



# Policy, Law & Politics

Complexities and Challenges for  
Case Management



# Protecting Public Health

Creating, Changing and  
Challenging Public Health Laws  
and Policies

# *Protecting Public Health: Creating, Changing and Challenging Public Health TB Laws and Policies*

*“What Can We Learn From Florida’s Experiences”*

Note: Not a Lawyer

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Miami School of Medicine  
Co-Principal Investigator, Southeast National TB Center

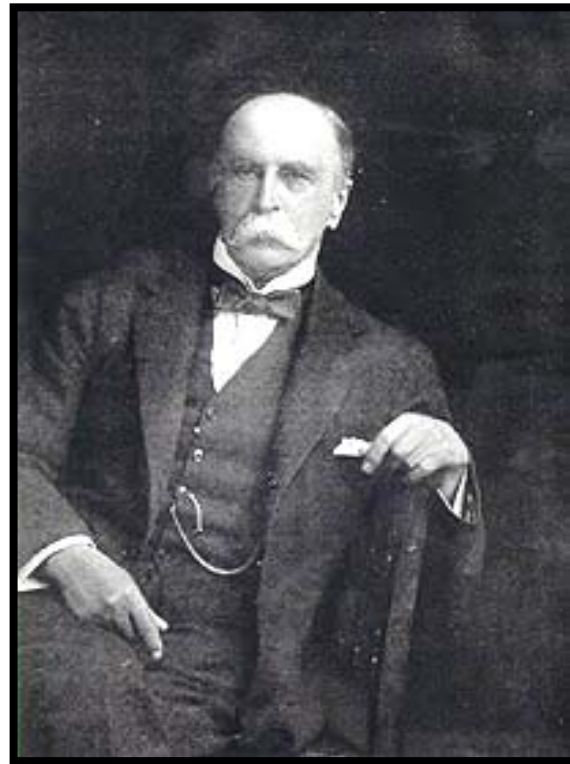
# Envy Of Other Diseases

- Know the etiology of TB
- Possess very good tools for diagnosing TB
- Possess very good therapies for TB
- The therapy is relatively cheap
- Still over 2 million people are dying of TB world wide!!!



**‘Tuberculosis  
is a  
social disease with  
a medical aspect.’**

*TB will need to be Controlled  
With Social Solutions*



**Sir William Osler  
1849-1919**



# The Calm behind the Storm

“Consumption was rarely mentioned in the programs of the reformers. Although the disease was ubiquitous and the greatest killer of the white race, its ravages were less obvious and less likely to produce hysteria than those of infections occurring as explosive outbreaks and causing rapid death. Epidemics of cholera and of yellow fever were short-lived and limited in space, but they exerted a terrifying impact on society because of their suddenness and destructive power; it was easy to single them out as well-defined events and to focus attention on them.”

“Tuberculosis, by contrast, appeared to be so constantly and universally present that there was a tendency to regard it as an act of God, affecting both the rich and poor and against which little action was possible”

Dubos-The White Plague 1952

”



# World TB Day

## March 24<sup>th</sup> 2007

- In 2006, the CDC's statistics boasted the lowest case rate in the United States since the federal government started collecting data in 1953.
- In celebration of this year's World Tuberculosis Day, the World Health Organization (WHO), the organization responsible for monitoring and setting global standards, announced that the global TB incidence has "leveled off", representing "a fruition of all our efforts."



# WAKE UP!!!!

## New Deadly Strains of TB are on the Rise in the World!!!

*The New York Times*  
**Virulent TB in South Africa May Imperil Millions**  
 By MICHAEL WINES  
 Published: January 28, 2007

**New, killer TB crossing borders**  
 07/09/2006 23:00 - (SA)

Johannesburg - A killer strain of extremely drug-resistant tuberculosis has been found in at least 28 hospitals across South Africa and almost certainly has spilled across borders, a specialist said on Thursday.

**TB 'out of control' in SA**  
 21/08/2006 10:40 - (SA)

Lindsay Barnes and Health-e News

Durban - The South African government must immediately declare TB and TB/HIV a national emergency and increase dramatically the intensity of its response to what is one of the worst epidemics in the world, the World Health Organisation said.

### Global alert over deadly new TB strains

- Disease untreatable with currently available drugs
- South African cases raise fears for Aids programme

Sarah Boseley, health editor  
 Wednesday September 6, 2006



**THE XDR-TB EMERGENCY WILL REQUIRE NEW STRATEGIES AND NEW TOOLS: BUSINESS AS USUAL WOULD BE FATAL**

30 October, 2006





A close-up photograph of a hand holding a small, realistic-looking globe of the Earth. The hand is positioned with the palm up, and the fingers are slightly curled around the globe. The lighting is dramatic, with strong highlights on the skin and the globe, and deep shadows in the background. The globe shows blue oceans and green landmasses.

# *TB on A Plane: What Did We Learn?*

- World is small and anything can be in your living room instantly
- Access to Best treatment
- 92% of people expect patients with TB to protect others and if don't they should be legally forced to be isolated

# “A Paradigm Shift?”

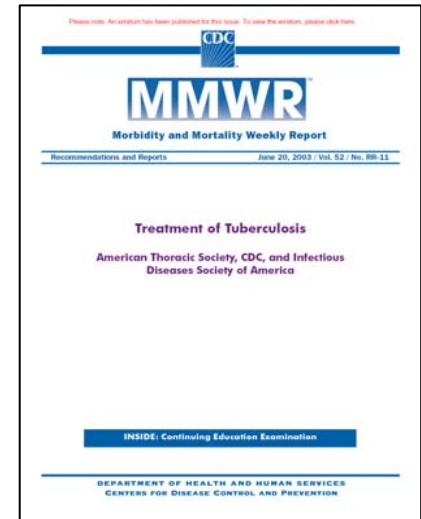
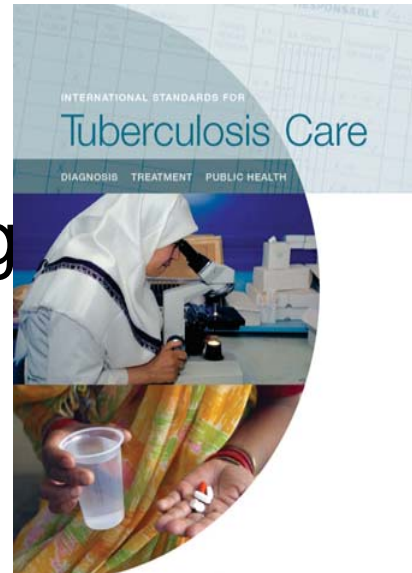
- Over last 20 years there has been a movement to assure health information is protected and kept individualized
  - “Only Between You and Your Doctor”
- When it comes to public health issues there may be a paradigm



# Who's Responsible?

- CDC Changes: “The responsibility for successful treatment is clearly assigned to the **public health program** or private provider, not to the patient.”

- “Any practitioner treating a patient for tuberculosis is assuming an important public health responsibility.”



Developed by the Tuberculosis Coalition for Technical Assistance (TBCTA)

**TBCTA**  
The Tuberculosis Coalition  
for Technical Assistance

TBCTA Partners:



K N C V TUBERCULOSE FOUNDATION



Funded by the United States Agency for International Development (USAID)



Southeastern National  
**Tuberculosis Center**  
SHARE • LEARN • CURE

# Paradigm Shift?

- Public Health Programs responsible for the cure of every TB patient
- The State and Local Governments have authority over the Public Health Programs
- Ultimately, **THE GOVERNMENT** is responsible for the cure of every TB patient
  - This sentiment is supported by the recent polls concerning the recent high profile TB cases



# Future - We need to know what we want and need?

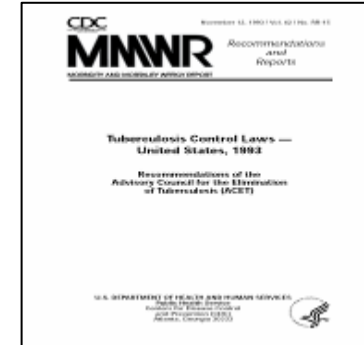
- While Society Expects the Government to Protect Them Against TB, Public Health has the responsibility of educating and advising the Government what is needed in a responsible and realistic manner
  - *Lots of competing interests*



# Our Future

- Decreases in the Cases Of TB in the US and Changes in Our Economy will soon impact TB Control Significantly
- We can't let history repeat itself-we need to be prepared!!
  - Protect TB Healthcare Infrastructure





# “What Do We Need and How Do We Maintain the Infrastructure?”

## Goals for state tuberculosis control programs

States should have systems that incorporate the following guidelines:

- Ensure the mandatory reporting of each confirmed and suspected case of TB, and observe local laws and regulations protecting patient confidentiality;
- Examine persons at high risk for TB infection and disease, prescribe the appropriate preventive or curative treatment for these persons, and monitor their treatment;
- Monitor the treatment of patients, and require that a treatment plan be devised for all hospitalized patients before they are discharged;
- Ensure the rapid laboratory examination of specimens and reporting of results to the appropriate health department and the requesting clinician;
- Ensure that TB-infected patients receive treatment until they are cured;
- Protect the health of the public by isolating and treating persons who have infectious TB and detaining persons who, although not infectious, are unwilling or unable to complete their treatment and are at risk for becoming infectious and for acquiring drug-resistant TB;
- Finance the treatment of indigent patients.



