under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation];
 - The person provides evidence by words or action of being likely to leave the jurisdiction of the court prior to the hearing date; or
 - The person is likely to continue to expose the public to the risk of active tuberculosis until the hearing date.
 - 2) An emergency hold order may not be issued unless the court finds that:
 - The department has requested a hearing under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation] to consider the examination, treatment to cure, or placement of the person who has or who is reasonably suspected of having active tuberculosis;
 - The department presents competent evidence that a threat to the public health exists unless the emergency hold order is issued;
 - The department has no other reasonable alternative means of reducing the threat to the public health; and
 - The department is likely to prevail on the merits in a hearing under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation].
 - 3) When issuing an order for an emergency hold, the court shall direct the sheriff to immediately confine the person who has active tuberculosis. The sheriff shall confine and isolate the person in such a manner as required by the court. The sheriff and the circuit court shall consult with the department concerning any necessary infection control procedures to be taken.
 - 4) In order to reduce the time before a full hearing may be held, the person

confined under an emergency hold order, or the person's counsel, may waive the notice periods for hearings required under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation]. An emergency hold order may not continue for more than 5 days or the time period necessary for conducting hearings under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation], whichever time period is shorter. FLA. STAT. ANN. § 392.57 (LexisNexis 2009).

- When a person who has active tuberculosis or who is reasonably suspected of having active tuberculosis presents to a [healthcare worker] for examination or treatment and the [healthcare worker] has reason to believe that if the person leaves the treatment location the person will pose a threat to the public health based on test results or the patient's medical history and the [healthcare worker] has reason to believe that the person is not likely to appear at a hearing scheduled under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation], the [healthcare worker] shall request the State Health Officer or his or her designee to order that the person be involuntarily held by executing a certificate stating that the person appears to meet the criteria for involuntary examination or treatment and stating the observation upon which that conclusion is based. The sheriff of the county in which the certificate was issued shall take such person into custody and shall deliver the person to the nearest available licensed hospital, or to another location where isolation is available, as appropriate, for observation, examination, and treatment for a period not to exceed 72 hours, pending a hearing scheduled under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation]. The certificate must be filed with the circuit court in which the person is involuntarily held and constitutes a petition for a hearing under [statutory provisions relating to a petition for court-ordered examination or treatment; or hospitalization, placement, or residential isolation]. FLA. STAT. ANN. § 392.565 (LexisNexis 2009).
- If a physician, the department, or a local health officer reasonably believes that a person has tuberculosis and that the person is likely to attempt to leave the jurisdiction to avoid a hearing on commitment, the physician, department, or local health officer shall notify the sheriff of the county in which the person is found, who shall cause the person to be detained in a hospital. At least by the next regular business day, the physician, department, or local health officer shall petition for an order from the district court of the county in which the person is found for continued detention of the person and to require examination or treatment for tuberculosis pursuant to [statutory provision authorizing application to court for examination or treatment order]. The sheriff must serve the summons required by [state law] on the person the same day the petition is filed.
 - Immediately after the petition is filed the court will decide whether further emergency detention is required and may order continued hospital detention of the person for no more than 7 days if it finds that the person is an unacceptable danger to the public health and safety in that the person probably has tuberculosis and unless detained will probably leave the jurisdiction to avoid a hearing pursuant to this part.

- The district court of the county in which the person is found has jurisdiction over the person for the purposes of this section. The district court may, in the interests of justice, order that jurisdiction over further proceedings be transferred to the district court of the county of the person's residence. MONT. CODE. ANN. § 50-17-115 (2009).
- If the patient has suspected or confirmed infectious or potentially infectious TB disease, is suspected or confirmed to have either MDR TB or XDR TB, and is non-adherent or threatens non-adherence with infection control measures, regardless of his or her risk for flight, the health officer shall immediately serve the patient an order of temporary commitment pursuant to this section, rather than an order for isolation due to the severity of the consequences of transmission. N.J. ADMIN. CODE § 8:57-5.12 (2009).

F. Confinement in a Facility

1. Administrative or Court Order for Confinement

Descriptive Note: This section contains examples of existing state statutory provisions on confinement of individuals with TB in a facility (also referred to as commitment, involuntary hospitalization, or isolation). Confinement in a facility is generally considered to be the most restrictive TB control measure, but may be necessary when less restrictive alternatives have failed and confinement is the only way to assure that the patient is adherent (and may be the only way to cure the patient of TB) and the public's health is adequately protected. The provisions in this section were specifically chosen because they are reportedly effective in the jurisdictions in which they are in place. The first two bullets are provisions from high incidence jurisdictions (New York City/California [California's and NYC's laws on detention are identical] and Florida, respectively), and the third bullet is Wisconsin's confinement law, which was recently upheld by the Wisconsin Supreme Court in *In re Washington*, 735 N.W.2d 111 (Wis. 2007). See Appendix B for more information on state cases related to TB prevention and control.

- Where the health officer determines that the public health or the health of any other person is endangered by a case of tuberculosis, or a suspected case of tuberculosis the health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of such orders. In any court proceeding for enforcement, the health officer shall demonstrate the particularized circumstances constituting the necessity for an order. Such orders may include, but shall not be limited to:
 - An order for the removal to and/or detention in a hospital or other treatment facility of a person 1) who has active tuberculosis that is infectious or who presents a substantial likelihood of having active tuberculosis that is infectious, based on epidemiologic evidence, clinical evidence, x-ray readings or laboratory test results; and 2) where the Department finds, based on recognized infection control principals, that there is a substantial likelihood that such person may transmit to others tuberculosis because of his or her inadequate separation from others; and
 - An order for the removal to and/or detention in a hospital or other treatment facility of a person 1) who has active tuberculosis, or who has been reported to the

Department as having active tuberculosis with no subsequent report to the Department of the completion of an appropriate prescribed course of medication for tuberculosis; and 2) where there is a substantial likelihood, based on such person's past or present behavior, that he or she cannot be relied upon to participate in and/or to complete an appropriate prescribed course of medication for tuberculosis and/or, if necessary, to follow required contagion precautions for tuberculosis. Such behavior may include, but is not limited to, refusal or failure to take medication for tuberculosis, or refusal or failure to keep appointments for treatment of tuberculosis, or refusal or failure to complete treatment for tuberculosis, or disregard for contagion precautions for tuberculosis. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009).

- Hospitalization, placement, and residential isolation
 - 1) Subject to the provisions of subsections 2) and 3), the department may petition the circuit court to order a person who has active tuberculosis to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home as a result of the probable spread of tuberculosis, until such time as the risk of infection to the general public can be eliminated or reduced in such a manner that a threat to the public health no longer exists.
 - 2) A person may not be ordered to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home, except upon the order of a circuit court and upon proof:
 - By the department, by clear and convincing evidence, that a threat to the public health is posed by the person who has active tuberculosis;
 - That the person who has active tuberculosis has been counseled about the disease, the threat to the public health posed by tuberculosis, and methods to minimize the risk to the public, and, despite such counseling, indicates an intent by words or action to expose the public to active tuberculosis; and
 - That all other reasonable means of achieving compliance with treatment have been exhausted and no less restrictive alternative exists.
 - 3) A person may not be ordered by a circuit court to be hospitalized, placed in another health care facility or residential facility, or isolated from the general public in the home, unless:
 - A hearing has been held, with respect to which the person has received at least 72 hours' prior written notification and has received a list of the proposed actions to be taken and the reasons for each such action. However, with the consent of the person or the person's counsel, a hearing may be held within less than 72 hours;
 - The person has the right to attend the hearing, to cross-examine witnesses, and present evidence. After review and consultation by the court, counsel for the person may waive the client's presence or allow the client to appear by television monitor where available; and
 - The court advises the person of the right to have counsel present. If the person is insolvent and unable to employ counsel, the court shall appoint legal counsel for the person pursuant to the indigence criteria in [determination of indigence law].

