

User's Guide for Scenario-Based Assessment of Understanding and Sufficiency of TB Control Laws

Division of Tuberculosis Elimination, Public Health Law Program, and Division of Global Migration and Quarantine, Centers for Disease Control and Prevention
National Tuberculosis Controllers Association

Overview

This tuberculosis scenario-based assessment (Assessment) was developed by the Centers for Disease Control and Prevention's (CDC) Public Health Law Program, Division of Tuberculosis Elimination, and Division of Global Migration and Quarantine, in consultation with the National Tuberculosis Controllers Association. The Assessment is designed as a means to assess understanding, and possibly, sufficiency of state, local, and/or tribal laws to control TB. The Assessment comprises six sets of facts prompting consideration of a variety of legal issues related to TB control, each followed by questions designed to stimulate discussions of the participants' understanding of relevant legal authorities and identify potential gaps or limitations in the law.

The Assessment is designed to be readily modified to address other issues or fact patterns of interest to particular jurisdictions. **In addition, review of a jurisdiction's TB control laws should be an antecedent part of the Assessment.**

Background

By the early 1990s, the Centers for Disease Control and Prevention (CDC) and Advisory Council for the Elimination of Tuberculosis (ACET) had identified the need to assess state laws regarding evolving tuberculosis (TB) control issues such as requirements for curing persons with TB and for the growing problem of multi drug-resistance (MDR). In further response to these issues, CDC conducted a survey of and ACET developed recommendations regarding state TB control laws. The survey findings were disseminated nationally in November 1993 in a dedicated issue of *MMWR* ("Tuberculosis Control Laws -- United States, 1993: Recommendations of the Advisory Council for Elimination of Tuberculosis," available at <http://www.cdc.gov/mmwr/PDF/rr/rr4215.pdf>). A primary purpose for this report was to provide recommendations "to assist states in revising their TB-control laws and regulations."

The impact of ACET's 1993 recommendations has never been determined. Moreover, of the myriad developments since 1993 that have further confounded TB control and aspirations to eliminate TB in the United States, most have implicated questions regarding the status and enforcement of jurisdictions' laws for controlling and preventing TB.

These concerns, presented to the ACET in July and November 2007, and discussed in-depth with CDC's Division of Tuberculosis Elimination, have prompted the initiation of a set of activities

aimed at improving understanding and use of law in support of TB control efforts, including: 1) a 25 jurisdiction report on express TB control laws, 2) a report on express tribal TB control laws, 3) a handbook and accompanying PowerPoint on TB control laws that local, state, and tribal public health practitioners and their legal counsel can use to improve their understanding of and competency in applying those laws, 4) a TB scenario-based assessment, and 5) a “best practices” document composed of legislative and regulatory TB law provisions. The findings of the 25 jurisdiction report will serve as a resource for the Advisory Council for the Elimination of TB (ACET) in reviewing its recommendations in the 1993 Morbidity and Mortality Weekly Report article on state TB control laws.

Key parts of this project are being carried out under an existing cooperative agreement with CDC by the Georgetown Law / Johns Hopkins University Center for Law and the Public’s Health, a CDC Collaborating Center for Public Health Law (the Center).

Purpose

The Assessment is intended to assist public health officials of any tribe, state, locality, or territory in assessing legal preparedness for controlling tuberculosis. State and local public health practitioners and their legal counsel, emergency planners, tuberculosis control experts, representatives from the judiciary, and CDC representatives met in Kansas and Florida in May, 2008 as a means to assess understanding, and possibly, sufficiency of those states’ laws to control TB. The purposes of the Assessment include: identification of a jurisdiction’s legal authorities, application of fact sets and questions to the corresponding legal authorities, illustration of potential gaps in legal authorities, and testing of key TB control issues (e.g., TB control measures, consent to treatment, health information privacy, and interjurisdictional coordination).