# *“You can’t solve a problem in the same state of consciousness in which it was created.” - Einstein*

- We need to do an inventory both locally and nationally of Resources and Manpower and Integrate and Connect Them-? *REGIONALIZATION (Recommended by IOM-Ending Neglect Report 2000)*
- Public Health may fall into the purviews of State Responsibilities but it is rapidly becoming a national concern which is limited by artificial borders-will need cooperative local as well as national efforts-*“Homeland Security”*
  - Economic Realities Soon Will Result in Limited Funding- Need to Maximize Utilization of Required and Existing Resources (TB Programs are not in this alone)

*(Recommended by IOM-Ending Neglect Report 2000)*



# Inventory

- Do we have the medical support?
- Do we have the labs?
- Are the laws adequate?
- Can we treat and control TB in the community?
  - Do we have the medical expertise to recognize, diagnose and treat?
  - Do we have the clinical and field staff to CURE? (No more talking about treat only)
  - Do we have the clinical and field staff to PREVENT TB?
  - Do we have facilities and expertise for those who can't be treated in the community?
  - Do we have the support of the patients?
  - Do we have the support of the Citizens and Legal community?
    - They need to be educated or else we will not succeed-Public Health Is Doing Its Best when nobody knows what we are doing!!



# Access to Expert Care “For All”

“Assure the Cure” no matter where the patient lives

## THE FLORIDA TBMD NETWORK AS AN EXAMPLE

- Allowed for every patient in the state to be reviewed
- Support for the local HD MDs and RNs-consultants to the “experts”
  - Harder to find and train “experts”
- Created a standard of care
- Utilized “new” technology to create the network
  - Teleradiology
  - CXR database
- Became a training opportunity for future “experts” and interested healthcare workers in Public Health
  - UM
  - UF
  - NOVA



# Improve Diagnosis

## “Time of Significant Change”

- Improve communication-shift in philosophy
  - “ITS NOT OK!!!”
    - Labs need to understand what physicians need and physicians need to communicate better to assist in the prioritization and maximizing of resources
      - Fast Track
      - Rapid Molecular Diagnostics
        - NTM case
      - Molecular Susceptibility
- Does every area need to have a lab that provides all of these services or just access with rapid results?



# Improve HD Resources

- Nurse run program
  - Assure adequate manpower
    - DOT
  - Assure access to MD Support
  - Improve education and training
  - Reach Out and Incorporate the Community into TB Control
    - Improve communication and Educate as to their roles between HDs, private practitioners (“*trenches*”), hospitals, correctional facilities and other high risk environments (based on local experience)-“*Homeland Security Through Partnerships*”
  - Treat in least restrictive environment
- Access to incentives and resources
  - **TB Care Should be Free of Charge to the Patient**
    - Remove all obstacles to treatment
    - If Society and Government expect the patients to protect them against spreading their disease, “*this is the least we can do*” for the patient
  - Incentives and enablers
  - Money for Motels



# “DOT THERAPY WORKS!”

- 95% of patients with TB will be cured by DOT
  - Decreases Morbidity & Mortality and cost (~\$1500/pt)
  - Decreases Spread of Disease
    - Average patient with TB infects 30 other individuals
  - Decreases resistance
    - MDR costs ~\$250,000 to cure with only ~80% success
- 5% of patients with Active TB will be unable to complete therapy; requiring legal interventions and facilities to cure them
  - In S.F. one non-compliant patient with MDR-TB was responsible for 40 other cases



# Why Are Patients Unable to Complete Treatment in the Community?

- Severity of their illness or complexity of their complicating medical conditions
- Most require hospitalization for psychological and/or social problems (i.e. substance abuse, psychiatric illness, and/or homelessness) which prove to be impossible to manage, in certain patients, by traditional outpatient services
  - **May need legal interventions in order to cure these individuals.**



# Inventory Laws

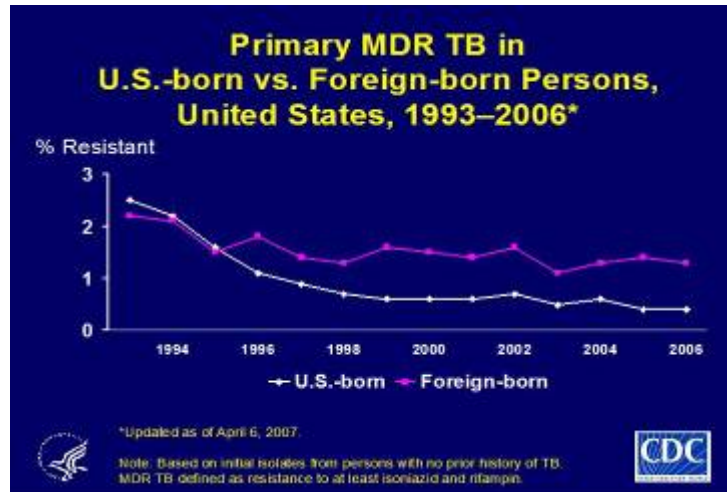
- Public Health will need the legal support to do its job
  - “*Too Much Confusion between Legal and Clinical*”
  - Not just about having the laws but an easy mechanism to access expertise on how to implement them
    - Had an central “authority” review the appropriateness of the order and added accountability of this person
    - Must be last resort, when all other alternatives have been exhausted or are not appropriate-must show **evidence of being threat to public health not perceived** threat and **least restrictive**
  - Take out contagiousness and use “active disease”
  - Must protect civil rights of patient but balanced with rights of society
    - Education must be shown
    - Due process
    - Treat As Patients not Criminals-Civil vs. Criminal Law and detain in medical facilities
  - Able to be implemented at all times
  - Stays in effect long enough to cure but avoids abuse of civil liberties
  - Ability to examine those who refuse and isolate those suspects but with limits and accountability
    - Can you force treatment?
      - include judges, legislators, NGOs, lawyers



CDC working on model Laws

# Importation and Exportation of TB

- Ability to restrict travel when necessary
  - “No Board Orders”-cooperative effort between the Federal Govt and States-currently being formalized
- Need improved mechanism for screening arrivals
  - Not new-The word *quarantine* originates from the Italian words *quarantena* and *quaranta giorni* which referred to the 40 day period which Venice isolated ships before their goods, crew and passengers could disembark during the plague-ridden days of the 14<sup>th</sup> and 15<sup>th</sup> centuries.
  - Seeing more MDR from FB



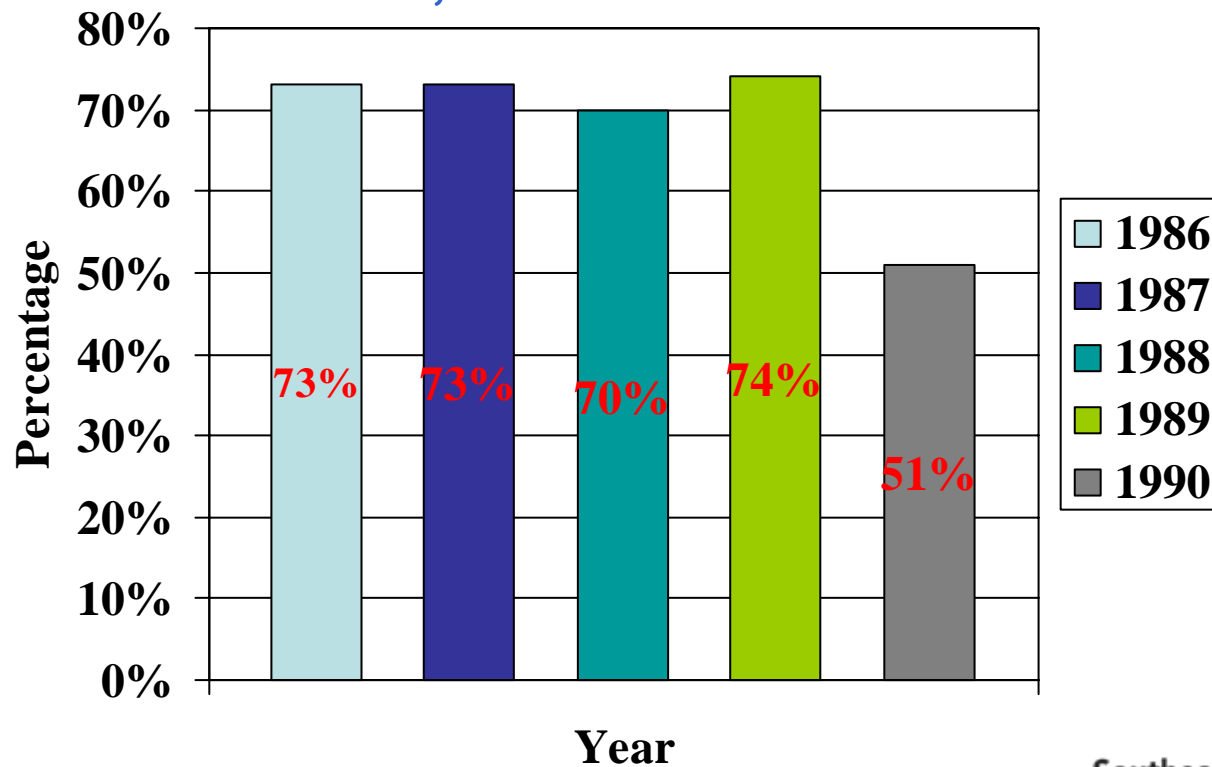
# Where are Patients Who Fail DOT Currently Treated?

