

**Legal Forum: Cross-Jurisdictional Issues in Tuberculosis Control**  
**October 3, 2007**

**Sponsoring Committee**

Arizona Department of Health Services Office of Border Health  
Arizona Department of Health Services Office of Infectious Disease Services  
Tuberculosis Control  
United-States-Mexico Border Health Commission Arizona Delegation Outreach Office

**Organizing Committee:**

Arizona Department of Health Services Office of Border Health  
Arizona Department of Health Services Office of Infectious Disease Services  
Tuberculosis Control  
United-States-Mexico Border Health Commission Arizona Delegation Outreach Office  
United States Department of Homeland Security, United States Immigration and Customs  
Enforcement, Division of Immigration Health Services  
Advisory Council of the Elimination of Tuberculosis  
Tuberculosis Continuity of Care Workgroup

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# **Legal Forum: Cross-Jurisdictional Issues in Tuberculosis Control**

## **October 3, 2007**

### **Executive Summary**

A cross-jurisdictional Tuberculosis (TB) Legal Forum was held on October 3, 2007. The meeting was held at the Arizona Department of Health Services (ADHS) in Phoenix, Arizona and was hosted by the United States-Mexico Border Health Commission, ADHS Office of Border Health, ADHS TB Control Section. The views expressed in this report are those of the forum participants and do not necessarily reflect the official views of participating agencies.

The meeting was opened by Dr. Karen Lewis, Arizona Department of Health Services, Tuberculosis (TB) Control Program, and Mr. Robert Guerrero, Arizona Department of Health Services, Office of Border Health. Dr. Lewis and Mr. Guerrero welcomed the participants, introduced the facilitators, and explained that the purpose of this TB multi-state forum is to foster an understanding of laws and policies in TB Control for the U.S. states along the United States-Mexico Border and cross-jurisdictional legal issues in TB control. It is expected that this understanding will serve as a starting point for a cross-border legal forum with the United States and Mexico to discuss cross-national TB cases, TB care standards, and TB legal statutes.

This forum provided an opportunity for public health program staff and legal counsel to come together to find ways to provide the best services for TB patients, and for TB control programs to articulate their needs so legal counsel will understand what public health programs need to accomplish. The format of the meeting included 1) a representative from each participating state, tribe, and federal agency provided a brief summary of their legal authorities relevant to control of tuberculosis (TB) and other infectious diseases of public health significance, 2) brainstorming and discussion of the key issues encountered with regard to control of TB and other infectious diseases for people who cross jurisdictional boundaries or are in the custody of federal law enforcement agencies while receiving treatment and case management, 3) Brainstorming and discussion of how to most effectively utilize current legal authorities and overcome legal barriers identified during the morning session, 4) development of recommendations, and 5) identification of next steps.

The participants were asked to describe the public health laws pertaining to tuberculosis in Arizona, California, New Mexico, Texas, Arizona Tribal Nations [note: tribal national representatives from the other states did not attend], and in the United States. They were asked whether the laws were TB-specific, the source of the legal authority, what criteria were used to initiate and continue legal action, and whether United States or state residency status affects TB care and court-mandated case isolation, quarantine, and management.

Interjurisdictional TB control issues that were discussed included the admissibility of evidence in a jurisdiction other than where it is collected, the varying rules of evidence between states for documentation of nonadherence with treatment, the need for regionalization, areas in which the four states can improve cooperation, communication between states and Native American tribes, and tribal inclusion in collaborations. Binational case management challenges were discussed,

including state spending on patients who were from another country, caring for multidrug-resistant (MDR) TB patients from another country, United States Centers for Disease Control and Prevention (CDC) funding to the states being calculated on the number of United States' cases but not taking into account the burden of treating TB cases from other countries, increasing numbers of MDR-TB cases along the border, second line TB drugs not being available in Mexico, and tribal inclusion in binational and border TB control activities.

Immigration enforcement issues that were discussed included United States Immigration and Customs Enforcement (ICE) not routinely retaining people in custody through completion of TB therapy due to: the fact that the statutory authority for ICE custody and detention is to facilitate removal (repatriation); statutory limits on duration of ICE custody; ethical considerations of providing treatment in the least restrictive setting; and civil liberties considerations. ICE will consider requests for stays of removal in special circumstances (e.g., MDR-TB) in order to delay removal until after treatment completion, but local jurisdictions would have to bear the cost of treatment and case management if ICE were to grant a stay of removal and the patient were released to the community or another secure facility.

Several recommendations and next steps were identified. Some of the key recommendations included the following:

- Develop a website for ongoing communications among this group
- Plan a binational legal forum with counterparts in Mexico
- Translate relevant United States state and federal laws into Spanish and relevant Mexican laws into English
- Post relevant laws and their translations on a common website
- Support tribal inclusion in cross-jurisdictional and cross-border TB control initiatives
- Review considerations of legal issues with regard to community standard of providing care in the least restrictive standard
- Consider definitions of “non-contagiousness” and “cured” of active TB with regard to legal authorities
- Consider regionalization to better utilize specialized treatment facilities that are not available in many states, but recognizing limitations in state law regarding patients entering a facility from out of state.
- Establish mechanisms to carry out legal orders from one state in another state
- Review and clarify pertinent definitions and scope of inclusion for utilizing legal orders and public funds, e.g., temporary, resident
- Review current agreements that allow states to share data, lab resources, etc.
- Establish mechanisms for sharing confidential information, moving medications and supplies across borders, providing access to facilities and laboratories, addressing resource issues, and addressing licensure issues—consistent with legal restrictions and resource considerations for the states involved.
- Implement guidelines to exchange epidemiologic information and send medications, reagents, etc. across borders and identify barriers to such agreements
- Establish a mechanism for TB surveillance information to account for TB care carried out by state and local health departments which are not counted by the Report of a Verified Case of Tuberculosis (RVCT), in order to accurately account for acuity, work loads, and resources.