Planning Your Jurisdiction’s TB Scenario-Based Assessment

- **Designate project lead.** The project lead will likely be the TB Controller or his/her legal counsel in a jurisdiction’s health department. Alternatively, a senior public health practitioner in a jurisdiction’s TB control program may serve as the project lead.
- **Identify project team members and form the project team.** The project lead should work with senior staff of all agencies with roles to play in implementing TB control measures – and with counterparts in health care and other private sectors – to identify and engage members of the project team. The two jurisdictions that conducted the Assessment engaged team members from emergency management, public health, education, law enforcement, and other government agencies as well as representatives of health care providers, and state and local elected officials.
- **Develop a plan for the project.** The project team lead should designate an experienced moderator, and that individual should be instructed as to the time allotted for the exercise and for a question and answer period. The project team should develop a timeline for the

Assessment and a location, which should include a u-shaped room with PowerPoint capabilities, a projector, and a microphone for the moderator. The project team should invite participants from multiple sectors, including, but not limited to:

- State and local health officers and counsel
- Governor's and Attorney General's office and counsel
- State legislative representatives and counsel
- Relevant state agencies, including public health, law enforcement, homeland security, transportation
- State and local boards of health
- Representatives of the judiciary, law enforcement, and other first responders
- Tribal leaders and their health and legal officials
- Members of the private bar (e.g., attorneys for healthcare entities)

In addition to the officials and entities cited above, please consider inviting CDC representatives to be present at your jurisdiction's Assessment.

- **Create a background memorandum or other guidance to be given to the meeting participants no later than two weeks prior to the meeting.** The memorandum should include a review of your jurisdiction's TB control and prevention authorities, both general and express.
- **Sample Agenda.** A sample agenda for the half-day Assessment is provided below. Time for breaks and lunch should also be figured into the below schedule.
 - **Review of Current TB Control Law** (*Time 45 minutes*)
This session includes:
 - 1) A general introduction to the meeting by the moderator
 - 2) An introduction of each participant
 - 3) A brief oral review of the jurisdiction's laws (both general and express), given by the most-qualified expert on tuberculosis control and prevention law (this will usually be the chief public health attorney of the jurisdiction)
 - **Scenario** (*Time 120 minutes*)
This session will provide participants the opportunity to exercise and/or discuss the jurisdiction's authority to prevent and control TB, and identify gaps and needs. **A hypothetical scenario for use in the Assessment is included in Appendix 1. The scenario used by Kansas is provided in Appendix 2.** Depending on the size of your jurisdiction's Assessment, participants should be divided into groups to discuss and evaluate the fact pattern based on your jurisdiction's current legal authorities and any practical considerations in implementing them. The scope of discussion should generally cover key areas in TB control (also covered in the 25-jurisdiction report referenced above):
 - Prevention of TB cases, including TB control programs
 - Identification of TB cases, including screening, examination and testing, and reporting

- Management of TB cases, including: investigation; treatment (treatment and directly observed therapy); specific measures (emergency detention, quarantine, isolation, and restricted activities); and enforcement
 - Safeguarding rights, including due process, confidentiality and privacy, anti-discrimination, and religious exemptions
 - Considerations for special populations
 - Any additional TB provisions
- **Wrap-up** (*Time 45 minutes*)

This session would consist of a wrap-up, with the facilitator leading the participants in addressing, at a minimum, the questions regarding understanding, and possibly, sufficiency, of the jurisdiction’s legal authorities, any gaps and other uncertainties regarding the powers and authorities to conduct a range of TB prevention and control measures, and consideration of priority action steps for addressing such gaps or uncertainties.
- **Create and disseminate a report of the meeting and after-action items.** The project team should designate the individual who will be responsible for producing and disseminating key findings from the Assessment.

