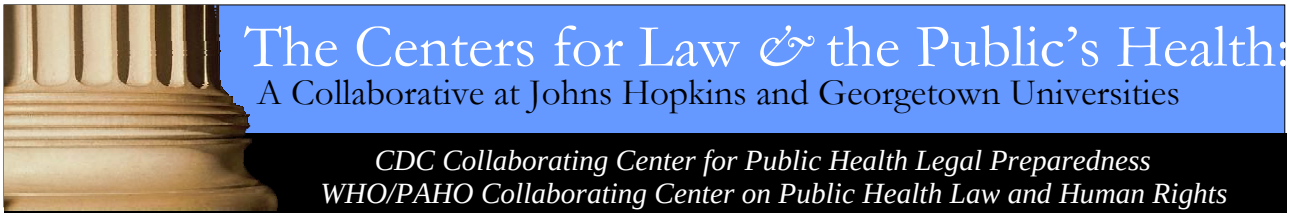

Express Tuberculosis Control Laws in Selected U.S. Jurisdictions[1]

A Report to the
Centers for Disease Control and Prevention (CDC)

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As of October 1, 2008

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EXECUTIVE SUMMARY[a]

Tuberculosis (TB), a serious communicable disease, remains a significant public health threat in the United States despite long-standing public health prevention efforts at various levels of government. TB control has become an increasingly crucial concern with the emergence of multi-drug resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB). Legal preparedness and its core elements are central to ensuring the success of public health efforts to control the spread of TB. To assist public health practitioners and policy makers in assessing and improving the use of law as a tool to control TB, the Centers for Disease Control and Prevention (CDC) in 2007 initiated a series of applied research and development projects: (1) a review and characterization of select jurisdictions' express TB control laws; (2) creation of a handbook on TB control laws that local, state, and tribal public health practitioners can use to improve their understanding of those laws and competency in applying them; and (3) development of a model state TB control act (specifically suggested by the Advisory Committee on the Elimination of Tuberculosis (ACET)). This report and accompanying Tables prepared by the *Centers for Law and the Public Health: A Collaborative at Johns Hopkins and Georgetown Universities* (*Center*) address the first of these projects.

This project seeks to comprehensively characterize key legal patterns through an examination of express TB (including MDR-TB and XDR-TB) control laws in twenty-five (25) selected U.S. jurisdictions (see Figure 1 in Section II.A).[2] The goal is to provide a baseline of factual information to assist efforts for improving public health authorities' use of law as a tool for controlling TB. *Express TB control laws* are jurisdiction-specific laws (*e.g.*, statutes, regulations, cases) that directly mention TB (or some derivative) in the body of the law, and whose main purpose is limited to the control of TB. This report does not examine general communicable disease or other laws, even if they may be relevant to, or adequate for, controlling cases of TB in some jurisdictions.

Results. Based on legal research, review, and feedback provided by legal and TB practitioners in the 25 selected jurisdictions, a series of findings are presented in Tables 1 and 2 and discussed in Section III. These findings include:

- *Prevention of TB Cases*. In 84% of the selected jurisdictions, express TB control laws appear to authorize the regulation and establishment of TB control programs by various levels of state or local government.
- *Identification of TB Cases*. In 96% of the selected jurisdictions, express TB control laws generally seem to address the identification of TB cases.
    - *Screening*. All of the selected jurisdictions appear to authorize screening (to varying degrees) through their express TB control laws.

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    - *Examination and Testing*. Laws in 88% of the selected jurisdictions appear to authorize government to use diagnostic examination and testing to determine cases of TB among individuals.
    - *Reporting*. Express TB control laws appear to establish reporting requirements in 100% of the selected jurisdictions.
- *Management of TB cases*. In 66.5% of the selected jurisdictions, express TB control laws seem generally to address the management of TB cases.
    - *Investigation*. Express TB control laws in 17 (68%) of the selected jurisdictions appear to address aspects of TB investigations.
    - *Treatment*. Among the selected jurisdictions, 96% appear to authorize health authorities to prescribe appropriate treatments for TB patients. However, directly observed therapy (DOT) is expressly authorized in only 52% of the jurisdictions.
    - *Detention, Quarantine, Isolation, and Restriction of Activities*. Laws in the selected jurisdictions appear to allow a range of public health interventions aimed at controlling the spread of TB once patients with suspected or confirmed TB disease have been identified, such as emergency detention (68%), quarantine (4%), isolation (88%), and the restriction of personal activities (80%).
    - *Enforcement*. In 76% of the jurisdictions selected, health authorities are apparently granted enforcement mechanisms to compel observance of TB orders.
- *Safeguarding Rights.* Some jurisdictions appear to have laws addressing rights to due process (68%), confidentiality and privacy (44%), antidiscrimination (8%), and religious exemptions (36%).
- *Considerations for Special Populations.* Express TB control laws in 44% of the jurisdictions selected appear to give special consideration to certain groups or populations.

Discussion. Although this report identifies interjurisdictional variations, including potential legal gaps, in several key aspects of express TB control laws, it is important to note that general communicable disease laws or other legal provisions may supplement express laws. Concerns related to the identified express TB control laws, however, include: 1) discrepancies about the level of government or the public official responsible for enforcing and promulgating public health measures related to TB control; 2) some jurisdictions' interchangeable use of the terms "isolation" and "quarantine," posing potential for confusion about the extent of public health legal power authorized to control TB cases; and 3) although MDR-TB and XDR-TB present different threats to individual and communal health than more treatable cases of TB, five (20%) of the selected jurisdictions have laws that specifically address MDR-TB, and no jurisdiction selected specifically addresses XDR-TB.

Optimally, express TB control laws clearly define roles and responsibilities of specified actors at each level of government and authorize health officials to control the disease, while incorporating necessary safeguards to protect individual rights. While diversity among express TB control laws between jurisdictions is expected, potential gaps in individual jurisdictions' express TB control laws may present officials with opportunities for review and enhancement. These efforts may be assisted through the development and application of model legislative provisions for TB control that provide a menu of options for state and local governments to consider in developing legal regimens to address the continuing, serious threat TB poses to the public's health.

I. INTRODUCTION[b]

Despite significant achievements over recent decades in controlling the spread of tuberculosis (TB) in the United States, this communicable disease remains a major public health threat. Public health authorities at the federal, tribal, state, and local levels seek consistently to develop and apply new tools to identify and respond to thousands of TB cases nationally. Legal preparedness, as described by the Centers for Disease Control and Prevention (CDC), is an important component of public health preparedness and efforts to control the spread of TB.[3,4]

The emergence of multi drug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB) has stimulated review of the adequacy of existing public health measures and public health laws to control TB. These laws have not been systematically reviewed since the Advisory Council for the Elimination of TB (ACET) published its review of state TB control laws and recommendations for considering revisions in 1993.[5] More recent events highlight the need for such review, including the 2007 case of a U.S. citizen who travelled abroad with drug-resistant TB against public health advice.

In 2007, CDC asked the *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities* (Center) to undertake a series of projects to assist CDC and its state, tribal, and local partners in fostering improved use of law as a tool to address the spread and control of TB in the United States. These projects include (1) a review and analyses of selected jurisdictions' express TB control laws; (2) creation of a handbook on TB control laws that public health practitioners can use to improve their understanding of those laws and competency in applying them; and (3) development of a model state act on TB control (which has been specifically suggested by the Advisory Committee on the Elimination of Tuberculosis (ACET)). This report and accompanying tables address the first of these projects.

This report characterizes key domains in express TB control laws in 25 selected U.S. jurisdictions. This analysis specifically focuses on *express* TB control laws (*i.e.*, those laws that specifically address public health control measures and practices concerning TB). This report does not examine general communicable disease or other laws, even if these laws may sometimes be relevant to, or adequate for, controlling cases of TB.

This project's primary objective is to identify, review, and characterize laws that explicitly refer to controlling cases of TB (including MDR-TB and XDR-TB). The characterization of express TB control laws through this analysis is also intended to provide a modern baseline for improving competencies of public health officials and their partners to use law as a tool for TB control.

Section II of the report describes the scope and methodology of the characterization of express TB control laws presented in Tables 1 and 2. Results of the examination of these express

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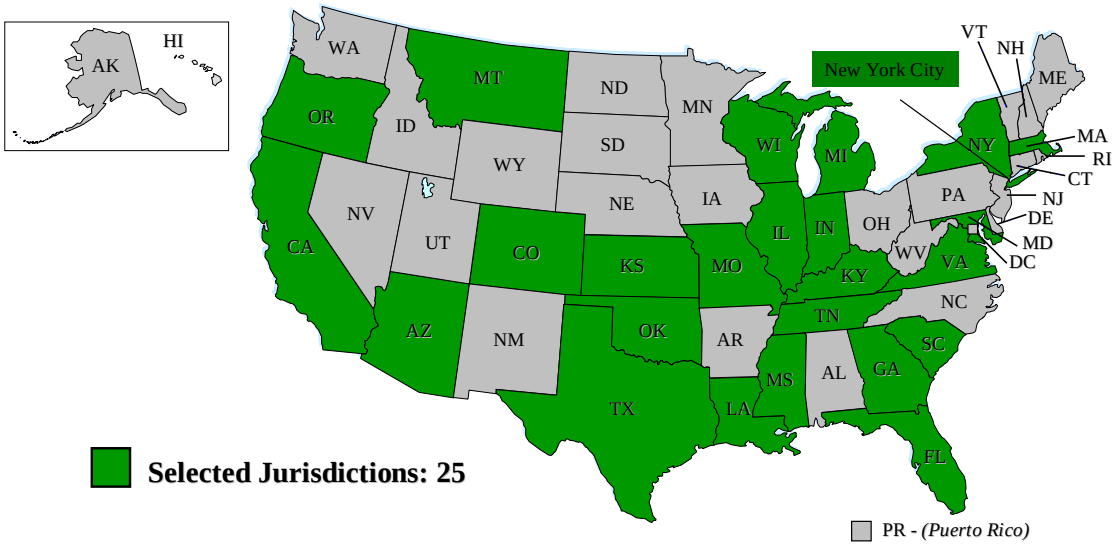
laws based on this characterization are set forth in Section III and Tables 1 and 2. Section IV provides a discussion of four predominant issues that emerged from the analysis: (1) the interface between general communicable disease laws and express TB control laws; (2) potential gaps in TB control laws across jurisdictions; (3) the nature of provisions for isolation and quarantine across jurisdictions; and (4) express provisions concerning MDR-TB or XDR-TB.

II. SCOPE AND METHODOLOGY

A. OVERVIEW

As noted, the primary research objective is to specifically identify, examine, organize, and characterize legislative, regulatory, and judicial (case) laws in 25 selected jurisdictions (see Figure 1, below)[6] that *expressly* relate to the control of cases of TB, MDR-TB, or XDR-TB through state or local health departments, other governmental agencies, and private sector partners. The 25 jurisdictions were identified by CDC's Division of Tuberculosis Elimination (DTBE) in consultation with partners. This encompasses a review of laws addressing key areas of TB control, including surveillance and reporting; investigation; testing; screening; directly-observed therapy (DOT) and other forms of treatment; quarantine and isolation; privacy and discrimination; and interjurisdictional controls. As noted throughout this report, numerous general public health laws and regulations may relate to the prevention and management of TB, but are not included in this study because they are not expressly aimed at TB.

Figure 1 – Jurisdictions Selected for the Study of Express TB Control Laws



B. DEFINITIONS

Express TB control laws refer to those jurisdiction-specific laws (*e.g.*, statutes, regulations, cases) that explicitly mention TB (or some derivative) in the body of the law, and whose main purpose is limited to the control of TB (and not the control of other communicable diseases or conditions).