- Identify interstate and binational legal issues needing further study.
- Request a detailed, written legal brief from ICE attorneys regarding whether ICE detainees can be retained in custody until completion of TB treatment. This would include a discussion of whether the patient's current contagious status has any legal relevance (i.e., patient can have TB and not currently be contagious, but with a high degree of medical certainty that he will become contagious if treatment is not completed). The legal brief should also include whether there are any federal restrictions and/or obligations regarding federal payment for such treatment, if the treatment is provided at the state level, i.e., following release from custody.
- Review whether patients in federal custody (i.e., ICE, United States Marshals Service, Federal Bureau of Prisons, etc.) can be served a state legal order.
- Obtain assurance from a Federal agency (e.g., United States Customs and Border Protection) that public health officials should not be at risk for having their vehicle confiscated or being arrested for performing a public health function while acting within their scope of duties (e.g., while transporting a patient who is an illegal alien for treatment under a local legal order).
- Continue regular meetings of the Transnational TB Continuity of Care Workgroup

# **Legal Forum: Cross-Jurisdictional Issues in Tuberculosis Control**

## **October 3, 2007**

### **Meeting Report**

#### **Introduction**

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The participants were asked to describe the public health laws pertaining to tuberculosis in Arizona, California, New Mexico, Texas, Arizona Tribal Nations [note: tribal national representatives from the other states did not attend], and in the United States. They were asked whether the laws were TB-specific, the source of the legal authority, what criteria were used to initiate and continue legal action, and whether United States or state residency status affects TB care and court-mandated case isolation, quarantine, and management. The following survey questions were distributed to the legal counsel for the four represented states; responses were provided in advance of the meeting and are available as part of the meeting documentation. Relevant statutory or regulatory citations referenced below were provided to participants.

1. Please describe and attach copies of statutes and regulations in your state relating to detection and control of tuberculosis, including reporting, investigation, contact tracing, isolation, quarantine and treatment.
2. For the purpose of detecting and controlling tuberculosis, please state whether, in appropriate circumstances, health officials in your state possess the legal authority to:
  - A. Share information that is protected health information under HIPAA [the Health Insurance Portability and Accountability Act of 1996] or that might otherwise be subject to other federal or state laws governing disclosure, with health officials from another U.S. state;
  - B. Share protected health information under HIPAA or that might otherwise be subject to other federal or state laws governing disclosure, with health officials from a Mexican state or the Mexican federal government;
  - C. Share protected health information under HIPAA or that might otherwise be subject to other federal or state laws governing disclosure, with a tribal government;
  - D. Agree to either accept or relinquish custody of a person with TB from or to another state for the purpose of providing treatment;
  - E. Agree to either accept or relinquish custody of a person with TB from or to a Mexican state or the Mexican federal government for the purpose of providing treatment;
  - F. Agree to either accept or relinquish custody of a person with TB from or to a tribal government for the purpose of providing treatment;
  - G. Agree to either accept or relinquish custody of a person with TB from or to a U.S. federal agency for the purpose of providing treatment
3. Please describe and attach all existing memoranda of understanding or agreement, mutual aid agreements, or similar documents relating to detection or control of tuberculosis.

The Table summarizes some of the key information collected.

### **Jurisdiction Reports**

#### **Arizona**

Arizona has emergency power statutes that allow for isolation and quarantine and mentioned the general Statutes for Communicable Disease Rules, including ARS 36-621, ARS 36-624, and 36-627. The relevant legal authorities include the following provisions:

- There is a state TB control officer who is a physician.
- TB control is done at the county level; the local health authority has broad authority for TB control.
- There is no residency requirement for TB care.
- There is a well-developed emergency custody process that protects the due process rights of patients.
- The standard of proof resides with public health.
- Noncriminal TB patients can be put in jail facilities under certain circumstances.

- A person cannot be forced to receive treatment if he or she ascribes to a religious tenet that forbids it. However, the statutes do allow for court ordered examination, evaluation, treatment, isolation and quarantine if the individual fails to comply with voluntary measures.
- If no other alternative is available, TB patients may be placed in a correctional facility.
- There is a mechanism to transfer patients out of state.

## **California**

The relevant legal authorities in California include the following provisions:

- California Department of Public Health (CDPH) is the lead agency for TB control, but much authority is conferred to the Local Health Officers (LHOs). The state can order LHOs to take action. TB control activity is at the county level.
- About 10 years ago, the legislature passed a bill that allowed the local health officer to retain a patient in custody until completion of their TB therapy.
- If a patient has active TB, they can be ordered to receive treatment, but they cannot be forced to receive treatment. If a patient has infectious TB, they can be ordered to a facility for treatment, but the treatment cannot be forced.
- There is no statute regarding transferring from jurisdiction to jurisdiction.
- TB can be prosecuted under either civil or criminal statutes. However, if prosecuted under criminal statutes, the record may be expunged once the treatment is finished. This is the case in Alameda County, and may not be the case in all counties in California. This evolved out of an agreement between the County District Attorney and the TB Controller/Local Health Officer.)
- Civil and criminal is not sequential or obligatory.
- Least restrictive measures are implemented before criminal detention is sought. This is done by patient education, through Directly Observed Therapy (DOT), documentation of noncompliance via DOT, re-education, provision of incentives and enablers (fiscal and food vouchers, etc.), and legal orders to comply with treatment.
- The following apply regarding the legal process:
  - Failure to comply may result in a letter of warning; a warning letter is used in some, but not all counties.
  - Continued failure to comply results in serving of legal orders
  - A warrant is issued for violation of legal orders (continued failure to comply)
  - Most people comply and further steps are not necessary
  - Once a local health officer's custody order is issued, it is binding.
  - The Sheriff may enforce the local health officer order
  - Any peace officer who witnesses a misdemeanor can arrest an individual who is subject of and has been served legal orders.
- There are no statutes to deal with requirements to treat co-morbid conditions.
- Some local health officers like to use contracts with patients, but contracts cannot be enforced; contracts may serve to improve the patient's compliance.
- There is no residency requirement for TB treatment.
- If no other alternative is available, TB patients may be placed in a correctional facility.
- In California there is no expressed authority to accept or transfer patients to or from other states.

