United States Legal Manual for
Continuity of Care for Tuberculosis Patients

United States - México Border Tuberculosis Consortium
United States-México Border Health Commission

Framework in the United States

INTRODUCTION AND SUMMARY: This manual identifies and describes United States laws and procedures for the management and transfer of tuberculosis cases. Tuberculosis control in the United States is primarily governed by state law. For this reason, Part I reviews the laws and procedures of Arizona, California, New Mexico, and Texas, along with relevant local and tribal law. Federal government law is secondary to and supportive of state initiatives. U.S. laws for tuberculosis management comply with (and in some respects exceed) the tuberculosis control recommendations of the World Health Organization.

The objective for this manual is to explain laws and procedures that are relevant to case management and therapy completion for persons with infectious tuberculosis. As such, the focus is upon practical applications of public health law. Optimal TB case management includes prompt disease diagnosis, close monitoring of medical regimens, adherence to treatment, and identification and evaluation of close contacts. Each of these strategies becomes more difficult when case management must be coordinated among health jurisdictions, particularly across international borders. In the immediate U.S.-México border area, case management involves substantial numbers of persons moving across the border. TB patients who live on one side of the border might have their disease diagnosed or treated in the adjacent country; therefore, investigation of close contacts often involves school, work, and social settings on both sides of the border. Limited forums exist for disseminating information regarding successful case-management

---

1 Polly J. Price, Professor of Law, Emory University, and co-chair of the Legal Issues Workgroup. This project was funded by the Robert Wood Johnson Foundation’s Public Health Law program; the views expressed herein do not represent official government policy or statements or the views of the U.S.-Mexico Border Health Commission.
strategies across international borders. Ongoing coordination among TB control programs in border areas is vital.

Laws and procedures for tuberculosis case management in the U.S. Border States are similar in key respects, and this document describes the commonalities. Inter-jurisdictional transfers for persons within the United States rely largely on cooperation among state and local health authorities with assistance from non-governmental organizations for registry as well as the U.S. Centers for Disease Control and Prevention.

Part II of this manual reviews Bi-national case management. Local health authorities in several border cities share contact and treatment information for tuberculosis patients who have contacts or travel within both countries. In border cities where cross-border tuberculosis control programs exist, local health departments rely upon cooperation and have demonstrated successful contact tracing, transfer of care, and medication management. These programs operate under various Memoranda of Understanding (MOU). There are also local MOU’s governing cross-border lab specimen and medication delivery, along with MOU’s at the national level between México and the United States.

Management of the repatriation of non-U.S. citizens with active TB has been problematic. Repatriation of Mexican nationals by U.S. immigration authorities poses distinct issues with respect to continuity of care for bi-national tuberculosis cases. At present, U.S. repatriation policy specifies advance notification to Mexican officials along with transfer of medical records and an initial supply of medication for persons with active cases of tuberculosis. Current U.S. immigration policy for the treatment and release of such persons is examined in detail, along with the administrative difficulties that can impede continuity of care.
Table of Contents

Definitions ................................................................. 4

Part I: Continuity of Care for Tuberculosis Patients within the US

A. State, Local, and Tribal law in the U.S. ............................... 8
B. Who is in Charge: Federal and State Authority ...................... 8
C. Explanation of Quarantine/Isolation Laws and Procedures ..........10
D. Standards of Care ......................................................10
E. Case Management; Patient Rights and Obligations ..................11
F. Case Example and Statistics ..........................................13
G. TB Program Summaries and State Laws ............................... 16
   • Arizona ........................................................................ 16
   • California ..................................................................... 18
   • New Mexico ................................................................... 21
   • Texas ............................................................................ 23
H. World Health Organization Guidance on Human Rights
   and Involuntary Detention for TB .......................................27

Part II: Continuity of Care for Bi-National TB Patients and Repatriated
         Immigration Detainees

A. Introduction ..................................................................... 29
B. Legal Authority in Bi-National Context .................................30
   • Bi-National Case Definition ..........................................30
   • U.S. Law: Legal Restrictions on Federal Treatment Authority ....30
   • Memoranda of Understanding as Legal Basis ....................32
C. Local Cooperative Projects ..............................................34
D. Registries and Reporting Challenges ....................................36
   • Bi-National TB Card ....................................................39
E. U.S. Immigration and Customs Enforcement Repatriation ........40
F. Immigration Enforcement Policies and Procedures ................43
   • Post-Detention Coordination of Care ...............................44
   • Notification Procedures ...............................................45
   • Continuity of Care Issues for Removal/Repatriation ............45

Appendices: [Separate Document]
Sample Patient Affidavits (New Mexico, Arizona)
Forms Used by Public Health Workers (Texas)
Protocol for Civil Order of Detention for Tuberculosis (California)
Health Authority’s Affidavit of Medical Evaluation (Texas)
Full Text Statutes and Regulations in U.S. Border State
TB Case Management Protocols for Repatriation of Non-Citizens
Definitions

The following definitions apply to terms used in this legal guide:

**Tuberculosis (TB):** Tuberculosis is a contagious and often severe airborne disease caused by a bacterial infection, and is a communicable disease of specific concern in the U.S.-México border region. TB typically affects the lungs, but also may affect any other organ of the body. It is usually treated with a regimen of drugs taken for 6 months to 2 years, depending on the type of infection. TB testing and treatment is provided free of charge by local public health offices to all residents, regardless of nationality or immigration status. TB is on the federal list of quarantinable diseases.2

**Latent TB Infection (LTBI):** Persons with latent TB infection do not feel sick and do not have any symptoms. They are infected with *M. tuberculosis*, but do not have TB disease. The only sign of TB infection is a positive reaction to the tuberculin skin test or TB blood test. Persons with latent TB infection are not infectious and cannot spread TB infection to others.

**Active or Infectious TB:** A person with active or infectious TB usually has live TB bacteria cultured from respiratory secretions or tissue, may have a skin test or blood test result indicating TB infection (about 30% of active TB have false negative TB skin tests); may have an abnormal chest x-ray; usually feels sick and may have symptoms such as prolonged coughing, fever, night sweats and weight loss; needs treatment for TB disease; and may spread TB bacteria to others.3

**Multidrug-Resistant Tuberculosis (MDR TB):** MDR TB is a form of drug-resistant TB in which TB bacteria can no longer be killed by at least the two most effective antibiotics, isoniazid (INH) and rifampin (RIF), commonly used to cure TB. As a result, this form of the disease is more difficult to treat than ordinary TB and requires up to 2 years of multidrug treatment.

**Extensively Drug-Resistant Tuberculosis (XDR TB):** XDR TB is a less common form of multidrug-resistant TB in which bacteria with gene mutations that resist TB drugs are selected by exposure to inadequate treatment. XDR TB is resistant to the two best antibiotics, INH and RIF, as well as most of the alternative second line drugs used against MDR TB, plus any fluoroquinolone, and at least one of the other three injectable anti-TB drugs: amikacin, kanamycin, or capreomycin. As a result, XDR TB needs up to 2 years of extensive drug treatment and is challenging to treat.

---

2 The current revised list of quarantinable communicable diseases is available at http://www.cdc.gov and http://www.archives.gov/federal-register. 42 CFR §34.2(b).
3 Definitions Source: Centers for Disease Control, TB Fact Sheet –The Difference Between Latent TB Infection and TB Disease.
4 TB Definitions Source: U.S. Dept. of Health and Human Services, National Institutes of Health.
**Contact Tracing**: Contact tracing is a priority TB control activity. It is a systematic process to find and evaluate persons who have been in contact with TB cases and provide appropriate latent TB infection (LTBI) or TB disease treatment as needed. Contacts are persons who have shared airspace with a person with infectious TB disease. These might include household members, friends, co-workers, and others (e.g., cellmates, shelter residents).

**Continuity of Care**: Successful treatment of patients with active or infectious tuberculosis requires appropriate medication administered continuously over a period of many months. It is usually described in terms of continuous treatment in the setting of frequent mobility between different geographical areas and medical agencies. Interruption of the medication regimen poses a significant risk for the patient and may lead to the development of drug resistant tuberculosis. Patient continuity of care is thus a priority for two reasons: (1) the patient’s interest in cure and alleviation; and (2) societal interest in containing the spread of TB and prevention of MDR-TB and XDR-TB.

**Isolation and Quarantine**: Isolation and quarantine are public health practices used to stop or limit the spread of disease. Isolation and quarantine protect the public by preventing exposure to infected persons or to persons who may be infected. In addition to serving medical functions for the benefit of the patient, isolation and quarantine authority is derived from the right of the State to take action affecting individuals for the benefit of society. The two terms have different technical definitions:

- **Isolation** separates *ill* persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of certain diseases. For example, hospitals use isolation for patients with infectious tuberculosis, and patients may be requested to observe in-home isolation.

- **Quarantine** separates and restricts the movement of *well* persons who may have been exposed to a communicable disease to see if they become ill. These people may not be aware of exposure to a disease, or they may have the disease but do not show symptoms. Quarantine can also help limit the spread of communicable disease, but geographic quarantine is not used for tuberculosis control. In common usage, however, both “quarantine” and “isolation” tend to be used interchangeably to refer to an order restricting the movement of a person with infectious TB.

**Transfer of tuberculosis patients** in the United States occurs when a resident moves from one local jurisdiction (or state) to another. State, local, and tribal health authorities within the United States cooperate with each other to provide continuity of care when the destination is or becomes known. These jurisdictions cooperate with each other (and the federal Centers for Disease Control) to trace close contacts of a person with infectious tuberculosis.
Management of tuberculosis patients within the United States follows a standard protocol with minor variations among jurisdictions. The key issues to be discussed in Part I of this manual include (1) patient counseling and agreement by the patient with the course of treatment and isolation precautions, via a signed affidavit; and (2) guidelines for civil detention or other judicial orders for a persistently non-adherent tuberculosis patient.

For reasons explored in Part I below, civil detention is rarely used in the United States. The patient’s awareness of the possibility of civil confinement in the event of noncompliance (as explained in the affidavit which each patient signs) is sufficiently persuasive in most cases, and serves to underscore for the patient the importance of compliance for the patient’s own health and the health of others.
Part I:

Continuity of Care for Tuberculosis Patients within the US

A. State, Local, and Tribal Law in the United States

States have police power functions to protect the health, safety, and welfare of persons within their borders. To control the spread of disease within their borders, states have laws to investigate, access medical records, and enforce the use of isolation and quarantine.

These laws can vary from state to state and can be specific or broad. In some states, local health authorities implement state law. In most states, breaking a quarantine or isolation order is a criminal misdemeanor. State enforcement actions are rare, however, and are usually civil (not criminal) court proceedings. Continuous practice has shown that awareness of potential health authority enforcement is usually sufficient to ensure compliance with medical directives.

Native-American tribes also have police power authority to take actions that promote the health, safety, and welfare of their own tribal members. Tribal health authorities may enforce their own isolation and quarantine laws within tribal lands, if such laws exist.