TB may refer to either latent TB infection (LTBI) or TB disease (also called active TB). Individuals with LTBI usually have a positive reaction to a TB skin test, but are not infectious and therefore do not pose a threat to the public's health. Conversely, individuals with TB disease have clinical symptoms, such as fever, chest pain, or prolonged coughing, and may be infectious. TB control laws mandating reporting or screening requirements apply to TB generally, which includes both LTBI and TB disease. Other TB control laws imposing disease control measures, such as DOT, treatment, isolation, and emergency detention, apply typically to individuals with suspected or confirmed TB disease. The purpose behind such TB control measures is to protect the health of the public and that of the individual with TB disease.

C. ASSUMPTIONS

For the purposes of this report, it is assumed that every jurisdiction has some general public health legal authority that may be used to control TB cases. For example, statutes authorizing public health officials to generally control communicable diseases presumably authorize implementation of specific measures to control TB cases even if these laws do not specifically refer to TB. In Illinois, for example, the state Department of Public Health is statutorily authorized to "take means to restrict and suppress" infectious diseases, and whenever a disease "becomes, or threatens to become epidemic, … may enforce such measures as it deems necessary to protect the public health…."[7] Likewise, in Maryland, the State Secretary of Health and Mental Hygiene is statutorily authorized to "[a]ct properly to prevent the spread of disease" when the Secretary "has reason to believe that an infectious or contagious disease … that endangers the public health exists within the State…."[8] These examples illustrate the sort of broad public health authority that may allow government to respond to public health threats, including TB, even though TB is not mentioned specifically. These and other communicable disease laws may be important tools for controlling cases of TB in any jurisdiction. However, as noted elsewhere, these laws are not addressed in this report.

D. APPROACH

This report focuses on *express* laws that appear to specifically relate to controlling cases of TB, MDR-TB, XDR-TB, or any other derivatives of TB. *Express TB control laws* may grant different levels and agencies of government the authority to control TB cases solely or in partnership with private actors (*e.g.*, health care workers, hospitals, clinics). While the focus of this characterization is on public health laws, relevant provisions are included from other areas of law, such as education and penal codes. Tables 1 and 2 categorize the express TB control laws in each of the 25 selected jurisdictions based on the cited legal provisions as of May 1, 2008.

E. RESEARCH METHODOLOGY

Generally accepted legal methods of statutory and legal interpretation were used to comprehensively examine the laws of 24 states and New York City concerning express authorities for TB control. The scope of laws and other legal authorities include state statutes, administrative regulations, judicial cases, and local ordinances (for New York City only). Express TB control laws identified in this report were found through legal research engines (*e.g.*, LexisNexis, Westlaw); publicly available websites featuring state and local legal compilations; and websites of state and local health departments and other government departments. Basic search engines (*e.g.*, Google, Yahoo) also were used to (1) help corroborate information obtained through more specialized research engines (*e.g.*, LexisNexis, Westlaw), and (2) obtain hyperlinks included in **Table 1**.

Table 1 ("Characterizing Express Laws Regarding the Control of Tuberculosis in Selected U.S. Jurisdictions") organizes each jurisdiction's express TB control laws under the following major TB control categories as established in conjunction with CDC and representatives of the National TB Controllers Association (NTCA):

- Prevention of TB cases – This category focuses on preventive measures to avert TB cases and interrupt the transmission of TB. The additional category, "TB Control Programs," focuses on laws regulating TB control programs.

- Identification of TB cases – This category refers to measures designed to confirm TB cases as part of the process to control TB. This section is divided into three sub-categories:

    - Screening – Refers to provisions requiring defined populations to be systematically tested and examined for TB detection.
    - Examination & Testing – Focuses on government officials seeking or ordering an individual to undergo "diagnostic or investigative analyses or medical procedures [to] determine the presence or absence, or exposure"[9] to TB.
    - Reporting – Addresses the obligation of health care institutions, laboratories, and health care or allied health professionals who diagnose, treat, or care for TB patients to report confirmed or suspected cases to the appropriate health agencies. In some cases, this obligation includes notifying the appropriate agencies or authorities of a patient's adherence or non-adherence to treatment.

- Management of TB cases – This category focuses on measures concerning management of suspected and confirmed TB cases. This category is divided into four sub-categories:

    - Investigation – Refers to health officials' investigation of reported or suspected cases of TB, including investigation of persons who have had contact with individuals with TB disease (contact investigation or contact tracing). This category also includes investigation of treatment adherence.
    - Treatment – Refers to the provision of care and medical treatment (prophylaxis and curative) for patients with confirmed or suspected TB, including government officials ordering DOT. This category is sub-divided further into "Treatment" and "DOT."

- Specific Measures – Refers to certain measures that may be adopted for some individuals with TB disease, including:

    - Emergency detention – Detaining an individual when an immediate health threat arises.
    - Quarantine – Ordering the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to TB and do not show signs or symptoms of TB disease, from non-quarantined individuals.
    - Isolation – Ordering the physical separation and confinement of an individual or groups of individuals who have or are reasonably suspected of having TB disease from non-isolated individuals.
    - Activities restricted – Restricting individuals with TB disease from taking part in various activities, including employment.

- Enforcement – Refers to provisions that compel observance of TB-related orders, including mechanisms to implement and ensure adherence to TB-related orders.

- Safeguarding Rights – This category refers to those measures designed (or implemented) to protect TB patients' rights. This category is sub-divided into four categories:

    - Due Process – Refers to respecting a TB patient's procedural rights when implementing public health measures.
    - Confidentiality and privacy – Refers to a patient's right to privacy and the confidentiality of information relating to TB.
    - Anti-discrimination – Refers to provisions to prevent discrimination or stigmatization related to TB infection.
    - Religious exemptions – Refers to legal exemptions for medical examination or treatment of TB based on religious beliefs.

- Special Populations – This category refers to TB control measures targeting specific groups (*i.e.*, vulnerable populations including people in correctional facilities, HIV-infected persons, and indigenous communities).

- Additional TB Provisions – This category refers to additional TB control provisions not otherwise classified above, including specific measures to manage or control interjurisdictional cases.

Relevant search terms used to find express TB control laws included *tuberculosis, tuberculin, tuberculous, tubercle, tubercli,* and *sputum*. These terms were also combined with each of the public health measures identified in **Table 1**. For example, research terms also included *tuberculosis* and *isolation*; *tuberculosis* and *screening*; and *tuberculosis* and *DOT*.[10] During the course of research, new research terms emerged, such as *sputum* or *tubercle*. To ensure that results were consistent and comprehensive across jurisdictions, the identification of each new research term prompted searches using the newly found term for every jurisdiction. Research results containing specific terms such as *animal, bovine,* or *cattle*, coupled with TB or

other similar terms were excluded from review since the focus is limited to TB control laws applicable to humans.

Within each jurisdiction, these searches yielded numerous legal references from which relevant laws related to the primary research objective were selected. Results reported in **Table 1** were submitted for jurisdiction-specific review through CDC and the NTCA. Jurisdiction-specific reviews that were shared with the Center were examined and used to edit or refine the results for **Table 1**. While not all jurisdictions provided reviews, if one jurisdiction identified a new or different law that may not have been identified in the initial searches, other jurisdictions' laws were systematically re-examined for similar laws or themes. The final results of **Table 1**, as of May 1, 2008, were then summarized in **Table 2** to illustrate general patterns of express TB control laws across jurisdictions.

F. LIMITATIONS

The findings and conclusions in this report are subject to several limitations. While a draft of this report was vetted with public health and legal practitioners in many of the selected jurisdictions, its findings relating to jurisdiction-specific express TB control laws largely represent the authors' analyses and inferences (and not those of legal counsel representing each jurisdiction) regarding the extent of legal authority concerning TB control. Although a variety of electronic and other search approaches were used to identify all relevant TB-specific laws in each jurisdiction, some provisions may not have been found.

In addition, the report is limited by the scope of the research (i.e., express TB-related laws only) as requested by CDC. Clearly not all public health laws of potential significance to TB control have been examined. The exclusion of relevant general laws related to communicable disease control or other provisions precludes a complete analysis of the legal environment for controlling TB in these jurisdictions. Section IV.A discusses the interface between communicable disease laws and express TB control laws, providing examples of how general communicable disease laws may fill gaps unmet by express TB control laws.

This report also does not include an examination of all reported judicial cases, proposed legislation or regulations, agency opinions, compacts, or memorandums of agreement that may affect current or future TB control measures. Relevant international or federal laws are also not explored even though they may affect state or local express TB control laws. Except for New York City, local laws (*e.g.*, county, city), which may regulate TB control especially in larger metropolitan areas (*e.g.*, Atlanta, Chicago, Los Angeles), are not included.

Finally, this report's characterization of express TB control laws is based solely on the findings from the selected 25 jurisdictions. Other jurisdictions' laws may provide differing approaches to and authorities for TB control. Opportunities for long-term, longitudinal follow-up to examine express TB control laws may be limited to the 25 jurisdictions selected for this study.

III. RESULTS: CHARACTERIZATION OF EXPRESS TB CONTROL LAWS[c]

A. PREVENTION OF TB CASES (TB CONTROL PROGRAMS)

This section focuses on express laws concerning measures to prevent TB and impede its transmission, as well as laws establishing and regulating TB control programs. In 21 (84%) jurisdictions, express TB control laws seem to authorize various levels of government to establish and regulate TB control programs. In many jurisdictions, this obligation is assigned to state government (*e.g.*, AZ, CO, IN, KS). In California, however, local governments are apparently required to maintain TB control programs to receive state aid.

The scope of these express TB control laws varies considerably. For instance, some jurisdictions' laws appear to designate a specific agency or state/local official to design, implement, or regulate TB control programs (*e.g.*, AZ, CO, FL, SC). Other jurisdictions seem only to have a general government obligation to establish TB control programs (*e.g.*, CA, KY, LA, MT, NY). A Florida provision seems to require the state legislature to allocate sufficient funds for maintaining TB control programs. Other legal provisions, in Arizona and Kentucky, for example, seem to refer to interjurisdictional collaboration among different levels of government - federal, tribal, state, and local - in developing TB control programs.

Express TB control laws also vary on the specific characteristics and objectives of TB control programs. Some jurisdictions feature TB control programs targeting specific groups, such as people living in high-risk congregate settings (*e.g.*, IL, MD, TN) or prisons (*e.g.*, TX, VA). Other jurisdictions refer to programs addressing TB control measures for the general population without specifying certain groups (*e.g.*, CA, FL, LA, MT). Express TB control laws in Arizona and Colorado appear to specifically address MDR-TB in their TB control programs.

B. IDENTIFICATION OF TB CASES

This section refers to express laws designed to detect and confirm TB cases as part of the process to control TB. Twenty-four (96 %) jurisdictions[11] appear to have express TB control laws concerning the identification of TB cases.

1. Screening

Screening generally refers to the requirement that defined populations be tested and examined for the detection of TB. All 25 (100%) jurisdictions appear to have express TB control laws addressing screening as a TB control measure.

Most of the jurisdictions' laws appear to identify specific groups or classes of individuals that are subject to TB screenings. Some jurisdictions, such as Colorado and Maryland, also require health care providers to maintain a registry of TB screenings. In Colorado, TB screenings are generally limited to individuals who are at a higher risk for TB infection or disease. State or

[c] Throughout the report, presentations of findings concerning specific jurisdictions or aggregate jurisdictions represent the authors' analyses and inferences (and not legal counsel representing each jurisdiction) regarding the extent of legal authority concerning TB control.

local health authorities in Colorado may also develop voluntary screening programs. Oregon requires health care facilities to follow TB screening recommendations set forth in CDC guidelines. In some cases, TB screening is established as a condition for employment (*e.g.*, CA, IN, MT). In Maryland, screening of volunteers at comprehensive care facilities is recommended, but not mandated. Illinois is apparently the only jurisdiction that differentiates screening of persons with active TB as contrasted with those with non-active TB.