## **New Mexico**

The relevant legal authorities in New Mexico include the following provisions:

- Statutes are general to include threatening communicable diseases.
- There are no local health authorities in New Mexico; all authorities pertain to the state.
- Only the strongest cases of non-compliance go to court; seeking a court order is rarely done in New Mexico.
- There is no authority to order DOT.
- There is authority to issue Public Health orders.
- Once a patient is isolated, he or she cannot be forced to take the medicines.
- In 2006, New Mexico an agreement was reached between New Mexico and Navajo Nation which allows for court-mandated treatment in accordance with Navajo Nation laws. [The Navajo Nation enacted the Health Commitment Act of 2006 (Title 13 Navajo Nation Code, Section 2101, et seq.) allowing the commitment of individuals in the least restrictive environment necessary for the satisfactory control or resolution of their illness when lack of treatment presents a substantial likelihood of serious harm to the health or safety of the community and/or the afflicted individual.]
- In 2006, an agreement was reached between New Mexico and Texas which allows a court order for isolation and treatment in New Mexico to be operationalized in Texas at the Texas Center for Infectious Disease (TCID), a secure facility for inpatient care for TB patients who are not able to be cooperative in an unsecured environment.
- In order for a Navajo Nation patient to be court-ordered for isolation and treatment services, both of the above agreements were operationalized.
- There is an agreement between New Mexico and the state of Chihuahua, Mexico on Influenza Surveillance.

## **Texas**

The relevant legal authorities in Texas include the following provisions:

- Local health authorities (a locally-appointed physician) have the authority to handle TB cases, although they must obtain state concurrence before they can seek court-ordered management. The state has concurrent jurisdiction, but generally only exercises it in exceptional cases (e.g., action is needed that covers several jurisdictions simultaneously; local health authority will not take an action the state feels is needed). In areas of the state without a local health authority, the DSHS regional office manager acts, by statute, as the local health authority.
- Court-ordered management of a TB patient is a civil matter, triggered by the patient violating a control order (issued either by the local health authority, or by DSHS). Such a violation is also a criminal violation (misdemeanor), and that criminal case may be pursued concurrently with the civil court-ordered management (criminal case must be pursued by a local prosecutor, so DSHS cannot ultimately control when, or if, such cases are brought).
- If the patient is contagious, the local health officer can seek a short-term, *ex-parte*, protective custody order from the court. If the patient is not contagious, the *ex-parte* option is not available. Such an order allows the contagious person to be isolated quickly, pending further legal proceedings.
- Court-ordered management may include mandatory treatment/isolation at TCID, which is a Texas state-funded TB treatment facility, until such time as the patient no longer has TB. There are strict statutory limitations on who may be treated there.

- In 2003 the Texas legislature passed a law that allows transfer to TCID of a patient with TB from another U.S. state. This requires, by statute, a state-to-state agreement with specific provisions (e.g., payment to TCID). The state of person's residence pays for all treatment if they are not a resident of Texas. At any time that capacity becomes an issue, a Texas resident patient, by statute, always takes precedence over an out-of-state patient. The statute does not currently allow such agreements with other entities (e.g., federal government; Indian Nations).
- People in Texas temporarily are not allowed to be isolated at TCID; this would apply to people in United States Immigration and Customs Enforcement (ICE) custody and slated for deportation, since by definition they would be in Texas temporarily.. The Texas statute states that the individual's residency must not be temporary. They are ineligible to receive treatment at TCID if deportation is pending (i.e., person will ultimately be deported).
- Texas policy is not to accept admissions to TCID for persons with pending criminal charges. Charges which have been dismissed or for which the sentence has already been served would not ordinarily affect admissions.

### **Tribal Nations**

- Each state has intertribal councils (ITCAs).
- ITCA and tribal meetings have yet to focus on TB, but this needs to be done.
- Tribes don't have public health departments, epidemiology centers, public health laws, or infectious disease laws—they need to develop them.
- Once a tribe establishes their own isolation and quarantine laws, it is expected that these would take precedence over federal laws.
- In the views of the Tribal representative, it is essential to have tribes involved in TB meetings.
- Per executive orders under President Clinton, Federal and State governments must be actively engaged with tribal governments if there is an issue that is going to impact them. There are 14 sovereign nations along the US-Mexico Border. There is a need to include the tribes on TB legal interjurisdictional issues.

### **Tohono O'odham Nation**

- The Tohono O'odham Nation is the 2<sup>nd</sup> largest tribe in the United States after the Navajo nation. It comprises 4600 square miles; there are 27,000 tribal members in the U.S., and about 1,000 members in Mexico.
- The Tohono O'odham Nation has no tribal laws regarding infectious diseases.
- United States federal laws can operate in the Nation. The Indian Health Service (IHS) is responsible for ordering or acting to isolate or quarantine individuals with infectious disease; IHS orders are enforceable.
- Title 25 U.S. Code Section 198 from 1914 allowed the Secretary of the Interior to isolate and quarantine a person with a contagious disease on Indian Reservations.

### **Reports of Relevant Federal and International Laws**

#### **Indian Health Service (IHS) Laws**

- There are two existing statutes: 25 USC 198 and 25 USC 231.

- There are no federal procedures regarding implementation of the laws; it is not clear which entity would seek an isolation or quarantine order—perhaps this would fall to CDC.
- The statutes are very broad.

### **Department of Health and Human Services (HHS) Legal Authorities**

- Section 361 of the Public Health Service Act authorizes the HHS Secretary to make and enforce such regulations as may be necessary to prevent the introduction, transmission, and spread of communicable diseases into the United States from foreign countries or from one state or possession into another. This section also authorizes the apprehension, detention, or conditional release of individuals believed to be infected with certain specified communicable diseases, which includes infectious tuberculosis.
- Under section 212(a)(1)(A) of the Immigration and Nationality Act, medical examinations are conducted on certain classes of aliens to determine the presence of inadmissible conditions. Such examinations are conducted based on technical instructions issued by CDC and are typically conducted overseas prior to granting of a visa or in the United States when the alien seeks to readjust his or her immigration status. Overseas, the exams are conducted by panel physicians (local physicians designated by the Department of State), while in the United States the exams are conducted by civil surgeons (physicians designated by the Department of Homeland Security).
- Overseas screening is in place; new screening practices are to be phased in country by country for incoming foreign nationals.
- Certain diseases are inadmissible unless there is a waiver. HIV and active TB are on the inadmissible list.
- CDC has role regarding examinations of immigrants to assess presence of an infectious disease at the port of entry.
- Statutes address individuals in a pre-communicable or communicable stage of an infectious disease, with the 10 diseases included in interstate and federal quarantine diseases, including pandemic influenza, SARS, infectious TB.
- The federal government can accept state and local assistance in implementation.
- Implementation of a federal isolation order is very rare (2007 and 1963 were the two most recent federal quarantine events).
- Public health is a police function that is left to the state by the 10<sup>th</sup> amendment of the US constitution.
- The Department of Homeland Security (DHS) can restrict individuals from traveling using the lookout and no board processes.
- There is a need for memoranda of understanding (MOUs) or memoranda of agreement (MOAs) with counties and states to support transfer of patients or quarantine and/or isolation of patients.
- At the federal level, individually identifiable information may be subject to the Privacy Act of 1974, 5 U.S.C § 552a.