B. Who Is in Charge: Federal and State Authority

The federal government:

- Acts to prevent the entry of communicable diseases into the United States. Quarantine and isolation may be used at U.S. ports of entry.
- Is authorized to take measures to prevent the spread of communicable diseases between states.
- May assist state and local authorities in preventing the spread of communicable diseases.
- Maintains a “Do Not Board” list preventing air travel for patients with any infectious disease that is a potential public health threat to passengers, including infectious TB. Persons are added to the DNB list only with reliable medical information provided by a state public health official and following a reviewed approval process by the U.S. Department of Health and Human Services and approval by DHS.
- The “Do Not Board” is usually accompanied by a public health “Border Look Out” list available to U.S. Customs and Border Protection (CBP) inspectors at air, sea and land border ports of entry. CBP officers do not prevent entry for persons on the DNB list, but instead contact the CDC or local public health authorities to meet with the patient and arrange public health follow-up. Local health authorities may serve a prepared PH judicial order for persons with infectious TB
who have demonstrated unwillingness to comply with treatment and other public health measures.

State, local, and tribal public health authorities:

- Provide diagnosis, medication, DOT, and monitor for treatment response, adverse reactions and any medical complications.
- Initiate isolation and quarantine within their borders, relying on local law enforcement officers to enforce public health orders. Assume primary responsibility for tracing contacts of persons with infectious tuberculosis as well as testing for latent or active TB.

Relevant Federal Law:5

Section 311 of the Public Health Service Act
General Grant of Authority for Cooperation
42 U.S.C. § 243
This provision of the Public Health Service Act states that the Secretary of HHS shall assist states and local authorities in the prevention and suppression of communicable diseases and to help state and local authorities enforce quarantine regulations. This section also authorizes the Secretary to accept state and local authorities’ assistance with enforcement of federal quarantine regulations.

Interstate Quarantine
42 C.F.R. Part 70
These federal regulations allow the CDC Director to take measures to prevent the spread of communicable diseases from one state or possession into another, including in the event that the Director determines that the measures taken by the health authorities of a state (including political subdivisions) or possession are insufficient to prevent such communicable disease spread. These regulations also authorize the detention, isolation, quarantine, or conditional release of persons for purposes of preventing the interstate spread of communicable diseases listed in an executive order of the President. See Executive Order 13296, as amended by Executive Order 13375.

---

C. Explanation of Quarantine/Isolation Laws and Procedures

Public health quarantine and isolation are legal authorities that may be, but rarely are, implemented to prevent the spread of communicable diseases including tuberculosis. State, local, and tribal governments have primary responsibility for controlling the spread of diseases within state borders. For persistently non-compliant patients, in-home isolation or treatment in a medical facility may be ordered by a court.

Use of quarantine or isolation powers may create sensitive issues related to civil liberties. Individuals have rights to due process of law, and generally, isolation or quarantine must be carried out in the least restrictive setting necessary to maintain public health. In all U.S. Border States, TB patients have the right to an attorney provided free of charge to represent him or her in any judicial proceeding related to the patient’s care.

Part H below summarizes state law authority for quarantine and isolation within state borders, including authority to initiate quarantine and isolation, limitations on state quarantine powers, and penalties for violations. (Full text of these statutes and regulations are provided in the Appendix.)

TB screening for persons who may have been exposed to TB is voluntary. There is no legal authority to require any individual to submit to a TB test. Exceptions include prisoners and immigration detainees, who are screened for TB (and other health conditions) prior to, or upon, admission to a prison or detention facility.

A recent case from Amarillo, Texas, illustrates the importance of outreach, persistence, and persuasion with respect to contact tracing and screening. A student’s active case of tuberculosis led to testing hundreds of students and staff members. The student, who contracted the disease from a relative, did not respond to local health officials’ earlier requests for testing, according to the Director of the Amarillo Department of Public Health. Earlier testing could have avoided exposing other students at the school.

D. Standards of Care

Patient Counseling. An important part of patient counseling at the outset of treatment is emphasizing the necessity for long-term treatment by medication, including the availability of treatment in the event of a change of residence. Under standard protocols in US jurisdictions, patient counseling and consent to treatment is memorialized in an affidavit signed by both the patient and the public health worker assigned to that patient. An example affidavit from each Border State is provided in the appendix.

Directly Observed Therapy (DOT). Anti-tuberculosis medication is provided free of charge to each patient. Directly observed therapy is the standard of care in the United States and is administered through local, tribal, or state public health departments. DOT means that every dose of anti-tuberculosis medication is given to the patient by a trained

---

outreach worker who is held accountable for observing and documenting medication intake. DOT is normally observed in the home or other community setting. Non-adherence to therapy is the major cause of treatment failure and the development of drug-resistant tuberculosis. Patients on DOT are more likely to complete therapy.

In the U.S. Border States, the use of directly observed therapy for patients, commonly in the patient’s home, has resulted in declining rates of TB and reduced incidence of drug resistance.

Ideally, DOT is started when suspected TB is diagnosed. DOT plans should be part of the discharge orders from the hospital. In outpatient situations, it is started with the first prescription. The patient is likely to be more accepting of DOT if initiation of DOT is immediate. Physicians and health department case managers should encourage cooperation with the DOT outreach workers.

In many U.S. states these protocols are reflected in department regulations as authorized by statute.

E. Case Management; Patient Rights and Responsibilities

Inpatient long term-treatment may be indicated where the Local Health Department has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.

Public health authorities at the state, local, and tribal levels may sometimes seek help from police or other law enforcement officers to enforce a public health order. If a quarantinable disease is suspected or identified in a person arriving at the U.S. border or port of entry, CDC may issue a federal isolation or quarantine order. Such orders are rarely used.

In U.S. Border States, patients referred to civil authorities for persistent non-adherence are protected by U.S. Constitutional provisions including due process. Border States provide an attorney free of charge to represent the patient in any judicial or administrative proceedings. An initial confinement order must be periodically reviewed. Federal and state law also allows the conditional release of persons from quarantine if they comply with medical monitoring and surveillance.

The priority for legal authority for detention is to respect patient rights as well as the rights of the community. For this reason, quarantine and isolation are used only in cases of consistent or repeated non-adherence with a treatment regimen. Least-restrictive alternatives must be eliminated prior to civil detention.

7 U.S. Customs and Border Protection and U.S. Coast Guard officers are authorized to help enforce federal quarantine orders.
**Patient Confidentiality**

Any information, data, and reports with respect to a case of tuberculosis that are furnished to, or procured by, a county or district tuberculosis control unit or the department of health are confidential. This information may be used only for patient treatment, contact tracing and investigation, and statistical, scientific, and medical research for the purpose of controlling tuberculosis in the state.

Because TB is considered a significant threat to the public’s health, the disclosure of the patient information from the health care worker to a designated public health authority is allowed (and required) for the purpose of TB control. In addition to routine case reporting, some TB control programs conduct active surveillance to identify TB cases through laboratory or pharmacy records. Health departments are required to protect the confidentiality of all TB case reports.

In the United States, health-care providers must maintain confidentiality about the identity and health status of any patient they treat. Health information privacy is governed by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA. The U.S. Department of Health and Human Services issues regulations to implement HIPAA. These rules are fairly detailed:

- The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Medical professionals are required to report patients with certain contagious disease to the state public health department. Public health officials who are government employees, state or federal, may share patient information with each other for specified purposes. But as a general rule, public health agencies may not disclose a patient’s name or identifying information to the general public.

---


10 *Id.*
Public health authorities that are also covered entities under HIPAA must comply with the requirements of the Privacy Rule, but HIPAA does not apply to all situations that tuberculosis (TB) programs and their legal counsel may face concerning patient confidentiality. Express TB control laws in 11 states appear to protect TB patients’ rights to privacy and confidentiality of health information concerning their TB status. In Arizona, medical records of TB patients must be kept confidential. Health authorities may disclose medical records to health care providers, other agencies, and courts only when such information is required for enforcing TB control measures. Court hearings related to TB patients in Arizona are not open to the public, and records are kept confidential. In other jurisdictions, judicial proceedings to enforce TB isolation orders are, by default, available as public documents.

Inter-jurisdictional movement or relocation must be accomplished without treatment interruptions. If a patient travels or moves from one health jurisdiction to another, the health department of the patient’s home jurisdiction should notify the health department for the area to which the patient is moving. It is important that as much information as possible be relayed to the receiving jurisdiction, within the limitations of current laws and regulations governing the confidentiality of records.

Patient Obligations

A person diagnosed with infectious tuberculosis poses a severe threat not only to themselves, but to the public as well. Tuberculosis is a dangerous and potentially deadly disease if not treated correctly and efficiently. Generally, a person has a right to refuse treatment for an illness based on liberty principles; however, tuberculosis poses a significant threat to the public and must be treated to curtail that threat. For this reason public health departments have considerable authority to require patients to comply with treatment and to avoid infecting others.

When a person diagnosed with infectious tuberculosis repeatedly fails to comply with health department directives, public health professionals may seek a court order for treatment, home isolation, or detention in a health-care facility to comply with treatment protocol. When a person fails to comply with a judge-issued treatment and isolation order, the state may detain the noncompliant person following a hearing at which the patient may contest the proceedings with the assistance of an attorney provided free of charge.

At such proceedings, state judges, as an independent branch of government, ensure strict adherence to principles of “due process of law.” Due process of law is a fundamental, constitutional guarantee that all legal proceedings will be fair and that one will be given notice of the proceedings and an opportunity to be heard before the government acts to take away one's life, liberty, or property. It is also a constitutional guarantee that a law shall not be unreasonable, arbitrary, or capricious.

The U.S. Supreme Court has not addressed procedural due process specifically for the treatment of tuberculosis, but it has addressed the procedural due process that is required
for individuals with mental illness. Tuberculosis control laws in the U.S. share many of the procedural requirements of mental health safety codes, and for this reason state court judges follow the Supreme Court’s procedural directions for TB patients. In Green v. Edwards, for example, the West Virginia Supreme Court held that an individual may be detained for failure to comply with tuberculosis treatment if the state board of health can testify that the person has communicable tuberculosis and poses a threat to the health of others. The court held that persons with an infectious disease have a due process right to notice and representation as part of isolation proceedings.11

In all U.S. Border States, attorneys are provided free of charge to TB patients for whom any compliance order is sought.

F. Case Example and Statistics

Case Example. Although the following recent case occurred in Illinois, the judicial process described below is similar to legal authority in U.S. Border States. This summary is drawn from news reports that were uniquely thorough – most judicial orders for TB patients are not reported in the press.

An Illinois doctor diagnosed Patient X with active pulmonary tuberculosis on March 14, 2014. Public health officials met with Patient X to discuss medical treatment and precautions. The patient was asked to sign an affidavit outlining the tuberculosis treatment, including regular visits from a state-provided nurse to administer medication (DOT), home isolation, and the requirement to wear a surgical mask in public. The affidavit also stated that noncompliance may result in legal consequences such as jail time or fines.