Jurisdictions' express TB control laws appear to require an array of groups or individuals to be screened for TB. Examples include:[12]

- Close contacts of suspected or confirmed TB cases (IL, OK);
- State employees seeking compensation after contracting TB (GA);
- City and county park, beach, and recreation center employees and concession stand operators (CA);
- School employees (*e.g.*, CA, IL, MT, NYC, SC, TN, VA, WI):
    - Limited to school employees who are in contact with pupils (KS);
    - Limited to employees supervising children at state residential educational facilities (MD);
    - Limited to individuals at risk (KY);
    - Limited to school employees who are symptomatic (AZ);
- Students (*e.g.*, IL, KY, TX):
    - Limited to all new entrants to a secondary school (NYC);
    - Limited to students in health care professions (LA);
    - Limited to foreign students at state universities (IN);
- Community college employees (CA);
- Hospital employees (*e.g.*, AZ, NY, OK, SC);
- Employees in health care facilities (*e.g.*, CA, IL, IN, KS):
    - Limited to pre-employment and annually thereafter (KY);
    - Limited to those in contact with patients (SC);
    - Limited to birth center employees (*e.g.*, GA, IN, MA);
    - Limited to employees at abortion clinics (IN);
    - Limited to employees of nursing facilities (*e.g.*, CA, KY, MI, MO)
- Residents of nursing care institutions (*e.g.*, LA, OR);
- Prisons:
    - Limited to employees (*e.g.*, MS, TX)
    - Limited to employees who are in contact with inmates (CA);
    - Limited to inmates (*e.g.*, CA, LA, MA, MI, TN);
    - Limited to volunteers (TX);
- Minors (*e.g.*, CA, NY) and employees (*e.g.*, CA, KS, MD, OK) in juvenile detention facilities;
- Applicants to adopt a child (NY);
- Prospective foster parents (GA, NY);
- Employees and volunteers in foster homes (KS, MA);
- Persons with HIV/AIDS who are receiving treatment for such conditions (LA); and
- Police officer candidates (NY).

2. Examination and Testing

Medical examination and testing generally refer to decisions to physically examine and/or test an individual for TB based on a clinical evaluation. Express TB control laws may authorize government officials to seek or order an individual to be subject to "diagnostic or investigative analyses or medical procedures [to] determine the presence or absence, or exposure" of or to TB.[13] Express TB control laws in 22 (88%) jurisdictions appear to authorize different levels of government to examine and test individuals for TB. In some jurisdictions (*e.g.*, AZ), a court order is required for an individual to undergo TB examination when an individual refuses to voluntarily be examined. In other jurisdictions (*e.g.*, OK), health authorities appear to be authorized to order examination without a court order. In Illinois, all persons suspected of having TB disease must undergo diagnostic evaluation. In Massachusetts, health authorities appear to be authorized to order TB examinations only when an individual tests positive for TB.

3. Reporting

Reporting refers to the requirement that specified health care professionals or laboratories notify public health agencies of a positive finding of TB among individual cases. In all 25 (100%) jurisdictions selected for this study, express TB control laws appear to establish reporting requirements. In some cases, health care institutions, laboratories, and health professionals who diagnose, treat, or care for TB patients appear to be obligated to report confirmed or suspected TB cases to appropriate health agencies. In other cases, this obligation extends to notifying the appropriate agencies or authorities of a patient's adherence with treatment. Health care professionals (*e.g.*, IL, KY, MI) and laboratories (*e.g.*, CA, FL, KS) seem to be required to report confirmed or suspected cases of TB to appropriate health authorities, typically local and state health authorities (*e.g.*, FL, GA, KY). In California, the Department of Corrections must notify the state health department of TB cases in the inmate population. In some states (*e.g.*, AZ), the local health department must report cases to the state TB control officer. In other jurisdictions (*e.g.*, IL), local health authorities must report cases of TB to state health authorities.

C. MANAGEMENT OF TB CASES

This section specifically focuses on measures concerning management of suspected or confirmed TB cases. The following sub-sections provide a more detailed assessment of the different public health interventions, including investigations; treatment and DOT; and other specific measures (detention, quarantine, isolation, and restricted activities).

1. Investigation

Investigating individuals with reported or suspected TB is an important component of case management. This includes investigation of (a) persons who have had contact with individuals with TB disease (contact investigation or contact tracing), and (b) persons undergoing treatment for TB. Express TB control laws in 17 (68%) jurisdictions appear to address aspects of TB investigations. In Arizona, health officials appear to be authorized to

investigate reported cases of TB. In California and Colorado, health officials appear to be authorized generally to use all available means to investigate reported or suspected TB cases. In Colorado, broad investigative powers appear to include the ability to order examination, quarantine, or isolation as needed for investigative purposes. In Indiana, health authorities seem to be authorized to investigate contacts of confirmed or suspected TB cases. In Kansas, health authorities are apparently required to periodically investigate whether TB patients are following precautions and treatment.

2. Treatment and DOT

This sub-section discusses the provision of care and medical treatment to patients with confirmed or suspected TB either through (a) treatment or (b) DOT.

Treatment. In 24 (96%) jurisdictions, express TB control laws appear to authorize health authorities to prescribe appropriate treatments for TB patients. For instance, laws in California and Kansas appear to authorize local health officials to order TB patients to follow specific TB treatments. Forcible treatment appears to be prohibited in California without a court order, except in corrections facilities. In Massachusetts, treatment for TB must apparently comply with the standards established by CDC and the American Thoracic Society. In Colorado, express TB control laws appear to (1) require the state to provide treatment and assistance to TB patients if they are unable to pay for such services; (2) preclude using residency requirements as deterrents to providing treatment services; and (3) require hospitalization for treatment through the state health department for persons with MDR-TB.

DOT. DOT has been identified by domestic and international health agencies as an important method of treatment for TB and essential public health intervention to limit the development and/or spread of MDR-TB and XDR-TB.[14] However, express TB control laws appear to authorize DOT in only 13 (52%) jurisdictions. In some jurisdictions, health authorities appear to be required to obtain court orders for mandatory DOT (*e.g.* AZ, MT), although in California, health authorities may apparently may order DOT without seeking advance court approval.

Some jurisdictions (*e.g.*, CO, IN, OK) consider DOT the appropriate standard of treatment for persons with TB. In Colorado, TB patients apparently must be treated through DOT unless the department of public health approves an alternate treatment. In other jurisdictions, DOT is authorized apparently in specific circumstances. In Wisconsin, DOT may be ordered when a TB patient is unwilling to adhere to health officials' orders. In California and New York City, DOT may be ordered when a TB patient is unable or unwilling to complete a prescribed course of treatment. In Louisiana, DOT must be negotiated as part of a voluntary compliance agreement; if, however, a patient does not adhere, state health authorities may order DOT. In Florida, all individuals diagnosed with TB disease are placed on a treatment plan, which includes the provision of DOT.

3. Specific Measures

Multiple public health interventions are aimed at controlling the spread of TB once individuals with suspected or confirmed TB disease have been identified. As discussed below, these include powers of emergency detention, quarantine, isolation, and the ability to restrict personal activities.

Emergency detention. Under certain circumstances and pursuant to prescribed requirements, public health authorities may detain an individual when immediate health threats related to TB disease arise. In 17 (68%) jurisdictions, express TB control laws seem to authorize multiple levels of government to order emergency detention of individuals having or reasonably suspected of having TB disease.

In some jurisdictions (*e.g.*, AZ, FL, LA), it appears that emergency detention may be ordered as a precautionary measure when individuals have or are reasonably suspected of having TB disease and pose a risk to others. Emergency detention can also be used as an enforcement measure when TB patients fail to adhere to treatment or other public health orders (*e.g.*, AZ, CA, LA). In California, emergency detention may be used when a TB patient has a history of non-adherence to TB treatment and there is sufficient evidence to believe the patient will not complete a prescribed course of treatment.

Some express TB control laws appear to directly authorize health authorities to order emergency detention. In Arizona, health authorities are apparently authorized to issue emergency detention orders. In California, prior court orders for emergency detention are not required, but a hearing to determine whether detention may continue must be held within 72 hours after a person requests release. In other states (*e.g.*, GA, MT, SC), express TB control laws appear to require court orders prior to detaining a patient with TB. At least one state, Massachusetts, appears to authorize health officers to order a short-term detention for observation purposes. After this short term elapses, health authorities must obtain a court order to continue the detention.

Quarantine. Quarantine refers to the physical separation and/or confinement of an individual or groups of individuals, who have or may have been exposed to TB but do not show signs or symptoms of TB, from others to prevent or limit the transmission of the disease. Express TB control law in one (4%) jurisdiction (MS) refers specifically to the power to quarantine persons. However, as discussed in Section IV.C. below, express TB control laws often refer to "quarantine" and "isolation" interchangeably. As a result, public health interventions categorized as "quarantine" may actually involve "isolation." Based on these observations, the quarantining of persons who have been exposed to TB, but are not known to actually be infected, appears to be authorized only in Mississippi, where medical directors in correctional facilities can apparently quarantine individuals for screening purposes.

Isolation. Isolation refers to the physical separation and confinement of an individual or groups of individuals, who have or are reasonably suspected of having TB disease, from others who do not have suspected or confirmed TB disease. Express TB control laws appear to authorize the use of isolation in 22 (88%) jurisdictions. While in some jurisdictions (*e.g.*, IN, MA) express TB control laws appear to grant health authorities general powers to isolate individuals, other jurisdictions limit these powers. In Louisiana, isolation may apparently be

ordered when a TB patient does not adhere to DOT and more generally for failure to seek voluntary treatment. In Florida, Arizona, and New York, isolation must be ordered by courts.

Express TB control laws in Colorado appear to grant the Chief Medical Officer general powers to impose isolation measures when deemed necessary. Isolation orders must be in writing and may not exceed 6 months in duration. Colorado also apparently authorizes isolation of MDR-TB patients when they fail to comply with treatment. In Illinois, express TB control laws seem to recommend continuous isolation for patients with MDR-TB who seek in-patient services. In some jurisdictions, TB patients may be isolated at home (*e.g.*, FL, IL, CA, IN, MD, WI) or in health care facilities (*e.g.*, IN, MD). In other jurisdictions, (*e.g.*, AZ, MT, OR), TB patients may be isolated until they are no longer infectious. California and Texas appear to expressly authorize the isolation of inmates.

Restricted Activities. In 20 (80%) jurisdictions, express TB control laws appear to authorize restrictions on persons with TB disease from taking part in specific activities, including certain kinds of employment. In some jurisdictions, individuals with TB disease may be excluded from employment (*e.g.*, CA, NYC, TN, WI), or denied employment in schools (*e.g.*, CA, MD, MS, VA, WI). Licensed optometrists in Texas and midwives in Georgia apparently may not practice if they have TB disease. Georgia also apparently excludes private home care providers with TB disease from working directly with clients. In Oklahoma, persons with TB disease in a communicable stage are not allowed to enter places where exposed or unpacked edible products are prepared, processed, or handled. Oregon law seems to prohibit persons with TB disease in a communicable stage from working in any occupation in which they provide personal care to, or have direct contact with, patients in health care facilities.

4. Enforcement

In 19 (76%) jurisdictions, express TB control laws appear to compel observance of TB orders and provide health authorities with enforcement mechanisms. Express TB control laws grant health officials enforcement mechanisms when TB patients fail to adhere voluntarily to health authorities' orders related to examination, testing, treatment, and isolation. In Colorado, health authorities seem to be empowered to isolate MDR-TB patients who fail to follow a prescribed course of treatment.

In some jurisdictions, it appears that failure to adhere to orders of health officers (*e.g.*, CA, CO, SC) or courts (*e.g.*, AZ) constitutes a misdemeanor. In Florida, TB patients who fail to follow treatment plans or do not adhere to court orders may be punished by contempt proceedings and penalties. In Louisiana, criminal charges may be filed against TB patients who do not adhere to court orders for quarantine or isolation. In California and Colorado, health officials must apparently notify the district attorney when TB control orders have been violated.

Civil commitment is used as an enforcement mechanism in some jurisdictions. In Montana, courts must order commitment for examination or treatment purposes when TB patients fail to adhere to an examination or treatment order issued by a court. When all reasonable means to obtain voluntary adherence have been exhausted, Florida health authorities may apparently request courts to enforce such orders. Enforcement mechanisms in some cases

also apply to reporting requirements. Failure to comply with TB reporting requirements in Colorado, for example, appears to constitute a misdemeanor. In Florida, express TB control laws seem to authorize the state Department of Health to adopt enforcement measures for individuals who do not adhere to TB treatment.