### **International Health Regulations (IHR)**

On May 23, 2005, the WHO adopted international health regulations (IHR). These were adopted by the United States on July 17, 2007. Key provisions of the IHR include the following:

- Any Public Health Emergency of International Concern (PHEIC) should be assessed within 48 hours and reported to the WHO Secretariat.

- The United States informed WHO that not all evaluations will be done at the Federal level, and that the CDC relies on state and local health departments to report events.
- Diseases on the IHR list include smallpox, SARS, wild type polio, pandemic influenza, cholera, pneumonic plague and yellow fever.
- PHEIC require an international response on a time sensitive basis.
- The IHR include standards for travelers who are infectious.
- The IHR has requirements for sharing information between member countries; this would be done under other federal domestic laws; the United States would implement these under the principles of federalism.

### **Legal Authorities Regarding United States Immigration/Detention and Removals**

The following legal issues have been discussed with the Transnational TB Continuity of Care Workgroup, specifically with regard to how long someone can be detained by United States Immigration and Customs Enforcement (ICE):

- ICE authority to detain is for removal (repatriation).
- Decisions (e.g., to issue a final order of removal) are made by immigration judges, who are part of the United States Department of Justice, Executive Office of Immigration Review).
- Foreign nationals that are convicted of crimes serve their sentence after which they may be transferred to ICE for immigration proceedings.
- Once the final order of removal is issued, ICE generally has 90 days to carry out the removal.
- By statute, if ICE has been unable to remove the individual and it is established that the removal will occur in the reasonable foreseeable future, the removal may be extended to 180 days; these provisions are the result of two Supreme Court decisions.
- ICE does not have statutory authority to detain someone for the entire course of their therapy if they are able to remove the individual or for the sole purpose of treatment.
- Individuals may be released from ICE custody for a number of reasons, e.g., immigration proceedings terminated, bond, order of recognizance, order of supervision, etc. ICE cannot pay for services for people not in custody (e.g., after release from custody).
- ICE and other federal law enforcement agencies (e.g., The Federal Bureau of Prisons and the United States Marshals Service) often move people between states, which can make continuity of care for TB difficult.
- ICE collaborates as much as possible with state and local health departments.
- ICE detainees are screened for TB upon admission to custody; some facilities have ICE medical staffing; some contract detention facilities and many intergovernmental service agreement facilities (e.g., local jails) are not staffed by ICE; these facilities have local staffing or locally-contracted staffing.
- International referrals for TB continuity of care are arranged through TBNNet and CureTB; these processes often require initial notification by and collaboration with local or state health departments. In order to facilitate international referrals, ICE must be notified, often by the local health department; there is no requirement for detention facilities without ICE staffing to report cases to ICE. ICE can then request a short-term medical hold until the referral process is complete.
- ICE does not deport people known to be infectious. A medical hold can be requested until it is safe for them to be transported.

- A determination of contagiousness is made by the health care provider and should follow CDC guidelines.
- In exceptional cases (e.g., multidrug-resistant TB), stay of removal requests may be made; state and county support is preferred because a stay may be granted but the patient may be released from custody to continue treatment in the community. If released, the local or state health department will bear the responsibility for and costs of treatment.
- When special requests are made (e.g., by TB Control Programs to stay the removal), each case is looked upon on an individual basis.

## **Discussion**

### **General Inter-Jurisdictional Issues**

- Rules of evidence (e.g., documentation of nonadherence with treatment) vary by state.
- There are provisions for states to contact each other informally (e.g., communication between health departments), however not all state laws allow sharing of confidential information to the same extent between states (e.g., Texas would have to share with “medical personnel” at the New Mexico health department, although Texas can share the info with CDC staff without the “medical personnel” restriction).
- Regionalization should be seriously considered to maximize use of scarce resources, such as TCID. Texas law, as it is currently structured, does not make TCID a truly regional facility however (e.g., Texas patients must, in every instance, get preference).
- It is very expensive to care for complicated and noncooperative TB patients—sometimes as much as \$250,000 or more.
- The four U.S. states that border Mexico should continue to cooperate in areas where laws permit, e.g., sharing epidemiological data
- The CDC tribal liaison in Albuquerque (Dr. Ralph T. Bryan, MD, Senior Tribal Liaison, [rrb2@cdc.gov](mailto:rrb2@cdc.gov), 505-248-4226) could be of assistance to communicate with the tribal governments about TB issues.
- Dr. Simpson summarized a meeting of the First Regional Legal and Jurisdictional Forum sponsored by the National Tuberculosis Controllers Association held Dec 7, 2006 at Texas Center for Infectious Diseases (TCID) in San Antonio. The purpose of that meeting was to address the challenges of regionalizing access to specialty facilities for the treatment of threatening communicable diseases of public health significance. Many of those attending the meeting supported regionalizing access to TB care services. Texas law does not currently establish TCID as a regional facility, so DSHS must correspondingly qualify any endorsement of “regionalization.” Dr. Simpson mentioned four core values/guiding principles that came out of that meeting:
  - Treatment should be provided as close as possible to patient’s home, family and community, consistent with state law and available resources.
  - There should be dedication to a patient-centered process
  - TB patients need to be cared for in a medically appropriate facility
  - It is unacceptable to incarcerate uncooperative TB patients for isolation and treatment in jail, detention centers, prisons or forensic psychiatric facilities.