- Acute care hospitals
  - usually do not have the accommodations (secured rooms and grounds, necessary programs to treat psychological and social problems) to treat patients for long periods of time
  - Expensive- \$600-1200/day
- Jails (Secured facilities)
  - Often Lack
    - the necessary infection control precautions
    - the required medical expertise and/or staff to treat this population



# Florida's Experience

## Percentage of Active TB Cases Completing Drug Therapy Within 12 Months, Florida 1986-1990



Source: US Centers of Disease Control, 1992



# Causes of Increase of TB in FL

Numerous causes but some of the most profound:

1. Lost Infrastructure
  - a. Health departments had experienced staff leave TB and no means to attract new staff
  - b. No centralized leadership to seek solutions
  - c. No means of education and training
  - d. Poor surveillance capabilities
  - e. Inappropriate management of active TB cases
  - f. Poor timely laboratory support
2. Change in patient population
  - a. More HIV
  - b. More immigrants
  - c. More psychosocial problems (eg homeless, drug abuse) leading to increased non adherence and resistance
3. TB not perceived as problem in other facilities dealing with high risk population (eg correctional facilities, rehabilitation centers)
  - a. Lack of communication
4. Inability to handle complex cases in the community
5. Lack of respect by others towards TB program
6. Lack of Funding



# Efforts to Control TB in FL

## ”Getting Back to Basics”

1. *Find and assure the successful cure of all cases of active TB*
  - a. DOT is “standard of care” in the community
  - b. All cases of TB are the ultimate responsibility of the Health Department by Florida Statute
    - Establish health department as the TB leader in the community
    - Bureau of TB through the TB MD Network and Hotline provides consultation and support for the health departments and the community MDs
    - Improved surveillance and data collection to monitor every case
  - c. Change the statutes to have legal authority to order someone to confined care



# Definitions

- "Active tuberculosis" means tuberculosis disease that is demonstrated to be contagious by clinical or bacteriological evidence, or by other means as determined by rule of the department. Tuberculosis disease is considered active until cured.
- "Threat to the public health" means a rebuttable presumption that a person has active tuberculosis and:
  - (a) Is not taking medications as prescribed;
  - (b) Is not following the recommendations of the treating physician;
  - (c) Is not seeking treatment for signs and symptoms compatible with tuberculosis; or
  - (d) Evidences a disregard for the health of the public.



# Florida Statutes 392

- “Strong” Statutes enacted in 1994
- Due Process, Legal Representation, Appearance before Judge, Appeal Process
- Emergency Provision by MDs so can work 24/7
- Has Worked Well
  - Has been invoked over 400 times since 1994
  - Has significantly contributed to the effective control in Florida
    - TB has been declining in the state since 1995
    - Resistance rates also significantly declining
  - Has been challenged in court by patients at least twice and upheld



# “When All Else Fails”

## Access To TB Centers of Excellence

- **AG Holley Hospital** as an example
  - **Medical Facility**
  - **Safety Net to the Health Departments**
  - **For those who could not be cured in the community**
    - **Concomitant Medical Problems**
      - Drug levels
      - MDR
      - Surgery
    - **Associated Psychological, Substance Abuse and/or Social Issues**
  - **Consultation**
  - **Research**
  - **Education**
  - **Training**



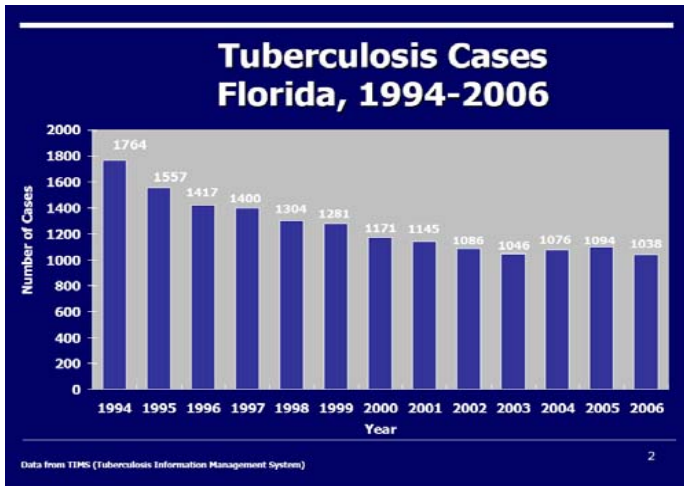
Training

**BUILDING 1  
EAST**  
← HOSPITAL ENTRANCE

Southeastern National  
Tuberculosis Center  
SHARE • LEARN • CARE



# Is it Working?



Experienced a decrease in cases but not truly indicative if change in system worked

## Changing Face of MDR in Florida

- 1994 48 MDR cases-35 American Born (21 prior history of TB), 13 Foreign Born
- 2006 5 cases of MDR-4 Foreign Born, 1 American Born

Stopped “*Growing Our Own*” by “*Assuring The Cure*”



# Threats

- Funding
- Resistance
  - “Small World After All”-Subject to Problems with TB Control throughout the world
- Continuing to “Pay Attention” and Support TB efforts in “Our Community”
  - Recognize inadequate TB control expectations internationally has the potential to destabilize control efforts in this country (eg XDR)



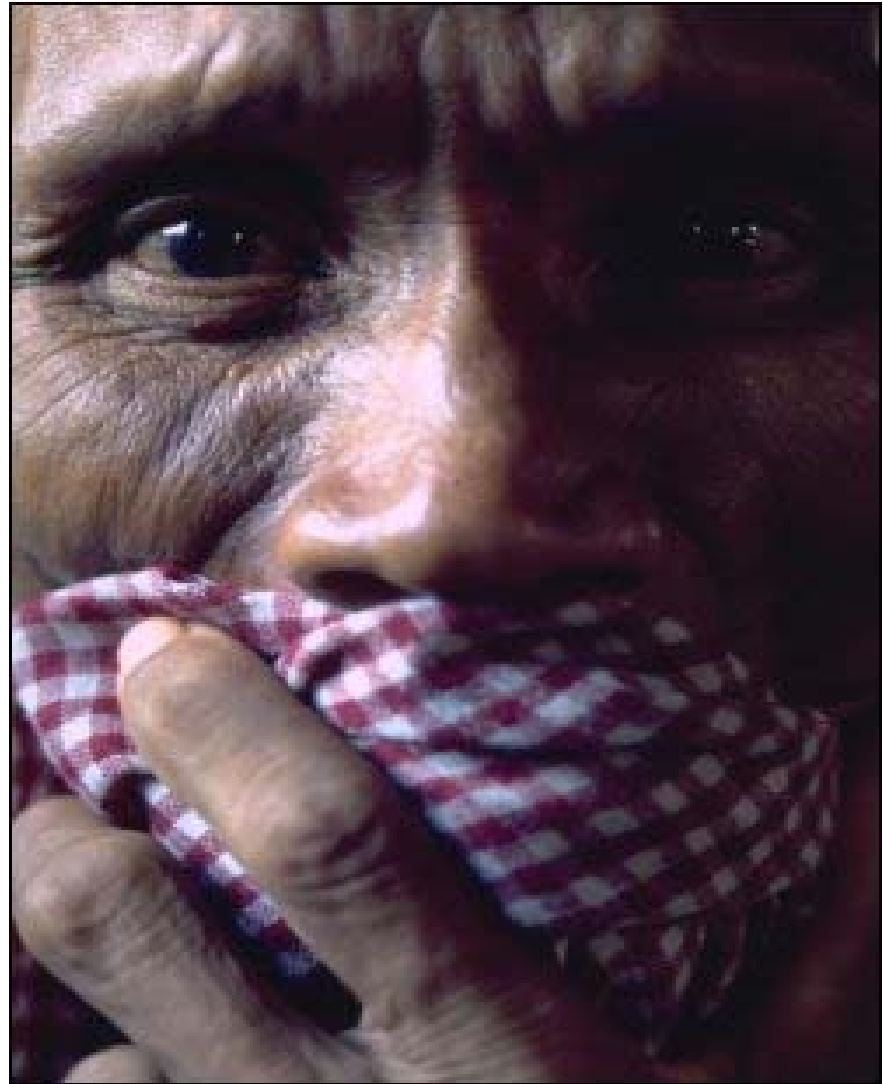
# Holy Grail

- Ultimate future is a vaccine
  - Support Research
- We have the ability to obtain eradication but do we have the will?
  - Ultimately means do we want to do it?