- 4) An order requiring the hospitalization, placement in a health care facility or residential facility, or isolation from public in the home must expire no later than 180 days after the date of the order or when the physician charged with the care of the person determines that the person no longer poses a threat to the public health, if the determination is made before the end of the 180-day period. Orders for hospitalization of a person or placement in a facility or isolation in the home may not be renewed unless the person is afforded all rights conferred in subsections 2) and 3). A hearing must be held within 14 days before the expiration of the 180-day period to determine the necessity for the person's continued hospitalization or necessary care and treatment to cure after release. The person's records from the inception of the disease are admissible evidence in the hearing.
- 5) If the department petitions the circuit court to order that a person who has active tuberculosis be hospitalized in a facility operated under [statutory provision on hospitalization and placement programs], the department shall notify the facility of the potential court order.
- 6) The circuit court, legal counsel, and local law enforcement officials, as appropriate, shall consult with the department concerning any necessary infection control procedures to be taken during any court hearing or detention. FLA. STAT. ANN. § 392.56 (LexisNexis 2009).
- Tuberculosis
 - 1) 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:
 - 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.
 - That the individual has failed to comply with the prescribed treatment regimen or with any rules promulgated by the department under [statutory provision authorizing the department to promulgate rules to control TB]; or that the disease is resistant to the medication prescribed to the individual.
 - 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.
 - That the individual poses an imminent and substantial threat to himself or herself or to the public health.
 - 2) 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:
 - The date, time and place of the hearing.
 - The grounds, and underlying facts, upon which confinement of the individual is being sought.

- An explanation of the individuals rights specified under par. [4]
 - The proposed actions to be taken and the reasons for each action.
- 3) 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 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.
- 4) 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 [indigence] determinations specified under [determination of indigence law]. 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 [indigence], as provided in [right to counsel law]. Unless good cause is shown, a hearing under this subsection may be conducted by telephone or live audiovisual means, if available. [NOTE: “indigency” was replaced with “indigence,” and the legal citation was retained].
- 5) 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. WIS. STAT. ANN. § 252.07 (LexisNexis 2009).

2. Length of Confinement/Discharge

Descriptive Note: The provisions in this section are examples of different approaches to length of confinement. The final bullet is reported to be effective in Louisiana in ensuring a cure for patients who are discharged or released from confinement prior to completion of treatment.

- A person who is detained solely for the reasons described in [statutory provision stating the following: 1) the person has infectious tuberculosis disease, or who presents a substantial likelihood of having infectious tuberculosis disease, based upon proven epidemiologic evidence, clinical evidence, X-ray readings, or tuberculosis laboratory test results; and 2) the local health officer finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit tuberculosis to others because of his or her inadequate separation from others] shall not continue to be detained after he or she ceases to be infectious or after the local health officer ascertains that changed circumstances exist that permit him or her to be adequately separated from others so as to prevent transmission of tuberculosis disease after his or her release from detention. CAL [HEALTH & SAFETY] CODE § 121368 (Deering 2009).
- A person who is detained for the reasons described in [statutory provision stating the following: 1) the person has active tuberculosis disease, or has been reported to the health officer as having active tuberculosis disease with no subsequent report to the health

officer of the completion of an appropriate prescribed course of medication for tuberculosis disease; and 2) there is a substantial likelihood, based on the person's past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course of medication for tuberculosis disease and, if necessary, follow required infection control precautions for tuberculosis disease] shall not continue to be detained after he or she has completed an appropriate prescribed course of medication. CAL [HEALTH & SAFETY] CODE § 121368 (Deering 2009).

- An order requiring the hospitalization, placement in a health care facility or residential facility, or isolation from the public in the home must expire no later than 180 days after the date of the order or when the physician charged with the care of the person determines that the person no longer poses a threat to the public health, if the determination is made before the end of the 180-day period. Orders for hospitalization of a person or placement in a facility or isolation in the home may not be renewed unless the person is afforded all rights conferred in [statutory due process provisions]. A hearing must be held within 14 days before the expiration of the 180-day period to determine the necessity for the person's continued hospitalization or necessary care and treatment to cure after release. The person's records from the inception of the disease are admissible evidence in the hearing. FLA. STAT. ANN. § 392.56 (LexisNexis 2009).
- The director of the treatment facility, upon the recommendation of the state health officer or his designee, or the court may discharge the person. The director and the official making the recommendation shall not be legally responsible to any person for the subsequent acts or behavior of a person discharged in good faith and in accordance with the provisions of this Part.
 - A person who is committed to a treatment facility for active tuberculosis may be conditionally discharged for a period of up to one year by the director, upon the recommendation of the state health officer or his designee, or by a court of competent jurisdiction after a hearing. The person may be required to report for outpatient treatment as a condition of his release. The terms and conditions of the conditional discharge shall be specifically set forth in writing and signed by the person. A copy of the conditional discharge shall be given to the person and explained to him before he is discharged.
 - If the person is conditionally discharged by the director upon the recommendation of the state health officer or his designee, a copy of the conditional discharge shall be sent to the court which judicially committed him and to the person's counsel of record. If the person is conditionally discharged by the court, a copy of the conditional discharge shall be sent to the director of the treatment facility to which the person has been committed, the state health officer or his designee, and the committed person's counsel of record.
 - The director, upon the recommendation of the state health officer or his designee, or the court may extend the conditional discharge of a person for a period of up to two years and the person may be required to report for outpatient treatment as a condition of his release. The terms and conditions of the extension of the conditional discharge shall be specifically set forth in writing and signed by the person. A copy of the extension of the conditional discharge shall be given to the person and explained to him.

- If a conditional discharge is extended by the director upon the recommendation of the state health officer or his designee, a copy of the extension shall be sent to the court which judicially committed the person and to the person's counsel of record. If the conditional discharge is extended by the court, a copy of the extension shall be sent to the director, to the state health officer or his designee, and to the person's counsel of record.
- If a person does not comply with the terms and conditions of his conditional discharge, he shall be subject to any of the procedures for involuntary treatment, including but not limited to the issuance of an order for protective custody. A conditionally discharged person who is confined pursuant to any of these involuntary procedures shall have all rights of a person committed involuntarily, including the right to periodic reports and review and an annual hearing pursuant to the provisions of this Part. LA. REV. STAT. ANN. § 40:31.28 (2009).

G. Social Distancing Measures – Workplace, Schools, and Other Public Settings

Descriptive Note: Exclusion of persons with infectious TB from the workplace, school, or other public settings – referred to as “social distancing measures” – may be necessary to protect the public from TB transmission. Below are examples of existing state laws on exclusion from the workplace and/or other public settings; the second bullet is a New Hampshire regulatory provision that establishes shared responsibility between “employers and admitting officials” and the health department.

- If the local health officer determines that the public health in general or the health of a particular person is endangered by exposure to a person who is known to have active tuberculosis disease, or to a person for whom there are reasonable grounds to believe has active tuberculosis disease, the local health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of the orders...The orders may include, but shall not be limited to, any of the following:
 - An order for exclusion from attendance at the workplace for persons with infectious tuberculosis disease. The order may, also, exclude the person from any place when the local health officer determines that the place cannot be maintained in a manner adequate to protect others against the spread of tuberculosis disease. CAL [HEALTH & SAFETY] CODE § 121365 (Deering 2009).
- Employers and admitting officials shall exclude confirmed or suspect cases of TB from the following places until TB has been ruled out or the confirmed or suspect case is deemed to be non-infectious by the department: 1) Public and non-public schools; 2) Child care agencies; and 3) Work places. N.H. CODE ADMIN. R. ANN. He-P 301.05 (2009).
- Pursuant to [enabling statute], the health officer in the patient’s jurisdiction of residence may exclude a patient posing an immediate or imminent risk to the public health from attending his or her place of work or school, or other premises where the health officer determines that such action is necessary to protect the public health.