Over the next month, Patient X repeatedly refused to remain at home for his DOT, telling public health workers that he was too busy. On April 2, a nurse arrived to administer Patient X’s DOT and found a woman and 5-year-old child sleeping unprotected and exposed to Patient X’s illness. The Illinois Public Health District informed Patient X that he must complete DOT or face legal consequences, because he was putting others at risk of infection.12

Because of Patient X’s repeated failure to comply with DOT, public health authorities brought Patient X’s noncompliance to the attention of the courts. An Assistant State Attorney filed a petition with the local court on behalf of the Public Health Administrator of the Champaign-Urbana Public Health District. The petition stated that Patient X’s actions violated the signed affidavit and risked infecting the public. It asked that the court order Patient X to stay isolated in his apartment during the rest of his treatment unless he had permission of the health district to leave, to wear a mask if he had to leave

his home, and to begin electronic monitoring. The petition also asked the court to direct Patient X to complete DOT.\(^{13}\)

Patient X failed to appear at the hearing. The presiding judge ordered Patient X to comply with DOT, wear an ankle bracelet-monitoring device, and remain at home in isolation to protect the public from his disease. Officials proceeded to Patient X’s apartment to inform him of the order and give him the monitoring device.\(^{14}\)

Patient X eventually acquiesced to the monitoring device but refused to remain at home. Because of Patient X’s further noncompliance, the State’s Attorney then filed a petition of indirect criminal contempt, the sentence for which is at most 180 days in jail and a fine of up to $500.\(^{15}\)

On April 17 the Circuit Court judge charged Patient X with contempt of court. Authorities jailed Patient X, placed him in a special negative air pressure cell to prevent the spread of tuberculosis, and provided him with state-funded DOT.\(^{16}\) Two weeks later, Patient X was released from jail. The State’s Attorney filed a petition to lift the isolation order against Patient X because he had received the minimum two-week treatment for tuberculosis while detained and was no longer contagious. However, the state will monitor Patient X for seven more months as a precaution against a resurgence of infection.\(^{17}\)

The above example illustrates generally the legal process which may be taken by U.S. state health authorities for a persistently noncompliant patient:

- The patient is diagnosed with contagious tuberculosis
- The patient is informed of his condition and asked to sign an affidavit acknowledging the medical treatment he will receive and the possible legal consequences resulting from noncompliance.
- The patient undergoes Directly Observed Therapy (DOT) administered by a state-provided public health nurse.
- If the patient is noncompliant or fails to be available for the DOT, the public health professional assigned to his case will warn of possible legal consequences.
- If noncompliance continues, a government attorney, on behalf of the local public health authority, may petition the local state court to order home isolation or placement in a medical facility. The patient is served with notice of the petition to the court.
- A hearing occurs in front of a state circuit court judge. The patient is allowed representation, free of charge, at the hearing. The Public Health Administrator

---


\(^{14}\) Source: http://in.reuters.com/article/2014/04/11/usa-tuberculosis-illinois-idINL2N0N31VR20140411

\(^{15}\) Source: http://will.illinois.edu/news/story/attorneys-seeking-plea-agreement-in-tb-patient-case

\(^{16}\) Source: http://www.sj-r.com/article/20140423/News/140429700

must prove the patient has contagious tuberculosis and provide evidence of his noncompliance. If the court holds for the state, the court may order the patient into isolation in his home or a medical facility until he is no longer contagious.

- If the patient does not comply with the order, the court may find the patient to be “in contempt of court” and confine him for treatment.
- When the patient is no longer contagious or indicates he will comply with DOT, he is released from detention, but still may face additional judicial proceedings for disobeying court orders.

**Statistics**

Judicial proceedings such as the example described above are extremely rare. Most TB patients comply with their plan of treatment to the best of their ability because they want to be cured and understand the risks to themselves and others. Through long experience, the possibility of civil detention has proven to be a valuable management tool for public health workers. Based upon data available from several of the border states, civil detention is rarely necessary or utilized.

In New Mexico, for example, over the last ten years the Department of Health’s TB program has resorted to judicial enforcement once per year or less among hundreds of active cases.\(^{18}\) In California, 19 judicial proceedings were initiated between 2001 to the present. Texas had 4 reported cases from 2009 to the present.\(^{19}\)

Public health nurses work hard on the front end building relationships with patients so that resort to the court system does not become necessary. When judicial process is necessary, the cause is often related to a mental illness or homelessness. For the latter, many health jurisdictions provide some form of housing during an infectious stage so that DOT and isolation may be observed.\(^{20}\)

**G. TB Program Summaries and State Laws**

**Program Summaries for U.S. Border States**

**Arizona:**\(^{21}\)

The Tuberculosis Control Program (TCP) provides technical assistance to health departments and health care providers on epidemiology, diagnosis, control, and prevention of TB in Arizona. The TCP monitors, controls and prevents infection, disease, and death associated with TB through: surveillance, data analyses, health education, guidelines, consultation, epidemiological investigations, and rule making. The TCP

\(^{18}\) Source: Michal M. Hayes, Assistant General Counsel, Office of General Counsel, New Mexico Department of Health. Excel Spreadsheet NMSA 24-15-1.1 (October 2013).

\(^{19}\) Source: Bloomberg Law Docket Search, May 2014.

\(^{20}\) See, e.g., *County to Pay for Housing, Treatment of Man Diagnosed with TB*, ELYRIA CHRONICLE-TELEGRAM, April 24, 2014.

monitors the occurrence, distribution, and trends of TB and Latent TB Infection (LTBI) morbidity, risk factors, completion of therapy, and TB drug-resistance patterns. The TCP also controls the necessary investigation and follow-up of persons exposed to active TB cases.

**Treatment**

The overall goals for treatment of TB are to cure the patient and to minimize the transmission of *Mycobacterium tuberculosis* to others. Successful treatment of TB benefits both the patient and the community in which the patient resides. Patients with TB in Arizona or who move to Arizona with reported TB should receive and complete treatment in accordance with national guidelines and following Arizona laws and regulations. Tuberculosis is treated with patient-centered care and Directly Observed Therapy (DOT). Treatment regimens must contain multiple drugs to which TB is susceptible and administered in a single dose. Each treatment regimen has an initial phase of two months, followed by a choice for a continuation phase of either four or seven months, dependent on the patient and type of TB. If there are no treatment interruptions, six months is usually the minimum duration of treatment.

**Contact Investigation**

A contact investigation is the process of identifying, examining, evaluating, and treating all persons who are at risk for infection with *Mycobacterium tuberculosis* due to recent exposure to a newly diagnosed or suspected case of pulmonary, laryngeal, or pleural tuberculosis. These investigations take place to identify, examine, and prevent the development of active TB among close contacts and determine whether there is an outbreak of TB. The Arizona Department of Health Services (ADHS) has a complex system of identifying when a contact investigation is needed. Their main goal is preventing and protecting the public from outbreaks.

Investigations include patient interviews, field investigations, risk assessments for transmission of the disease, determining priority of contacts, treatment for contacts, decisions on expansion of testing, and evaluation of the investigation activities. Investigations follow these steps as guidelines and do not consider them a fixed sequence of events.

**Transfer of Patients**

The Arizona Department of Health Services is responsible for coordination of transfer notifications between states and other local jurisdictions within the state. The local public health jurisdiction should notify the state public health department in advance when a patient plans or requests to transfer to another jurisdiction. The receiving and referring jurisdictions should stay in communication until final dispensation of the patient is known.
Infection Control

To accomplish TB control activities, ADHS states each local public healthcare agency should familiarize staff with the current CDC infection control guidelines for healthcare providers and settings, develop an infection control program for the county or state TB staff, and designate a staff person to guide facilities that may need to set up TB infection control programs. There are three infection control measures: administrative controls, environmental controls, and personal respiratory protection.

**Administrative controls** are primarily aimed at early identification, isolation, and appropriate treatment of infectious patients. An effective TB infection control plan contains measures for reducing the spread of TB that are appropriate to the risk of a particular setting. A written TB infection control plan helps to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed TB disease. The infection control plan should indicate procedures to follow to separate persons with suspected or confirmed infectious TB disease from other persons in the setting until time of transfer and should be evaluated annually. ADHS explains that it is essential to initiate promptly and maintain TB isolation for persons who may have infectious TB.

**Environmental controls** are used to prevent the spread and reduce the concentration of *Mycobacterium tuberculosis*. Ventilation is the most effective control, stopping contaminated air from reaching healthy individuals. It is important to note that without strong administrative controls, environmental controls are ineffective. **Personal respiratory protection** reduces exposure to TB by filtering out microscopic secretions with *Mycobacterium tuberculosis* from the room air. The ADHS recommends those treating infected individuals should use personal respiratory protection to avoid infection.

Isolation

To reduce disease transmission, a patient with tuberculosis may need to be isolated or have activities restricted. This means they may be confined to their homes, hospitals, or designated healthcare facilities to protect others from infection. In most cases, isolation is voluntary; however, many levels of government have the basic legal authority to compel isolation of sick people to protect the public. The patient may be placed in an Airborne Infection Isolation (AII) room. An AII room has negative air pressure relative to the hall and controls the air exchange with other rooms. Patients may be discharged when the tuberculosis disease is deemed medically stable and no longer contagious.

Petition for court ordered examination, monitoring, treatment, isolation, or quarantine

The tuberculosis control officer, the local health officer, or a designated legal representative may petition the superior court for court ordered examination, monitoring, treatment, isolation, or quarantine of an afflicted person who presents a substantial danger to another person or to the community and who has failed to comply with a voluntary
treatment plan or a written order to cooperate. The petition must include a statement containing the grounds and underlying facts demonstrating that the afflicted person presents a substantial danger to another person or the community. The petition shall request the court to issue an immediate order authorizing the compulsory detention and continued detention of the afflicted person in a designated treatment facility.

The detention hearing shall be held within fifteen days after the petition is filed to determine whether the afflicted person has tuberculosis. The burden of proof is on the petitioner to prove by clear and convincing evidence that detention is necessary because the afflicted person poses a substantial danger to another person or the community. Within five days after the filing of the petition, the petitioner must serve the afflicted person a copy of the petition, affidavits in support of it, and notice of the hearing. The afflicted person is entitled to representation and to be evaluated by an independent physician.22

California23

The California Tuberculosis Control Branch (TBCB) provides resources to prevent and control tuberculosis. The TBCB is a branch of the Center for Infectious Diseases, Division of Communicable Disease Control. The Branch is composed of four sections, Outbreak Prevention & Control Section (OPCS), Program Development Section (PDS), Resources Planning & Management Section (RPMS), and Surveillance & Epidemiology Section (SES).24

Outbreak Prevention & Control Section

The OPCS provides technical and direct assistance to California local health departments striving to contain the spread of TB. Assistance is often rendered in partnerships with local TB programs and other Sections of the TBCB and is intended to build local capacity for improved TB control. The OPCS also offers assistance through the Multidrug-resistant TB Service (MDR-TB), which was established to enhance the detection, treatment, and management of MDR-TB cases throughout the state.