# CDR - TB

- C- COMPLETELY
- D - DRUG
- R – RESISTANT
- TB - TUBERCULOSIS





**THANK YOU!!**

**Southeast National TB Center/  
A.G. HOLLEY Hospital  
TB HOTLINE**


**1-800-4TB-INFO**



# Complexities of Case Management

For U.S. Immigration and Custom Enforcement of Detainees

# Complexities of Tuberculosis Case Management for U.S. Immigration and Customs Enforcement (ICE) Detainees



*International Union Against TB and Lung Disease/NAR 2008*  
**March 1, 2008**

Diana Schneider, DrPH, MA  
CDR, US Public Health Service  
U.S. Immigration and Customs Enforcement  
Detention Health Care Unit

# Objectives

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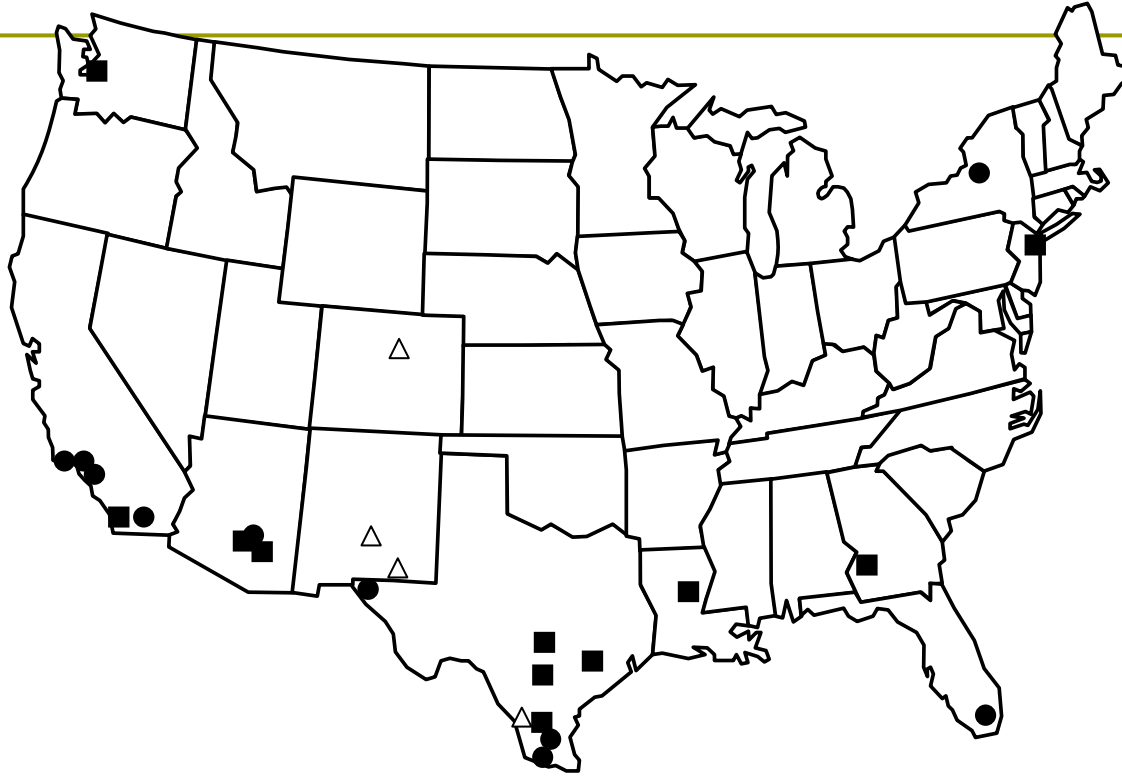
- ❑ Discuss unique tuberculosis (TB) case management needs for U.S. Immigration and Customs Enforcement (ICE) detainees
- ❑ Discuss collaborations with local and state public health departments to facilitate continuity and completion of TB treatment

# U.S. Department of Homeland Security Custody

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- U.S. Immigration and Customs Enforcement (ICE)
  - Detention and Removal (repatriation) Operations
  - Detention of illegal aliens during immigration proceedings
  - **Administrative process incident to deportation**
  - **Criminal charges resolved prior to ICE custody**
  - Housed in processing centers, contract detention facilities, and local jails (under intergovernmental service agreements)
  
- U.S. Customs and Border Protection (CBP)
  - Apprehension and custody at ports of entry
  - Custody is of short duration (usually hours)

# ICE Service Processing Centers, Staging Facilities, and Contract Detention Facilities\* and Contract Detention Facilities\*



- ICE Service Processing Center and ICE Staging Facility, ICE staffing
  - Contract Detention Facility or Intergovernmental Service Agreement (IGSA), ICE staffing
  - △ Contract Detention Facility or IGSA, Contractor staffing
- \* Locations without symbols have ICE detainees housed in local jails nationwide

# ICE TB Control Program

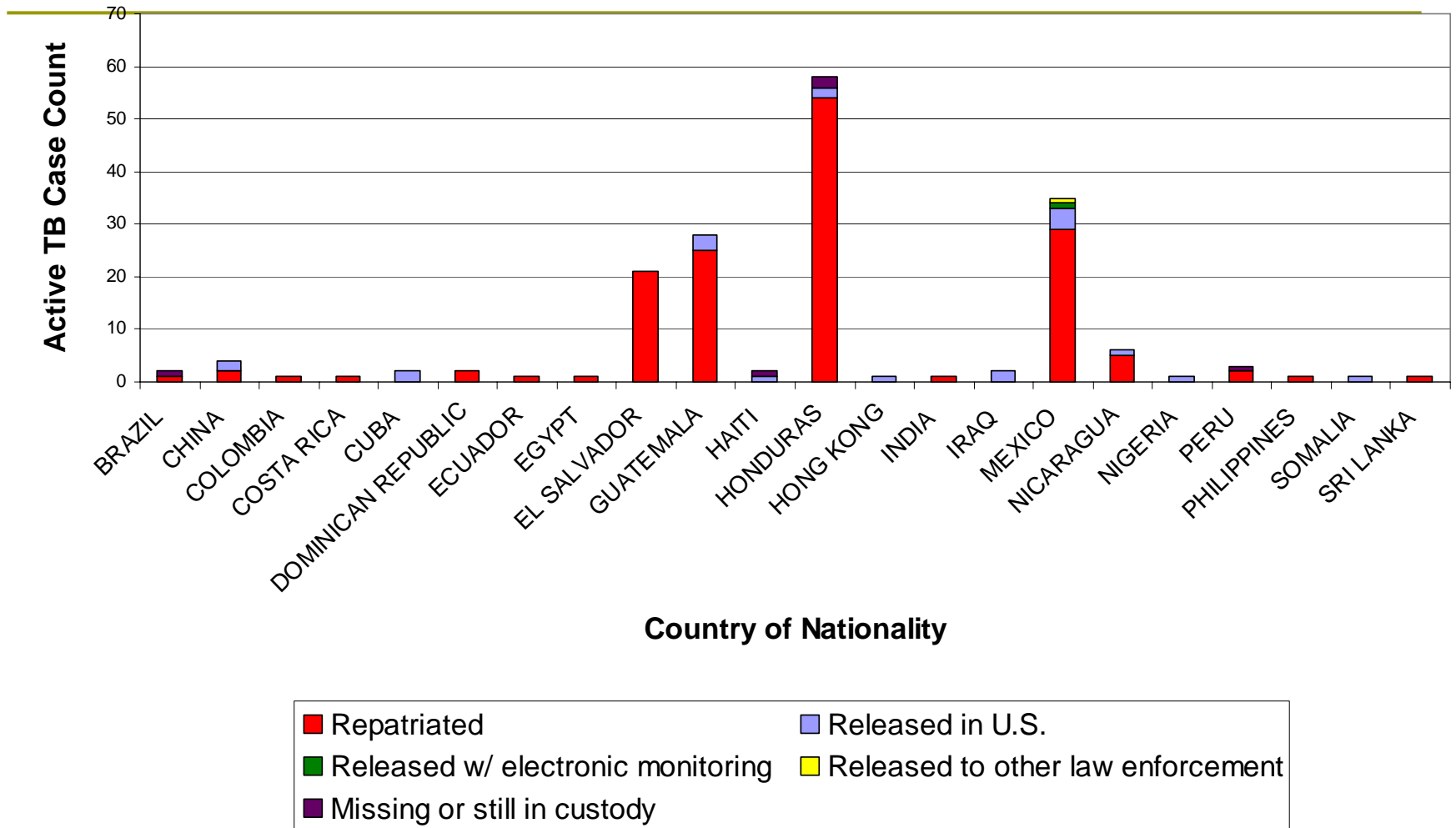
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- ❑ Detainees frequently arrive with no or poor medical documentation
- ❑ Intake medical screening/screening for TB disease
  - Symptom screening questions and clinical observation
  - At ICE locations -- digital radiography upon intake
  - Most other locations --TB Skin Test (TST) + chest x-ray if TST is positive
- ❑ Infection control measure
- ❑ Maintain a safe detention and working environment
- ❑ Case detection
- ❑ Continue or initiate treatment as indicated