D. SAFEGUARDING RIGHTS AND FREEDOMS

This section discusses express TB control laws that are intended to protect or safeguard TB patients' rights. This includes laws protecting due process rights, confidentiality, privacy, and antidiscrimination, as well as laws detailing religious exemptions with specific reference to TB.

1. Due Process[d]

In 17 (68%) jurisdictions, express TB control laws address procedural rights of a person with confirmed or suspected TB disease who is subject to public health measures. In some jurisdictions, detailed due process provisions require health authorities to obtain a court order before seeking to impose public health measures. In other jurisdictions, court orders are required only when seeking to enforce TB control measures that have been undertaken. In Arizona, for example, courts appear to be required to appoint an attorney to represent the rights of a TB patient if the patient cannot afford an attorney, and TB control officers must provide written information of the patient's rights. In California, forcible or involuntary treatment appears to be authorized only by a court order (except in relation to inmates and wards).

In Wisconsin, confinement orders that exceed 72 hours must be granted by courts pursuant to health authorities' showing that: (i) the individual has infectious TB, the individual has noninfectious TB but is at high risk of developing infectious TB, or the individual has suspect TB; (ii) the individual has failed to comply with treatment or any TB-related rules promulgated by the department of health, or the individual's TB disease is resistant to prescribed medications; (iii) all reasonable means of achieving voluntary compliance with treatment have been exhausted and there are no "less restrictive alternatives" available; and (iv) the individual poses an imminent and substantial threat to him/herself or to the public health. Persons subject to court proceedings in Wisconsin seem to have the right to appear in the hearing, defend themselves, present evidence, cross examine witnesses, and other explicit protections.[15]

2. Confidentiality and Privacy

Express TB control laws in 11 (44%) jurisdictions 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 held confidential. Health authorities may apparently 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 Florida, information and health

[d] "Due process," as described in this section, generally refers to procedural due process protections that each jurisdiction may require pursuant to constitutional principles or other legal or policy purposes. Some jurisdictions' due process measures may exceed specific requirements pursuant to federal or state constitutions. These measures may also include substantive due process components, although this section focuses on procedural mechanisms.

records of TB patients are deemed confidential and may apparently be released only under specific circumstances. The Florida Department of Health also may consider the protection of confidentiality and privacy of TB patients when developing TB reporting rules. It appears that Florida courts are required to protect the names of TB patients from public disclosure. In some jurisdictions (*e.g.*, CO, MD, SC), laboratory reports of persons with TB are apparently deemed confidential.

3. Antidiscrimination

In 2 (8%) jurisdictions, express TB control laws appear to be directed at preventing discrimination or stigmatization related to TB disease. Colorado law appears to ensure access of individuals to TB services by specifically noting that TB services must be provided regardless of race, religion, gender, ethnicity, national origin, or immigration status. Texas law appears to restrict state hospitals from discriminating against a TB patient when providing medical care and treatment and requires hospitals to provide equal services to all TB patients.

4. Religious Exemptions

In 9 (36%) jurisdictions, express TB control laws appear to consider individuals' religious beliefs when public health authorities implement some public health interventions for TB control, such as examination and treatment. In Arizona, a TB patient may be exempt from court-ordered TB treatment when the patient claims a religious exemption. In California, waiving treatment and examination based on the person's religious beliefs appears possible only if the person is subject to quarantine or isolation. Colorado laws appear to apply religious exemptions only to examination, reporting, and isolation measures. However, treatment and confinement may apparently be waived based on religious beliefs if the person can be isolated at home. Colorado also appears to authorize the waiver of screening requirements based on religious beliefs. Illinois law seems to explicitly forbid inmates from claiming a statutory right to refuse treatment for TB based on religious exemption. In Kentucky, immunization and testing of a child for TB may apparently be waived based on the parents' religious beliefs.

E. Considerations for Special Populations

This section refers to express TB control laws in 11 (44%) jurisdictions that appear to target specific groups or populations. Legal provisions focused on special populations appear to extend to people with visual or hearing impairments in California and Arizona. They also include consideration for language barriers and provision of translation services. Some jurisdictions (*e.g.*, CA, FL, GA, MA, MI, SC) seem to consider special circumstances of prisoners or incarcerated persons. In Texas, express TB control laws appear to authorize health authorities to establish a separate school for the education and care of children with TB. In Arizona, required notices explaining TB patients' rights must be written in the person's primary language. In Massachusetts, prison inmates must apparently receive TB treatment and, if necessary, be isolated. Before releasing inmates, Massachusetts' corrections facilities apparently must notify the Department of Public Welfare and keep inmates in treatment at the correction facility until the Department provides for their care and treatment.

F. ADDITIONAL TB PROVISIONS

This section refers to additional TB control provisions in 16 (64%) jurisdictions that are not otherwise classified in the above categories. A notable proportion of these additional provisions refer to interjurisdictional coordination of TB control activities. Eight (32%) jurisdictions (AZ, CO, IN, KS, NY, OK, TN, TX) feature such provisions. These provisions often seem to provide, as in Arizona, guidance on how public health officials can cooperate with officials from other jurisdictions and from different levels of government (*e.g.*, local, state, tribal and federal). For example, a Tennessee provision seems to authorize state officials to notify public health officers in other jurisdictions when a person with TB in Tennessee moves to another jurisdiction to ensure that the person completes treatment. As in New York, some of these provisions also appear to specify when and how persons with TB may cross jurisdictional lines. Indiana apparently requires local health officers to notify the state department of health whenever a person with TB moves into or out of the local jurisdiction. Kansas law appears to allow the state health authority to return anyone with TB, who has not been resident for at least one year prior to entering a Kansas health facility for TB care, to the person's state of origin.

Additional elements of express TB control laws include issues concerning civil liability, health education, duty to warn, visitation rights, and disposal of bodies of deceased persons with TB. In Georgia, for example, health care professionals who admit or discharge persons with TB appear to be immune from civil liability when acting in good faith. Massachusetts law appears to require instruction on TB in students' health curriculum. Express TB control laws in Michigan and Missouri refer to the visitation rights of nursing home patients. At least two states (MS and OR) provide guidance concerning the treatment and handling of decedents who had TB.

IV. DISCUSSION – KEY ISSUES IN EXPRESS TB CONTROL LAWS

A. GENERAL COMMUNICABLE DISEASES LAWS VS EXPRESS TB CONTROL LAWS

Primary objectives of this report are to identify and characterize express TB control laws in selected U.S. jurisdictions. As underscored in Section II.C., the scope of this study excludes general communicable disease laws. In many (if not all) U.S. jurisdictions, general communicable disease laws and express TB control laws likely provide an overlapping regulatory framework for controlling TB. Thus, it is crucial to acknowledge and emphasize the interface between these laws.

For example, this report did not identify express TB control laws addressing investigation of TB cases in Massachusetts. However, a general communicable disease statute in Massachusetts states that "[t]he Department [of Public Health] and local boards of health are authorized to conduct surveillance activities necessary for the investigation, control and prevention of diseases dangerous to the public health."[16] Because TB may be considered a dangerous disease that threatens public health, this legal provision appears to grant Massachusetts' health authorities broad investigative powers that apply to TB (as well as other

diseases). However, this Massachusetts provision is not included in this study because it is not an express TB control law as defined in Section II.B.

B. Potential Legal Gaps and Related Issues

Potential legal gaps or ambiguities among the selected jurisdictions were identified through the research for this report. In some jurisdictions, public health measures appear to be authorized without specification as to which level of government or health authority must implement such measures. Although these laws authorize specific public health measures to control TB, it is unclear who is responsible for implementation. For example, in some jurisdictions, express TB control laws establish screening or reporting requirements but do not clarify who in public or private sectors is responsible for implementing these requirements.

In some jurisdictions, confusion could arise from laws providing enforcement mechanisms for implementing public health interventions that have not been expressly granted to any level of government. For example, some jurisdictions establish penalties for non-adherence to a specific public health intervention that is not expressly regulated. This ambiguity and apparent gap, which may be attributed to overlapping general communicable diseases laws and express TB control laws, could complicate implementation and enforcement measures.

Potential gaps also exist between laws authorizing screening for TB and restricting activities of individuals with TB disease. There is an implicit connection between these two categories since in most cases screening provisions may set pre-conditions for employment or other activities for specific populations. Screening used as a precondition for employment is intended to restrict (or limit in some form) the participation of individuals with TB disease in such activities. In some cases, the connection between a screening requirement and restricted activity is explicit. In other cases, however, there is no explicit connection between screening results and restricted activities. TB screening laws in many jurisdictions are thus limited to listing individuals who are subject to screening without elaborating on the consequences of positive screening results.

C. Isolation and Quarantine Provisions

Express TB control laws often use the terms “isolation” and “quarantine” interchangeably. As explained in Section III.C.3, above, examination of these provisions revealed that while 11 (44%) jurisdictions use the term quarantine, 10 (40%) refer to “quarantine” in relation to public health powers that actually involve isolation. For example, after treatment is prescribed for a person who is confirmed to have TB disease, some jurisdictions’ express TB controls laws appear to authorize non-adherent patients to be “quarantined,” rather than “isolated.”

Equating the terms “quarantine” and “isolation” is likely a vestige of older express TB control laws that may not have been revised to reflect modern conceptions and public health practices. While existing express TB control laws or general communicable disease laws in each jurisdiction may sufficiently allow public health officials and legal actors to effectively control

cases of TB, equating quarantine and isolation powers through law is inconsistent with modern public health practices that distinguish these coercive powers.

D. SPECIFIC PROVISIONS CONCERNING MDR-TB AND XDR-TB

MDR-TB and XDR-TB have emerged as prevalent, distinct threats to the public's health over the past two decades. Correspondingly, public health responses for MDR- or XDR-TB cases may differ from responses to drug-susceptible active TB cases. However, laws of most jurisdictions selected for this study largely do not distinguish between drug-resistant and drug-susceptible cases of TB. Five (20%) jurisdictions' express TB control laws (AZ, CA, CO, GA, and IL) appear to address MDR-TB, and no jurisdiction's laws specifically address XDR-TB.

Of the jurisdictions addressing MDR-TB, Arizona and Colorado appear to provide specific measures for control, treatment, and isolation of MDR-TB cases. Under Arizona law, a diagnosing health care provider or an administrator of a health care institution is required apparently to isolate and institute airborne precautions for individuals with MDR-TB disease until approval of release by the TB control officer. Colorado law seems to require that the executive director of the Department of Public Health implement a TB control program that includes (1) working with hospitals to provide treatment for individuals with MDR-TB, and (2) ongoing program oversight to prevent the spread of MDR-TB. Furthermore, Colorado law appears to specifically authorize the state Chief Medical Officer to order isolation or quarantine of patients who have MDR-TB disease and have stopped treatment, regardless whether they are contagious.

In contrast, references to MDR-TB in California, Georgia, and Illinois do not appear to create any special powers or obligations for public health authorities. The legal provision mentioning MDR-TB in California notes that positive MDR-TB tests are among the positive TB tests that laboratories are required to report to local health authorities. Georgia law appears to suggest that persons with active TB who refuse to complete treatment present a threat to society because they could consequently develop MDR-TB. Illinois law seems to recommend that isolation be considered for individuals with MDR-TB at inpatient health facilities.

V. CONCLUSION

Consistent with legal preparedness for other public health threats, laws are an essential component of TB prevention, treatment, and control efforts. Optimally, express TB control laws should clearly relate to competencies for each level of government and provide health authorities with clear and sufficient powers to control the disease while safeguarding individual rights. This report identifies some areas of relative uniformity against a backdrop of extensive legal variations among selected U.S. jurisdictions' express TB control laws.