Program Development Section

The PDS is responsible for assessing, evaluating, and building the capacity of California’s overall TB control program, for legislative analysis, and for maintaining expert knowledge of TB laws and regulations. The PDS actively identifies current and emerging issues, and responds to inquiries and requests from the public, local TB programs, and other State agencies. The PDS seeks to maximize TB control capacity by developing technical assistance, programs, projects, and interventions to remedy program gaps and fulfill public health needs.

22 A.R.S. § 36-726
23 Source: Tuberculosis Control Branch, California Department of Health
24 Source: http://www.cdph.ca.gov/programs/tb/Pages/AboutTBCB.aspx
Resources Planning & Management Section

The RPMS manages Branch operational activities and provides fiscal guidance, funding, and support to local health departments to prevent and control tuberculosis in their respective communities. As part of its service to local TB programs, the RPMS provides technical advice and assistance in developing TB program budgets, reallocation of TB funding, and assistance with ongoing budget management and review.

Surveillance & Epidemiology Section

The SES collects accurate and complete information on the epidemiology of TB in California to inform public health action at the local, state, and national levels, and provides California TB data to the Centers for Disease Control and Prevention. The SES analyzes surveillance data reported by local TB programs to describe the distribution and determinants of TB in the California population, including the detection of outbreaks. The SES conducts clinical, epidemiological, and operation research and evaluation projects to advance the understanding of TB epidemiology and to inform control activities.

Detention of Noncompliant Patients

Detention may be necessary for patients when they are infectious, as they pose a danger to the public. Before detention is implemented, reasonable attempts should be made to address concomitant problems such as mental illness, homelessness, and substance abuse that may be contributing factors to non-adherence.

- The decision to detain should be based on a comprehensive and individuals assessment of the patient, including:
  - His or her medical condition
  - Course treatment
  - Risk of transmission if therapy is not completed
  - Barriers preventing the patient from completing therapy

If the local health officer determines that the public health in general or the health of a particular person is endangered by exposure to a person who is known to have active tuberculosis disease, or to a person for whom there are reasonable grounds to believe he has active tuberculosis disease, the local health officer may issue any orders he or she deems necessary to protect the public health or the health of any other person, and may make application to a court for enforcement of the orders.

- Upon the receipt of information that any order has been violated, the health officer shall advise the district attorney of the county in which the violation has occurred, in writing,
• And shall submit to the district attorney the information in his or her possession
relating to the subject matter of the order, and of the violation or violations
thereof.25

The local health officer may detain in a hospital or other appropriate place for
examination or treatment, a person who is the subject of an order of detention issued
pursuant to H&S Code § 121365 without prior court order except that when
• a person detained has requested release, the local health officer shall make an
application for a court order authorizing the continued detention within 72 hours
after the request.
• In no event shall any person be detained for more than 60 days without a court
order authorizing the detention.
• The local health officer shall seek further court review of the detention within 90
days following the initial court order authorizing detention and thereafter within
90 days of each subsequent court review.
• Any person subject to a detention order shall have the right to be represented by
counsel.26

Patient Release

Generally, patients will be released when they have completed therapy and are cured.
The local health officer may determine that early release is appropriate and either directly
revoke the order for detention or request release from the courts depending on
circumstances. The following criteria for release from detention should be considered
when appropriate:

• When the patient has demonstrated sufficient progress to reasonably conclude that
completion of therapy and cure can be achieved outside of detention,
• The patient demonstrates a willingness to continue treatment,
• The patient understands the nature of their illness and are willing to adhere to a
DOT program,
• Progress has been made in treating the concomitant conditions which made
adherence to treatment difficult,
• A plan for the outpatient treatment has been developed,
• Reasonable evidence exists that the patient will be locatable, and
• The patient understands the possibility of detainment if they do not adhere to the
treatment plan.

New Mexico:27

The TB Program serves people infected with TB, contacts of active TB cases, public and
private healthcare providers throughout New Mexico, and the general public. The

27 Source: Tuberculosis Prevention and Control Program, New Mexico Department of Health.
Tuberculosis Program’s purpose is to prevent and control the spread of Tuberculosis, by ensuring that active TB cases receive adequate care, directly observed therapy, and a contact investigation if infectious. Other important program activities are: case management of all active cases; interstate/international referrals; surveillance; training for healthcare workers and other stakeholders; and screening to identify and treat latent TB infection (LTBI).

**Case management**
- Provide directly observed therapy (DOT) to all active tuberculosis cases in New Mexico to prevent non-adherence, ensure a quick response to any adverse reactions and assure completion of an adequate treatment regimen.
- Stay in regular contact with physicians and public health nurses to monitor the status of individual TB cases, medical follow-up of patients and adherence of patients to drug regimens and documentation of clinical response to therapy.
- Make and receive referrals for TB cases and their contacts who move to or from New Mexico or the United States

**Education and Training**
- Consult with health care providers, including infection control practitioners, Indian Health Services, community-based organizations, correctional facilities, local health offices, and the general public.
- Offer training on TB, including case management, prevention, standard recommendations for diagnostic procedures, treatment regimens, isolation guidelines, clinical follow-up and contact investigations.

**Surveillance**
- Create standardized reports for all cases reported in New Mexico.
- Compile surveillance data and report program outcomes to the CDC.
- Identify cases through direct collaboration with the New Mexico State Laboratory, private labs, and by receiving reports from healthcare providers and infection control practitioners who report potential TB suspects to us immediately.

**Prevention**
- Screen individuals to determine if they have a latent TB infection.
- Public health nurses provide preventive treatment and follow-up through consultation with our nurse consultants;
- Maintain an LTBI (latent TB infection) registry
- Assure complete and timely contact investigations
- Isolation for tuberculosis

Patients who have or are suspected to have infectious TB are isolated from others to reduce the risk of transmitting the disease to others. In health-care settings such as hospitals, this often includes the use of special airborne isolation rooms so that air from the infected patient does not come in contact with others. Clients being treated at home
who may be infectious are asked to isolate themselves by doing things such as not having visitors and staying in their own home until they are safe to be around others.

*Tuberculosis treatment*

Tuberculosis is treated with a combination of medications over a period of at least 6 months. For drug susceptible TB, the initial phase of treatment includes the use of 3 to 4 anti-TB medications for 8 weeks. This is then followed by an additional 4 months of therapy using a combination of two medications. Directly observed therapy is the standard of care for ALL patients with active TB disease. This involves a treatment program of TB medications that are administered and monitored by health care workers with expertise in the treatment of TB. The New Mexico Department of Health (NMDOH) provides care and treatment for all individuals with active disease due to tuberculosis. Treatment includes a prescribed program of directly administered anti-tuberculosis medications along with nursing care, physician consultation, and laboratory monitoring.

*Administration of Effective Treatment*

TB patients rapidly become less contagious after starting effective TB medications. Medication quickly reduces the number of bacteria and kills the TB bacteria in the lungs. However, the exact rate of decrease cannot be predicted for individual patients. In general, many persons on effective therapy are considered not contagious after 2 to 4 weeks of effective therapy. The risk to the general public in the setting of a public space exposure (i.e. on the street, in a store, in a restaurant) is very small. These types of brief low risk exposures are not tracked as part of contact investigations.

*Points about Contact Investigations*

The Centers for Disease Control and Prevention have very detailed guidance on how to perform contact investigations for clients with active TB. NMDOH follows this guidance and has nurses with special training and experience in contact investigation to help prioritize who should be tested, how contacts should be evaluated and tested, and if further treatment should be offered. Evaluation of contacts involves gathering information about the infected person and their contacts, other medical illnesses, a review of any symptoms, and may include special tests such as a TB skin test and/or a blood test.

*Court ordered therapy*

This strategy is used infrequently and is pursued only for patients who have not complied with recommended treatment for their tuberculosis and may be at risk for spreading the disease to others or for developing a treatment resistant form of tuberculosis. A court order is pursued when all other methods to support the patient in their treatment have failed to bring about adherence with treatment.
Community-Based Tuberculosis Screening

Local health departments in selected urban and border counties receive funding from the Tuberculosis (TB) Program to establish a TB screening program in methadone drug treatment centers, HIV early intervention centers, homeless shelters, and other organizations that serve high-risk groups. Individuals identified with latent TB infection are referred to the appropriate health department for treatment and other follow-up as appropriate.

Correctional TB

The Correctional TB Program provides technical assistance to all county jails and other correctional facilities covered by Chapter 89 of the Texas Health & Safety Code (the statutes) and Title 25, Part I, Chapter 97, Subchapter H (the rules) of the Texas Administrative Code. These correctional facilities must have an approved TB control plan. The Correctional TB Program also consults with correctional facilities when they have a case of TB within their facility to facilitate identification of persons with risk of exposure and to facilitate continuity of care upon release or transfer. For more information about ensuring continuity of TB therapy for detainees of the U.S. Immigration and Customs Enforcement (ICE) see SOP 8.13.1.

Court-Ordered Management

The Communicable Disease Prevention and Control Act is a comprehensive statute (codified as Chapter 81, Texas Health and Safety Code) that provides for numerous control measures which are available for use in protecting the public health. When an individual who has, or is suspected of having, a communicable disease and does not comply with the control order issued by the local health authority and/or DSHS, Subchapter G of Chapter 81 provides for court-ordered management of the patient.

The process by which a local health authority seeks court-ordered management of a person who has violated a control order is a cooperative effort between that local health authority/local health department staff and the city, county or district attorney whose office represents them in legal matters. The Office of General Counsel of the Department of State Health Services is available to answer questions from local attorneys seeking court-ordered management in their jurisdictions.

Drug-Resistant TB Monitoring and Control

The DRTB Program coordinates, tracks, and monitors all reported laboratory confirmed drug-resistant TB cases throughout their course of treatment. The program works with medical providers to ensure rapid notification of the drug resistant status. It assists the provider in obtaining expert TB consultation to assure that the patient is provided with an

Source: Texas Department of State Health Services

28
adequate treatment plan and that the provider is aware of DSHS policies and requirements relevant to drug resistant TB. Consultations by designated TB experts are recommended and strongly encouraged for all cases with resistance to isoniazid only, rifampin only, or both isoniazid and rifampin (MDR) combined with other TB drugs. This program also monitors the directly observed therapy (DOT) policy, which is the standard of care in Texas in the treatment of TB patients.

*Evaluation and Program Reviews*

A regular system of reviews of TB programs has been established for local and regional health departments to assess the quality of service and to recommend strategies to improve the delivery of TB prevention and control services. Quantitative indicators of program performance are also monitored based on information contained in the TB case registry. Other indicators are derived from special performance or financial reports from local and regional TB programs.

**Summary of Legal Authorities in U.S. Border States**

The table below provides a summary of relevant statutory provisions governing quarantine generally. Each state also manages infectious tuberculosis through statutes or regulations governing process, as presented in full text in the appendices.