- The health officer shall consult with the Department's TB Program or State Epidemiologist or designee before excluding a patient from a workplace, school or other premises through a health officer order.
- In no case shall a health officer exclude a patient from a workplace, school or other premises for more than 60 days without a court order authorizing such exclusion pursuant to the hearing process established at [regulation describing the hearing process]. N.J. ADMIN. CODE § 8:57-5.11 (2009).

H. Penalties/Immunity

Descriptive Note: Penalties for patients with TB who are nonadherent generally are levied only after use of incentives and enablers and other measures designed to achieve adherence have failed. States may consider granting immunity to public health officials and others involved in patient care who act in good faith – this section contains two examples of such provisions.

- Unless otherwise provided in this chapter, a person who knowingly violates any provision of this chapter, or of the rules of the department or a local board, or any lawful order, written or oral, of the department or board, or of their officers or authorized agents, is guilty of a simple misdemeanor. IOWA CODE § 139A.25 (2009).
- Inasmuch as the order provided for by [statutory provision on powers and duties of health officers] is for the protection of the public health, any person who, after service upon him or her of an order of a health officer directing his or her treatment, isolation, or examination as provided for in [statutory provision on powers and duties of health officers], violates or fails to comply with the same or any provision thereof, is guilty of a misdemeanor, and, upon conviction thereof, in addition to any and all other penalties which may be imposed by law upon such conviction, may be ordered by the court confined until such order of such health officer shall have been fully complied with or terminated by such health officer, but not exceeding six months from the date of passing judgment upon such conviction: PROVIDED, That the court, upon suitable assurances that such order of such health officer will be complied with, may place any person convicted of a violation of such order of such health officer upon probation for a period not to exceed two years, upon condition that the said order of said health officer be fully complied with: AND PROVIDED FURTHER, That upon any subsequent violation of such order of such health officer, such probation shall be terminated and confinement as herein provided ordered by the court. WASH. REV. CODE ANN. § 70-28-033 (LexisNexis 2009).
- Any health care facility, provider agency, or agent, employee, administrator, physician, or other representative of such health care facility or provider agency who in good faith provides or fails to provide notification, testing, or other action as required by [disease control provisions] shall have immunity from any liability, either criminal or civil, that might result by reason of such action or inaction. NEB. REV. STAT. ANN. § 71-513 (LexisNexis 2009).
- Immunity. A public health official, disease prevention officer, peace officer, physician, licensed health professional, or treatment facility that acts in good faith under this section is immune from liability in any civil, administrative, disciplinary, or criminal action for acting under this section.

I. Costs

Descriptive Note: According to the ACET recommendations contained in the article “Tuberculosis control laws—United States, 1993: recommendations of the Advisory Council for the Elimination of Tuberculosis (ACET),” published in the *Morbidity and Mortality Weekly Report*, the inability to pay for medical care (including anti-TB medications) and/or a lack of healthcare insurance should not preclude initiation of an appropriate treatment regimen. Health departments may, however, have the ability to seek payment from third-party payers. This section contains provisions on financing for treatment and costs associated with isolation and detention.

- Where funds appropriated to the department have been expended for the purpose of meeting the cost of the care, maintenance or treatment of any person who has communicable or infectious tuberculosis pursuant to the provisions of this act and a third party has a legal obligation to pay such cost to or on behalf of the recipient, the [health official] may recover the same from the recipient or from the third party and in all respects shall be subrogated to the rights of the recipient in such cases. KAN. STAT. ANN. § 65-116m (2009).
- The department should establish a contract with the general hospitals in the larger cities for the care of tuberculosis patients, who do not have a third-party payment source. The department will pay the standard fee for hospitalization. The department will only pay for services relevant to the treatment of tuberculosis. Payment for services above the normal treatment requirements for tuberculosis will be the responsibility of the patient and/or provider. N.D. ADMIN. CODE 33-12-01-02 (2009).
- The costs incurred by the treatment facility and other providers of services to diagnose or treat the [person who has active tuberculosis or is clinically suspected of having active tuberculosis] must be borne by the [person who has active tuberculosis or is clinically suspected of having active tuberculosis, his/her health plan, or public programs]. During the period of insurance coverage, a health plan may direct the implementation of the care required by the health order or court order and shall pay at the contracted rate of payment, which shall be considered payment in full. Inpatient hospital services required by the health order or court order and covered by medical assistance or general assistance medical care are not billable to any other governmental entity. If the [person who has active tuberculosis or is clinically suspected of having active tuberculosis] cannot pay for treatment, and [he/she] does not have public or private health insurance coverage, [he/she] shall apply for financial assistance with the aid of the county. For persons not otherwise eligible for public assistance, the commissioner of human services shall determine what, if any, costs the [person who has active tuberculosis or is clinically suspected of having active tuberculosis] shall pay. The [health official] shall make payments at the general assistance medical care rate, which will be considered payment in full. MINN. STAT. ANN. § 144.4812 (West 2009).
- The expenses incurred for detention under [statute authorizing court-ordered detention] or [statute authorizing emergency detention] shall be paid by the individual detained or if the individual is indigent, by the board of county commissioners of the county from which the individual was removed. OHIO REV. CODE ANN. § 339.88 (LexisNexis 2009).

- Individuals who are isolated at the expense of the Department shall provide the Department with information to determine if any other payment source for the costs associated with isolation is available. UTAH ADMIN. CODE r. 388-804-8 (2009).

J. Grants of Authority to Take Any “Necessary” Action to Protect Public Health

Descriptive Note: States may consider incorporating general and broad authority into their statutes to ensure that TB control programs may take any reasonable action necessary to protect the public’s health.

- Each health officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the department, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases. CAL. [HEALTH & SAFETY] CODE § 120175 (Deering 2009).
- The order of the [health official] or the health officer may also contain such other conditions as the [health official] or the health officer believes are necessary to protect either the health of the infected individual or the public health. MD. CODE ANN., HEALTH-GEN. § 18-324 (LexisNexis 2009).
- Each and every provision of this subchapter shall be constructed liberally in aid of the powers vested in the public authorities looking to the protection of the public health, comfort, and welfare and not by way of limitation. D.C. CODE § 7-144 (2009).
- [TB control statutory provisions] of this title are in addition to any other statutes relating to communicable diseases generally or to tuberculosis specifically and shall not abrogate or repeal those other statutes unless in direct conflict therewith, in which case the provisions of such sections shall control. VT. STAT. ANN. tit. 18, § 1061 (2009).

VI. Protection of Individual Rights

A. Due Process

Descriptive Note: The due process clause of the Fourteenth Amendment to the U.S. Constitution prohibits state governments from depriving individuals of life, liberty, or property without due process of law. Due process has both substantive and procedural components. “Substantive due process” generally requires the government to have adequate justification for implementing laws or taking other official actions that deprive individuals of life, liberty, or property. “Procedural due process” requires the government to use fair and reasonable procedures when restraining a person’s liberty. Notice and an opportunity to be heard are among the most fundamental procedures that must be available. The disease control measures described above – examination, isolation, confinement, treatment, etc. – potentially implicate liberty interests protected by the due process clause. Due process is incorporated into many state laws relating to TB prevention and control, including those in this Menu, and states therefore may not have “separate” provisions addressing due process. This section contains examples of existing laws that address

due process. The first bullet is a good example of substantive due process because the justification and due process measures that must be taken increase with the level of restriction – in this case, detention. The provision also accounts for procedural due process, with specific requirements on what must be provided in the notice to the patient, and hearing requirements. The second provision below is a concise summary of procedural due process requirements concerning hearings conducted pursuant to the state’s TB control regulations. See Appendix A for more on due process as it relates to TB prevention and control.