Project Contacts

As you engage in the planning process, please feel free to contact CDC project staff at any time for technical or administrative assistance:

- Richard Goodman, Co-Director, PHLP
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APPENDIX 1

CDC Scenario-Based Assessment: Understanding and Sufficiency of States' TB Control Laws

Generic Version – 31 October 2008

Developed by:

**Public Health Law Program
Division of Tuberculosis Elimination
Division of Global Migration and Quarantine**

Objectives

This hypothetical scenario has been designed to assist persons in state agencies and/or other jurisdictional settings with roles and responsibilities for controlling and preventing the spread of tuberculosis to explore their understanding of, and to identify potential limitations of or gaps in:

- The viability and sufficiency of jurisdiction-specific legal authorities for limiting or preventing the transmission of TB through fundamental steps, including: screening and identification of cases; contact investigation; investigation of known or suspect cases; reporting of cases; treatment (including directly-observed treatment); the use of specific containment measures (e.g., isolation, quarantine, and other restrictions); and measures for ensuring the legal protections of persons with cases of TB, such as procedural due process, health information privacy, anti-discrimination, respect for religious beliefs, and other individual safeguards and protections.
- Legal authorities, requirements and options for coordination of multi-jurisdictional (intrastate, interstate, and international) TB case management, including screening for infectiousness before travel or movement outside of the original jurisdiction, managing risk of infection during travel, and ensuring continuity and completion of treatment (and coverage of associated costs) before and after travel.
- Legal authorities for coordination of control efforts (e.g., identification, reporting, contact investigation, and treatment of TB cases), across key sectors, including public health, health care providers, and public safety / law enforcement, and in various settings (e.g., schools, correctional facilities, nursing homes, mental health facilities, and homeless shelters).
- Legal authorities in relation to the infectiousness of smear-negative / culture-positive patients.
- Legal authorities for supporting treatment with static antimicrobial options in the face of

progressive increases in drug resistance.

- Laws addressing the financial costs associated with treatment of adherent individuals and with detention and treatment of non-adherent individuals, and the housing (voluntarily or involuntarily) and treatment of a person with a case of infectious TB in a treatment facility in a state other than that of the person's legal domicile.

Disclaimer

The information contained in this document does not constitute legal advice, and the contents have not been formally disseminated by the Centers for Disease Control and Prevention (CDC) and should not be construed to represent any agency determination or policy. The contents are for informational purposes only and are not intended as a substitute for professional legal or other advice. While every effort has been made to verify the accuracy of these materials, legal authorities and requirements may vary from jurisdiction to jurisdiction. Always seek the advice of an attorney or other qualified professional with any questions you may have regarding a legal matter. In addition, the hypothetical information in this original version of this scenario has been developed as a means to assist state agencies and other jurisdictional organizations in assessing state laws relating to TB control; state and other agencies should be aware of the hypothetical nature of information contained in the original version of this scenario as developed by CDC.

Context and assumptions

- For the purposes of the following scenario and facts, it is assumed that the situations would be addressed by existing TB control and other public health personnel, systems, and resources in (state).
- It also is assumed that (state) law will apply, as will state judicial procedure.

Background: A 45-year-old professor at a large private university located in Centralia, a major metropolitan area in (state) near the state line, has over a period of several weeks had onset of fever, night sweats, anorexia, weight loss, and a progressively productive cough. The professor (Patient A), a citizen of a country with high TB prevalence in Southeast Asia, has been admitted to the United States on a 24-month visa permitting him to teach and conduct research at the university. His duties include supervision of and frequent face-to-face contact with approximately 100 undergraduate students. He and his family – which includes his wife and son (age 17 years) – live in an apartment in a small community in a nearby county; his son attends a public high school. The university health service physician who is evaluating Patient A has diagnosed suspected active pulmonary TB based on Patient A’s medical and family histories, findings on physical examination, and a suspicious chest x-ray; Patient A’s TST is equivocal. Initial sputum specimens are smear-negative for AFB and sputum cultures have been initiated. Patient A’s 17-year-old son (Patient B) receives high-dose, systemic corticosteroids to treat juvenile rheumatoid arthritis, and recently has developed symptoms similar to his father’s, including fever, night sweats, and a cough. Because Patient B is not eligible to receive medical care at the university’s health service, his parents have taken him to an outpatient “doc-in-the-box” clinic located in a shopping center. The evaluating physician detected rales and other auscultatory abnormalities, but failed to elicit Patient B’s family history and did not order other diagnostic studies, including a chest x-ray and TST.