Several participants expressed it that commented that the fourth “guiding principle” above should be modified to express that it is *generally unacceptable to incarcerate uncooperative*

*TB patients for isolation and treatment in jail, detention centers, prisons or forensic psychiatric facilities unless no other option exists, and that due process is of utmost importance.*

- The Tohono O’odham Nation has experience with influenza pandemic planning exercises; one of their concerns is being cut off from the rest of the state as people were quarantined on the reservation.
- Currently in Arizona, when Navajo tribal courts order that a tribal member admitted to the Arizona State Hospital for psychiatric treatment, their order has to go through the Arizona Supreme Court. The Tribal Nation representatives would like to see that tribal court orders are directly accepted. This should apply to TB-related orders as well.

### **General Binational Case Management Issues**

- It is more cost effective to treat in country of origin. Some cases managed in the U.S. are not counted in national surveillance because they don’t meet national surveillance criteria. CDC reimburses based on reported morbidity, not on all cases treated and managed in a jurisdiction.
- In a recent review, there were 1200 patients that were not citizens and a large number of these had MDR- TB.
- Gaps and practices in the federal system may be contributing to MDR-TB and the associated risks to public health in the United States. When an illegal alien in ICE custody is deported before TB treatment is completed, if the patient interrupts or discontinues treatment, this can lead to drug-resistance and a TB condition which is more dangerous and harder and more costly to treat. The practical reality is that many deportees re-enter the U.S. across the Mexican border, and will continue to do so for the foreseeable future. The way we are doing now is not working, need to change the dynamics. This may make people uncomfortable and will require statutory changes.
- Resource issues also need to be addressed, including serious discussion of federal funding for TB treatment provided by the states for treatment and case management of patients following release from ICE custody.
- The United States-Mexico Border Health Commission is used as a vehicle for communicating about and solving binational border issues. For example, they are currently in discussion on how to get medicines and reagents across the United States-Mexico border. It seems to be primarily a Mexican customs issue, and they are working on the necessary steps to improve the process.
- Border health legal entities should be encouraged to have complementary statutes for completion of TB treatment.
- United States support of the Mexican public health entities is important in order to help control TB along the border. The Mexican state of Sonora currently has an epidemiology surveillance unit. It would be good to include this information sharing among all of the 10 (United States and Mexico) border states.
- The 10 border states have an agreement for epidemiology exchange between the CDC and INDRE (Mexico’s equivalent).
- Arizona and Sonora are working with CDC’s Early Warning ID System (EWIDS). This could be used as a model to be used along the border.

- At the Border Governors Conference of the 10 United States and Mexico border states, four resolutions were adopted. They include the following:
  1. To approve and adopt the *Guidelines for US-Mexico Coordination on Epidemiological Events of Mutual Interest*, which have been developed with input from United States and Mexican state health agencies: the Mexican Federal Health Secretariat, and the United States Department of Health and Human Services and Centers for Disease Control and Prevention. Included in the guidelines are provisions to facilitate the cross-border transfer of specimens, reagents, equipment and medications related to improving binational laboratory capacity, epidemiological surveillance, and effective responses to public health emergencies that threaten border populations in both countries, including pandemic influenza. *Note that the “Guidelines” were not reviewed during this meeting*].
  2. To address the binational problem of increasing numbers of tuberculosis cases along the border, including drug-resistant tuberculosis, by increasing financial resources to the United States-Mexico border region for tuberculosis control activities.
  3. Support and strengthen the initiative for the creation of an Epidemiology and Public Health Emergency Intelligence Unit that would serve as a monitoring center to provide binational early warning alerts in the event of public health risks or dangers. During the first phase the unit would serve the northern border states of Mexico and in later phases, based on agreements and defined protocols, it could be used to incorporate epidemiological surveillance for the ten states of the United States-Mexico border.
  4. To support and strengthen the development and implementation of tele-public health (telemedicine) technology, as a means with great potential to standardize the current health services and available human resource capabilities available in the United States-Mexico border states.
- MDR-TB drugs are expensive and often beyond the practical means of a small county; jurisdictions need to consider if they are willing to use their entire budget for TB treatment of one patient, especially if that patient is an illegal alien.
- The Arizona Sonora Commission is currently studying the feasibility of cross-border credentialing of licensed professionals; there is no current authority to do so. However, the Arizona governor has the authority in a declared emergency to relax credentialing.
- There currently are binational TB projects that are managing TB patients, exchanging information, sharing medicines, and sharing laboratory resources. There are significant legal issues involved with such programs (e.g., confidentiality; constitutional and funding restrictions), but these programs can be used as models and improved upon.
- Dr. Diana Schneider has a copy of Mexico’s Public Health Law partially translated into English. She will make the copy available to interested Forum participants. Mexican law does not allow for enforced isolation for TB. At a previous meeting it was explained that it would take Federal authority, and possibly presidential authority to enforce isolation in Mexico.
- NAFTA provides mechanisms to address potential environmental issues in the border region, e.g., tax breaks with factories? Is there a similar mechanism for Mexico and the United States to focus resources in the 100 km border states that specifically address the public health needs?