- An order of the health officer pursuant to [regulation authorizing administrative order for disease control measures] shall set forth:
 - The legal authority under which the order is issued, including the particular sections of this Article or other law or regulation;
 - An individualized assessment of the person's circumstances and/or behavior constituting the basis for the issuance of such orders;
 - The less restrictive treatment alternatives that were attempted and were unsuccessful and/or the less restrictive treatment alternatives that were considered and rejected, and the reasons such alternatives were rejected.

In addition, an order for the removal and detention of a person shall:

- Include the purpose of the detention;
- Advise the person being detained that he or she has the right to request release from detention by contacting a person designated on the health officer’s order at a telephone number stated on such order, and that the detention shall not continue for more than five (5) business days after such request in the absence of a court order authorizing such detention;
- Advise the person being detained that, whether or not he or she requests release from detention, the health officer must obtain a court order authorizing detention within sixty (60) days following the commencement of detention and thereafter must further seek court review of the detention within ninety (90) days of such court order and within ninety (90) days of each subsequent court review;
- Advise the person being detained that he or she has the right to arrange to be represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, that such counsel will be notified that the person has requested legal representation;
- Be accompanied by a separate notice which shall include but not be limited to the following additional information: 1) that the person being detained has the right to request release from detention by contacting a person designated on the health officer’s order at a telephone number stated on such order, and that the detention shall not continue for more than five (5) business days after such request in the absence of a court order authorizing such detention; 2) that he or she has the right to arrange to be advised and represented by counsel or to have counsel provided, and that if he or she chooses to have counsel provided, that such counsel will be notified that the person has requested legal representation; and 3) that he or she may supply the addresses and/or telephone numbers of friends and/or relatives to receive notification of the person's detention, and that the Department shall, at the patient's request, provide notice to a reasonable number of such people that the

person is being detained. NEW YORK, N.Y., 24RCNY HEALTH CODE § 11.21 (2009).

- At any hearing conducted pursuant to [TB control regulations], a person shall have the following due process rights:
 - Written notice detailing the grounds and underlying facts of the matter;
 - The right to have counsel present at the hearing and, if indigent, the right to appointed counsel; and
 - The right to be present at a court hearing, to cross examine, and to present witnesses, which rights may be exercised through telecommunication technology. N.J. ADMIN. CODE § 8:57-5.15 (2009).

B. Religious Exemptions

Descriptive Note: In addition to federal and state constitutional provisions and case law interpreting the First Amendment's free exercise clause, some states have enacted statutory religious exemptions to treatment, examination, or both to protect the religious interests of patients with TB. The statutory religious exemptions below allow patients with TB who rely on spiritual means or prayer for healing to do so while protecting the public's health because the patient is required to adhere to isolation. In practice, the burden is generally on the patient to demonstrate good faith belief in his/her particular religion, and the health department may require documentation in support of that belief.

- Any person who depends exclusively on prayer for healing in accordance with the teachings of any well-recognized religious sect, denomination, or organization, and claims exemptions on such grounds, shall nevertheless be subject to examination, and the provisions of [state TB control statutory provisions] regarding compulsory reporting of communicable diseases and isolations shall apply where there is probable cause to suspect that such person has active tuberculosis. Such person shall not be required to submit to any medical treatment or to go to or be confined in a hospital or other medical institution if the person can safely be isolated in the person's own home or other suitable place of the person's choice. COLO. REV. STAT. § 25-4-506 (2009).
- The [health official] or a health officer may not require an individual to have a physical examination, other than a chest X ray and to render sputum samples. The [health official] or a health officer may not restrict the right of the individual to select a treatment method, if the individual: (1) In good faith relies on spiritual means through prayer for healing; and (2) Complies with the laws, rules, and regulations that relate to sanitation for and isolation of infectious, contagious, and communicable diseases. MD. CODE ANN., HEALTH-GEN. § 18-324 (LexisNexis 2009).
- A [person who has or who based upon reasonable grounds is suspected of having active tuberculosis] is not required to undergo treatment under this article if that person depends exclusively on prayer or spiritual means for healing in accordance with the tenets and practices of a recognized church or religious denomination and claims an exemption on that ground. The requirements of this article regarding compulsory reporting of tuberculosis disease, exclusion from employment or school, monitoring, examination, and isolation apply if there is clear and convincing evidence that the person is a [person who has or who based upon reasonable grounds is suspected of having active

tuberculosis] and is a substantial danger to another person or the community. ARIZ. REV. STAT. § 36-734 (LexisNexis 2009).

C. Confidentiality

Descriptive Note: Public health authorities that are also covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) must comply with the requirements of the Privacy Rule, but HIPAA does not apply to all situations that TB programs and their legal counsel may face concerning patient confidentiality. The provisions in this section are examples of laws that some states have enacted or promulgated to address confidentiality, from use of a pseudonym to allowing patient information to be used for research purposes.

- Except as otherwise provided by law, all records kept by the department and by local public health agencies and all records retained in a county coroner's office in accordance with [regulation concerning retention of death certificate in county coroner's office], as a result of the investigation of tuberculosis shall be kept strictly confidential and shall only be shared to the extent necessary for the investigation, treatment, control, and prevention of tuberculosis; except that every effort shall be made to limit disclosure of personal identifying information to the minimal amount necessary to accomplish the public health purpose. COLO. REV. STAT. § 25-4-511 (2009).
- When requesting an order from a circuit court under the provisions of [state TB control provisions], the department shall substitute a pseudonym for the true name of the person to whom the order pertains. The actual name of the person shall be revealed to the court only in camera, and the court shall seal such name from further revelation. All court decisions, orders, petitions, and other formal documents shall be styled in a manner to protect the name of the person from public disclosure. The department, its authorized representatives, the court, and other parties to the lawsuit shall not reveal the name of any person subject to these proceedings except as permitted in [state confidentiality provision]. Such information is exempt from [state public records provision]. FLA. STAT. ANN. § 392.545 (LexisNexis 2009).
- Patient medical information or information concerning reportable events pursuant to any section of this subchapter shall not be disclosed except under the following circumstances:
 - For research purposes, provided that the study is reviewed and approved by the applicable Institutional Review Board, and is done in a manner that does not identify any person, either by name or other identifying data element;
 - With written consent of the person identified;
 - When the [public health official], or his or her designee, determines that such disclosure is necessary to enforce public health laws or to protect the life or health of a named party, in accordance with applicable State and Federal laws; or
 - Pursuant to a valid court order. N.J. ADMIN. CODE § 8:57-5.17 (2009).
- Information regarding communicable or reportable disease confidential – Exceptions
 - 1) Information collected pursuant to this chapter in the possession of the department or local health departments relating to an individual who has or is suspected of having a disease designated by the department as a communicable or

reportable disease under this chapter shall be held by the department and local health departments as strictly confidential. The department and local health departments may not release or make public that information upon subpoena, search warrant, discovery proceedings, or otherwise, except as provided by this section.