# TB Case Characteristics, 2006

TB cases, classified by provider as TB, clinically active	N=175
symptomatic	41/175 (25%)
AFB positive	46/175 (26.3%)
culture positive	80/175 (45.7%)
culture negative	88/175 (50.3%)
AFB positive & culture positive	41/175 (23.4%)
AFB positive & culture negative	5/175 (2.9%)
AFB negative & culture positive	37/175 (21.1%)
AFB negative & culture negative	88/175 (50.3)
AFB negative, culture negative, & asymptomatic	61/175 (34.9%)

# Reported Active TB,\* ICE Detainees, by Country and Release Status, 2006



\*Reflects case classification as TB, clinically active assigned by treating physician

# Case Management Challenges

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- Universal chest x-ray screening
  - Chest x-rays for all upon intake
    - vs. TB clinic setting: referrals or contacts of TB cases
    - Identifies many individuals with minor abnormalities
- Patients frequently disbelieve diagnosis when asymptomatic
- Patients may be unwilling to provide addresses and contacts
- Patients may give false addresses
  - unable to verify

## Case Management Challenges (continued)

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- ❑ Patients are often repatriated prior to completion of treatment
- ❑ Lack of/late notification from facilities (e.g., local jails) without ICE medical staffing
- ❑ Patients may be repatriated before culture and sensitivity results are available
  - ICE does not deport patients while known to be contagious
  - Occasionally considered “ruled-out for TB” and positive culture result received after the patient has been deported

# Case Management Challenges (continued)

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- Detention facilities are not TB clinics
  - Priorities are
    - intake screening
    - chronic disease & mental health management
    - sick call
    - physical examinations
    - medications upon release
  
- Chronic personnel shortages
  - High staff turnover
  - Hard to fill, remote locations

# Case Management Challenges (continued)

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## □ Contact investigations

- High prevalence LTBI
- May not have baseline TST result if screened with chest x-ray
- Cannot keep people detained solely for purpose of testing for contact investigation
- Index patient and contacts may be released or repatriated before contact investigation is initiated
- Detention facility medical staff may not be trained or skilled in contact investigations
- Not usually the priority of detention health service clinic

# Verified Tuberculosis Case

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<b>Latin America</b>	<b>United States</b>
<p data-bbox="110 482 700 539"><i>Confirmed Active TB</i></p> <ul data-bbox="110 568 536 759" style="list-style-type: none"><li data-bbox="110 568 441 616">• AFB smear</li><li data-bbox="110 639 460 688">• MTB culture</li><li data-bbox="110 711 536 759">• Histopathology</li></ul>	<p data-bbox="967 482 1728 539"><i>Laboratory Case Definition</i></p> <ul data-bbox="967 568 1774 759" style="list-style-type: none"><li data-bbox="967 568 1500 616">• Isolation of M. TB</li><li data-bbox="967 639 1774 759">• Identification by nucleic acid amplification (NAA)</li></ul>
<p data-bbox="110 896 643 953"><i>Unconfirmed Case</i></p> <ul data-bbox="110 982 841 1230" style="list-style-type: none"><li data-bbox="110 982 841 1230">• AFB smear negative with signs, symptoms, or abnormal CXR consistent with TB</li></ul>	<p data-bbox="967 896 1633 953"><i>Clinical Case Definition</i></p> <ul data-bbox="967 982 1736 1330" style="list-style-type: none"><li data-bbox="967 982 1348 1031">• Positive TST</li><li data-bbox="967 1045 1736 1202">• Signs &amp; symptoms consistent w/ TB, or clinical evidence of current disease</li><li data-bbox="967 1225 1595 1330">• A completed diagnostic evaluation</li></ul>

# Case Management Challenges (continued)

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- ❑ Diagnosis of active TB may be discarded following repatriation
  - The concept of starting treatment empirically is more common in the U.S.
    - ❑ Based on chest x-ray & clinical findings
    - ❑ Chest x-rays may not be routinely done in many developing countries
  - Clinical diagnosis may not be accepted by the receiving country's TB program

# Transnational TB Continuity of Care Workgroup

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- ❑ Established in 2002 to address continuity and completion of TB treatment for U.S. Immigration and Customs Enforcement (ICE) detainees
- ❑ Scope expanded to include general TB control issues affecting the U.S.-Mexico Border region
- ❑ Legal Issues Subgroup

# Transnational TB Continuity of Care

## Workgroup Participants

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Bertha Armendariz

Jo-Ann Arnold

Roscoe Barrow

Ayesha Bashir

Millie Blackstone

Angelito Bravo

Anne Cass

Jennifer Cheng

Alberto Colorado

Phyllis Cruise

Upeng Demske

Jim Elkins

Miguel Escobedo

Alice Fike

Deliana Garcia

Robert Guerrero

Toni Johns

Erik Johnson

Debra Katsch

Jimmy Keller

Kathy Kunkel

Kayla Laserson

Karen Lewis

Carol Lincoln

Mark Lobato

Nora Martinez

Marti McQueen Bretnall

Jim Misrahi

Marian Moe

José Moreira

Sandra Morris

Kevin Ray

Bill Reckward

Randall Reves

Dan Reyna

Alfonso Rodriguez

Maria Rodriguez

Cherise Rohr-Allegrini

Sarah Royce

Don Schmid

Diana Schneider (Chair)

Gary Simpson

Florencia Sisterson

Stephanie Spencer

Debra Spike

Dan Stier

Kimberly Tendrich

Charles Wallace

Steve Waterman

Christine Williams

Ed Zuroweste

# Transnational TB Continuity of Care Workgroup

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- ❑ Arizona Department of Health Services/Office of Border Health
- ❑ Arizona Department of Health/TB Control Program
- ❑ Arizona Attorney General's Office
- ❑ California Department of Health Services/TB Control Branch
- ❑ CDC/Division of Global Migration and Quarantine
- ❑ CDC/Division of TB Elimination
- ❑ CDC/Public Health Law Program
- ❑ Colorado Department of Health/TB Control Program
- ❑ Denver Metro TB Clinic and Control Program
- ❑ Florida Department of Health/TB Control Program
- ❑ HHS/Office of the General Counsel
- ❑ Migrant Clinicians Network/TBNet

# Transnational TB Continuity of Care Workgroup

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- ❑ New Mexico Department of Health/Office of General Counsel
- ❑ New Mexico Department of Health/TB Program
- ❑ Pan American Health Organization/El Paso Field Office
- ❑ San Diego County Health Department/CureTB
- ❑ Texas Department of State Health Services/TB Control Program
- ❑ Texas Department of State Health Services/TB Reporting Group
- ❑ Texas Department of State Health Services/Border Health Office
- ❑ University of New Mexico, Center for Disaster Medicine
- ❑ U.S. Marshals Service
- ❑ U.S. Immigration and Customs Enforcement/Detention and Removal Operations
- ❑ U.S.-Mexico Border Health Commission (*ex-officio*)