Facts I: During the (state) health department’s investigation of a recent statewide measles outbreak, the university health service and other university officials initially refused health department requests for medical records and other information on suspected measles cases in the university community and on potentially exposed students, faculty, and staff. The university also refused to assist the health department with efforts to screen some students, faculty, and staff for the presence of measles-specific antibody. The university had refused to cooperate because of concerns about invasions of privacy and the university’s own policies to strictly protect such information regarding members of the university community. Nonetheless, the director of the university’s health service has contacted the local public health unit for guidance in addressing the following. Because of a strong history of pulmonary TB (including MDR-TB) among Patient A’s extended family in his home country, Patient A fears that both he and his son might have TB; he therefore has informed the university health service that he has purchased plane tickets for himself and his family to leave for his home country in two days so that he can receive medical care in familiar surroundings. The nearest international airport is a short distance from Patient A’s apartment, just over the state line in the bordering state.

Question 1: If the local and state health departments decide to conduct TST and other TB screening of students, faculty, and staff who have been potentially exposed to the professor, Patient A, under what legal authority(ies) can these screening activities be carried out? What, if any, additional authority(ies) and procedures might be implicated if the university, or individuals within the university community, refuse to cooperate?

Question 2: If the health departments' assessment indicates that Patient A and his family should not be permitted to travel out of state because of requirements for treatment of infectious TB, further evaluation, and/or monitoring, and because of risks to others, then under what legal authority(ies) and procedures can Patient A and his family be detained?

Facts II: The local health department notifies Patient A that he and his family members are not to travel and asks them to remain at their apartment while further decisions are being made regarding diagnostic and screening activities, and case management measures. Following conversations that Patient A has with his family overseas, with a local attorney, and with officials in his country's embassy in Washington, D.C., Patient A informs the health department that he refuses to cooperate and will, in fact, leave (the state) and the United States by air the next day. The local and state health departments – having determined that both the professor (Patient A) and his son (Patient B) have potentially infectious cases of pulmonary TB and pose risks to others – now make a decision to order both of them into home isolation while culture results are pending for Patient A, and to order Patient A's wife also to cooperate with efforts to monitor her status for clinical indicators of TB.

Question 3: Under (state) law, what steps and procedures are required to order Patients A and B into home isolation if they will not comply with a request to do so voluntarily? What additional considerations of law might apply given that Patient A and his family members are not U.S. citizens?

Question 4: In addition to ordering home isolation, what additional tools would be available to public health officials to prevent Patient A from flying back to his home country?

Question 5: What provisions of (state) law address procedural due process considerations, as well as other personal liberty and privacy interests of non-U.S. citizens such as Patient A and his family members?