As documented in **Table 2**, each of the 25 selected jurisdictions appear to have some type of express TB law. Several jurisdictions (*e.g.*, AZ, CA, CO, GA) appear to have express TB control laws addressing most of the categories identified as relevant for TB control. Other jurisdictions' express TB control laws (*e.g.*, MI, NY, OR) appear to address considerably fewer of the categories. However, as explained above, this does not necessarily mean that these

jurisdictions lack a comprehensive legal framework for TB control. Since this characterization excludes general communicable disease laws, and such laws may provide an adequate framework for controlling TB, assessment of the sufficiency of any jurisdictions' legal framework for TB control is beyond the scope of this report.

The presence and scope of express TB control laws vary widely between jurisdictions. Express TB control laws in most of the selected jurisdictions seem to regulate public health interventions oriented at identifying cases of TB (all of the 25 jurisdictions feature screening and reporting provisions, and 22 (88%) feature examination and testing requirements). However, jurisdictions were less likely to feature express TB control laws concerning the safeguarding of patients' rights. Only 2 (8%) had antidiscrimination provisions, 9 (36%) had religious exemptions, and 11 (44%) had confidentiality or privacy provisions, and 17 (68%) had due process provisions.

This report shows that there is diversity in express TB control laws across the 25 selected jurisdictions. Some jurisdictions have recently revised their statutes (*e.g.*, OK). Others are in the process of considering legislative amendments or other changes (*e.g.*, SC). Such efforts may be facilitated through the use of assessment tools such as model legal provisions, which, if widely used, may foster greater consistencies among express TB control laws across jurisdictions.

REFERENCES:

[1] The *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities* acknowledges a number of contributors to the development and review of this report. This includes the following persons at the Center who provided research, editing, or drafting assistance, notably Ben Berkman, JD, MPH; Evan Anderson, JD, James Tsai, JD, Katrina Pagonis, JD, MPH, LLM; Karen Sokol, JD; Mimi Johnson, MPhil; Alice Suh; Simisola Akintola, JD, LLM; Alia Udhiri; Michelle Price; Morgan Rog; and P.J. Wakefield.

[2] The selected jurisdictions are: AZ, CA, CO, FL, GA, IL, IN, KS, KY, LA, MD, MA, MI, MO, MS, MT, NYC, NY, OK, OR, SC, TN, TX, VA, and WI.

[3] 2007 National Action Agenda for Public Health Legal Preparedness, JLME, Vol. 36:1 (Supp. Spring 2008).

[4] Moulton, A, Gottfried, R, Goodman, R, Murphy, A, Rawson, R What is public health legal preparedness? *The Journal of Law, Medicine & Ethics.* 2003: Winter;31(4):672-83.

[5] CDC. Tuberculosis Control Laws – United States 1993. *MMWR* 1993; Vol. 42 No. RR-15 (available at http://www.cdc.gov/mmwr/pdf/rr/rr4215.pdf) (October 1, 2008).

[6] The selected jurisdictions are: AZ, CA, CO, FL, GA, IL, IN, KS, KY, LA, MD, MA, MI, MO, MS, MT, NY, NYC, OK, OR, SC, TN, TX, VA, and WI.

[7] 20 ILCS 2305/2 § 2(a).

[8] MD CODE, HEALTH - GENERAL, § 18-102(b).

[9] The Turning Point Model State Public Health Act: A Tool for Assessing Public Health Laws (available at http://www.publichealthlaw.net/ModelLaws/MSPHA.php (August 13, 2008).

[10] The specific databases used within research engines such as *Westlaw* are the following. For Statutes, we first used "Statutes by State database". In this database, we conducted individual searches per each state. The terms used were the following: tuberculosis, TB, tubercular, tubercle, tubercli, tuberculin, sputum, tuberculous (excluding terms such as bovine, animal). We also used a truncation function and research for "tuberc!". Within each state, when available, we also searched on the "general index database" for terms such as Tuberculosis or TB. Regarding 'Regulations', within each states we used the 'Administrative Code' database. The terms used in the research were the following: tuberculosis, TB, tuberc! (truncation function). Terms excluded were bovine and animal. Regarding 'Case law' research was conducted in a two-fold manner. First, when researching legislation in annotated codes, we reviewed

the cases mentioned in the annotations. Secondly, in the "All States" case law database, we searched terms such as tuberculosis and tuberc! (truncation function), while excluding some terms (*e.g.* animal, bovine, cattle).

[11] According to **Table 1**, each public health objective is comprised of one or more "public health interventions." By adding the number of jurisdictions that implement each public health intervention within a specific public health objective and dividing it by the number of public health interventions covered under that objective an average of the number of jurisdictions per PH objective is calculated. In this case, 'Identification of TB cases' comprises three public health interventions, namely, screening (25 jurisdictions), examination and testing (22 jurisdictions) and reporting (25 jurisdictions). Thus, the average number of jurisdictions that address this public health objective is 24. Please refer to **Table 2** for a more detailed assessment.

[12] Please note that this list it is not comprehensive. For a more detailed assessment of the variety of groups that are subject of screening provisions see **Table 1**.

[13] The Turning Point Model State Public Health Act: A Tool for Assessing Public Health Laws (available at http://www.publichealthlaw.net/ModelLaws/MSPHA.php (August 13, 2008).

[14] *See, e.g.*, CDC. Treatment of Tuberculosis – American Thoracic Society, CDC, and Infectious Diseases Society of America. MMWR 2003; Vol. 52 No. RR-11 (available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm). DOT is an important public health intervention to limit the spread of all cases of TB, and also is designed to help prevent the development of MDR-TB and XDR-TB. Patients risk development of drug-resistant TB when treatment is interrupted or medication is not taken as prescribed. Treatment for drug-susceptible TB takes at least 6 months which increases the likelihood of non-adherence, making DOT an important intervention to prevent development of drug-resistant forms of TB.

[15] Wis. Stat. Ann. § 252.07(9).

[16] 105 Mass. Code Regs. 300.190.

Table 1: Characterizing Express Laws Regarding the Control of Tuberculosis in Selected U.S. Jurisdictions

Disclaimer *– Information in this document does not represent the official legal positions of the U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention/HHS, or state or local governments, and is not meant to provide specific legal guidance or advice. Thus, users of this report, including state and local officials, should consult with their state and local attorneys and legal advisors for a more complete review of laws and policies pertaining to tuberculosis control.*

Introduction. Tuberculosis (TB), which remains a considerable public health threat in the U.S., requires public health agencies at the federal, state, tribal, and local levels to develop and apply new tools to address cases of TB nationally. CDC – through its Division of TB Elimination (DTBE) and its Public Health Law Program (PHLP) – has determined that legal preparedness is an important framework for addressing this problem.

CDC asked the *Centers for Law and the Public's Health: A Collaborative at Johns Hopkins and Georgetown Universities (Center)* to engage in a series of projects to improve understanding and use of law to control TB. This table presents detailed information on the express TB control laws of 25 selected jurisdictions as of May 1, 2008.Table 2 presents a summary of this information.

Scope. The project's research objective was to specifically examine, organize, and characterize legislative, regulatory, or judicial (case) laws across 25 jurisdictions (*i.e.*, 24 states and one locality, NYC) that *expressly* relate to the control of cases of TB, MDR-TB, or XDR-TB through state or local health departments, other governmental actors, and private sector partners. Selection of these jurisdictions was based on several considerations, including TB prevalence, population characteristics, and other factors. The selected jurisdictions are: AZ, CA, CO, FL, GA, IL, IN, KS, KY, LA, MD, MA, MI, MS, MO, MT, NY, NYC, OK, OR, SC, TN, TX, VA, and WI.

This characterization entails a review of legislation, regulations, and cases in the selected jurisdictions that expressly address key issues of TB control, such as reporting, investigations, testing, screening, treatment, directly-observed therapy, quarantine, isolation, privacy, discrimination, case management, and interjurisdictional controls. By comprehensively characterizing these laws across multiple legal themes and among multiple actors, critical legal issues concerning express TB control laws may be explored.

Please note - the focus of this characterization is on *express* TB control laws. Accordingly, the Table does not reference general communicable disease laws or other public health laws in any of the selected jurisdictions despite their potential use or relevance in TB control.

Table Explanation: The Table below organizes express TB control laws under 6 main categories:[1, 2]

- Prevention of TB cases – This category focuses on preventive measures to avert TB cases and interrupt the transmission of TB. The additional category, "TB Control Programs," focuses on laws regulating TB control programs.

- Identification of TB cases – This category refers to measures designed to confirm TB cases as part of the process to control TB. This section is divided into three sub-categories:

    - Screening – Refers to provisions requiring defined populations to be systematically tested and examined for TB detection.
    - Examination & Testing – Focuses on government officials seeking or ordering an individual to undergo "diagnostic or investigative analyses or medical procedures [to] determine the presence or absence, or exposure"[3] to TB.
    - Reporting – Addresses the obligation of health care institutions, laboratories, and health care or allied health professionals who diagnose, treat, or care for TB patients to report confirmed or suspected cases to the appropriate health agencies. In some cases, this obligation includes notifying the appropriate agencies or authorities of a patient's adherence or non-adherence to treatment.

- Management of TB cases – This category focuses on measures concerning management of suspected and confirmed TB cases. This category is divided into four sub-categories:

    - Investigation – Refers to health officials' investigation of reported or suspected cases of TB, including investigation of persons who have had contact with individuals with TB disease (contact investigation or contact tracing). This category also includes investigation of treatment adherence.
    - Treatment – Refers to the provision of care and medical treatment (prophylaxis and curative) for patients with confirmed or suspected TB, including government officials ordering DOT. This category is sub-divided further into "Treatment" and "DOT."
    - Specific Measures – Refers to certain measures that may be adopted for some individuals with TB disease, including:

        - Emergency detention – Detaining an individual when an immediate health threat arises.
        - Quarantine – Ordering the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to TB and do not show signs or symptoms of TB disease, from non-quarantined individuals.
        - Isolation – Ordering the physical separation and confinement of an individual or groups of individuals who have or are reasonably suspected of having TB disease from non-isolated individuals.
        - Activities restricted – Restricting individuals with TB disease from taking part in various activities, including employment.

- Enforcement – Refers to provisions that compel observance of TB-related orders, including mechanisms to implement and ensure adherence to TB-related orders.

- Safeguarding Rights – This category refers to those measures designed (or implemented) to protect TB patients' rights. This category is sub-divided into four categories:

  - Due Process – Refers to respecting a TB patient's procedural rights when implementing public health measures.
  - Confidentiality and privacy – Refers to a patient's right to privacy and the confidentiality of information relating to TB.
  - Anti-discrimination – Refers to provisions to prevent discrimination or stigmatization related to TB infection.
  - Religious exemptions – Refers to legal exemptions for medical examination or treatment of TB based on religious beliefs.

- Special Populations – This category refers to TB control measures targeting specific groups (*i.e.*, vulnerable populations including people in correctional facilities, HIV-infected persons, and indigenous communities).

- Additional TB Provisions – This category refers to additional TB control provisions not otherwise classified above, including specific measures to manage or control interjurisdictional cases.

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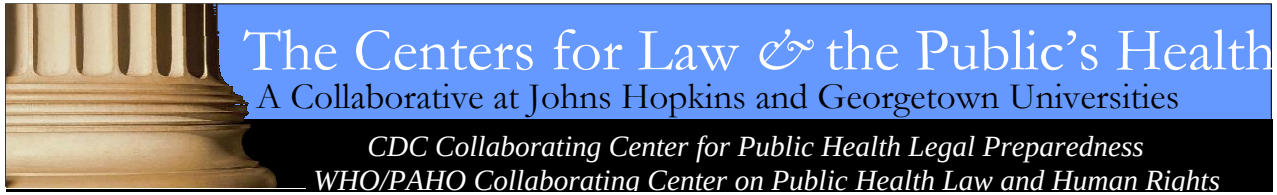
[1] These categories are based in part on prior TB legal survey projects. *See* CDC. Tuberculosis Control Laws – United States 1993. *MMWR* 1993; Vol. 42 No. RR-15 (available at http://www.cdc.gov/mmwr/pdf/rr/rr4215.pdf) (October 1, 2008); and Gostin LO. Controlling the resurgent tuberculosis epidemic: a 50 state survey of TB statutes and proposals for reform. *JAMA* 1993; 269:255--61.