# TB Continuity of Care Processes

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- ❑ Notification to ICE Epidemiology Unit
- ❑ Short-term medical holds
- ❑ International referrals for continued treatment and case management
- ❑ Coordinated Removals / Medical “meet and greet”
  - Routinely for non-Mexicans
  - Special requests for Mexicans
- ❑ Requests for stays of removal (exceptional cases)
- ❑ Medical Alerts in ICE custody databases

# International TB Referrals

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- ❑ Notify National TB Program
- ❑ Verify addresses and contacts
- ❑ Identify referral clinic
- ❑ CureTB
  - Patients moving or deported to Mexico
  - Binational Notification Form
  - [www.curetb.org](http://www.curetb.org)
- ❑ TBNet
  - Patients moving or deported to any country
  - Health Network Consent Form
  - Health Network Patient Information Form
  - TBNet Patient History and Brief Medical Information Form
  - <http://www.migrantclinician.org/network/tbnet>

# Coordinated Removals/Medical Meet and Greets

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- ❑ Arrangement for patient to be received by public health officials at the airport or land border at the date and time of repatriation
  - National TB Program (NTP) notified
  - Patient received by NTP or quarantine medical officer stationed at airport
  - Consulate assistance
- ❑ Provides an opportunity to
  - Educate patient
  - Verify address and contacts
  - Provide support services if available
  - Ascertain if patient intends to move soon

# Stay of removal requests

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- ❑ Exceptional circumstances
  - Multidrug-resistant (MDR), medically complicated, nonadherence, concomitant mental health conditions, frequent border crossers while under treatment
- ❑ ICE has authority to grant or deny
- ❑ Do not ensure continued custody
- ❑ ICE may require other secure environment
  - Flight risk, prior criminal convictions, national security threat
  - Could require state or local court-mandated treatment
- ❑ ICE cannot pay for services if not in custody

# Legal Considerations: U.S. Immigration

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- ❑ ICE authority to detain is to facilitate immigration proceedings and repatriation
  - Immigration and Nationality Act
  - U.S. Code Title 8
  - Code of Federal Regulations Title 8
  - Zadvydas v. Davis, et al., 533 U.S. 678 (2001)
  - Clark, et al. v. Martinez, 543 U.S. 371 (2005)
- ❑ Statutory limitations on duration of custody pre- and post- issuance of a final order of removal

# Ethical Considerations

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- ❑ Drug-resistant and medically complex cases
  - Appropriate treatment may not be available in country of nationality
- ❑ Requests to retain patients in custody:
  - until treatment completion
  - until culture results are available
    - ❑ ICE authority to detain is incident to deportation
    - ❑ Inconsistent with community standard of providing treatment in the least restrictive setting
    - ❑ Civil liberties considerations
- ❑ Requests to retain contacts in custody for testing during contact investigation

# Ethical Considerations

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- ❑ Occasionally local or state government agency request deportation of patients under treatment in the community
  - Inconsistent with principles of confidentiality
  - May result in distrust of public health agencies
  - Future patients may avoid seeking health care
- ❑ State and local government may have enacted policies that prohibit use of government funds to provide care for undocumented individuals

# Key Outcomes, Jan 2004-Jul 2006

Active TB Patients	N=416
Enrolled in referral program	356 (85.6%)
Completed treatment (overall)	218 (52.4%)
Completed treatment (enrolled)	208 (58.4%)
Repatriated, completed treatment	148/284 (52.1%)
Released in U.S., completed treatment	27/45 (60.0%)
Reclassified as not TB/treatment not recommended	22/416 (5.3%)
Did not complete treatment	112/416 (26.9%)
•Lost to follow-up	71/416 (17.1%)
•Refused or stopped treatment	30/416 (7.2%)
Treatment outcome unknown	50 (12.0%)

## Case Scenario -- PG

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- ❑ 33 year-old male from El Salvador
- ❑ Detained by ICE September 2006
- ❑ Initially sputum smear and culture positive for M. TB
- ❑ Referral for continuity of care in El Salvador coordinated through TBNet Program
- ❑ Scheduled for removal once non-contagious

## Case Scenario -- PG (continued)

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- ❑ Determined to be known to the local clinic in El Salvador
- ❑ History of non-adherence to anti-TB treatment in 2005
- ❑ History of non-adherence to LTBI treatment in 2000
- ❑ Health authorities in El Salvador had identified 3 family contacts with active TB, including the patient's 8 year-old son

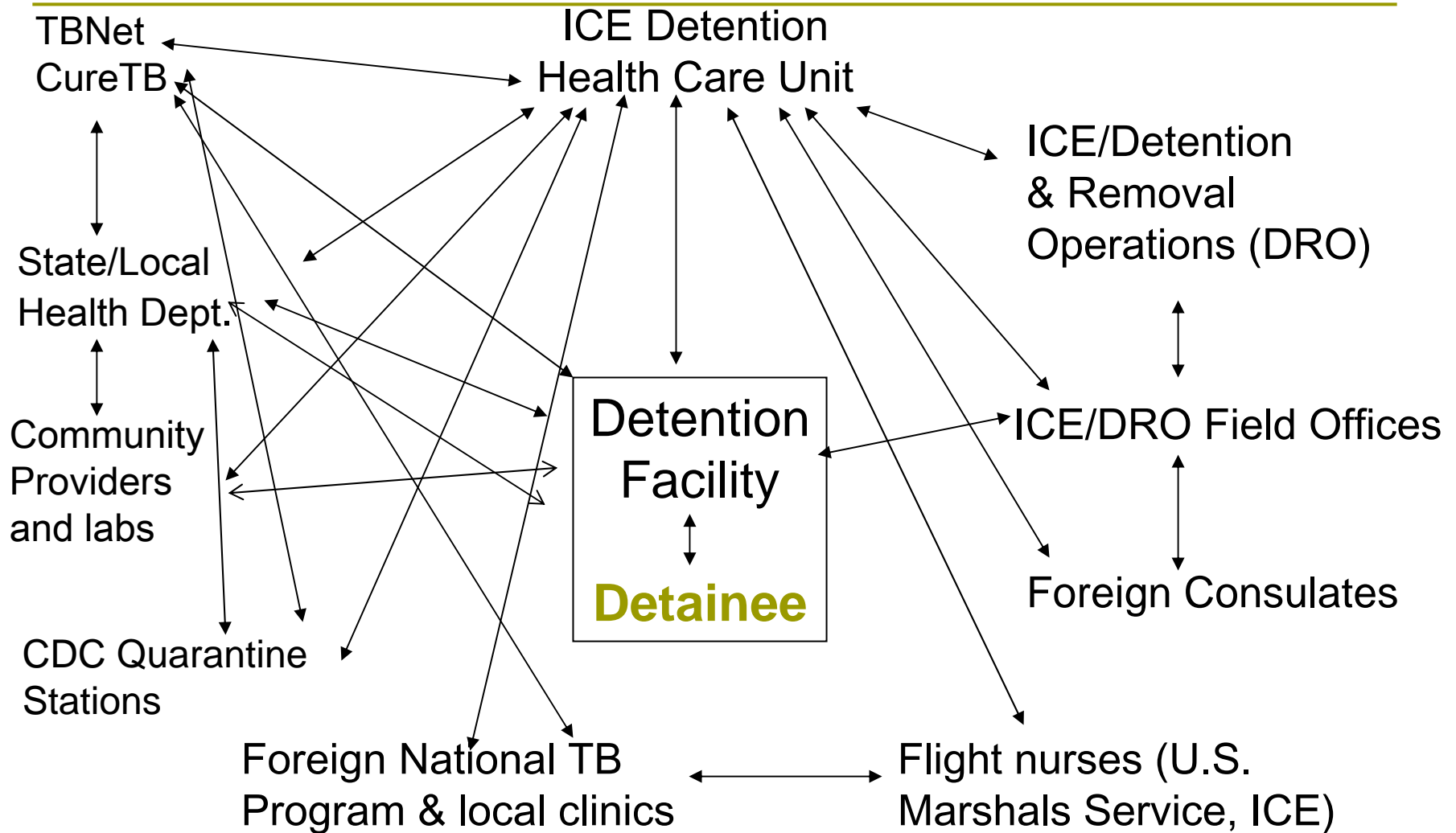
## Case Scenario -- PG (continued)

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- ❑ Case conference held with DIHS, TBNet, and the El Salvador National TB Program (NTP)
- ❑ NTP indicated that child protection laws could be used to retain patient in hospital
- ❑ Patient was repatriated with a pre-arranged coordinated removal/meet and greet
- ❑ Patient received supervised therapy at thoracic hospital under court order
- ❑ Patient successfully completed treatment May 2007

# TB Case Management for ICE Detainees

## Communication and Coordination



# Special Thanks

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- Jennifer Cheng, Alice Fike (ICE/Epidemiology)
- Nora Martinez, Ed Zuroweste, Al Osborne (MCN)
- Alberto Colorado, Dr. Florencia Sisterson  
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---