Facts III: As a result of health department orders, Patient A reluctantly agrees that he and his son (Patient B) will comply with the home isolation order and that his wife will comply with the request to cooperate with further evaluation and monitoring efforts. On multiple subsequent attempts to induce sputum, Patient A remains smear-negative. However, after three weeks, some of Patient A's initial sputum cultures are reported as positive for *M. tuberculosis* and resistant to isoniazid and rifampin, indicating that Patient A is infected with a multi-drug resistant (MDR) strain. Because of this, and taking into account the previous information, the health department has contacted the area Quarantine Station of CDC's Division of Global Migration and Quarantine about this situation and, as a result, the name of Patient A has been placed on a public health list to prevent him from boarding commercial airliners. The local public health department informs Patient A of this result, including the implications for his treatment, for ongoing evaluation of his son (Patient B), and for the continued monitoring of Patient A's wife. Hearing these details, Patient A becomes apprehensive, again deciding to travel with his family to his home country, and makes reservations to leave the following day. The next day, he and his family take a taxi from their apartment to the international airport just over the state line. The international airport is situated within both city and county limits in the adjacent state, but is operated jointly by both States (i.e., state and the adjacent state) under a charter agreement legislatively enacted by each state. At the airport's check-in counter, the airline agent observes that Patient A is sweating profusely and coughing up blood-streaked sputum. During the check-in process, the agent discovers that the name of Patient A appears on the public health list and, therefore, does not issue a boarding pass to Patient A, calls the Transportation Security Administration, and follows the instructions given on the public health request, including contacting the specified Quarantine Station. The agent also summons the airport's EMS responders who, in turn, elicit from Patient A details regarding his and his son's current status – including that he has been evaluated in (state) and has been diagnosed with active pulmonary MDR-TB.

Question 6: At this point, within the international airport, which government jurisdictions and agencies may be responsible for detaining Patient A, and under what legal authority(ies)? What issues of concurrent jurisdiction may apply to this situation?

Question 7: If on-site medical assessment at the airport determines that Patient A's condition warrants transfer to a hospital for further evaluation, then which government jurisdictions and agencies may be responsible for: managing his transportation to the hospital and covering associated costs, and for notifying the embassy of Patient A's home country that he and possibly other family members have been detained; and under what legal authority(ies)?

Facts IV: Separately and unrelated to the situation of Patient A and his family, a different local public health unit in Centralia is investigating a newly-diagnosed case of TB in an undocumented immigrant (Patient X) who is residing in laborers' housing on a farm. The investigation, which has included consultation with federal officials at ICE, reveals that Patient X, a citizen of a country in Central America, has on at least two previous occasions entered the United States, been apprehended, and then repatriated. Patient X now is acutely ill with fever, frank hemoptysis, and possible miliary spread, and is deemed to require immediate hospitalization for isolation and treatment. However, Patient X already has expressed a fear of being turned over to federal officials and has shown indications that he might, if presented with the opportunity, attempt to flee (state).

Question 8: What state legal authority(ies) will apply in determining in which facility(ies) Patient X may be ordered for hospitalization, isolation, and treatment?

Question 9: What legal authority(ies) will apply in determining that isolation and treatment can be compelled for Patient X, and for the enforcement of compelled isolation and treatment?

Question 10: What legal authority(ies) will apply in determining assurances of coverage of costs and reimbursements to the health-care facility for providing care and treatment to Patient X for the duration of his hospitalization?

Facts V: During the investigation of the newly-diagnosed case of TB in Patient X, the local public health unit in Centralia identifies a potential source case-patient (Patient Y) who moved to (state) 6 months ago from a nearby state. Further investigation reveals that, while residing in the other state, Patient Y had been non-adherent to that state health department's treatment regimen for him and, therefore, was placed under orders issued by that state's health officer that confined Patient Y during the pendency of his treatment. However, to avoid having to comply with those orders, Patient Y instead had relocated to (state).

Question 11: To facilitate continuity in treatment of Patient Y, what legal authority(ies) can (state) employ to incorporate or rely on the other state's legal authority and procedures for confinement and treatment of Patient Y, or will it be necessary to initiate an original and full proceeding in (state)?

(For Facts VI: Note – there are two options for the following facts and question, depending on whether (state) has a dedicated TB treatment facility.)

Facts VI (for states not having dedicated TB treatment facilities): Patient Z, a resident of (state) (e.g., Kansas or other state without a state TB facility), has been diagnosed with MDR-TB and also has a history of non-adherence to treatment. As a result, the health department in (state) (Kansas or other) has contracted with another state to provide treatment of Patient Z in an inpatient facility that is equipped for isolation and long-term treatment of MDR patients.