[2] Definitions of key terms in this section, including screening, examination, testing, reporting, quarantine, and isolation, vary across jurisdictions. Accordingly, the Table refers to standard definitions of these terms to provide consistency and help categorize relevant provisions. Thus, when categorizing provisions, legal authorities are categorized according to standard definitions and not necessarily following the jurisdictions' characterization. When misrepresentations are found, provisions are included in the correct category, without changing/substituting terms. Definitions and various quotes in this section are from The Turning Point Model State Public Health Act: A Tool for Assessing Public Health Laws (available at http://www.publichealthlaw.net/ModelLaws/MSPHA.php (August 18, 2008).

[3] The Turning Point Model State Public Health Act: A Tool for Assessing Public Health Laws (available at http://www.publichealthlaw.net/ModelLaws/MSPHA.php (August 18, 2008).



Disclaimer *– Information in this Table does not represent the official legal positions of the U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention/HHS, or state or local governments and is not meant to provide specific legal guidance or advice. Thus, users of this report, including state and local officials, should consult with their state and local attorneys and legal advisors for a more complete review of laws and policies pertaining to TB control.*

Table 1: Characterizing Express Laws Regarding the Control of Tuberculosis in Selected U.S. Jurisdictions (As of May 1, 2008)

Abbreviations

Department / Health Authority

BOH	Board of Health
DE	Department of Education
DH	Department of Health
DHR	Department of Human Resources
DHS	Department of Health Services
DMH	Department of Mental Health
DOC	Department of Corrections
DPH	Department of Public Health
DTBC	Division of TB Control
LBH	Local Board of Health
LHD	Local Health Department
SHA	State Health Authority
SHD	State Health Department

Officials / Providers

ALJ	Administrative Law Judge
CMHO	Chief Medical Health Officer
HA	Health Authority
HCP	Health Care Provider (includes public and private medical providers and health professionals)
HF	Health Facility (or other treatment facility)
HCF	Healthcare Facility
HO	Health Officer
LHA	Local Health Authority
LHO	Local Health Officer
MP	Medical Provider
PHO	Public Health Officer
SHO	State Health Officer
TBCO	Tuberculosis Control Officer

Public Health Intervention

DOT	Directly Observed Therapy
DOT for LTBI	Directly Observed Therapy for Latent TB Infection
TB	Tuberculosis

State	Objective	PH Intervention		Legal Authorities
AZ	**Prevention of TB Cases**	**TB Control Programs**		AZ DHS director administers TB services (Ariz. Rev. Stat. § 36-104) and must adopt rules to: regulate report; keep county statistics; regulate standards of care for persons afflicted with TB (a person who has, or is reasonably suspected of having, active TB) and enforce TB control provisions (Ariz. Rev. Stat. § 36-721). TBCO can contract with federal, state and local agencies, foreign governments, Indian tribal governments or private entities to assist TB control programs (Ariz. Rev. Stat. § 36-714(B 3)).
	Identification of TB Cases	**Screening**		School employees are not subject to screenings (should only be tested when symptomatic) (Ariz. Rev. Stat. § 15-505). Arizona regulations establish a comprehensive list of employees, staff or patients under a duty to provide evidence of a negative TB test prior to employment or admittance, *e.g.*: (i) applicants and certified child care providers in family child care facilities (Ariz. Admin. Code § R6-5-5202); (ii) clients in community residential settings (Ariz. Admin. Code § R6-6-806); (iii) staff of child care centers or group homes (Ariz. Admin. Code § R9-3-303); (iv) hospital personnel (Ariz. Admin. Code § R9-10-206); (v) personnel in adult health care day facilities (Ariz. Admin. Code § R9-10-503); (vi) staff and volunteers of nursing care institutions (Ariz. Admin. Code § R9-10-905).
		Examination & Testing		TBCO or the LHO may petition the superior court to order examination or monitoring of a TB afflicted person who presents a substantial danger to others or to the community and who has failed to comply with a voluntary treatment plan or a written order to cooperate (Ariz. Rev. Stat. § 36-726). The TBCO may conduct or supervise clinics for the diagnosis, treatment and control of TB in convenient places throughout the state (Ariz. Rev. Stat. § 36-714.A).
		Reporting		LHO shall notify the TBCO of the existence and nature of TB and control measures employed (Ariz. Rev. Stat. § 36-723). Treating, screening or attending HCP, laboratory, or operator of a homeless shelter who knows of an afflicted person shall notify the TBCO or the LHO and cooperate with any investigation conducted. (Ariz. Rev. Stat. § 36-723). LHA must report to DHS confirmed and suspected TB cases and persons exposed to TB (Ariz. Admin. Code § R9-6-1202).
	Management of TB Cases	**Investigation**		When a LHO is notified that an afflicted person is within the officer's jurisdiction, the LHO shall immediately initiate an investigation. In performing the duty to prevent and control TB, the TBCO or LHO may enter and inspect (with the purpose of locating afflicted persons) a public place, any public or commercial means of transportation or common carrier, and private property and premises (Ariz. Rev. Stat. § 36-723). Local health agency shall conduct investigation of reported or suspected TB cases (Ariz. Admin. Code § R9-6-380).
		Treatment	**Treatment**	**County** LBH is responsible for providing medical care and treatment to TB afflicted persons (Ariz. Rev. Stat.. § 36-717). The director of the DHS may contract for the care of any afflicted person, following a determination that monies from medical insurance have been exhausted or are insufficient (Ariz. Rev. Stat. § 36-718). TBCO or LHOs shall encourage afflicted persons to accept or consent to voluntary control measures and voluntary treatment. (Ariz. Rev. Stat.. § 36-724). TBCO or the LHO may petition the superior court for court ordered treatment of an afflicted person who presents a substantial danger to others and who has failed to comply with a voluntary treatment plan or a written order to cooperate. (Ariz. Rev. Stat. § 36-726). An afflicted person is not required to submit to any medical treatment or be confined in a medical institution if he/she can be safely examined, monitored, isolated or quarantined. (Ariz. Rev. Stat. §36-734). Afflicted persons may choose a physician and treatment plans with TBCO or LHP approval (Ariz. Rev. Stat. § 36-733). Administrator of HCF shall notify local health agency before discharging patients (Ariz. Admin. Code § R9-6-380).
			DOT	Court may order afflicted persons to undergo DOT, when he/she poses a danger to another person or to the community (Ariz. Rev. Stat. § 36-728).
		Specific Measures	**Emergency Detention**	If the afflicted person refuses to comply with an order to cooperate or if the TBCO or LHO knows that an afflicted person has previously failed or refused to comply with an appropriate prescribed course of medication, treatment or monitoring, and if the TBCO or the LHO has reasonable grounds to believe that the afflicted person poses a substantial danger to another person or the community and that emergency custody is necessary to prevent a substantial danger to another person or the community, the TBCO or the LHO may issue an emergency custody order directing a sheriff or law enforcement officer to take the afflicted person into custody, to take precautions reasonable and necessary under the circumstances to protect the health of law enforcement officers and to transport the afflicted person to an institution or facility specified in the order. An afflicted person admitted pursuant to an emergency custody order shall be released from custody if the medical director of the receiving facility, with the advice and consent of the TBCO or LHO, determines that the afflicted person is any of the following: 1. Not afflicted with active tuberculosis; 2. Not a danger to another person or to the community and release is appropriate; or 3. Qualified for release as a voluntary patient. (Ariz. Rev. Stat. § 36-725). Court may order afflicted person to be committed to an appropriate facility (Ariz. Rev. Stat. § 36-728).
			Quarantine	
			Isolation	TBCO or LHO may petition for court-ordered isolation (or quarantine) of an afflicted person who poses a danger to others and has failed to comply with voluntary treatment (Ariz. Rev. Stat. § 36-726). Court may order isolation of afflicted person (Ariz. Rev. Stat. § 36-728). HCP or HF administrator shall isolate and institute airborne precautions for confirmed or suspected cases of infectious active TB until: 1) at least 3 successive sputum samples collected at least 8 hours apart are negative for acid-fast bacilli; 2) anti-TB treatment is initiated with multiple antibiotics; 3) clinical signs and symptoms of active TB are improved; and 4) for a case of multi-drug resistant active TB, a TB control officer has approved the release of the case from airborne precautions. (Ariz. Admin. Code § R9-6-380).
			Activities Restricted	Court may order afflicted person to refrain from a determined conduct that is a health threat to others (Ariz. Rev. Stat. § 36-728). LHA shall exclude confirmed or suspected cases of infectious active TB from the workplace, unless TBCO approves the individual's work setting, until: 1) at least 3 successive sputum samples collected at least 8 hours apart are negative for acid-fast bacilli; 2) anti-TB treatment is initiated with multiple antibiotics; 3) clinical signs and symptoms of active TB are improved; and 4) for a case of multi-drug resistant active TB, a TB control officer has approved the release of the case from airborne precautions. (Ariz. Admin. Code § R9-6-380).
		Enforcement		HCPs shall report to TBCO when an afflicted person refuses treatment or does not comply with medical recommendations for voluntary examination, isolation, monitoring, quarantine or treatment for active TB (Ariz. Rev. Stat. § 36-723). TBCO or LHO may petition for court-ordered examination, monitoring, treatment, isolation or quarantine of an afflicted person who presents danger to others and has failed to comply with voluntary treatment or a written order to cooperate (Ariz. Rev. Stat. § 36-726.A). Courts may order an afflicted person to, *e.g.*, participate in education, counseling and treatment programs and be tested for TB (Ariz. Rev. Stat. § 36-728). The following are misdemeanors: (i) Afflicted person knowingly or intentionally exposing others to TB; (ii) the non-compliance of an afflicted person with court orders of isolation, quarantine or detention; (iii) obstruction of investigation; and (iv) making false reports (Ariz. Rev. Stat. § 36-737). An afflicted person who is not incarcerated on a criminal charge and who is the subject of a TB order or petition shall not be confined in any prison or jail where those charged with crimes are incarcerated unless: 1) the afflicted person represents an immediate and serious danger to HCF staff or physical facilities, or 2) the afflicted person has failed to obey a court order or has failed to obey a lawful order of the TBCO or LHO; and 3) HCF has determined that no less restrictive confinement measures are appropriate. (Ariz. Rev. Stat. § 36-731).
	Safeguard-ing Rights	**Due Process**		Court orders for emergency detention shall provide notice of detention to the afflicted person's physician, or, if minor or incapacitated, to parent or guardian. Court shall appoint an attorney for the afflicted person (Ariz. Rev. Stat. § 36-726). Court shall provide written information notifying the afflicted person of his/her rights when ordering examination, treatment, monitoring, isolation or quarantine (Ariz. Rev. Stat. § 36-735). Afflicted persons shall not be confined in prisons or jails unless they represent an immediate danger to HCF personnel, or unless they have failed to obey orders issued by courts, TBCO or LHO and HCF determines that there are no less restrictive measures available. Court shall review such decisions and determine the appropriate level of confinement (Ariz. Rev. Stat. §36-731). The court shall order the least restrictive measures necessary to protect the public's health and provide appropriate care for the TB patient (ARS § 36-728).
		Confidentiality and Privacy		Medical records of afflicted persons are confidential (thus, shall not be divulged so as to disclose the identity of the person) (ARS § 36-727). TBCO or LHO may disclose records to HCFs, HCPs, other agencies and courts as necessary to enforce rules concerning TB control measures (*e.g.* examination, treatment, isolation, and quarantine) (Ariz. Rev. Stat. § 36-714). Court hearings shall not be open to the public and all records are confidential (Ariz. Rev. Stat. § 36-727).
		Anti-Discrimination		
		Religious Exemptions		Afflicted persons may claim a religious exemption, in which case the individual is not required to undergo treatment ordered by the court (Ariz. Rev. Stat. §36-734).
	Special Populations	**Considerations for Certain Populations**		Court orders notifying the afflicted person of his/her rights (see due process above) must be in the person's primary language, if reasonably possible, and shall consider the needs of a hearing impaired or visually impaired person (Ariz. Rev. Stat. § 36-735). Certain considerations are made to control TB in correctional facilities (Ariz. Admin. Code § R9-6-1203).
	Additional TB Provisions			Interjurisdictional Control: TBCO shall cooperate with state, local, federal authorities, agencies and organizations, tribal governments, or foreign governments in controlling TB (Ariz. Rev. Stat. § 36-714(C)). Director of DHS shall cooperate (by signing reciprocal agreements) with federal or state agencies, foreign governments, tribal governments, or other jurisdictions to facilitate the return of TB afflicted persons (Ariz. Rev. Stat. § 36-715). TBCO shall inform other agencies, or relatives, when a TB patient who is receiving Department of Economic Security assistance is sent out-of-state (Ariz. Admin. Code § R6-13-913). An afflicted person may apply to the Department of Economic Security for assistance while not employable due to TB (Ariz. Rev. Stat. § 36-716, Ariz. Admin. Code § R6-13-902-R6-13-922). Decisions of eligibility of TB patients for state assistance is made by DHS.