## **Immigration Enforcement Issues**

- ICE does not routinely retain custody for the sole purpose of completion of therapy (the authority to detain and provisions regarding detention are in accordance with U.S. Code Title 8 and Title 8 Code of Federal Regulations).
- It is important to address ethical considerations of keeping people in custody longer than otherwise would be needed for their immigration issues to be resolved. However, we must also be cognizant of the health risks to U.S. citizens posed by illegal aliens with TB who repeatedly cross the border, often with an increasingly-harmful and hard-to-cure strain of TB due to partial (but not complete) treatment while in ICE custody. Serious legal and policy analysis should be done to determine the limits of federal law regarding TB treatment of illegal aliens in ICE custody.
- Requests for stays of removal may raise concerns in some jurisdictions because resources may not be available to support treatment and case management for patients who are only in the jurisdiction because they were held there while in custody. Therefore, it is preferable to have concurrence from public health authorities when requesting stays.
- Early data from the Arizona Meet and Greet program showed that many patients were lost to follow up following deportation; such patients often return to the U.S., sometimes with more problems (i.e., MDR-TB) with the concurrent risks to public health and higher treatment costs.
- Very few ICE cases remained in custody through the completion of treatment.
- Some participants expressed that they would like TB patients in ICE custody to remain in custody until completion of anti-TB treatment, or at least until the cultures are negative; this was met with concerns that such a practice would not be consistent with the community standard of providing treatment in the least restrictive setting and may be inconsistent with United States immigration statutes and regulations regarding the period of time in which removal must occur. Further legal research into the limits of federal immigration law in this area is needed. Also, high-level federal policy guidance is needed to help determine the proper balance between the concern for patient's rights and the health risks to United States citizens posed by illegal aliens with TB who repeatedly cross the border.
- Concerns were expressed that the system we have in place creates an environment that cultivates MDR-TB by repetitious incomplete treatments because patients sometimes do not follow through with their referral and may be lost to follow up; some of these have contagious TB and some return to the United States. It was acknowledged that while the United States may make certain efforts to foster better follow-up for patients outside of the United States, ultimately the only thing we can control is what we do in the United States.
- There is a need to define security, e.g., if a secure setting is required when stay of removal is granted and the patient is to be released to another secure environment.
- State laws regarding treatment and residency constrain some treatment options. Lack of state residency is a legal barrier to accepting patients into care in some jurisdictions (e.g., Texas) following release from ICE custody (when a patient will ultimately be deported, he is not a resident of the state under Texas law and thus cannot be treated at TCID).
- There are also resource considerations that factor into decisions of a local or state jurisdiction to accept patients into their care if released from ICE custody.
- It is important to note that people of all nationalities are in ICE custody.
- This discussion is important because TB control needs are affected by public health laws and immigration laws, and some individuals' needs are not adequately addressed by either sector

alone. Some solutions would require changes in federal public health law. Even with legislative change, there would be a need for resources to be tied to implementing them. Border states have a resource concern about being asked to shoulder the financial burden of treating patients following release from ICE custody.

- Concern was expressed that public health officials have reportedly been stopped at interior border control posts in Texas and threatened with vehicle confiscation or arrest when transporting patients to TCID under a local legal order.

## **Recommendations**

### **General Recommendations**

- Create a website for ongoing communications among this group.
- Translate relevant United States state and federal laws into Spanish and relevant Mexican laws into English.
- Post relevant laws and their translations on a common website for easy access.

### **General Interjurisdictional Issues**

- Prepare a contact list or organizational chart for TB inter-state or cross-jurisdictional cases and transfers [note: Interjurisdictional TB coordinators are listed on the National TB Controllers Association website].
- Clarify whether a federal authority can detain someone for a state misdemeanor.
- Clarify whether governmental agencies can put holds on residents or their jurisdictions while they are abroad.
- Review current agreements that allow states to share data, lab resources, etc.
  - Some models include Mid-America Alliance, New Mexico-Texas/New Mexico-Navajo Nation agreements, Four Corners states' agreements.
- Establish mechanisms to operationalize legal orders from one state in another state, to the extent allowed by the various state laws involved. In order to obtain a legal order, identify what documentation is needed, applicable, and admissible, and whether the documentation is applicable in another region.
- Review considerations of legal issues with regard to community standard of providing care in the least restrictive standard.
- Consider definitions of non-contagiousness and cured of active TB with regard to legal authorities
- Support the ability of the tribal governments to have full participation in TB legal determinations.
- Support travel for tribes to be able to participate in meetings and planning activities.
- Where applicable, support legal language for TB to be considered as an active infectious disease until cured.
- Consider regionalization to better utilize specialized treatment facilities that are not available in many states. Current Texas law does not provide for TCID to be a fully "regional" treatment facility (i.e., Texas patients must always take precedence in admissions).
- States should assess their resources, if they have not already done so, regarding their TB control needs. It is not always necessary to build a new facility like TCID in another state in

order to isolate patients in that state. For example, New York City's TB program has done well in working with the New York City Public Hospital System to identify a section of a city hospital to isolate TB patients who've received a court order.

- Consider general applicability to threatening communicable diseases (infectious disease of public health significance) vs. laws that are specific to TB. Some jurisdictions public health laws are generic, and others are disease specific.
- Share epidemiologic information about TB between states, between tribes, and between nations (specifically United States and Mexico), to the extent it is not already being done.
- Consider adoption of the four guiding principles elaborated at the San Antonio meeting: Dr. Simpson summarized a meeting of the First Regional Legal and Jurisdictional Forum sponsored by the National Tuberculosis Controllers Association held Dec 7, 2006 at Texas Center for Infectious Diseases (TCID) in San Antonio. The purpose of that meeting was to address the challenges of regionalizing access to specialty facilities for the treatment of threatening communicable diseases of public health significance. Many of those attending the meeting supported regionalizing access to TB care services. Texas law does not currently establish TCID as a regional facility, so DSHS must correspondingly qualify any endorsement of "regionalization." Dr. Simpson mentioned four core values/guiding principles that came out of that meeting:
  - Treatment should be provided as close as possible to patient's home, family and community, consistent with state law and available resources.
  - There should be dedication to a patient-centered process
  - TB patients need to be cared for in a medically appropriate facility
  - It is generally unacceptable to incarcerate uncooperative TB patients for isolation and treatment in jail, detention centers, prisons or forensic psychiatric facilities.

Some participants expressed it that commented that the fourth "guiding principle" above should be modified to express that it is *generally unacceptable to incarcerate uncooperative TB patients for isolation and treatment in jail, detention centers, prisons or forensic psychiatric facilities unless no other option exists*, and that due process is of utmost importance.

- Identify interstate and binational legal issues needing further study.