- 2) The information described in Subsection 1) may be released by the department or local health departments only in accordance with the requirements of this chapter and as follows:
 - Specific medical or epidemiological information may be released with the written consent of the individual identified in that information or, if that individual is deceased, his next-of-kin;
 - Specific medical or epidemiological information may be released to medical personnel or peace officers in a medical emergency, as determined by the department in accordance with guidelines it has established, only to the extent necessary to protect the health or life of the individual identified in the information, or of the attending medical personnel or law enforcement or public safety officers;
 - Specific medical or epidemiological information may be released to authorized personnel within the department, local health departments, official health agencies in other states, the United States Public Health Service, the Centers for Disease Control and Prevention (CDC), or when necessary to continue patient services or to undertake public health efforts to interrupt the transmission of disease;
 - If the individual identified in the information is under the age of 18, the information may be released to the Division of Child and Family Services within the Department of Human Services in accordance with [state law]. If that information is required in a court proceeding involving child abuse or sexual abuse under [state law], the information shall be disclosed in camera and sealed by the court upon conclusion of the proceedings;
 - Specific medical or epidemiological information may be released to authorized personnel in the department or in local health departments, and to the courts, to carry out the provisions of this title, and rules adopted by the department in accordance with this title;
 - Specific medical or epidemiological information may be released to blood banks, organ and tissue banks, and similar institutions for the purpose of identifying individuals with communicable diseases. The department may, by rule, designate the diseases about which information may be disclosed under this subsection, and may choose to release the name of an infected individual to those organizations without disclosing the specific disease;
 - Specific medical or epidemiological information may be released in such a way that no individual is identifiable;
 - Specific medical or epidemiological information may be released to a “health care provider” as defined [under state law], health care personnel, and public health personnel who have a legitimate need to have access to the information in order to assist the patient, or to protect the health of others closely associated with the patient. This subsection does not create

rehabilitative services and shall be used to encourage the fullest development and maintenance of an integrated statewide tuberculosis control program. ARIZ. REV. STAT. § 36-714 (LexisNexis 2009).

- The [state public health official] or the [state public health official's] designee may enter into reciprocal agreements with federal agencies, foreign governments, state agencies, Indian tribal governments, political subdivisions and other jurisdictions to facilitate the return of any person who has or who based upon reasonable grounds is suspected of having active tuberculosis. The expense of this transportation may be paid by the [insert name of agency/department here].
- Reciprocal agreements: The [state public health official] may, on behalf of the [State], enter into a reciprocal agreement with another state providing for care and treatment of persons having active tuberculosis disease who are residents of the other state, or for the transportation or return of any such nonresident person from one of the states to the other state of which such person is a resident. OKLA. STAT. tit. 63, § 1-409 (2009).
- The department shall have the power and authority, and it shall be the duty of such department, to arrange for the care on a contractual basis of [individuals with tuberculosis], without regard to residence or means tests, at public or private medical installations, within or outside the state, at which care may be provided and paid for by the state after any insurance, worker's compensation, retirement plan, or other benefits accruing to the patient shall have been exhausted; provided, however, that this section shall not be deemed to preclude supplementation by state funds of such other sources of benefits prior to the exhaustion of the latter. S.D. CODIFIED LAWS § 34-22-15 (2009).
- Nothing in this chapter requires the admission of an enrolled Indian, resident on any reservation in this state, to any off-reservation institution except upon written request and authorization of the superintendent of the reservation on which said Indian is enrolled. However, in the public interest and with the objective of eradication of tuberculosis in the [State], an Indian with tuberculosis off any reservation is subject to this chapter. It is the responsibility of the Indian affairs commission pursuant to the commission's powers and duties stated in [state law], to work closely with the tribal councils and other reservation officials to adopt any agreements found necessary in assisting the state health officer in carrying out responsibilities under this chapter so that all residents of this state will benefit, and eradication of tuberculosis in [State] can be achieved. N.D. CENT. CODE § 23-07.1-13 (2009).
- Municipal interstate cooperation.
 - 1) In this section, "municipality" has the meaning given in [statutory definition that includes the state or any department or agency thereof, or any city, village, town, county, school district, city-county health department, etc.]...
 - 2) A municipality may contract with municipalities of another state or with federally recognized American Indian tribes or bands located in another state for the receipt or furnishing of services or the joint exercise of any power or duty required or authorized by statute to the extent that laws of the other state or of the United States permit the joint exercise.
 - 3) (a) Except as provided in par. (b), an agreement made under this section shall, prior to and as a condition precedent to taking effect, be submitted to the attorney general who shall determine whether the agreement is in proper form and compatible with the laws of this state. The attorney general shall approve any

agreement submitted under this paragraph unless the attorney general finds that it does not meet the conditions set forth in this section and details in writing addressed to the concerned municipal governing bodies the specific respects in which the proposed agreement fails to meet the requirements of law. Failure to disapprove an agreement submitted under this paragraph within 90 days of its submission constitutes approval. The attorney general, upon submission of an agreement, shall transmit a copy of the agreement to the governor who shall consult with any state department or agency affected by the agreement. The governor shall forward to the attorney general any comments the governor may have concerning the agreement. (b) An agreement under this section between a municipality of this state and a municipality of another state that relates to the receipt, furnishing, or joint exercise of fire fighting or emergency medical services need not be submitted to or approved by the attorney general before the agreement may take effect.

- 4) An agreement entered into under this section has the status of an interstate compact, but in any case or controversy involving performance or interpretation of or liability under the agreement, the municipalities party to the agreement are real parties in interest and the state may commence an action to recoup or otherwise make itself whole for any damages or liability which it may incur by reason of being joined as a party. The action by the state may be maintained against any municipality whose act or omission caused or contributed to the incurring of damage or liability by the state. WIS. STAT. § 66.0303 (2009).

B. Interstate Movement of Patients

Descriptive Note: A state statute or regulation may require a healthcare provider or local health department to provide notice to a jurisdiction to which an infectious TB patient is relocating. Providing notice facilitates continuity of care and fosters interstate coordination of TB prevention and control. The first bullet below is an example of a provision that authorizes domestication of out-of-state court orders for commitment.

- Filing and Status of Foreign Court Orders
 - In the case of a person who is not a resident of this state and who may be admitted to a state chest hospital in accordance with [statutory provision on admission of nonresident patients], the attorney general, at the request of the department, shall file a copy of an order issued by a court of another state that authorizes the commitment of the person to a health care facility for inpatient care in the manner provided by the Civil Practice and Remedies Code, for enforcement of foreign judgments.
 - The application must be filed with the district court in the county in which the state chest hospital to which the person will be admitted is located.
 - A filed foreign court order that authorizes the commitment of a person to a health care facility for inpatient care may be enforced in the same manner as a court order of the court in which it is filed.

- A foreign court order that authorizes the commitment of a person to a health care facility for inpatient care is subject to the contractual agreement with the foreign state. TEX. [HEALTH & SAFETY] CODE ANN. § 81.211 (West 2009).
- Those persons with a legal residency outside the [state] and known to have infectious tuberculosis may be admitted temporarily to an approved hospital and receive other tuberculosis services to protect the public health of the citizens of the [State]. TENN. COMP. R. & REGS. 1200-14-1-.14 (2009).
- State, district, municipal and county health officers involved in tuberculosis control and elimination shall notify appropriate health authorities of jurisdictions in the appropriate states, territories, and municipalities when an individual with confirmed or clinically diagnosed infectious tuberculosis or currently under treatment for tuberculosis disease relocates from [State] into another jurisdiction, such notification being subject to approval of the state health officer or such officer's designee. Notwithstanding any provision of law to the contrary, the commissioner of health is authorized to notify the appropriate tuberculosis infection control staff of this or another state of an individual's tuberculosis infection for the sole purpose of containing a potential threat to the public health and welfare or to assure completion of proper treatment of the diseased person. All persons who receive notification of the infectious condition of an individual under this subsection shall hold the information in the strictest confidence and shall not reveal the information to others. A person making disclosure by providing patient identifying information and medical information related to the patient's tuberculosis status is immune from liability for making this disclosure of information for the purpose of preventing the further spread of disease and assuring completion of proper treatment of the [person with tuberculosis]. TENN. CODE ANN. § 68-9-201 (2009).
- Return of a tuberculosis patient to location of residence
 - A [State] resident who is receiving tuberculosis health care services in another state and desires to return to [State] shall be referred to the local health official where the patient resides. The information requested of the other state by the local health official regarding the patient, shall include at least the following: 1) medical history including sufficient clinical data to indicate need for further care and treatment of tuberculosis; 2) a statement that the patient is physically able to travel without harm to himself or others, and arrangements have been made for his transfer to [State]; 3) information for residence verification; 4) a statement indicating the patient's willingness to return to [State] for further care and treatment of tuberculosis; and 5) names and addresses of individuals who will assume responsibility for the patient.
 - Once residence is established and the patient is able and willing to return, final arrangements for transfer shall be made by the local health official directly with the authorities of the other state.
 - When a non-resident tuberculosis patient is willing and able to return to the political subdivision in which the patient resides in another state or country, the local health official where the patient's provider is located, or the Commissioner's designee, shall make arrangements with the health official of the political subdivision in which the patient resides so that the patient can be met on return and be provided the health care services needed. Copies of provider reports shall

also be forwarded to said health official. N.Y. COMP. CODES R. & REGS. tit. 10, § 43-1.16 (2009).