State	Objective	PH Intervention		Legal Authorities
CA	**Prevention of TB Cases**	**TB Control Programs**		SHD is required to maintain a TB Control Program (Cal. Health & Safety Code § 121350). LHD must maintain a TB Control Program to receive state aid from SHD (Cal. Code Regs. tit. 17, § 1276).
	Identification of TB Cases	**Screening**		Screening for TB: certain populations must be screened for TB (and must test negative for active TB, within times specified by statute), including: (i) school district employees (Cal. Educ. Code § 49406(a) & Cal. Health & Safety Code § 121525); (ii) community college employees (Cal. Educ. Code § 87408.6); (iii) city and county park, beach, recreation center employees and concession stand operators (Cal. Pub. Res. Code § 5163); (iv) private, parochial, and nursery school employees and volunteers (Cal. Code Regs. tit.17, § 6600 et seq.); (v) HCF employees (tested before employment and annually) (22 Cal Code of Regs § 72535(b)); (vi) minors in juvenile detention (Cal. Code Regs. tit. 17, § 1432); (vii) employees of juvenile detention facilities (Cal. Code Regs. tit. 15, § 1320); (viii) employees, volunteers, clients of mental health rehabilitation centers (Cal Code Regs. tit. 9, §§ 784.12, 785.00); (ix) employees, volunteers and clients of drug and alcohol programs (Cal. Code Regs. tit. 9, § 10564, 10567); (x) prison employees with inmate contact (Cal. Penal Code § 6006 et seq.); (xi) inmates and wards (Cal. Penal Code § 7573(b)).
		Examination & Testing		LHOs may issue written orders for examination as a tool for implementing preventive measures in the territory. LHOs may also: (i) order examinations for TB infection for the purposes of directing preventive measures for persons in the territory, for whom the LHO has reasonable grounds to determine are at heightened risk of TB exposure; (ii) order detention or confinement for the purpose of examination; (iii) order examination of a person seeking admission to schools (public, private, elementary or secondary). Thereafter, such persons may be periodically ordered to undergo further examinations. HCPs have the duty to test or refer to LHOs any household members of active TB patients that they have treated (Cal. Health & Safety Code §§ 121363–121365, 121485(a)). DOC shall order examination of inmates and wards (Cal. Penal Code § 7572).
		Reporting		HCPs must report: (i) suspected or confirmed TB cases; (ii) patients who cease TB treatment; and (iii) referrals of household contacts of active TB patients (Cal. Health & Safety Code §§ 121362–121363). Laboratories must report to LHO if a specimen tests positive for TB (or MDR-TB) (Cal. Code Regs. tit. 17, § 2505 et seq). DOC must report to SHD the results of TB examinations (Cal. Penal Code § 6008). DOC must also report annually to SHD the prevalence of TB in its population and compliance with and response to treatment (DOT & DOT for LTBI) (Cal. Penal Code § 7576).
	Management of TB Cases[1]	**Investigation**		LHOs and DOC must use "every available means" to investigate reported or suspected TB cases (Cal. Health & Safety Code § 121365) & (Cal. Penal Code § 7572)
		Treatment	**Treatment**	HFs may not discharge suspected or confirmed TB patients until prescribing a written treatment plan and notifying LHOs. LHOs may order individuals with active TB disease to follow a specific treatment plan (LHOs are not authorized to order involuntary treatment, see due process section below) (Cal. Health & Safety Code §§ 121361(e), 121365(b), 121369(b)). DOC may order an inmate or ward to receive treatment if there is reasonable suspicion to believe that the inmate or ward has, has had, or has been exposed to infectious TB and DOC has reasonable grounds to believe that it is necessary for the preservation and protection of staff and inmates or wards (Cal. Penal Code § 7573).
			DOT	LHOs may order DOT for active TB patients who are unwilling (or unable) to follow a prescribed treatment (LHOs are not authorized to order involuntary treatment, see due process section below) (Cal. Health & Safety Code § 121365(c)). DOT is defined as the "appropriate prescribed course of treatment for tuberculosis disease" (Cal. Health & Safety Code § 120115(e)).
		Specific Measures	**Emergency Detention**	LHO may order detention if: 1) The person has infectious TB disease, or who presents a substantial likelihood of having infectious TB; and 2) LHO finds, based on recognized infection control principles, that there is a substantial likelihood the person may transmit TB to others because of his or her inadequate separation from others. LHO may also order detention if : 1) The person has active TB disease, or has been reported to the LHO as having active TB disease with no subsequent report to the health officer of the completion of an appropriate prescribed course of medication for TB disease; and 2) There is a substantial likelihood, based on the person's past or present behavior, that he or she cannot be relied upon to participate in or complete an appropriate prescribed course of medication for TB disease and, if necessary, follow required infection control precautions for TB disease (Cal. Health & Safety Code § 121365(a), (d)–(e)) Prior court orders are not required for these measures, unless the detainee requests release (Cal. Health & Safety Code § 121366). Civil detentions ordered by LHOs may not take place in correctional facilities (Souvannarath v. Hadden, 116 Cal. Rptr. 2d 7, 95 Cal. App. 4th 1115 (Cal. Ct. App. 2002)).
			Quarantine	
			Isolation	LHOs may order home isolation of persons with infectious TB until they no longer are infectious (Cal. Health & Safety Code § 121365(g)). If home isolation is inadequate, LHO may designate quarters for isolation until no longer necessary to protect the public (Cal. Code Regs. tit. 17, § 2624). DOC may order isolation of inmates or wards with confirmed or suspected TB (Cal. Penal Code § 7572).
			Activities Restricted	LHOs may order persons with infectious TB not to attend the workplace (Cal. Health & Safety Code § 121365(f)). Individuals with active TB may not be employed by a school district, and individuals with communicable TB may not be employed by a nursery school (Cal. Educ. Code § 49406(a) & Cal. Health & Safety Code § 121525). If a LHO issues an examination order to a person seeking admission to a school (public/private or elementary/secondary) the school should refrain from admitting him/her until proof of a negative TB test has been submitted. However, conditional admission is possible (Cal. Health & Safety Code §§ 121485(b), 121495).
		Enforcement		LHOs must inform the county's district attorney if any order has been violated (Cal. Health & Safety Code § 121365). Failure to comply with LHO's orders is a misdemeanor (Cal. Health & Safety Code § 120280).
	Safeguarding Rights	**Due Process**		Forcible or involuntary treatment is strictly forbidden without a court order (Cal. Health & Safety Code § 121365(b)). However, inmates and wards may be tested and treated involuntarily without court order (Cal. Penal Code § 7574). Due process in proceedings for orders of detention for TB does not require jury trial, unanimous verdict or proof beyond a reasonable doubt to justify detention (Levin v. Adalberto, 67 Cal. Rptr. 3d 277, 156 Cal. App. 4th 288 (2007)).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		Examination and treatment may be waived based on religious beliefs, provided that individuals with confirmed or suspected infectious TB may be quarantined or isolated (Cal. Health & Safety Code § 121370). School board may waive examination requirements to employees based on religious beliefs (Cal. Educ. Code § 49406(g)).
	Special Populations	**Considerations for Certain Populations**		LHO's orders do not apply to incarcerated persons (Cal. Health & Safety Code § 121365(h)). Language interpreters and persons able to communicate with the vision and hearing impaired must be provided for individuals with confirmed or suspected TB with such needs (Cal. Health & Safety Code § 121369(a)).
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
CO	**Prevention of TB Cases**	**TB Control Programs**		TB control is a state and local responsibility (Colo. Rev. Stat. § 25-4-501). DPH must instruct and provide consultation services to government officers (DE, DOC) and HCPs regarding TB control (Colo. Rev. Stat. § 25-4-508). The state board of health may adopt rules and regulations necessary for TB control (Colo. Rev. Stat. § 25-4-511(1)(a)). The executive director of the DPH must direct the TB control program (including programs of investigation and examination, treatment), and will also make arrangements with hospitals for the treatment of MDR-TB (Colo. Rev. Stat. § 25-4-511(2)).
	Identification of TB Cases	**Screening**		CMHO may conduct screening programs among populations who are at a high risk of contracting TB (Colo. Rev. Stat. § 25-4-506(1)(b)). Individuals admitted to Alcohol and Drug Abuse Centers (for Opioid Treatment Programs) must be tested before admission and every two years thereafter (6 Colo. Code Regs. § 1008-1(15.223.54)). All hospitals and nursing homes must maintain a register of TB test results (6 Colo. Code Regs. § 1009-1(4(J)(J)). Screening in Colorado is limited to persons that are at higher risk of exposure to TB (through activities or work) (6 Colo. Code Regs. § 1009-1(4(K)(1)(1)). SHAs or LHAs may develop voluntary screening programs (6 Colo. Code Regs. § 1009-1(4(K)(6)(1)).
		Examination & Testing		When required by a HCP or physician, LHA (CMHO) must examine (or cause to be examined) the specimens sent to him/her of persons with TB symptoms. Such examination must be carried out by DPH (Colo. Rev. Stat. § 25-4-503). CMHO may order examination when investigating known or suspected cases of infectious TB (Colo. Rev. Stat. § 25-4-506(1)(a)).
		Reporting		The following shall report to the DPH when TB positive or suspected cases are found: (i) physicians and HCPs (Colo. Rev. Stat. § 25-4-502); (ii) CMHO (Colo. Rev. Stat. § 25-4-504); (iii) laboratories (Colo. Rev. Stat. § 25-4-505) (6 Colo. Code Regs. § 1009-1(4(C)(1)) (laboratories fulfill reporting requirements by sending a sputum specimen of the TB patient (6 Colo. Code Regs. § 1009-1(4(E)(1)); (iv) Physicians (MPs, HCFs, within 7 days when the positive result occurs in a health care worker, correctional or detention facility worker) (6 Colo. Code Regs. § 1009-1(4(B)(1)). MPs and HCFs must report to DPH if patients under DOT miss a dose (6 Colo. Code Regs. § 1009-1(4(H)(1)). All hospitals and health care facilities providing in-patient treatment to persons with active tuberculosis disease shall notify the state or local health department immediately after plans are made to discharge the patient from the facility (6 Colo. Code Regs. § 1009-1(4(I)(1)).
	Management of TB Cases	**Investigation**		CMHO is authorized to use all available means to investigate reported or suspected infectious TB cases and those individuals' contacts (Colo. Rev. Stat. § 25-4-506(1)(a)). CMHO has full investigative powers of inspection, examination, quarantine and isolation when investigating all reported or suspected cases of infectious TB and to identify the contacts of such cases (Colo. Rev. Stat. § 25-4-506(1)(a)). DPH may inspect and access medical records of HCPs where TB patients are treated (Colo. Rev. Stat. § 25-4-508).
		Treatment	**Treatment**	Treatment of TB is a state and local responsibility. In order to prevent the proliferation of MDR-TB, an active program of hospitalization for treatment purposes must be conducted by the DPH (Colo. Rev. Stat. § 25-4-501). CMHO is authorized to prescribe treatment (Colo. Rev. Stat. § 25-4-506(1)(a)). The state shall provide treatment and assistance to any person suffering from TB who is unable to pay for outpatient treatment (Colo. Rev. Stat. § 25-4-511(1)(b)). There is no residency requirement for providing treatment to persons with MDR-TB (Colo. Rev. Stat. § 25-4-512(1)(c))
			DOT	MPs, HCFs must provide DOT (full course of therapy) for TB patients (unless DPH approves an alternative treatment for the patient) (6 Colo. Code Regs. § 1009-1(4(H)). MPs may request that the DPH or LHA provide DOT (fulfilling their obligation to provide DOT) (6 Colo. Code Regs. § 1009-1(4(H)).
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	Isolation (and quarantine) may be ordered in the following circumstances: (i) by CMHO when investigating confirmed TB cases and contacts (Colo. Rev. Stat. § 25-4-506(1)(a)); (ii) whenever CMHO deems necessary, such orders have to be made in writing and cannot exceed six months (Colo. Rev. Stat. § 25-4-507(1)); (iii) when an MDR-TB patient stops following treatment (Colo. Rev. Stat. § 25-4-507(3)). There is no residency requirement for providing hospitalized isolation services (Colo. Rev. Stat. § 25-4-512(1)(c)).
			Activities Restricted	
		Enforcement		When orders for examination, quarantine or isolation are violated, CMHO must inform the district attorney (Colo. Rev. Stat. § 25-4-507(2)). Violations of CMHO's orders (examination, isolation) are misdemeanors (Colo. Rev. Stat. § 25-4-509(1)). If MDR-TB patients cease taking prescribed medications against medical advice, CMHO may issue isolation (or quarantine) orders, even if the patient is no longer contagious, so long as the patient has not completed an entire course of therapy (Colo. Rev. Stat. § 25-4-507(3)). Failure to comply with reporting requirements is a misdemeanor (Colo. Rev. Stat. § 25-4-509(2)).
	Safeguarding Rights	**Due Process**		When quarantined or isolated, TB patients must be examined at their request to determine if they have infectious TB (Colo. Rev. Stat. § 25-4-507(1))
		Confidentiality and Privacy		DPH will keep a TB registry, including information on persons with TB. Such information may only be accessed by HAs who shall not permit personal information to be divulged (Colo. Rev. Stat. § 25-4-504) All reports made by laboratories to DPH must be kept confidential (Colo. Rev. Stat. § 25-4-505).
		Anti-Discrimination		TB related services must be provided regardless of "race, religion, gender, ethnicity, national origin, or immigration status" (Colo. Rev. Stat. § 25-4-512(2))
		Religious Exemptions		Religious exemptions do not apply to examination, reporting and quarantine. Treatment and confinement in HCFs may be waived if a patient may be isolated or quarantined at home (Colo. Rev. Stat. § 25-4-506(3)). Individuals may be excluded from screening based on religious exemptions (6 Colo. Code Regs. § 1009-1(4(K)(2)(1)).
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Interjurisdictional control: DPH shall cooperate with state, local and federal authorities, agencies and organizations in order to receive federal aid for TB control (Colo. Rev. Stat. § 25-4-511(3)).