### Summary of State Laws

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>Statute Citation (Last Amend)</th>
<th>Statute Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Ariz. Rev. Stat. § 36.787-789 (2002)</td>
<td>Authority: The Governor along with the state director of health services has primary authority in a state of emergency involving possible infectious disease. If investigation reveals a suspicion of a highly contagious disease to be accurate, the state or local health authority may declare a quarantine if it is the least intrusive means of protecting public health. A quarantine or isolation should be established by written court order unless there is an urgent threat to public health, in which case the Department of Health or local health authority can initiate a quarantine by written directive provided they file a petition for court order within ten days. The maximum court order for quarantine is thirty days before requiring a new order.</td>
</tr>
</tbody>
</table>

29 Source: National Conference of State Legislatures
<table>
<thead>
<tr>
<th>State</th>
<th>Code</th>
<th>Authority</th>
<th>Penalties</th>
<th>Police Power and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Ariz. Rev. Stat. § 36.630, 737 (1982, 1997)</td>
<td>Penalties: Knowingly or intentionally exposing others to infection or attempting to leave quarantine or isolation is a class 2 misdemeanor. Obstructing an investigation, making a false report, or knowingly assisting someone else in violating quarantine is a class 3 misdemeanor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>Ariz. Rev. Stat. § 36.624,732 (2002, 1997)</td>
<td>Police Power and Limitations: No treatment shall be provided against the will of an individual provided they cooperate with quarantine and sanitation orders. If an individual under quarantine is shown to no longer pose a public health risk, they may be released prior to end of court ordered period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Cal. Health &amp; Safety Code § 120175-120250 (1995)</td>
<td>Authority: Health officers should take all necessary steps to prevent the spread of a contagious disease within their jurisdiction. Officers are required to enforce quarantine of state Department of Health and cannot enforce a quarantine against another jurisdiction without state approval.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Cal. Health &amp; Safety Code § 120275-120305 (1995)</td>
<td>Penalties: Anyone who violates or refuses a regulation or order of quarantine is guilty of a misdemeanor. A first offense is punishable by forced compliance with quarantine up to a year and two years probation with a repeat offense punishable by confinement of not more than a year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>Cal. Health &amp; Safety Code § 120175-120250 (1995)</td>
<td>Police Power and Limitations: In the event of the outbreak of a communicable disease, a health official may have access to all supplies necessary from health providers that can either assist in responding to the outbreak or are implicated in the outbreak. If disinfection of goods or property would be unsafe, officers may destroy items, with proper compensation to owner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>N.M. Stat. Ann. § 24-1-3</td>
<td>Authority: The Department of Health has authority to establish, maintain and enforce isolation and quarantine. The department of health may establish or require isolation or quarantine of any animal, person, institution, community or region. The secretary of health may isolate or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>N.M. Stat. Ann. § 12-10A-8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Penalties: The secretary of health, the secretary of public safety or the director may enforce the provisions of the Public Health Emergency Response Act by imposing a civil administrative penalty of up to five thousand dollars ($5,000) for each violation of that act.

Police Power and Limitations: Isolation or quarantine shall be by the least restrictive means necessary to protect against the spread of a threatening communicable disease or a potentially threatening communicable disease to others and may include confinement to a private home or other private or public premises.

A person isolated or quarantined pursuant to the provisions of the Public Health Emergency Response Act has the right to refuse medical treatment, testing, physical or mental examination, vaccination, specimen collections and preventive treatment programs.

An employer or an agent of an employer shall not discharge from employment a person who is placed in isolation or quarantine.

N.M. Stat. Ann. § 12-10A-8


Authority: If the department or a health authority has reasonable cause to believe that an individual is ill with, has been exposed to, or is the carrier of a communicable disease, the department or health authority may order the individual, or the individual's parent, if the individual is a minor, to implement control measures that are reasonable and necessary to prevent the introduction, transmission, and spread of the disease in this state.

The governing body of a Type A general-law municipality may take any action necessary or expedient to promote health or suppress disease, including actions to prevent the introduction of a communicable
disease into the municipality, including quarantine rules, and may enforce those rules in the municipality and in any area within 10 miles of the municipality. A home-rule municipality may adopt rules to protect the health of persons in the municipality, including quarantine rules to protect the residents against communicable disease.

**Penalties:** A person commits an offense if the person knowingly fails or refuses to obey a rule, order, or instruction of the department or an order or instruction of a health authority issued under a department rule and published during an area quarantine under this section. An offense under this subsection is a felony of the third degree.

**Police Power and Limitations:** The state, a county or a hospital district shall pay for medical expenses if individual is indigent and cannot pay and if that individual is not eligible for benefits under an insurance contract.

---

**I. World Health Organization Guidance on Human Rights and Involuntary Detention for TB**

The World Health Organization's position with respect to the legal and ethical issues surrounding compulsory TB treatment has the specific purpose of ensuring prevention and control within a legal and human rights framework. WHO’s most recent guidance has highlighted the issues around compulsory treatment, particularly in relation to drug-resistant TB.

WHO supports the rights and responsibilities of TB patients as recommended in the Patients’ Charter for TB Care:

> If a patient willfully refuses treatment and, as a result, is a danger to the public, the serious threat posed by XDR-TB means that limiting that individual's human rights may be necessary to protect the wider public. Therefore, interference with freedom of movement when instituting quarantine or isolation for a communicable disease such as MDR-TB and

---

XDR-TB may be necessary for the public good, and could be considered legitimate under international human rights law. *This must be viewed as a last resort, and justified only after all voluntary measures to isolate such a patient have failed.*

In the United States, public health professionals emphasize cooperation and voluntary measures, as described above. Judicial process is a last resort. Patients subject to judicial process are guaranteed significant due process protections, including a high standard of evidence presented by the government and representation by an attorney free of charge.

---

PART II:

Continuity of Care for Bi-National TB Patients and Repatriated Immigration Detainees

A. Introduction

Converging factors contribute to elevated TB incidence and complicate TB control efforts along the U.S.-México border. An elevated TB incidence occurs in the geographic areas most affected by cross-border immigration. Low economic status, crowded living conditions, and limited access to health care increase the risk for TB transmission on both sides of the border. Frequent bilateral border crossings and movement within the United States contribute to delays in TB diagnosis and impede treatment completion. TB case management across an international border is complicated and may compromise outcomes for some TB patients.

Ultimately, lowering TB rates in the border area and reducing racial and ethnic disparities of TB disease depend on identifying and completing treatment of infected persons. Therefore, TB prevention and control efforts along the U.S.-Mexico border require the cooperation of local, state, and national TB control programs in both countries, including strategies for coordinated interventions and funding to ensure that adequate resources are available.

U.S. and Mexican citizens routinely cross the border for TB diagnosis and treatment without notifying health departments of either their country of origin or destination. Additionally, immigrants from México and Central America who do not have documentation of citizenship or visas are not screened for active TB unless they are detained by U.S. immigration officials. Gaps and changes in treatment, failure to share clinical and diagnostic information, perform timely contact investigations, and promote therapy completion may compromise case management. Improved communication among TB agencies and health-care providers at local, state, national, and international levels is needed to ensure effective case management and to coordinate care and completion of therapy.

U.S. procedures for removal of non-citizens are of significant concern for both countries. Persons detained by U.S. Immigration and Customs Enforcement (ICE) are at a high-risk for active TB. Screening at intake to ICE custody identifies persons with active TB and allows the Division of Immigration Health Services (DIHS) to begin treatment. However, ICE is often required as a matter of law to repatriate or release patients into the U.S. before completing therapy. Protocol for repatriation by ICE aims to minimize disruption of treatment, but compliance with this protocol is administratively difficult for
a number of reasons. ICE collaboration with public health professionals in México is essential to support completion of treatment.\textsuperscript{32}

The section below explains the relevant legal issues for continuity of care in these two situations, considering first continuity of care for bi-national TB patients, followed by continuity of care for repatriation of TB patients in ICE custody.

B. Legal Authority in Bi-National Context\textsuperscript{33}

\textit{Bi-National Case Definition}

No standard surveillance definition for a bi-national TB case is in use by border TB control programs. Using a uniform case definition would enable standardized data collection and increase accuracy in data analysis and comparison. A standardized case definition should be flexible enough to encompass all factors related to bi-national TB patients and the health providers who serve them, yet specific enough to facilitate accurate, consistent reporting. Additionally, the bi-national TB case definition should enable collaboration with México's programs and public health providers who might use a different TB case definition than used in the United States.

- Optimal case management requires communication or collaboration with TB control programs or health-care providers on the opposite side of the border. For example, a TB control program in the United States would transfer clinical or laboratory data, refer a patient for treatment completion, or share information for a contact investigation with a Mexican TB control program.
- The patient is a contact of a bi-national TB case-patient or is the TB source case-patient for contacts on the opposite side of the U.S.-México border.

The Continuity of Care workgroup will draft a bi-national case definition for the next U.S.-México Border TB Consortium. The need for such a definition is noted here because of its significance to the legal process.

\textit{U.S. Law: Federal Treatment Authority}

As described in Part I, medical treatment for TB patients is a state and local government responsibility.\textsuperscript{34} The federal government provides medical treatment to incarcerated individuals and immigration detainees. The federal government has no authority or funding to provide medical treatment upon release from detention or repatriation to a

\textsuperscript{32} Source: Diana L. Schneider and Mark N. Lobato, \textit{Tuberculosis Control Among People in U.S. Immigration and Customs Enforcement Custody}, \textit{AMERICAN JOURNAL OF PREVENTIVE MEDICINE} 2007;33(1).

\textsuperscript{33} Source: CDC MMWR Report: Preventing and Controlling Tuberculosis along the U.S.-México Border (work group report); http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5001a1.htm.

\textsuperscript{34} Section 311 of the Public Health Service Act, 42 U.S.C. § 243, states that the Secretary of HHS shall assist states and local authorities in the prevention and suppression of communicable diseases and to help state and local authorities enforce quarantine regulations. This section also authorizes the Secretary to accept state and local authorities’ assistance with enforcement of federal quarantine regulations.
home country. This limited federal authority is a significant impediment to continuity of care for both bi-national TB patients and immigration detainees. For the latter, repatriation should occur through a “Meet and Greet” with the detainee’s country of origin. DIHS and ICE seek to provide the receiving country with the patient’s records and a 2-week supply of prescribed medications to prevent treatment interruptions during the transition period from repatriation until follow-up at a clinic to which patients are referred in their country of origin. This process is explained in section E below.

Ensuring treatment completion for active TB disease is a priority for TB control programs. In addition, treatment of latent TB infection is cost-effective in reducing the burden of disease and limiting future spread of TB infections. The CDC works with border TB control programs to address case-management priorities and evaluate actual practices against established goals, objectives, and outcomes. Border States need guidance regarding federal funding sources for TB case-management and program evaluation activities. Among the U.S. Border States, California is the only state to adopt an expanded Medicaid program under the Affordable Care Act. Action is needed to amend Medicaid regulations to allow funding for TB treatment for persons without citizenship or visa documentation who otherwise would be eligible for Medicaid. State and local TB control programs should emphasize technical assistance, quality improvement, and enhanced follow-up communication to co-manage bi-national patient care in their interactions with Mexican counterparts.