### **General Binational Case Management Issues**

- Address legal issues with Mexican counterparts; clearly outline more specific issues that need to be addressed. This work could begin by convening representatives from this meeting and state health department representatives. The Border Governors Conference may be able to provide assistance.
- Where they don't already exist, establish mechanisms for sharing confidential information, moving medications and supplies across borders, addressing resource issues, and addressing licensure issues.
- Implement guidelines to exchange epidemiologic information and send medications, reagents, etc. across borders and identify barriers to such agreements.
- Encourage public health entities on both sides of the border to address public health authorities to ensure completion of TB treatment.
- Promote tribal inclusion on the border initiatives. This is already being done with bioterrorism and pandemic influenza preparedness initiatives. Designate officials, at federal and state levels as appropriate, to communicate with tribes.

- Expand epidemiologic surveillance initiatives to all 10 United States and Mexican border states; this is supported by the Border Governors Conference.
- Consider a role the United States-Mexico Border Health Commission may have regarding TB issues, e.g., gathering the evidence, being the convener.
- A recommendation was made by some participants to support the recommendation of the Border Governors Conference for sharing of epidemiologic information between the 10 states as it relates to TB, and regarding TB control (see list of 4 resolutions, above). Support all border states in order for them to have the ability to treat complicated binational patients, including medical expertise, effective binational case management, laboratory expertise, and access to second line drugs, consistent with state laws and state resource constraints. *Note that the “Guidelines for US-Mexico Coordination on Epidemiological Events of Mutual Interest” were not reviewed during this meeting, and therefore its content cannot be officially endorsed by participants of this meeting.*
- Establish a mechanism for TB surveillance information to account for TB care carried out by state and local health departments which are not counted by the Report of a Verified Case of Tuberculosis (RVCT), in order to accurately account for acuity, work loads, and resources.
- Look at best practices to model binational programs for epidemiologic sharing, such as the CDC’s EWIDS.

### **Immigration Enforcement Issues**

- Request detailed, written legal brief from ICE attorneys regarding whether ICE detainees can be retained in custody until completion of TB treatment. This would include a discussion of whether the patient’s current contagious status has any legal relevance (i.e., patient can have TB and not currently be contagious, but with a high degree of medical certainty that he will become contagious if treatment is not completed). The legal brief should also include whether there are any federal restrictions and/or obligations regarding federal payment for such treatment, if the treatment is provided at the state level, e.g., following release from ICE custody.
- Request clarification from ICE legal counsel regarding whether TB could be considered infectious until cured therefore permitting them to be held in custody until completion of TB treatment. The benefit would be protection of public health in the United States, and to prevent the long term issue of MDR-TB. As a medical issue, TB is not always contagious up to the point it is cured—but if treatment is not completed, it will become contagious again (if not already) and may turn into a more virulent strain. The real question that needs extensive legal briefing by ICE attorneys is whether ICE can complete (or pay a state to complete) TB treatment through the cure of TB before deportation is carried out.
- Review whether patients in federal custody (i.e., ICE, United States Marshals Service, Federal Bureau of Prisons, etc.) can be served a state legal order.
- Obtain a letter or other form of assurance from a federal agency [e.g., United States Customs and Border Protection (CBP)] that public health officials should not be at risk for having their vehicle confiscated or being arrested for performing a public health function while acting within their scope of duties.

**Issues identified that require additional discussion or solutions outside the scope of the legal forum**

- Distribute the *Guidelines for US-Mexico Coordination on Epidemiological Events of Mutual Interest* for review.
- There is not currently sufficient federal or state funding and resources to meet all TB control needs.
- Work on funding issues and case management resources to ensure patients are treated appropriately for TB.
- Support United States-Mexico Border Health initiatives.
- Consider having TB programs become Medicaid/Medicare providers in order to get additional funding.
- Accurate definitions of isolation and quarantine should be used consistently in federal and state regulations and statutes and in policies and procedures.
- There is a need to address resource considerations for patients slated for deportation who may be released from ICE custody to allow them to complete TB treatment in the United States prior to repatriation.
- Ascertain whether two large TB funding bills that are in Congress right now focus on binational problems and/or federal funding for state TB treatment provided to patients released from ICE custody in the United States.
- Establish an inventory, expand on, improve on, and fund activities with which there is already experience, e.g., systems in place to manage and refer patients which work well, such as the binational health card. The Binational TB Card is not currently funded, and its use is waning.
- Facilitate binational case management, consistent with applicable laws and state resource constraints, including the following:
  - Establishing consensus on diagnostics and treatment guidelines
  - Providing access to:
    - Radiographic services
    - Laboratory services
    - Anti-TB drugs
    - Culturally sensitive services
  - Providing of DOT services
  - Collaborating on contact investigations
  - Addressing patient confidentiality/HIPAA/EMR/HER/Telemedicine
  - Providing medical consultation
  - Strengthening medical and public health infrastructure
  - Supporting patient transportation
  - Providing specimen transport
  - Addressing reported cases versus total case burden for determining funding
  - Addressing comorbid medical and psychiatric cases
  - Providing access to specialized medical facilities
  - Standardizing processes for obtaining isolation court orders across jurisdictions
  - Addressing legal custody/federal custody complexity
- Request a detailed, written legal brief from ICE attorneys regarding whether ICE detainees can be retained in custody until completion of TB treatment and including the following issues:

- This would include a discussion of whether the patient’s current contagious status has any legal relevance (i.e., patient can have TB and not currently be contagious, but with a high degree of medical certainty that he will become contagious if treatment is not completed).
- The legal brief should also include whether there are any federal restrictions and/or obligations regarding federal payment for such treatment, if the treatment is provided at the state level, i.e., following release from custody in the United States.
- If treatment completion could be accomplished in 180 days, following which the patient would be deported, would the law allow that (given the recent case law)?
- What if the person was still considered to be technically in ICE “custody” while being treated at a state facility? Would the possibility of this be dependent on the level of security available at the state facility at issue? If it’s really the case that a person cannot be considered in ICE custody if they are treated at a state facility, regardless of the security at that facility, then Texas would like to see that laid out in detail in the ICE legal brief requested in our comments above. If the legal brief concludes that TCID treatment is not legally allowed while a person is in ICE “custody”, then Texas would like to see the brief discuss any other legal options available to ICE for the full treatment of the detainee’s TB, including whether the federal government could/would pay for such treatment in the various scenarios. Texas is particularly interested, in the legal brief, about options that ICE can take on its own initiative, as opposed to states asking for a stay regarding the treatment of a federal detainee. In other words, Texas wants to know what federal law would allow ICE to do to take responsibility for full treatment of its own detainees (although we realize that what ICE may choose to do, as a matter of policy, may be narrower than what it can do under federal law...we are trying to separate the law from the policy to get a clearer picture of why ICE does what it does).