Question 12: Can (state's) (Kansas or other state without a state TB facility) treatment orders for Patient Z be enforced in another state and, if so, under what legal authorities, or can Patient Z leave the facility at any time?

Facts VI (for states having dedicated TB treatment facilities): Patient Z, a resident of another nearby state, has been diagnosed with MDR-TB and also has a history of non-adherence to treatment ordered and provided by that state. As a result, the health department in that state has contracted with (this state) (e.g., Florida) to provide treatment of Patient Z in an inpatient facility that was established and equipped expressly for isolation and long-term treatment of MDR patients.

Question 12: Can (this state) (e.g., Florida) enforce the other state's orders for Patient Z and, if so, under what legal authorities, or can Patient Z leave the facility at any time?

APPENDIX 2

CDC Scenario-Based Assessment: Understanding and Sufficiency of States' TB Control Laws

Kansas Version – 20 May 2008

Developed by:

**Public Health Law Program
Division of Tuberculosis Elimination
Division of Global Migration and Quarantine**

Objectives

This scenario has been designed to assist persons with roles and responsibilities for controlling and preventing the spread of tuberculosis to explore their understanding of, and to identify potential limitations of or gaps in:

- The viability and sufficiency of jurisdiction-specific legal authorities for limiting or preventing the transmission of TB through fundamental steps, including: screening and identification of cases; contact investigation; investigation of known or suspect cases; reporting of cases; treatment (including directly-observed treatment); the use of specific containment measures (e.g., isolation, quarantine, and other restrictions); and measures for ensuring the legal protections of persons with cases of TB, such as procedural due process, health information privacy, anti-discrimination, respect for religious beliefs, and other individual safeguards and protections.
- Legal authorities, requirements and options for coordination of multi-jurisdictional (intrastate, interstate, and international) TB case management, including screening for infectiousness before travel or movement outside of the original jurisdiction, managing risk of infection during travel, and ensuring continuity and completion of treatment (and coverage of associated costs) before and after travel.
- Legal authorities for coordination of control efforts (e.g., identification, reporting, contact investigation, and treatment of TB cases), across key sectors, including public health, health care providers, and public safety / law enforcement, and in various settings (e.g., schools, correctional facilities, nursing homes, mental health facilities, and homeless shelters).
- Legal authorities in relation to the infectiousness of smear-negative / culture-positive

patients.

- Legal authorities for supporting treatment with static antimicrobial options in the face of progressive increases in drug resistance.
- Laws addressing the financial costs associated with treatment of adherent individuals and with detention and treatment of non-adherent individuals, and the housing (voluntarily or involuntarily) and treatment of a person with a case of infectious TB in a treatment facility in a state other than that of the person's legal domicile.

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Context and assumptions

- For the purposes of the following scenario and facts, it is assumed that the situations would be addressed by existing TB control and other public health personnel, systems, and resources in Kansas.
- It also is assumed that Kansas law will apply, as will state judicial procedure.

Background: A 45-year-old professor at a large private university located in Centralia, a major metropolitan area in Kansas near the state line, has over a period of several weeks had onset of fever, night sweats, anorexia, weight loss, and a progressively productive cough. The professor (Patient A), a citizen of a country with high TB prevalence in Southeast Asia, has been admitted to the United States on a 24-month visa permitting him to teach and conduct research at the university. His duties include supervision of and frequent face-to-face contact with approximately 100 undergraduate students. He and his family – which includes his wife and son (age 17 years) – live in an apartment in a small community in a nearby county; his son attends a public high school. The university health service physician who is evaluating Patient A has diagnosed suspected active pulmonary TB based on Patient A’s medical and family histories, findings on physical examination, and a suspicious chest x-ray; Patient A’s TST is equivocal. Initial sputum specimens are smear-negative for AFB and sputum cultures have been initiated. Patient A’s 17-year-old son (Patient B) receives high-dose, systemic corticosteroids to treat juvenile rheumatoid arthritis, and recently has developed symptoms similar to his father’s, including fever, night sweats, and a cough. Because Patient B is not eligible to receive medical care at the university’s health service, his parents have taken him to an outpatient “doc-in-the-box” clinic located in a shopping center. The evaluating physician detected rales and other auscultatory abnormalities, but failed to elicit Patient B’s family history and did not order other diagnostic studies, including a chest x-ray and TST.