The general laws and procedures identified below include “infectious tuberculosis” as well as other communicable diseases.\(^{35}\) For persons entering the United States, the U.S. Secretary of the Department of Health and Human Services has statutory responsibility for preventing the introduction, transmission, and spread of communicable diseases in the United States. Under its delegated authority, the Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, works to fulfill this responsibility through a variety of activities, including

- The operation of Quarantine Stations at ports of entry,
- Establishment of standards for medical examination of persons destined for the United States, and
- Administration of interstate and foreign quarantine regulations, which govern the international and interstate movement of persons, animals, and cargo.

Titles 8 and 42 of the U.S. Code and relevant supporting regulations provide the legal foundation for these activities.\(^ {36}\) 42 Code of Federal Regulations parts 70 and 71 authorize CDC to detain, medically examine, and release persons arriving into the United States and traveling between states who are suspected of carrying these communicable diseases.


\(^{36}\) Source: Centers for Disease Control and Prevention, Specific Laws and Regulations Governing the Control of Communicable Disease, http://www.cdc.gov/quarantine/specificlawsregulations.html.
As part of its federal authority, CDC routinely monitors persons arriving at U.S. land border crossings as well as passengers and crew arriving at U.S. ports of entry for signs or symptoms of communicable diseases.

The U.S. Department of Homeland Security, Immigration and Customs Enforcement (ICE) has the authority to detain and remove undocumented persons. ICE has in place an administrative process to facilitate repatriation; criminal charges are resolved before ICE custody. Undocumented persons with criminal convictions serve their sentences with the appropriate local, state, or federal law enforcement agency before transfer to ICE custody.37

ICE holds detainees in ICE detention centers, in detention facilities managed under contract with the Department of Homeland Security, and in local jails nationwide through intergovernmental service agreements. In accordance with ICE detention standards, detainees are expected to be screened upon admission into custody. ICE evaluates suspected TB patients further and starts or continues treatment for TB if medically indicated.38

Memoranda of Understanding as Legal Basis

Some U.S. health departments have memoranda-of-understanding (MOU) with Mexican health departments to provide diagnostic and therapeutic services in México. Other health departments provide services to Mexican TB patients in the United States or facilitate co-management of patients who work or live on both sides of the border. The Texas Department of State Health Services Region 11 Bi-National TB Project exemplifies this cooperation model based upon a Memorandum of Understanding.39

An MOU is a bilateral or multilateral agreement between two or more parties. It is often used in situations where the parties cannot create a legally enforceable agreement. An MOU may be used as a confirmation of agreed upon terms when an oral agreement is not a formal contract. It may be used to set forth the basic principles and guidelines under which the parties will work together to accomplish their goals. In international relations, whether a particular MOU is meant to be a legally binding document (i.e., a treaty) depends upon the intent of the parties as well as the position of the signatories.

At the national level, the U.S.-México Border Health Commission facilitates bi-national agreements that also take the form of a Memorandum of Understanding. In 1999, Presidents Clinton and Zedillo signed a Memorandum of Understanding on Cooperation in Prevention and Control of Tuberculosis.

37 Source: Diana L. Schneider and Mark N. Lobato, Tuberculosis Control Among People in U.S. Immigration and Customs Enforcement Custody, AMERICAN JOURNAL OF PREVENTIVE MEDICINE 2007;33(1).
39 See https://www.dshs.state.tx.us/region11/services/tb_bi-national.shtml. However, current Health Care Financing Administration (HCFA) regulations only permit reimbursement for emergency care to persons without documentation of citizenship or visas.
The CDC, through the U.S.–México Unit in the Division of Global Migration and Quarantine, serves as the U.S. government’s official liaison with the México Secretariat of Health and is authorized to negotiate MOU’s at the national level. The U.S.-México Unit implements CDC programs that focus on the U.S.–México border, including management of CDC Quarantine Stations in El Paso and San Diego and bi-national infectious disease surveillance projects.40

The most recent MOU between the U.S. and México “provides a framework to encourage bilateral cooperation in addressing issues and problems of importance in the fields of public health, medicine, and science for both countries.”41 The purpose of the agreement is to “strengthen cooperation across a broad range of health issues of mutual interest,” including:

(1) The United States-México Border Health Commission, for which the U.S. Secretary of Health and Human Services and the Secretary of Health of the United Mexican States serve as Commissioners, and other efforts in the United States-México border area;

…

(3) Health-related concerns of women and special populations, including migrants, older persons, persons with special needs, adolescents and children, other vulnerable groups, and border populations;

…

(5) Public policies oriented to disease prevention and health promotion;

(6) The detection, surveillance, and reporting of infectious and chronic diseases, to enable better tracking and analyses of prevalence and trends, so as to improve the prevention and care of, and the response to, these diseases …42

C. Local Cooperative Projects

Texas is an example of successful and ongoing local cooperative TB control projects. The Texas Office of State Health Services TB program, managed by binational TX DSHS TB program managers in partnership with host state regional or local HD and their respective officers of border health, operates three bi-national TB programs based upon MOUs.43

---


42 Id.

43 These projects are described at https://www.dshs.state.tx.us/borderhealth.
Project Juntos, in El Paso, Texas and Juarez, Mexico, targets the prevention of infectious diseases (tuberculosis, or TB), and specifically multiple drug resistant tuberculosis, by increasing completion of tuberculosis treatment by bi-national TB patients. The El Paso City-County Health and Environmental District (EPCCHED), the Texas Department of State Health Services (DSHS), and the Mexican Secretariat of Health (Secretaria de Salud) (SSA) entered into an MOU to work collectively to control and prevent TB in El Paso and Ciudad Juarez. A proposal was submitted to the Centers for Disease Control and Prevention (CDC) to enhance bi-national TB control. The CDC approved a modest grant in August 1991. The funding from CDC provided the El Paso City-County Health and Environmental District the opportunity to begin building the infrastructure and developing the capacity needed to enhance bi-national TB control in the greater El Paso/Ciudad Juarez area. This Project has been recognized internationally as a model project for Bi-national TB control.44

The project’s goal is to increase completion rate of TB treatment among the target population; to identify contacts of TB patients in El Paso, Texas, who reside in Juarez, Mexico; to prevent multiple drug resistant TB by increasing treatment completion rates; and to maintain and improve bi-national TB tracking system. All active cases of TB have a nurse case manager to assist the patient with treatment compliance and to encourage the patient to complete the prescribed treatment. Nurses from the TB program in El Paso work in collaboration with Projecto Juntos and the Departamento de Salud in Juarez Mexico.45

Grupo Sin Fronteras performs similar functions with locations in Matamoros and Reynosa, Tamaulipas MX.46 Grupo Sin Fronteras was formally established on April 2, 1995 when it was inaugurated with a signing of a Memorandum of Understanding by the respective Commissioners of Health for the State of Texas and the Mexican State of Tamaulipas.47

Los Dos Laredos is a third collaboration of the Texas Office of State Health Services in the sister-cities of Laredo, Texas and Nuevo Laredo, Tamaulipas. The Program Coordinator is responsible for the maintenance of the Bi-national Patient Registry and the Laboratory Database that records all specimen cultures processed by the Texas Department of State Health Services TB Laboratory. The Program Coordinator also supervises the bi-national outreach nurses and the activities they conduct. The outreach activities range from clinical patient care, assisting the TB Clinicians, conducting both clinic and field Directly Observed Therapy (DOT), making home visits, locating noncompliant patients that have lapsed in their treatments, reporting patient non-compliance to TB Clinicians, monitoring for and recording signs of drug toxicity, contact

44 Source: https://www.dshs.state.tx.us/borderhealth/bi-national_tb/juntos.shtm.
45 Source: Presentation by Lupe Gonzalez, Bi-National Tuberculosis Project Manager (October 2011), available at the web site www.dshs.state.tx.us
46 Source: Presentation by Cynthia Tafolla, Bi-National Tuberculosis Project Manager (2012), available at the web site www.dshs.state.tx.us
47 Source: https://www.dshs.state.tx.us/borderhealth/binational_tb/gruposinfronteras.shtm.
investigation, and most importantly maintaining an open line of communication between the TB Clinician and the patient.\(^{48}\)

**Sharing Laboratory Support**

Sharing laboratory data regarding bi-national TB patients diagnosed in México is a critical component of case management for TB patients. However, transfer of laboratory data among programs requires a secure, confidential information system. Laboratory facilities in certain Mexican border health departments lack the equipment and infrastructure to confirm diagnoses of TB bacteriologically (cultures are not routinely performed by Mexican TB control programs along the border). Collaboration between Mexican and U.S. laboratories encounter customs issues that are dependent upon locally-negotiated MOUs. Customs laws differ, for example, making the exchange of patient drugs and laboratory samples difficult in border cities such as El Paso and Ciudad Juarez. Preferably, customs protocols for transmission of laboratory specimens as well as transit of medications should be uniform for all border crossings. This requires coordination at the national level and should be reflected in an MOU.

**Contact Tracing**

Contact tracing is a critical but complex component of identifying persons who have active TB disease or who have latent TB infection and are at high risk for experiencing active TB disease. A patient's reluctance to divulge contacts can complicate contact tracing for bi-national TB patients. Bi-national patients fear the stigma of disease and the possible social and legal repercussions of a TB diagnosis (e.g., loss of housing, employment, and income or legal action against persons without citizenship or visa documentation). Lack of experience with or understanding of preventive health models, cultural beliefs regarding causes of TB other than a germ-based etiology, and self-medication approaches to treatment (e.g., use of herbal products) may further interfere with adherence to public health interventions.

Health-care providers and public health officials may be unsympathetic regarding the problems of border-crossing patients, limiting the effectiveness of contact tracing. Deficiencies in communication among public health jurisdictions may hinder contact investigations, especially if coordination must span international borders. Finally, protocols for contact tracing differ between the United States and México, further frustrating the process.

U.S. state and local TB control programs should:

- Designate a liaison to work with other jurisdictions in coordinating contact investigations across state and international borders to better understand protocols and policies in México,
- Evaluate the usefulness of patient interviews in the United States to identify close contacts in México,

\(^{48}\) Source: https://www.dshs.state.tx.us/borderhealth/binational_tb/losdoslaredos.shtm.
• And collaborate with CBOs that serve bi-national TB patients to determine if techniques used in other screening programs (e.g., use of nonprofessional community health workers as liaisons and educators) could enhance contact tracing.49

D. Registries and Reporting Challenges

Registry of Bi-national TB Cases50

U.S. TB control programs along the border identify locally defined bi-national cases in their own TB registries, but none maintain local or statewide electronic records for these cases. An electronic registry of bi-national TB cases available to all programs would a) enhance documentation of the number of TB cases not included in the annual TB morbidity count, b) facilitate sharing of up-to-date clinical data (e.g., prior anti-TB drug treatment), and c) improve case management of bi-national TB cases.