- Tuberculosis; removal of patients to another state or country; costs
 - When any state charge, as defined in this article, who has not acquired state residence has settlement or residence or otherwise belongs to or in any other state or country, has legally responsible relatives or friends willing to undertake the obligations to support him or to aid in supporting him in such other state or country, the department may furnish him with transportation to such state or country, provided, in the judgment of the commissioner the interest of the state and the welfare of such person will be promoted thereby.
 - The commissioner shall designate or employ nurses or attendants to accompany such persons being removed out of the state unless it appears that such persons are in suitable condition to travel alone with safety.
 - The expense of such removal shall be paid from the state treasury on the audit and warrant of the comptroller pursuant to a verified account submitted by the department, and the commissioner shall thereupon seek reimbursement for such expense from the state or country of residence. N.Y. PUB. HEALTH LAW § 2204 (Consol. 2009)

C. Miscellaneous – Local Travel Restrictions and Notices

Descriptive Note: The provisions in this section relate to intrastate coordination of TB prevention and control. Public health officials may generally impose travel restrictions for persons with infectious TB to prevent interruption of treatment and to protect the public's health from TB transmission.

- A health officer or health care provider treating an individual with tuberculosis or suspected tuberculosis may: (1) Impose limitations on travel; and (2) Place restrictions on hospital discharge. MD. CODE REGS. 10.06.01.21 (2009).
- An individual with active tuberculosis who intends to travel or relocate shall notify the county or district tuberculosis control unit. The unit shall notify the department of health when an individual with active tuberculosis relocates. The department shall notify the tuberculosis control unit of the tuberculosis control district to which the individual intends to travel or relocate or the appropriate public health authority of the state to which the individual intends to travel or relocate. OHIO REV. CODE ANN. § 339.82 (LexisNexis 2009).
- When a tuberculosis patient leaves the hospital against medical advice, the administrator shall, within 24 hours thereafter, notify both the local health officer of the county responsible for the tuberculosis patient's hospital care and the local health officer of the jurisdiction to which the tuberculosis patient is believed to have gone. MICH. ADMIN. CODE r. 325.178 (2009).
- Whenever any local health officer learns that any person with infectious or noninfectious tuberculosis has been or is being transported into or out of his health jurisdiction, the health officer shall immediately notify the department of such movement. Both the new and old address shall be stated. 410 IND. ADMIN. CODE 2-1-4 (2009).

Appendix A. Due Process

Acknowledgements: We would like to extend our thanks to Joseph Foster, JD, Senior Attorney, Office of the General Counsel, Public Health Division, CDC, and James Misrahi, JD, Senior Attorney, Office of the General Counsel, Public Health Division, CDC, for their invaluable input on this Appendix.

Tuberculosis (TB) is an airborne infectious disease that is caused by *Mycobacterium tuberculosis*. Approximately 11,000 to 12,000 individuals develop TB disease annually in the United States and there are about 9 million new TB cases worldwide each year. Measures taken by public health officials to prevent and control TB that involve physical constraint (e.g., isolation, confinement in a facility) implicate due process because such action may infringe on individual liberty. A proper balance must be struck between protecting the public's health and protecting the liberty interests of the person suspected or confirmed to have active TB. With treatment, persons with pan-susceptible TB (TB that is susceptible to all four first-line anti-TB drugs) may be rendered non-infectious in as little as 1 to 2 weeks, but it can take months of treatment before MDR and XDR TB patients become non-infectious. In addition, the treatment period for TB is longer than most other communicable diseases (6 to 9 months for pan-susceptible TB and 2 years or more for MDR or XDR TB). Therefore, measures that may be necessary to protect the public's health from transmission of TB, such as isolation and confinement in a facility, could entail physical restriction spanning weeks, months, or longer. Consequently, due process has been a frequent subject of challenges to TB laws or other types of government action.

The due process clause of the Fourteenth Amendment to the U.S. Constitution prohibits state governments from depriving individuals of life, liberty, or property without due process of law. "Substantive due process" generally requires the government to have adequate justification for implementing laws or taking other official actions that deprive individuals of life, liberty, or property. "Procedural due process" requires the government to use fair and reasonable procedures when restraining a person's liberty. Notice and an opportunity to be heard are among the most fundamental procedures that must be available. Public health officials generally employ a step-wise approach to implementing TB control measures, beginning with the least restrictive measure necessary to address the specific facts and circumstances of a case. The "least restrictive measure" is the intervention that restricts the patient's activities the least while providing sufficient protection to the public from TB transmission. A determination of the least restrictive measure requires an individualized assessment of the patient and his/her circumstances, and includes consideration of factors such as past or present adherence to treatment and infectiousness.

All state TB prevention and control laws must comport with federal constitutional requirements; however, considerable variation exists state-to-state not only in the laws but also the applicable due process standards based upon state constitutions, court decisions, and legislative enactments. While the table below presents general examples of public health actions and the possible

measures that may be taken to accommodate due process implications, some states may require more than what is presented and some may require less. It is therefore imperative that TB programs consult their legal counsel to determine the applicable requirements in their jurisdiction.

Generally speaking, public health officials may exercise TB control laws that deprive an individual of his or her liberty if reasonable justification exists for doing so and the individual is afforded commensurate due process. Health officers may order a person suspected or confirmed to have active TB to adhere to a variety of TB control measures. Notice and an explanation of the consequences of violating the order generally must be provided to the patient. In the majority of states, a health officer or other public health official may issue an initial order (for treatment or examination), but then must apply to a court of competent jurisdiction for enforcement or validation of the order if the individual is nonadherent. Some states grant public health officials authority to petition the court directly for an order for TB control measures such as examination or outpatient treatment. Persons suspected or confirmed to have active TB generally may be detained without a prior hearing if public health officials reasonably believe that the public's health would be threatened in the absence of such detention. This is commonly referred to as "emergency detention." Most state laws then require a hearing before a court within a timeframe specified by law to determine whether the patient should remain confined, in which due process protections generally include a right to counsel, a right to present evidence, a right to cross-examine witnesses, and a right to appeal. In these circumstances, confinement in a facility until completion of treatment is generally considered to be the most restrictive measure.