Facts I: During the Kansas health department’s investigation of a recent statewide measles outbreak, the university health service and other university officials initially refused health department requests for medical records and other information on suspected measles cases in the university community and on potentially exposed students, faculty, and staff. The university also refused to assist the health department with efforts to screen some students, faculty, and staff for the presence of measles-specific antibody. The university had refused to cooperate because of concerns about invasions of privacy and the university’s own policies to strictly protect such information regarding members of the university community. Nonetheless, the director of the university’s health service has contacted the local public health unit for guidance in addressing the following. Because of a strong history of pulmonary TB (including MDR-TB) among Patient A’s extended family in his home country, Patient A fears that both he and his son might have TB; he therefore has informed the university health service that he has purchased plane tickets for himself and his family to leave for his home country in two days so that he can receive medical care in familiar surroundings. The nearest international airport is a short distance from Patient A’s apartment, just over the state line in the bordering state.

Question 1: If the local and state health departments decide to conduct TST and other TB screening of students, faculty, and staff who have been potentially exposed to the professor, Patient A, under what legal authority(ies) can these screening activities be carried out? What, if any, additional authority(ies) and procedures might be implicated if the university, or individuals within the university community, refuse to cooperate?

Question 2: If the health departments' assessment indicates that Patient A and his family should not be permitted to travel out of state because of requirements for treatment of infectious TB, further evaluation, and/or monitoring, and because of risks to others, then under what legal authority(ies) and procedures can Patient A and his family be detained?

Facts II: The local health department notifies Patient A that he and his family members are not to travel and asks them to remain at their apartment while further decisions are being made regarding diagnostic and screening activities, and case management measures. Following conversations that Patient A has with his family overseas, with a local attorney, and with officials in his country's embassy in Washington, D.C., Patient A informs the health department that he refuses to cooperate and will, in fact, leave Kansas and the United States by air the next day. The local and state health departments – having determined that both the professor (Patient A) and his son (Patient B) have potentially infectious cases of pulmonary TB and pose risks to others – now make a decision to order both of them into home isolation while culture results are pending for Patient A, and to order Patient A's wife also to cooperate with efforts to monitor her status for clinical indicators of TB.

Question 3: Under Kansas law, what steps and procedures are required to order Patients A and B into home isolation if they will not comply with a request to do so voluntarily? What additional considerations of law might apply given that Patient A and his family members are not U.S. citizens?

Question 4: In addition to ordering home isolation, what additional tools would be available to public health officials to prevent Patient A from flying back to his home country?

Question 5: What provisions of Kansas law address procedural due process considerations, as well as other personal liberty and privacy interests of non-U.S. citizens such as Patient A and his family members?