Fundamental requirements for creating an electronic bi-national TB case registry are a standard case definition and key database variables. Key database variables should reflect the unique characteristics of bi-national TB cases. Critical variables include information regarding the frequency and duration of border crossings before and during treatment, ICE custody and disposition, anti-TB drug treatment regimen, drug resistance, treatment using directly observed therapy, and beginning and ending treatment dates. Creating a bi-national TB case database also requires decisions regarding data validation and security, ability to link with other databases, ease of modification and updating, and patient confidentiality.

• CDC's TB Information and Management System (TIMS). TIMS is a comprehensive software program for surveillance, patient management, and program evaluation that is used by U.S. state health departments to report TB surveillance data to CDC. In each jurisdiction, TIMS can be adapted for local use as a registry of bi-national TB cases via the user-defined variable option. The current availability of the system throughout the United States is a clear advantage. Disadvantages include the need for computer support, confidentiality, and the current limitations to directly link TIMS with other jurisdictions in the United States; however, indirect links are possible using exported data sets from TIMS.

• Internet-based system. An Internet-based system, modeled on fully operational existing systems (e.g., OpenEMed ** [formerly TeleMed]), could provide a secure database of bi-national TB case records available for viewing and updating. Such a system would have advantages for following and managing patients whose TB care spans multiple locations in the United States and México. An Internet-based system would require data security, analytic capabilities, ability

49 Source: CDC MMWR Report: Preventing and Controlling Tuberculosis along the U.S.- México Border (work group report); http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5001a1.htm.
50 Source: CDC MMWR Report: Preventing and Controlling Tuberculosis along the U.S.- México Border (work group report); http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5001a1.htm.
to link with existing databases, platform- and operating-system independence, and users' ability to access a secure Internet site. Additional information is needed regarding feasibility, cost, maintenance, data security, data integrity, and access to data in English and Spanish.

- **Existing bi-national program databases.** Electronic databases from existing bi-national referral and follow-up programs could be used. CureTB and TBNet are two such programs that have electronic databases; however, they use different software and formats. Their primary function is patient follow-up and management.

**CureTB and TBNet**

A key difference between these entities is that CureTB is a government organization, health-department based, and TBNet is an NGO. The former does not need patient informed consent to assist with referral, while the latter does require consent. This limits TBNet to pre-departure case management planning.

CureTB is a bi-national tuberculosis referral program for the United States and México that has been operating since 1997. The main objective of CureTB is to facilitate the continuity of care and management of patients with TB moving between the US and México. CureTB is a San Diego County California-based network that operates primarily in California and Arizona, but assists other states in which there is a large Mexican immigrant population. CureTB ideally contacts patients before they cross the border to assist and motivate them to continue TB treatment and care, but they can also assist with helping to locate and refer patients after they have re-located. CureTB staff also works with medical providers to facilitate the exchange of clinical information using an over-the-phone case management system and a computer database to monitor treatment outcomes for patients.\(^ {51}\)

When a public health clinic finds a potential TB patient leaving the US for México, they may refer that patient to the CureTB program through a referral form with an attached TB test. CureTB provides a preliminary outcome to the referring program within 30 days of referral, determining whether the patient is eligible for the CureTB program. If so, the patient is treated while the CureTB program provides the referring clinic with updates at three month intervals until a final outcome is reached. Outcomes include: completed treatment - where “cure” confirmation is impossible, cured – treatment was completed and the patient is smear negative, died, lost – patient disappeared, refused/abandoned – patient failed to continue treatment, or stopped on medical advice – provider decided to stop medication due to side effects.\(^ {52}\)

TBNet Patient Registry\(^ {53}\) is a multi-national TB patient tracking and referral program designed to keep mobile, underserved populations in Texas and New Mexico in care.

---

\(^{51}\) Source: https://www.dshs.state.tx.us/borderhealth/binational_tb/cureTB.shtm

\(^{52}\) Source: http://www.sdcounty.ca.gov/hhsa/programs/phs/cure_tb/cases_and_suspects.html

\(^{53}\) Source: http://www.migrantclinician.org/services/network/tbnet.html
Much of their multi-national work involves referrals to central/south America and potentially any country throughout the world. TBNet most often serves patients moving in and out of the United States. TBNet will receive a patient referral from Immigration and Customs Enforcement (ICE) for detainees who may have TB or from the Department of Immigration Health Services (DIHS) for those attempting to immigrate to the US while infected with TB.

Treatment for underserved populations is complicated by the fact that many are unable to remain in a given location long enough to complete the lengthy TB treatment regimen. TBNet works with migrant workers, the homeless, immigration detainees, and prison parolees free of charge. To enroll in TBNet a public health official or practicing physician must refer the patient. Public health professionals in Texas and New Mexico identify whether potentially migrant patients are eligible for TBNet through a verbal screening process. If they identify a migrant patient, the health clinic may then refer the patient to TBNet. The patient must consent to release of their patient information regarding their TB treatment; however, TBNet keeps all information collected confidential. Once a patient enrolls in TBNet, regular contact with both the patient and the treating clinician documents treatment adherence.

TBNet supplies TB clinics with portable treatment records for their patients, providing a summary of the patient’s treatment history. The patient can carry this record with them to other clinics to continue treatment. TBNet also maintains a record of all enrollees so clinics in the US or México can call to request an updated copy of the patient’s treatment record. Finally, migrant patients can also call TBNet to locate treatment facilities.54

Bi-National TB Card55

A Bi-National TB card is a state-issued identification card developed by the CureTB program in conjunction with the Centers for Disease Control and Prevention (CDC) and state departments of health. 56

The card can assist in completion of treatment programs for those TB patients who routinely cross the US-México border. Each of those states (CA, AZ, NM, and TX) can issue a Bi-National TB card to patients whose travel may interrupt treatment. The card lists their treating healthcare provider, when their treatment began, when the patient took their last dose, and their treatment regimen. The card also provides contact information for the CureTB program. Anyone who has active TB, is a TB suspect at risk of being deported, is México-born, is expected to travel to México while on TB therapy, have recently arrived from México with drug therapy started in México, or works in the United States and lives in México is eligible for the card. As well as helping with treatment

54 Source: https://www.dshs.state.tx.us/borderhealth/binational_tb/tbnet.shtm
55 Source: http://www.bc.lung.ca/lungdiseases/uiatld-pdfs/2008/Cure_TB_and_the_Use_of_the_BiNational_TB_Card.pdf
continuity, it will also allow for easier transfer of information between doctors in México and the United States.

Example TB Card:  

---

**TB Card**

---

E. **U.S. Immigration and Customs Enforcement Repatriation**

**Ensuring TB Patient Care While in ICE Custody**

International law does not address conditions under which sick detainees may be released or repatriated. There is no stated right to be “cured” prior to removal from the U.S., and no generally recognized set of obligations to either a sick deportee or to the receiving nation. In fact, the opposite seems to be true: international guidelines specify that immigration detention “must be as short as possible,” implying at least that immigrants may not be detained solely for the purpose of treating a disease. A receiving country, understandably, would prefer not to accept repatriations of persons with tuberculosis, especially the drug-resistant variety. But the only alternative for that country is to deny travel documents for repatriation, creating potentially severe diplomatic repercussions.

---

57 Source: http://www.bc.lung.ca/lungdiseases/uiatltdpdfs/2008/Cure_TB_and_the_Use_of_the_BiNational_TB_Card.pdf

58 The International Health Regulations require notification of “all events which may constitute a public health emergency of international concern” occurring within the U.S., but it is not clear whether an individual case of infectious tuberculosis requires notification. See World Health Organization, *International Health Regulations*, Part III, Article 6, http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf?ua=1 (accessed Feb. 21, 2014). In the case of the Nepalese traveler with XDR-TB, the CDC initiated “a far-reaching investigation by the U.S. and other health authorities to track down potentially exposed people around the world.” Knox, *supra* note --.

59 See *Immigration Detention and the Rule of Law*, *supra* note --, at 79-81 (compiling detention guidelines in various international instruments).

In 2013, ICE removed 368,644 persons. This includes 235,093 removals of recent border crossers through a process known as “expedited removal.” These persons are processed, detained, and removed from the U.S. without judicial process, and often without medical screening. Coordinating health care is rarely possible when expedited removal is used, because in most instances ICE escorts detainees to the Mexican border without pre-planning for continuity of care, or even any knowledge of the detainee’s health condition.

Mexican nationals constitute the highest percentage of expedited removals, but the number from neighboring countries in Central America has increased. This shift in the demographics of border apprehensions triggered an increase in ICE’s use of its detention and removal resources for recent border crossers as CBP is only able to effectuate the return of individuals to México.

One advocacy group reported that “the provision of health care in the [immigration] detention system…suffers from conflicting missions of the agencies handling health care, inadequate staffing, muddled accountability, inadequate independent oversight, insufficient procedural protections for detainees, and lack of legally enforceable standards.”

For all removals through judicial process, non-citizens are detained in custody under ICE observation until their departure. Although the exact proportion of ICE detainees having TB is unknown, the rate of active TB disease among Mexican-born persons without documentation of citizenship or visas is likely higher than México's national average.

Each year, ICE confronts approximately 150 to 200 cases of active or suspected tuberculosis nationwide. Because standard data regarding the disposition and outcomes of TB patients in ICE custody are not collected (or not publicly available), the magnitude of this problem is unknown. In addition, the majority of detainees are housed in local jails and state prisons, each of which has its own TB screening policies and relationships with TB control programs. Detainees are transferred frequently between facilities, and certain facilities might not transfer medical records containing TB status information.

Another barrier to TB patient care while in ICE custody is the lack of communication among TB control programs, federal agencies, and local and state facilities that house ICE detainees. Immigrants without documentation of citizenship or visas might be released to the community or repatriated to their country of origin without notification of medical staff providing care to TB patients while in ICE custody or the local health department. Undocumented immigrants might return to the United States after release in their country of origin. ICE has no system for informing local TB programs regarding the


62 As of June 2014, many city and county law enforcement agencies are reviewing Immigration and Customs Enforcement (ICE) detainer policies in light of an Oregon federal district court’s decision, Miranda-Olivares v. Clackamas County, 2014 WL 1414305 (D. Ore. April 11, 2014), which concluded that an ICE detainer, without a determination of probable cause, is not legally sufficient to hold an inmate beyond his or her sentence ending date.
disposition of active or suspected TB cases. Resulting lapses in treatment can lead to continued TB transmission and development of drug-resistant TB.

The U.S. government should address problems related to TB patients in ICE custody, and areas for collaboration with ICE, USPHS/Division of Immigration Health Services, and local, state, and federal correction agencies. There is also a need to clarify what case-specific information can legally be shared among health departments, private health-care providers, and ICE. The legally responsible agencies should also determine the legalities of ensuring completion of therapy by TB patients slated for repatriation.

The USPHS/Division of Immigration Health Services provides policies and practices for TB case reporting; discharge planning, including notification of Mexican consulates; continuity of care; and notification of local TB control programs for community contact investigations for active and suspected TB cases.