### **Next Steps**

- Prepare a summary from this forum to be shared with the following organizations:
  - United States-Mexico Border Health Commission (USMBHC) [note: the next meeting of the full Commission will be held in late February or early March 2008]
  - Four participating states’ public health departments and tribal nations
  - Advisory Committee for the Elimination of TB (ACET)
  - CDC Division of TB Elimination
  - DHS/Office of Health Affairs
  - DHS/ICE
  - DHS/ CBP
  - Border Governors Conference
  - Association of State and Territorial Health Officials (ASTHO)
  - National Association of City and County Health Officials (NACCHO)
  - American Public Health Association (APHA)
  - State regulatory agencies
  - Pan American Health Organization (PAHO)
- Dr. Diana Schneider will send out the available translation of Mexican Public Health Law
- Plan for a binational, United States-Mexico border meeting of the border states and nations once we have received feedback from the United States-Mexico Border Health Commission

- Prepare an article for publication.
- Before an international forum, hold an educational meeting to educate lawyers and public health officials about laws.
- Currently, Texas statute allows direct agreements with other states (but not other entities, like the federal government, or Indian Nations) for subordinate admissions of out-of-state patients to TCID (i.e., Texas patients by statute always get precedence). DSHS upper management will consider, prior to the next Texas legislative session, whether the agency will recommend that this provision in the statute be expanded.
- Continue the Transnational TB Continuity of Care Workgroup meetings.

## **Tuberculosis Legal Forum Participants**

Note: some individuals participated via teleconference

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**Table  
Summary Legal Authorities related to Tuberculosis Control**

	<b>TB specific</b>	<b>Authority</b>	<b>Criteria to initiate/continue legal action</b>	<b>Applicability/residency requirement</b>
<b>Arizona</b>	TB-specific	Local/county	Failure to comply with voluntary measures. Burden of proof resides with public health	no residency requirements
<b>California</b>	TB-specific	Local/county	Authorities exist to retain patients in custody until completion of anti-TB therapy. This can be prosecuted under civil or criminal statutes. Failure to comply may result in a warning letter (not all counties utilize warning letters). Continued failure to comply results in issuance of legal orders. A warrant is issued for violation of legal orders, i.e., continued failure to comply. A Health Officer's custody order is binding; it may be enforced by the Sheriff. Criminal records may be expunged after treatment completion (This by agreement between local District Attorney's Office and a Local TB Controller/Health Officer).	no residency requirements
<b>New Mexico</b>	no; general to include threatening communicable diseases	State	Knowledge that a person is infected with a threatening communicable disease and has refused voluntary treatment, detention or observation	no residency requirements
<b>Texas</b>	Texas law handles TB through provisions regarding "communicable diseases", except that TCID is limited to TB treatment.	There is essentially concurrent jurisdiction between the state (DSHS) and local health authorities (although the system is designed for local health authorities to take the lead, as a	Violation of local Health Officer's (or state's) control order. If contagious the local health officer can seek an <i>ex-parte</i> , protective custody order (short term)	A court can order management of TB cases to anyone in Texas but cannot legally compel treatment in TCID if the person is temporarily in Texas (e.g., the person will ultimately be deported).

	<b>TB specific</b>	<b>Authority</b>	<b>Criteria to initiate/continue legal action</b>	<b>Applicability/residency requirement</b>
		general matter).		
<b>Tribal Nations</b>	Generally do not have TB control laws	Tribes; if tribes do not have their own laws they usually follow Indian Health Service laws; tribal laws take precedence		
<b>Navajo Nation</b>	Does not have TB control laws	Tribe	The Navajo Nation enacted the Health Commitment Act of 2006 (Title 13 Navajo Nation Code, Section 2101, et seq.) allowing the commitment of individuals in the least restrictive environment necessary for the satisfactory control or resolution of their illness when lack of treatment presents a substantial likelihood of serious harm to the health or safety of the community and/or the afflicted individual.	
<b>International Health Regulations</b>	Public Health Emergencies of International Concern (PHEIC)	WHO member States		No; Public Health Emergencies of International Concern (PHEIC)

	<b>Settings for court-mandated isolation</b>	<b>Key definitions</b>	<b>Transfers/interjurisdictional agreements</b>	<b>Information Sharing</b>
<b>Arizona</b>	non-criminal patients can be put in jail facilities	TB: someone who had not completed a course of treatment for TB	Mechanism exists to transfer patients out of state	
<b>California</b>	non-criminal patients can be put in jail facilities		There is no expressed authority to accept or transfer patients to or from other jurisdictions	
<b>New Mexico</b>	non-criminal patients can be put in jail facilities	"threatening communicable disease" means a disease that causes death or great bodily harm, passes from one person to another and for which there is no means by which the public reasonably can avoid the risk of contracting the disease.	There is an agreement between New Mexico and Navajo Nation. There is an agreement between New Mexico and Texas to use TCID. There is an agreement between New Mexico and Chihuahua, Mexico on influenza surveillance	
<b>Texas</b>	Texas Center for Infectious Diseases (TCID)	Temporarily in Texas -- if residency in Texas is temporary. Applies to individuals slated for deportation	Legislature passed a law that allows transfer of patients to TCID from other states; if patient is transferred under an order from another state, the Texas state attorney goes to district court in San Antonio to acknowledge the order; the originating state must agree to pay costs care at TCID.	
<b>Tribal Nations</b>				
<b>Navajo Nation</b>				

	<b>Settings for court-mandated isolation</b>	<b>Key definitions</b>	<b>Transfers/interjurisdictional agreements</b>	<b>Information Sharing</b>
<b>International Health Regulations</b>	N/A	PHEIC -- requires an international response on a time-sensitive basis	N/A	Imposes requirements for sharing information between member countries; this would be done under federal domestic laws for each country; the U.S. would implement these regulations under the principles of federalism.