Facts III: As a result of health department orders, Patient A reluctantly agrees that he and his son, Patient B, will comply with the home isolation order and that his wife will comply with the request to cooperate with further evaluation and monitoring efforts. On multiple subsequent attempts to induce sputum, Patient A remains smear-negative. However, after three weeks, some of Patient A's initial sputum cultures are reported as positive for *M. tuberculosis*, and resistant to isoniazid and rifampin indicating, that Patient A is infected with a multi-drug resistant (MDR) strain. Because of this, and taking into account the previous information, the health department has contacted the area Quarantine Station of CDC's Division of Global Migration and Quarantine about this situation and, as a result, the name of Patient A has been placed on a public health list to prevent him from boarding commercial airliners. The local public health department informs Patient A of this result, including the implications for his treatment, for ongoing evaluation of his son (Patient B), and for the continued monitoring of Patient A's wife. Hearing these details, Patient A becomes apprehensive, again deciding to travel with his family to his home country, and makes reservations to leave the following day. The next day, he and his family take a taxi from their apartment to the international airport just over the state line. The international airport is situated within both city and county limits in the adjacent state, but is operated jointly by both States (i.e., Kansas and the adjacent state) under a charter agreement legislatively enacted by each state. At the airport's check-in counter, the airline agent observes that Patient A is sweating profusely and coughing up blood-streaked sputum. During the check-in process, the agent discovers that the name of Patient A appears on the public health list and, therefore, does not issue a boarding pass to Patient A, calls the Transportation Security Administration, and follows the instructions given on the public health request, including contacting the specified Quarantine Station. The agent also summons the airport's EMS responders who, in turn, elicit from Patient A details regarding his and his son's current status – including that he has been evaluated in Kansas and has been diagnosed with active pulmonary MDR-TB.

Question 6: At this point, within the international airport, which government jurisdictions and agencies may be responsible for detaining Patient A, and under what legal authority(ies)? What issues of concurrent jurisdiction may apply to this situation?

Question 7: If on-site medical assessment at the airport determines that Patient A's condition warrants transfer to a hospital for further evaluation, then which government jurisdictions and agencies may be responsible for: managing his transportation to the hospital and covering associated costs, and for notifying the embassy of Patient A's home country that he and possibly other family members have been detained; and under what legal authority(ies)?

Facts IV: Separately and unrelated to the situation of Patient A and his family, a different local public health unit in Centralia is investigating a newly-diagnosed case of TB in an undocumented immigrant (Patient X) who is residing in laborers' housing on a farm. The investigation, which has included consultation with federal officials at ICE, reveals that Patient X, a citizen of a country in Central America, has on at least two previous occasions entered the United States, been apprehended, and then repatriated. Patient X now is acutely ill with fever, frank hemoptysis, and possible miliary spread, and is deemed to require immediate hospitalization for isolation and treatment. However, Patient X already has expressed a fear of being turned over to federal officials and has shown indications that he might, if presented with the opportunity, attempt to flee Kansas.

Question 8: What state legal authority(ies) will apply in determining in which facility(ies) Patient X may be ordered for hospitalization, isolation, and treatment?

Question 9: What legal authority(ies) will apply in determining that isolation and treatment can be compelled for Patient X, and for the enforcement of compelled isolation and treatment?

Question 10: What legal authority(ies) will apply in determining assurances of coverage of costs and reimbursements to the health-care facility for providing care and treatment to Patient X for the duration of his hospitalization?

Facts V: During the investigation of the newly-diagnosed case of TB in Patient X, the local public health unit in Centralia identifies a potential source case-patient (Patient Y) who moved to Kansas 6 months ago from a nearby state. Further investigation reveals that, while residing in the other state, Patient Y had been non-adherent to that state health department's treatment regimen for him and, therefore, was placed under orders issued by that state's health officer that confined Patient Y during the pendency of his treatment. However, to avoid having to comply with those orders, Patient Y instead had relocated to Kansas.

Question 11: To facilitate continuity in treatment of Patient Y, what legal authority(ies) can Kansas employ to incorporate or rely on the other state's legal authority and procedures for confinement and treatment of Patient Y, or will it be necessary to initiate an original and full proceeding in Kansas?

Facts VI: Patient Z, a resident of Kansas, has been diagnosed with MDR-TB and also has a history of non-adherence to treatment. As a result, the health department in Kansas has contracted with another state to provide treatment of Patient Z in an inpatient facility that is equipped for isolation and long-term treatment of MDR patients.

Question 12: Can Kansas' treatment orders for Patient Z be enforced in another state and, if so, under what legal authorities, or can Patient Z leave the facilit