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- ❑ Arizona Attorney General's Office: Kevin Ray, Don Schmid
- ❑ CA Dept. of Public Health: Sarah Royce, Anne Cass, Stephanie Spencer, Jan Young, Roscoe Barrow, Peter Baldrige
- ❑ Colorado Department of Health: Mary Goggin
- ❑ Denver TB Control Program: Randall Reves
- ❑ Florida Dept. of Health: Jimmy Keller, Debra Spike
- ❑ New Mexico: Gary Simpson
- ❑ New Mexico Department of Health: Kathy Kunkel
- ❑ Texas Dept. of State Health Services: Charles Wallace, Phyllis Cruise, Sandra Morris, Walter Erhesman, Jose Moreira, Maria Rodriguez
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---

## **ICE Medical Staff:**

Aguadilla, PR: CDR Karen Dorse, CDR Wanda Gonzalez

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El Paso, TX : LCDR Erik Hierholzer, LCDR Zita Guerrero, Dr. Rosa Colon, LCDR Chiara Rodriguez

Elizabeth, NJ: , LCDR Rusty Waldron, LCDR Jonee Mearns, Dr. Chang Park

Eloy, AZ: LCDR Melissa George

Florence, AZ: CDR Claire Karlson, LCDR Dawn Kordas

Harlingen, TX: LCDR William Rekward

Houston, TX: CAPT Christine Williams, LT Cynthia Beard, Dr. Monique Matuzcowitz

Jena, LA: Patrick Humphries, CAPT Jeff Brinkley

Los Angeles, CA: LCDR Jason Ortiz, LT Kelly Royce

Miami, FL: LCDR Eunice Jones-Wills, CDR Jaime Muñiz, Dr. Abelardo Montalvo, LCDR Andrew Ganzon

Pearsall, TX: CAPT BuJean Jenkins, Dr. Erik Johnson, LT Lysa Hieber

Pinal County, AZ: LCDR Shawna Hutchins, LCDR Steve Morin

Port Isabel, TX: CAPT Marian Moe, Brian Bonser, Dr. Luz Peredo-Berger, LTJG Kari Sander

San Diego, CA: LCDR David Lau, CDR Joel Johnson, LT Mario Pallante

San Pedro, CA: LCDR Shelly Hollandsworth, LT Diana Vargas, Dr. Jeff Sherman

Stewart, GA: CDR Lynn Harris, CDR Christopher Walsh

Tacoma, WA: LCDR Deanna Gephart, LT Victoria Oboczky Vigil, Dr. Phil Farabaugh

Taylor, TX: LCDR Tom Hochberg, CDR Peggy Mathis, LCDR Angel LaSanta

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❑ [www.ice.gov](http://www.ice.gov)

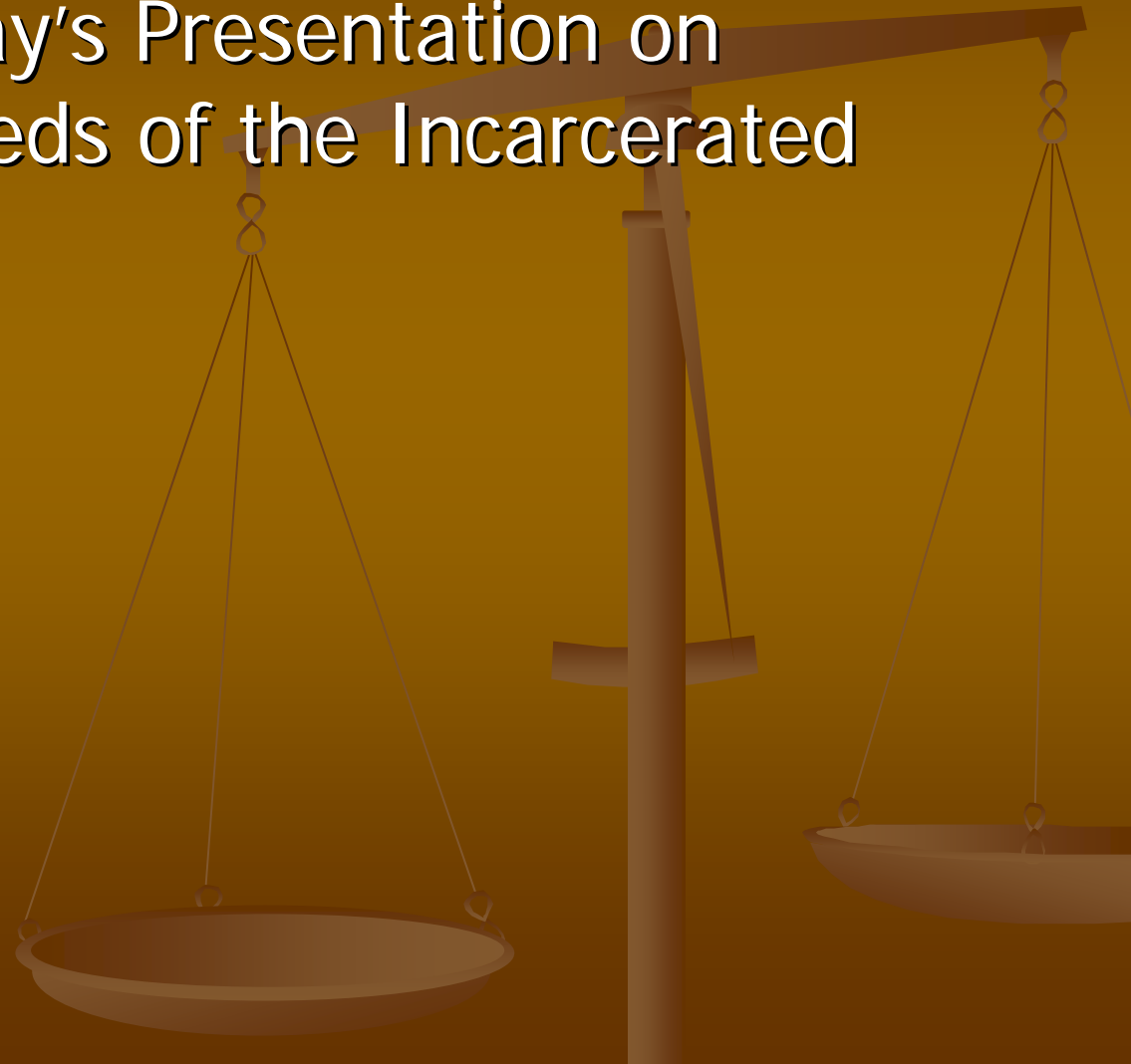


# Meeting the Needs

Of the Incarcerated Population

# Place Holder

- For Dr. John May's Presentation on Meeting the Needs of the Incarcerated Population





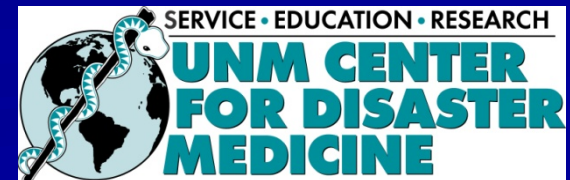
# Examining and Re- Evaluating

Legal Authorities for TB Control  
Across Jurisdiction

# Examining & Re-Evaluating Legal Authorities for TB Control

**Clifford M. Rees, JD**  
**University of New Mexico**  
**Center for Disaster Medicine**

**San Diego, CA**  
**March 1, 2008**



# Overview

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**Basics of Public Health Law**

**Inter-Jurisdictional Legal  
Mechanisms**

**Applicable to TB Control**

# Basics of Public Health Law

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## 5 Levels of Jurisdiction

- International
- Federal
- State
- Local
- Tribal

# Basics of Public Health Law

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**Laws are rules that govern our conduct**

## **General Sources of Law**

- **Constitution (federal/state)**
- **Common Law (federal/state)**
- **Statutes (federal/state)**
- **Rules/Regulations/Ordinances  
(federal/state/local)**
- **Executive Orders (federal/state)**

# Basics of Public Health Law

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## State/Local Health Law Powers

**U.S Constitution - “Police Powers”**

**10<sup>th</sup> Amendment to the U.S. Constitution**

**Powers not given to the Federal Government  
are reserved to the States**

**State authority - Intrastate issues – TB Control**

- **Infectious Disease Control Measures**
- **Public Health Treatment Facilities**
- **Licensure of Public and Private Health Facilities**



November 12, 1993 / Vol. 42 / No. RR-15

**MMWR**

*Recommendations  
and  
Reports*

MORBIDITY AND MORTALITY WEEKLY REPORT

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## **Tuberculosis Control Laws — United States, 1993**