ICE should standardize the system for monitoring and collecting data regarding active and suspected TB patients in ICE custody (e.g., number of cases identified, length of treatment before release, drug-resistant TB, arrangements for ongoing care, location of release, and rate of return to the US). Upon reaching a noninfectious phase of TB, ICE agents enroll detainees in a treatment completion program such as CureTB or TBNet before release. However, not having a standardized reporting program creates communication issues and can cause interruptions in treatment. ICE should review the reporting program to ensure consistent monitoring of TB patients.

State and local TB control programs create liaisons with local ICE officials to provide educational materials regarding TB to personnel who work directly with detainees, ensure timely reporting of active and suspected TB cases, establish referral systems to increase continuity and completion of treatment, and provide medical consultation as needed. Local public health professionals work with facilities housing ICE detainees within their jurisdiction to ensure that systems are in place for identifying, isolating, and treating active and suspected TB patients.

More effort is needed to identify barriers to therapy completion after patients with active TB are released from ICE custody and assess the impact of measures to maintain continuity of TB care among detainees and persons who are being repatriated.

Repatriation of Persons with Latent or Active TB

Repatriation of immigrants detained by ICE or DIHS may occur while the detainee is infected with tuberculosis. DIHS works with ICE to screen immigrant detainees for tuberculosis and other health problems upon detention. Once diagnosed, it is federal law that infected TB patients receive treatment until they are noncontagious before they may be released. ICE field office directors can consider a stay of removal for those with MDR-TB or XDR-TB until they receive complete treatment in the US. The average length of TB treatment before removal was 22 days in 2001.63  A three-week treatment

---

63 Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5219a3.htm
regimen is often enough to render a patient’s TB noninfectious; however, in 2006, roughly 84% of detainees were repatriated before treatment was completed.\textsuperscript{64} Repatriation occurs through a “Meet and Greet” with the detainee’s country of origin.\textsuperscript{65} However, standardized Meet and Greets often do not occur and much of the patient’s information may be lost when they are repatriated. Programs like CureTB and TBNet work to correct this problem. The United States-México Border Tuberculosis Consortium resolved in May 2013 to standardize handoff protocols, improve follow-up and continuity of care for repatriated TB patients, and make sure all patients are enrolled in a program like CureTB or TBNet.\textsuperscript{66}

F. Immigration Enforcement Policies and Procedures

The Advisory Council for the Elimination of Tuberculosis (ACET) recommends the post-detention completion of tuberculosis (TB) treatment for persons repatriated or released from ICE custody. The completion of TB therapy prevents disease relapse, subsequent transmission, and the emergence of drug resistance. Integral to treatment completion are issues of security and law enforcement involving persons who, under immigration law are ineligible for legal admission into the United States. Before transfer or repatriation, ICE policies require that detainees with TB disease receive treatment until they become noncontagious, even if treatment is not completed.\textsuperscript{67} ICE policies are consistent with federal law, which does not bar repatriation of persons with TB disease before the completion of treatment. This report describes three cases that illustrate several issues associated with the removal of patients with incomplete treatment of TB disease after detention. These cases highlight the need for interagency coordination to ensure completion of treatment for persons being evaluated or treated for TB.\textsuperscript{68}

Any facility used to detain undocumented immigrants in immigration proceedings or awaiting removal to their countries must comply with ICE National Detention Standards. The Performance Based National Detention Standards (PBNDS) operations manual outlines these standards. In it, policies and procedures, including those for medical care, are provided.

All detainees brought into an ICE detention facility are routinely checked for TB, as a mandatory component of their general intake medical screening. This examination may take the form of a chest X-ray, a skin test, or a new type of blood test. If health personnel

\textsuperscript{64} Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5626a3.htm
\textsuperscript{65} Source: http://www.borderhealth.org/files/res_2543.pdf
\textsuperscript{66} Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5219a3.htm
\textsuperscript{67} According to ICE policy, “Detainees shall receive continuity of care from time of admission to time of transfer, release or removal. Detainees, who have received medical care, released from custody or removed shall receive a discharge plan, a summary of medical records, any medically necessary medication and referrals to community-based providers as medically-appropriate.” U.S. Immigration and Customs Enforcement, Detention Standards: Medical Care, at 278 (as modified February 2013), http://www.ice.gov/doclib/detention-standards/2011/medical_care.pdf (accessed Feb. 13, 2014).
\textsuperscript{68} Source: CDC MMWR Weekly, Post-Detention Completion of Tuberculosis Treatment for Persons Deported or Released from the Custody of the Immigration and Naturalization Service – United States, 2003.
detect active TB, or suspect that the symptoms may soon develop, the detainee is kept in an isolation room until the situation is clarified.

Depending on the outcome of such tests, the detainee might be deemed free of TB and moved in with the general population, might be kept in isolation, might be moved to an entirely different medical facility (such as a local hospital), or -- if they are considered not contagious -- might be repatriated to their home country. ICE considers these options to be part of its overall “continuity of care” program for “detainees with confirmed or suspected active tuberculosis.”

Health care officials within Immigration and Customs Enforcement (ICE) have established more than 50 “airborne infection isolation rooms” at more than a dozen different detention centers across the country to deal with detainees they suspect may already have – or might soon develop – active tuberculosis. The airborne infection isolation rooms, which house one detainee at a time, are designed to maintain negative air pressure (to prevent any contagions from escaping the room and infecting other detainees or staff members in the center). The isolation rooms are outfitted with High-Efficiency Particulate Arresting, or HEPA, filters, which are intended to remove the vast majority of particles from the air passing through them.

*Post-Detention Coordination of Care*

The findings in this report demonstrate some of the barriers to post-detention completion of treatment of TB for ICE detainees being repatriated, including the limited coordination among TB-control programs, federal agencies, and facilities that house ICE detainees. No uniform system exists to inform state and local TB programs when a person under detention by ICE who has TB or suspected TB is released or repatriated. Medical treatment often is not readily available. Effective treatment of persons with drug-susceptible TB requires a minimum duration of 6 months. One of the most challenging tasks in managing TB among detainees is the coordination of care during the post-detention period in the United States or in the patients' countries of origin.

Repatriation before treatment completion or continuity of care case management planning allows for the export and re-import of TB, thus placing other detainees, law enforcement officials, and communities in the country of origin at increased risk for exposure to persons with infectious TB. To reduce the risk for exporting and re-importing persons with TB diseases identified while in ICE custody, the U.S. Department of Health and Human Services and the U.S. Department of Justice should resolve issues concerning the post-detention completion of TB treatment of persons released from ICE custody or repatriated to his home country. At present there is no legal authority to treat ICE detainees in the United States until their TB is cured. No policies permit ICE to complete TB therapy after an immigration judge issues a final order of removal or when ICE is no longer authorized to hold a detainee.

ACET proposed revising or amending current policies or federal laws for detainees who are being evaluated or receiving treatment for TB disease to allow repatriation only after
the responsible state TB controller or their designate reviews and approves the treatment plan. For cases of multidrug-resistant TB, the availability of drugs needed to complete treatment in the country of origin should be ensured before repatriation. Progress on these recommendations will involve working with professional correctional associations to improve adherence to local public health laws and CDC guidelines for TB screening and case notification and to enhance collaboration among ICE contract facilities, and TB programs.

Protocols should be developed to require the sharing of medical information and safeguarding its confidentiality and to describe mechanisms for the transfer of care when a patient is deported or released to the community. ACET recommended that appropriate agencies require the reporting of TB and suspected TB patients in ICE custody before the transfer or deportation of ICE detainees with TB to DIHS and state and local TB-control programs of jurisdictions in which sending and receiving facilities are located. In addition, ACET recommends the expansion of the medical hold authority of DIHS to permit notification of receiving health-care providers or a national referral program (e.g., CURE-TB or TBNet), transfer of medical records, and provision of sufficient TB medications to ensure treatment until the patient's care is resumed (ACET, unpublished data, 2002).

Notification Procedures

ICE has Field Medical Coordinators (FMC) assigned to each field office; the FMC’s coordinate medical issues within their respective area of responsibility.

The local health department or medical staff must contact ICE at one of its facilities to report the detainee’s health status, to facilitate appropriate case management, and to ensure continuity of care planning before transfer, release or removal. When ICE, the Bureau of Prisons, or the U.S. Marshall Service identify non-citizen patients with confirmed or suspected active TB disease, that official must notify the appropriate state or local health department in that jurisdiction, as well as the health program contacts at the law enforcement agency with legal custody. At least accordingly to policy: lack of agency coordination occurs. Contracted immigration detention facilities may have separate screening and referral policies, making coordination difficult.

State and local health departments are legally permitted to release medical records to BOP, USMS, and ICE. Depending upon facility policy and agency agreements, any TB patient who is discharged should receive a 14-day supply of anti-TB meds when repatriated.

Continuity of Care Issues for Removal/Repatriation

A removable alien with a final order of removal cannot be detained solely for the purpose of completion of treatment or receipt of culture results.

---

69 Source: Tuberculosis Case Management for Removal Alien Inmates/Detainees in Federal Custody
BOP, USMS, and ICE state that they “will make every attempt to arrange continuity of care” for foreign nationals in their custody so that they are able to complete TB treatment in their respective country of nationality. Enrollment and referral coordination through either the Migrant Clinician’s Network’s TBNet program or the Cure TB program (Mexicans only) ensures continuity of care. The policy further specifies that “All removable alien suspected TB patients in law enforcement custody should be enrolled in an international TB referral program.

The following instructions are provided to detention personnel (and are reproduced in full in the Appendix):

**How to refer a patient (Mexican only) to CureTB**

- Provide education to the patient on the continuity of care program and referral process
- No written consent is required for enrollment in CureTB
- Fax the Bi-national Notification Form and all pertinent clinical radiology, laboratory reports and treatment information to CureTB
- Call CureTB staff to arrange the patient interview by phone
- Call CureTB to confirm that the patient’s addresses have been verified and a clinic has been identified Be sure to provide the patient with the CureTB toll free numbers upon discharge
- Notify CureTB when the patient is transferred, released or repatriated so that they can begin post custody case management

The following charts provided by ICE depict (1) the process for detention of suspected removable non-citizens; and (2) overview of TB Case Management for Undocumented Patients:

---

70 CureTB is operated by the San Diego, California health department, and provides referral services for Mexican nationals and individuals moving across the U.S. and Mexican border.
ICE also provides two checklists: a “Detention Facility Checklist” and a “Health Department Checklist” for persons with a suspected or confirmed case of active TB disease in a local detention facility. (Reproduced in Appendix --)

The overriding concern is intermittent compliance with these policies and procedures, given that detainees are housed in both large and small facilities, including local jails, with various screening and reporting policies. The time frame within which ICE enforces a removal order may be only a few hours. But preparing for release or repatriation of a complex TB case, and assuring continuity of treatment and safe transport from an ICE detention center, takes time to do well. ICE attempts to accomplish these aims, but with uneven results. Particularly with repatriations to México, a mechanism to ensure compliance with the “Meet and Greet” protocol is desirable.