Examples of Public Health Actions	Examples of Potential Due Process Measures
Order to report to the health department or to a physician for counseling and education (about TB disease, infection control measures, and/or drug and alcohol issues) ³	<ul style="list-style-type: none"> • Reasonable grounds to believe the person has active TB and is nonadherent to his/her treatment plan, or has exhibited a need for drug and alcohol counseling • Notice provided to person with suspected active TB <ul style="list-style-type: none"> - Legal authority under which the order is issued - Other terms and conditions that may apply - Explanation of consequences of nonadherence to order
Order for examination for suspected active TB ⁴	<ul style="list-style-type: none"> • Reasonable grounds to believe the person has active TB and is nonadherent to voluntary examination • Notice provided to person with suspected active TB <ul style="list-style-type: none"> - Legal authority under which the order is issued - Name of person to be examined - Time and location of examination - Other terms and conditions that may apply - Explanation of consequences of nonadherence to order
Order for emergency detention	<ul style="list-style-type: none"> • Reasonable grounds to believe the person has active TB and will not adhere to voluntary confinement • Notice provided to person with suspected or confirmed active TB <ul style="list-style-type: none"> - Legal authority under which the order is issued - Location of facility where person will be detained - Right to request release - Explanation of consequences of nonadherence to order • Right to a hearing after person is detained as required by state law, if public health officials seek continued detention (see footnote 6)
Order for: <ul style="list-style-type: none"> - Completion of treatment until cure (outpatient) - Directly observed therapy - Exclusion from work or other public settings - Isolation in the home (with or without electronic monitoring device)⁵ - Confinement in a facility for treatment 	<ul style="list-style-type: none"> • Reasonable belief or clear and convincing evidence that the person has active TB and is nonadherent to voluntary disease control measures • Notice provided to person with suspected or confirmed active TB <ul style="list-style-type: none"> - Legal authority under which the order is issued - Individualized assessment of circumstances that constitute basis of the order - Period of time during which the order is effective - Explanation of consequences of nonadherence to order • Right to request release, if order is for confinement • Right to hearing, if hearing is required under state law⁶

³ An order to report to the health department for counseling and education is separated from other types of orders because it is a less restrictive alternative and would not encompass the same due process measures as orders for more restrictive disease control measures.

⁴ An order for examination is separated from other orders because state laws generally treat examination as a less restrictive alternative to other disease control measures, such as confinement.

⁵ Isolation with electronic monitoring is offered as a less restrictive alternative to confinement in a facility when a patient has demonstrated nonadherence to isolation in the past or presently. If an isolation order compels isolation through completion of treatment, a court hearing would generally be required with full hearing rights.

⁶ State laws vary with respect to when a hearing is required: some states provide for a hearing when a health order is challenged by the individual with suspected or confirmed TB, and state law allows for judicial review; some provide for a hearing when an order is violated and the health officer petitions the court to enforce/validate the order; and others provide for a hearing when a court order is sought in the first instance. The government is generally required

Appendix B. Selected State Tuberculosis Control Cases⁷

Acknowledgement: We would like to extend our thanks to Tara Ramanathan, JD, MPH, ORISE Fellow, Public Health Law Program, CDC, for her work on this Appendix.

1. Dept. of Community Aff. v. Eden House, Inc., No. A-3311-05T2, 2009 WL 1163983 (N.J. Super. App. Div. May 1, 2009).
The court affirmed the administrative law judge's determination that a for-profit residential healthcare facility violated health/safety/welfare regulations, including failure to ensure that all of its employees were tested for TB in accordance with state law. Consequently, revocation of the facility's license and imposition of fines and penalties were appropriate.
2. Huffman v. State, 204 P.3d 339 (Alaska 2009).
A regulation requiring all students new to public school to receive a tuberculin skin test that also provided for an exemption for any child who provided an affidavit from a physician did not infringe on parents' First Amendment right to free exercise of religion.
3. Levin v. Adalberto M., 156 Cal. App. 4th 288, 67 Cal. Rptr. 3d 277 (Cal. Ct. App. 2 Dist. 2007).
A patient with TB did not have a due process right at the civil detention hearing to a unanimous jury verdict on proof beyond a reasonable doubt of his unwillingness to complete a prescribed course of medication and to follow infection control precautions, which justified the detention order.
4. In re Washington, 292 Wis. 2d 258, 716 N.W.2d 176 (Wis. App. 2006).
The state TB control statute authorizes long-term confinement, to a jail, of a person with noninfectious TB who is at a high risk of developing infectious TB and who fails to comply with a prescribed treatment regimen. Confinement in a jail is allowable under Wisconsin law, so long as a court determines that the facility is a place where proper care and treatment will be provided, and the spread of disease will be prevented (a court may consider cost as a factor if faced with a choice between two or more facilities that meet these criteria).
5. Adair's Peace of Mind Day Care, LLC v. Comm'n, No. 2001-CA-000546-MR, 2003 WL 1389875 (Ky. App. Mar. 21, 2003).
The day care's operating license was revoked due to numerous deficiencies in violation of state regulations, including a lack of documentation that employees had been tested for TB.

to prove by clear and convincing evidence that confinement is necessary to protect the public's health at a hearing for a court order for confinement in a facility (also called commitment). The individual has a right to counsel, right to present evidence and cross-examine witnesses, right to a transcript of the proceedings, and a right to appeal.

⁷ We chose the state cases (listed in chronological order with a brief description of the court's holding) in this Appendix based on potential interest and relevancy to readers of the Menu, particularly state TB programs and their legal counsel.

6. *Dorsey v. Adams*, 255 Ga. App. 257, 564 S.E.2d 847 (Ga. Ct. App. 2002).
The court held the county responsible for insufficient inmate medical care in the county jail, including lack of documentation of required TB testing and defective TB isolation rooms.
7. *Souvannarath v. Hadden*, 116 Cal.Rptr.2d 7, 95 Cal. App. 4th 1115 (Cal. Ct. App., 5 Dist. 2002).
The court held that detaining TB patients in jail is a violation of California law, and ordered the county to desist from placing nonadherent TB patients in the county jail.
8. *Hannis ex rel. Hannis v. Sacred Heart Hosp.*, 789 A.2d 368 (Pa. Cmmw. Ct. 2001).
Names and addresses of persons identified by the Bureau of Health in connection with its investigation of a physician who allegedly exposed patients to TB was confidential information contained in confidential records protected by statute, and thus not discoverable in parents' class action negligence suit against a physician for damages arising out of TB exposure; disclosure of names and addresses would not further the statute's purposes but would undermine the local health agency's ability to collect information and deter patients from seeking treatment.
9. *Bradley v. Crowell*, 694 N.Y.S.2d 617, 181 Misc. 2d 529 (N.Y. Sup. Ct. 1999).
A petition by the county health officer requesting involuntary detention of an individual with communicable TB required proof by clear and convincing evidence.
10. *City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008, 165 Misc. 2d 1014 (N.Y. Sup. Ct. 1995).
The court upheld an order requiring involuntary detention in a hospital of a person with active TB until completion of treatment, or until a change in circumstances indicates that the patient can be relied upon to complete the prescribed course of medication without being in detention.
11. *Kappers v. DeKalb County Bd. of Health*, 214 Ga. App. 117, 446 S.E.2d 794, (Ga. Ct. App. 1994).
The trial court ordered a patient with infectious TB to adhere to the board's petition for involuntary home isolation and outpatient treatment. The patient appealed and the appellate court dismissed the case as moot because the board lifted the order of home isolation once the patient was determined to be noninfectious.
12. *City of New York v. Doe*, 205 A.D.2d 469, 614 N.Y.S.2d 8 (N.Y. App. Div., 1 Dept. 1994).
A patient appealed an order of the trial court directing continued detention, arguing that her MDR TB could be treated and the public's health protected by less restrictive means. The court disagreed – "Clear and convincing evidence of respondent's inability to comply with the projected 18 to 24 month prescribed course of medication in a less restrictive environment was provided by proof of her history of drug abuse, unstable or uncertain housing accommodations, apparent inability as demonstrated by her own testimony, to understand the nature and seriousness of her condition, and refusal to

cooperate with petitioner's repeated efforts to have her participate in voluntary forms of directly observed therapy.”