**Recommendations of the  
Advisory Council for the Elimination  
of Tuberculosis (ACET)**

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**Public Health Service**  
Centers for Disease Control  
and Prevention (CDC)  
Atlanta, Georgia 30333



# Basics of Public Health Law

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## State/Local Health Law Power

### New Mexico State Statute

**Public Health Act, Sections 24-1-1., et seq., NMSA 1978 (from Laws 1919, Chapter 85, Section 10)**

- ***24-1-3.C.; ... to investigate, control and abate causes of disease, especially epidemics, sources of mortality and other conditions of public health.***
- ***24-1-3.D.; ... to establish, maintain and enforce isolation and quarantine***
- ***24-1-3.E.; ... to close any public place and forbid gatherings of people when necessary for the protection of public health***

# Basics of Public Health Law

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## State/Local Health Law Power

### New Mexico State Statutes & Rules

- *24-1-15. “Reporting of Contagious Diseases”*  
*Subsection A. – Reporting Requirement*

*Rule – 7.4.3 NMAC, “Control of Disease and Conditions of Public Health”*

*Subsections B. – L. - Due Process procedures to detain a person infected with a threatening communicable disease*

# Basics of Public Health Law

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## State/Local Health Law Power

### New Mexico State Statute

- *Public Health Emergency Response Act, Sections 12-10A.-1., et seq., NMSA 1978, (Laws of 2003, Chapter 218, as amended)*

New Mexico Legislative Council Service  
website - [www.legis.state.nm.us](http://www.legis.state.nm.us) > Statutes

# Basics of Public Health Law

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## Federal Health Powers

**U.S. Constitution (Article I, Section 8)**

- **Commerce Clause – Interstate**
- **Tax and Spend Clause - General Welfare**

# **Basics of Public Health Law**

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## **Federal Health Powers**

**Federal Statutes (USC)**

**42 USC Section 264**

**Federal Regulations (CFR)**

**Quarantine Authority (42 CFR Parts 70 and 71)**

**Federal Executive Orders**

**EO 13375 (April 1, 2005)**

**Amending EO 13295 (April 4, 2003) Relating to  
Certain Influenza Viruses and Quarantinable  
Communicable Diseases**

# Basics of Public Health Law

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## Federal Quarantinable Diseases

- Smallpox
- Cholera
- Plague
- Viral Hemorrhagic Fevers
- Infectious Tuberculosis
- Yellow Fever
- Diphtheria
- SARS
- Novel Influenza Virus

# Basics of Public Health Law

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## Tribal Health Powers

- **Navajo Nation: Adopted the Health Commitment Act of 2006, Title 13 Navajo Nation Code, Section 2101, et seq., providing a mechanism for the health commitment of individuals for treatment in the least restrictive setting**
- **If Tribal governments do not have their own laws, they may follow federal or state laws**
- **25 USC Section 198, 25 USC 231, 42 USC Section 243, 42 USC Section 264**

# **Basics of Public Health Law**

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## **International Health Powers**

### **International Health Regulations (IHR)-2005**

#### **Defines Public Health Emergency of International Concern (PHEIC)**

- Requires response on a time-sensitive basis**
- Imposes requirements for sharing information between member countries**
- Implemented under domestic laws for each country**

# **Basics of Public Health Law**

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## **International Health Powers**

**U.S. will implement IHR under principles of federalism**

**State and Local public health legal authorities will be honored as well as**

**Federal legal authorities**

**Inter-Jurisdictional  
Legal Mechanisms  
Applicable to TB Control**

# Inter-Jurisdictional Legal Authorities

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- United States Constitution, Article I, Section 8  
– Congress shall have the power to regulate Commerce with foreign nations, among the several States and with Indian Tribes;
- United States Constitution, Article I, Section 10 – No State shall enter into any Treaty, Alliance or Confederation; No State shall, without the consent of Congress . . . enter into any Agreement or Compact with another State, or with a foreign power . . .

# **Inter-Jurisdictional Legal Authorities**

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## **Options for U.S. International Agreements**

- **Formal treaties between nations, signed by the President with advice and consent of Congress.**
- **Agreements negotiated by the US State Department based on its statutory authority.**
- **Non-binding agreements that do not require involvement by the US State Department.**

# Inter-Jurisdictional Legal Authorities

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## Examples of Existing International Agreements

- **Pacific Northwest Emergency Management Arrangement**
  - Pacific Northwest States and Western Canadian Provinces (April, 1996)
- **International Emergency Management Assistance Memorandum of Understanding**
  - New England States and Eastern Canadian Provinces (July, 2000)

# Inter-Jurisdictional Legal Authorities

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**Examples**

(continued)

## ■ **Great Lakes Border Health Initiative**

(Fall 2004)

See-[http://www.michigan.gov/mdch/0,1607,7-132-2945\\_40279---,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_40279---,00.html)

# Inter-Jurisdictional Legal Authorities

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## Types of Agreements

- **International Treaties**
- **Interstate Compacts**
- **Mutual Aid Agreements**
- **Memoranda of Understanding/Agreement -Joint Powers Agreements**
- **Professional Services Agreements**

# Inter-Jurisdictional Legal Agreements Matrix

	Federal	State	Local	Tribal	International
Federal	<ul style="list-style-type: none"> <li>❖ Federal Statute</li> <li>❖ Homeland Security Presidential Directive 8</li> </ul>	<ul style="list-style-type: none"> <li>❖ Federal Statute</li> <li>❖ Grants -Stafford Act</li> </ul>	<ul style="list-style-type: none"> <li>❖ Federal Statute</li> <li>❖ Grants -Stafford Act</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties</li> <li>❖ Federal Statute</li> <li>❖ Grants</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties (binding) Article 1, Section 10, U.S. Const.</li> <li>❖ Federal Statute</li> <li>❖ IHR</li> </ul>
State	<ul style="list-style-type: none"> <li>❖ Federal Statute</li> <li>❖ Grants</li> <li>❖ Stafford Act</li> <li>❖ JPA</li> </ul>	<ul style="list-style-type: none"> <li>❖ EMAC (Emergency)</li> <li>❖ Mutual Aid (non-emergency)</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ MOU/MOA</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ MOU/MOA</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties (non-binding)</li> <li>❖ Federal Statute</li> <li>❖ IHR</li> <li>❖ Stafford Act</li> </ul>
Local	<ul style="list-style-type: none"> <li>❖ Federal Statute</li> <li>❖ Grants</li> <li>-Stafford Act</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ MOU/MOA</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid (non-binding)</li> </ul>
Tribal	<ul style="list-style-type: none"> <li>❖ Treaties</li> <li>❖ Federal Statute</li> <li>❖ Grants</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ MOU/MOA</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> <li>❖ JPA</li> <li>❖ PSA</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties?</li> </ul>
International	<ul style="list-style-type: none"> <li>❖ Treaties (binding) Article 1, Section 10, U.S. Const.</li> <li>❖ Federal Statute</li> <li>❖ IHR</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties (non-binding)</li> <li>❖ Federal Statute</li> <li>❖ IHR</li> <li>❖ Stafford Act</li> </ul>	<ul style="list-style-type: none"> <li>❖ Mutual Aid (non-binding)</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties?</li> </ul>	<ul style="list-style-type: none"> <li>❖ Treaties</li> <li>❖ IHR</li> </ul>

# Inter-Jurisdictional Legal Authorities

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**Example of mechanisms to transfer TB patients between U.S. jurisdictions**

- **Legal agreements for cross-jurisdictional use of TB residential treatment facilities**
  - **Between Navajo Nation and New Mexico state government**
  - **Between New Mexico and Texas state governments**

# Inter-Jurisdictional Legal Authorities

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## Future Directions

- **New England Compact on Involuntary Detention for TB Control**
  - The National Center for Interstate Compacts-Council of State Governments-<http://www.csq.org/>

# Inter-Jurisdictional Legal Authorities

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## Future Directions (Continued)

- **House Bill 709, New Mexico Legislature, 2005 Regular Session. Interstate Compact on Threatening Communicable Disease**

**[www.legis.state.nm.us](http://www.legis.state.nm.us)**

# Inter-Jurisdictional Legal Authorities

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## Future Directions (Continued)

### ■ Model/Uniform Infectious Disease Laws

- Model State Emergency Health Powers Act (2001)
- “Turning Point” Model State Public Health Act (2003)
- Uniform Law ?

# Inter-Jurisdictional Legal Authorities

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## Future Directions (Continued)

- **Security and Prosperity Partnership (SPP)**
  - **Mutual Assistance Agreement-  
Nov. 1, 2007**
- **US-Mexico Border Health Commission**
  - **International TB Legal Forum, 2008**

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