13. *Langton v. Comm’r of Correction*, 614 N.E.2d 1002, 34 Mass. App. Ct. 564 (Mass. App. Ct. 1993).
The court upheld a mandatory TB testing program in prisons because the Department of Public Health had authority to order TB testing, the Department of Correction had authority to implement the mandatory testing program, the inmates had no constitutional right to refuse TB tests, and conducting testing in allegedly unsanitary conditions was not cruel and unusual punishment.
14. *City of Newark v. J.S.*, 652 A.2d 265 (N.J. Super. Ct. Law Div. 1993).
The court upheld confinement of a patient with TB, finding that public health officials proved by clear and convincing evidence that the patient had active TB and posed a risk to the public’s health. The court determined that since the patient was homeless and neither the patient nor his attorney proposed a less restrictive setting than a hospital, the patient must be isolated in a hospital to protect the public’s health. The court also upheld the involuntary confinement statute, but construed it to include due process rights and guarantees under the Americans with Disabilities Act.
15. *County of Cook v. Chicago*, 593 N.E.2d 928, 229 Ill. App. 3d 173 (Ill. App. Ct. 1992).
The county brought suit against the city, seeking reimbursement of expenses for treating city residents with TB at the county hospital after the city closed the municipal TB sanitarium. The court found that the city was not unjustly enriched by deciding to close the TB sanitarium, even though the county hospital treated residents who formerly received inpatient treatment for TB, since the city had no duty to maintain or establish the TB sanitarium and the county hospital had an independent duty of care to all patients. The court also held that the city had no statutory duty under public health laws to provide inpatient care and treatment to residents with TB.
16. *L.G. v. State*, 775 S.W.2d 758 (Tex. Crim. App., El Paso 1989).
After a TB patient was ordered confined at a hospital designated by the state commissioner of health, the trial court changed the patient's confinement and treatment to another hospital. The appellate court held that the trial court lacked authority to change the place of confinement and treatment unless the commissioner designated another facility.
17. *Greene v. Edwards*, 263 S.E.2d 661, 164 W. Va. 326 (W. Va. 1980).
The court granted a writ of habeas corpus and a new hearing for a patient with active TB involuntarily confined to a hospital, because counsel was not appointed until after the commitment hearing commenced and was therefore unprepared to defend the patient. The court held that patients must be afforded the following due process rights under the state TB Control Act: “adequate written notice detailing the grounds and underlying facts on which commitment is sought; the right to counsel; the right to be present, to cross-examine, to confront and to present witnesses; the standard of proof to be by clear, cogent

and convincing evidence; and to the right to verbatim transcript of the proceeding for purposes of appeal.”

18. *District of Columbia v. Weiss*, 263 A.2d 638 (D.C. 1970).

The appellee did not pay a hospital bill for TB treatment, and the city brought an action for breach of contract. The court held that the statute of limitations does not apply to the suit brought by the city, even if based on contract, because expending money for the treatment of TB is for the public health and the public good.

19. *Hermitage Health & Life Ins. Co. v. Cagle*, 420 S.W.2d 591, 57 Tenn. App. 507 (Tenn. Ct. App. 1967).

The court held the insurer liable for hospitalization expenses for a TB patient hospitalized in a tax-supported state institution by statute, which provides that “all policies which afford coverage for tuberculosis, as this policy does, ‘shall not exclude hospitalization benefits for tubercular patients hospitalized in tax supported institutions of the state of Tennessee or any county or any municipality thereof.’” The court noted that the rule of law in Tennessee is that any statute applicable to an insurance policy becomes part of the policy and such statutory provisions override and supersede anything in the policy repugnant to the provisions of the statute.

20. *Application of Halko*, 54 Cal. Rptr. 661, 246 Cal. App.2d 553 (Cal. Ct. App. 1966).

The court denied the writ of habeas corpus filed by a TB patient isolated at a hospital pursuant to a health officer’s successive quarantine orders issued in 6 month intervals. The court held that “[state law] does not contain any limitation or prohibition respecting the period of quarantine or the power of the health officer to issue consecutive certificates of isolation. The law reasonably assumes that consecutive orders for quarantine may issue so long as any person continues to be infected with tuberculosis and on reasonable grounds is believed by the health officer to be dangerous to the public health.”

21. *Moore v. Armstrong*, 149 So. 2d 36 (Fla. 1963).

The court found that the petitioner had not been deprived of his civil rights during periods of isolation for nonadherence while confined in a state hospital for treatment of infectious TB; writ of habeas corpus denied.

22. *Jones v. Czapkay*, 6 Cal. Rptr. 182, 182 Cal. App. 2d 192 (Cal. Ct. App., 1 Dist. 1960).

The court found the city and county health officers not liable to the plaintiff, who developed TB meningitis after allegedly being infected by a person who health officers knew had TB but who was not in quarantine.

23. *State v. Snow*, 324 S.W.2d 532, 230 Ark. 746 (Ark. 1959).

Health officials petitioned the probate court to involuntarily commit the defendant, who they alleged to have infectious TB, to the state TB sanatorium. The probate court held that the petitioner “failed to show by sufficient and competent evidence that the respondent has tuberculosis in a communicable or infectious stage; has failed to establish by sufficient and competent evidence that the circumstances are not suitable for proper isolation or contagious control; has failed to establish by sufficient and competent

evidence that the respondent is a source of danger to others and has failed to establish by sufficient and competent evidence that respondent should be committed to the sanatorium.” On appeal, the court affirmed the probate court’s ruling as not contrary to the preponderance of the evidence.

24. *State ex rel. Holcombe v. Armstrong*, 239 P.2d 545, 39 Wash. 2d 860 (Wash. 1952).

The court upheld a University of Washington rule requiring a chest x-ray examination for TB for all incoming students, finding that the public health interest of students and university employees outweighed the First Amendment interest of the student who sought a religious exemption. “Infringement of appellant’s rights is a necessary consequence of a practical attempt to avoid the danger.”

25. *Moore v. Draper*, 57 So. 2d 648 (Fla. 1952).

A patient was confined in the state TB sanitarium pursuant to a commitment order issued by a county judge under the state TB statute. The patient challenged the statute, arguing that it violated due process and the First Amendment right to free exercise of religion. The court denied the writ of habeas corpus, holding that “the statute relating to compulsory isolation and hospitalization of tubercular persons is not unconstitutional as discriminatory against all persons other than those of certain religious faith and belief.”

26. *In re Stoner*, 73 S.E.2d 566, 236 N.C. 611 (N.C. 1952).

The court denied the writ of habeas corpus filed by a TB patient who was convicted of violating the state TB statute, enacted for the prevention of the spread of TB, for failing “to take the health precautions prescribed by the Health Department to protect his family and the public from being infected with tuberculosis, he being an active tubercular carrier in the infectious stage.”

27. *County of Hennepin v. County of Houston*, 39 N.W.2d 858, 229 Minn. 418 (Minn. 1949).

The court found that the county in which a TB patient resides is responsible for the cost of treatment at a different county’s facility.

28. *Perez v. Lippold*, 198 P.2d 17, 32 Cal. 2d 711 (Cal. 1948).

The court struck down a state statute prohibiting interracial marriage based on the state’s interest in protecting marital partners from communicable diseases (based on the suggestion “that certain races are more prone than the Caucasian to diseases such as tuberculosis”) in part due to a violation of the Equal Protection Clause of the U.S. Constitution.

29. *Conlon v. Marshall*, 59 N.Y.S.2d 52 (N.Y. Sup. Ct. 1945).

The court upheld a regulation requiring teachers and school employees to obtain medical certificates clearing them of active TB promulgated pursuant to the authority of the Board of Health for the City of New York to protect children and the public good.

30. *In re Opinion of the Justices*, 14 N.E.2d 953, 300 Mass. 615 (Mass. 1938)

[Opinion by the Court to the Legislature of Massachusetts]. The court found a proposed act regulating the operation of barbershops, which were thought to promote the spread of TB and other communicable diseases, unconstitutional.