State	Objective	PH Intervention		Legal Authorities
FL	**Prevention of TB Cases**	**TB Control Programs**		SHD must run TB control programs in each county in the state (the specific characteristics of the programs, purpose, objectives, etc. are determined as well) (Fla. Stat. § 392.61). SHD must operate hospitalization and placement programs (Fla. Stat. §392.62). State Legislature shall designate sufficient funds to maintain TB Control programs and institutions (Fla. Stat. § 392.69; Fla. Admin. Code Ann. r. 64D-3.044).
	Identification of TB Cases	**Screening**		Certain populations may be required to undergo TB testing and test negative , including: (i) emergency responders (state employees such as law enforcement officer, firefighters, paramedics, etc) as part of a pre-employment medical examination (Fla. Stat. § 112.181); (ii) under the school-work program, state university and community college students that apply to work in elementary or secondary schools (Fla. Stat. § 1009.77); (iii) students of the FL School for the Blind and the Deaf (Fla. Admin. Code Ann. r. 6D-9.005); (iv) staff employees of the Department of Elder Affairs (before starting employment and annually thereafter) (Fla. Admin. Code Ann. r. 58A-5.019). New employees of home health agencies must submit a statement that they are free from signs and symptoms of TB (Fla. Admin. Code Ann. r. 59A-8.0185).
		Examination & Testing		SHD may require any person who has active TB, who is reasonably suspected of having active TB, or who is reasonably suspected of having been exposed to active TB, to undergo examination and testing (Fla. Stat. § 392.54(1))
		Reporting		Persons and laboratories that diagnose TB must report to SHD within 72 hours (Fla. Stat. § 392.53(1)); SHD may impose fines for failure to report (Fla. Stat. § 392.53(4)).
	Management of TB Cases	**Investigation**		SHD may interview any person who has active TB, who is reasonably suspected of having active TB, or who is reasonably suspected of having been exposed to active TB in order to investigate the source and spread of the disease (Fla. Stat. § 392.54(1))
		Treatment	**Treatment**	A person who has active TB or is reasonably suspected of having or having been exposed to active TB shall report for treatment to cure, as appropriate, to county SHD or other HCP (Fla. Stat. § 392.55(2)). SHD or HCP shall prescribe an individualized treatment plan for each person who has active TB; the goal of the treatment plan is to achieve treatment to cure by the least restrictive means (Fla. Stat. § 392.64). SHD shall adopt specific treatment rules (Fla. Stat. § 392.66) (Fla. Admin. Code Ann. r. 64D-3.043).
			DOT	After TB has been diagnosed, TB patient must continue treatment (outpatient), including DOT, until she/he is cured (Fla. Stat. § 392.55(2)). The DH shall prescribe an individualized treatment plan for each individual with active TB, which includes DOT (Fla. Stat. § 392.64).
		Specific Measures	**Emergency Detention**	After authorized by circuit court (see due process below), SHD may order hospitalization, placement in HCFs, and emergency detention (Fla. Stat. §§ 392.56(1), .57). Physician must request SHO to issue an involuntary hold certificate (for examination or treatment) if he/she has reason to believe that the patient has active TB or is reasonably suspected of having active TB, the patient poses a public health threat (based on test results or medical history), and that patient is not likely to appear at a hearing scheduled under s. 392.55 or s. 392.56 (Fla. Stat. § 392.565; Fla. Admin. Code Ann. r. 64D-3.045). SHD request that an emergency hold order be issued for a person if it has evidence that: (a) the person has or is reasonably suspected of having active TB; (b) the person poses a threat to the public health; (c) the person who has active TB is not likely to appear at a hearing scheduled under s. 392.55 or s. 392.56; (d) evidence suggests the person is likely to leave the court's jurisdiction prior to the hearing date; or (e) the person is likely to continue to expose the public to the risk of active TB. When issuing an order for an emergency hold, the court shall direct the sheriff to immediately confine the person who has active TB (Fla. Stat. § 392.57).
			Quarantine	
			Isolation	In-home isolation may be ordered by SHD after being authorized by circuit court (Fla. Stat. § 392.56(1)) Temporary leave from in-home isolation may be requested under certain circumstances (Fla. Stat. § 392.63).
			Activities Restricted	Individuals with communicable TB may not be hired by the Department of Elder Affairs (Fla. Admin. Code Ann. r. 58A-5.019).
		Enforcement		If all reasonable means of obtaining compliance have been exhausted, SHD may request circuit court to order apprehension, examination or treatment of persons who has, or is reasonably suspected of having, or having been exposed to, active TB (Fla. Stat. § 392.55(1)). Infection control procedures must be taken in court during the hearings (Fla. Stat. §§ 392.55(5), .56(6)). Individuals that do not follow treatment plans or do not comply with court orders may be punished by contempt proceedings (Fla. Stat. § 392.64) and penalties (Fla. Stat. § 392.67). SHD must adopt rules to regulate enforcement mechanisms in cases of noncompliance with treatment (Fla. Stat. § 392.66). Penalties may be imposed on: (i) any person who knows of his/her active TB disease and willfully exposes other persons to the disease; (ii) any person who maliciously disseminates any false information or report concerning the existence of TB; and (iii) any person who violates any provision of the SHD's rules pertaining to TB or the requirements for reporting TB (Fla. Stat. § 392.67).
	Safeguarding Rights	**Due Process**[2]		Circuit courts may authorize: (i) apprehension for examination or treatment purposes without consent (Fla. Stat. § 392.55(3)); (ii) hospitalization, placement in HCFs or in-home isolation (Fla. Stat. § 392.56(2)); and, (iii) emergency hold (Fla. Stat. § 392.57). SHD must prove by a preponderance of evidence that the person represents a public health threat and that all other means of obtaining compliance have been exhausted (Fla. Stat. §§ 392.55(3), .56(2)). A warrant will issue only after a hearing is held during which (i) right to attend the hearing must be granted (person must be allowed to defend him/herself); (ii) right to legal counsel must be advised and counsel appointed if the person is indigent (Fla. Stat. §§ 392.55(4), .56(3)). Hospitalization, placement in a health care facility or residential facility, or in-home isolation orders may last a maximum of 180 days (physician may determine that the person is no longer a public threat before that). Orders may only be renewed by compliance with the requirements listed above (Fla. Stat. § 392.56(4)). Court orders may be appealed by any aggrieved person. Circuit court must consult with SHD before granting release (Fla. Stat. § 392.60).
		Confidentiality and Privacy		SHD must consider protection of privacy and confidentiality of TB patients in rules for reporting TB (Fla. Stat. § 392.53 (2)). Information gathered in interrogations for investigation purposes is confidential (Fla. Stat. § 392.54(2)). Circuit court requests (for examination, treatment, confinement, isolation), shall be filed using a pseudonym and an individual's real name shall only be revealed to the court (the court shall refrain from revealing the name). Courts shall protect the names of TB patients from public disclosure. SHD shall not reveal the name of patients (Fla. Stat. § 392.545(1), (2), (3)). Information and health records of individuals known or suspected to have TB or exposed to TB are deemed confidential and may be released only under specific circumstances (Fla. Stat. § 392.65).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		SHD may examine, test and treat prisoners for TB. Detention facilities must cooperate with SHD. This does not relieve the DOC of the obligation to provide TB treatment for prisoners (Fla. Stat. § 392.655). DOC may transfer prisoners to HFs in order to provide them with specialized treatment (Fla. Stat. § 945.12).
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
GA	**Prevention of TB Cases**	**TB Control Programs**		The SHD must enforce rules and regulations to protect the public from TB (Ga. Code Ann. § 31-14-10). The DHR must develop procedures to prevent the spread and control of TB (Ga. Comp. R. & Regs. 290-5-16.01). LHD must ensure TB control services are available to residents (Ga. Comp. R. & Regs. 290-5-16.03).
	Identification of TB Cases	**Screening**		Some populations must be screened for TB, including: (i) state employees (in order to be allowed to receive compensation after contracting TB) (Ga. Code Ann. § 31-29-2(a)); (ii) prospective foster parents and persons (age 16 and older) living in the prospective foster home (Ga. Comp. R. & Regs. 290-2-5.13); (iii) personal home care staff (Ga. Comp. R. & Regs. 290-5-35.14); (iv) birth center employees (Ga. Comp. R. & Regs. 290-5-41.09); (v) staff of Community Living Arrangements (Ga. Comp. R. & Regs. 290-9-37.15).
		Examination & Testing		Court orders (see below) may require examination of persons with active TB (Ga. Code Ann. § 31-14-3(a)). A report of such examination must be submitted to the court (Ga. Code Ann. § 31-14-6). Courts may issue orders requiring parents to have their children (under the age of 18) tested for TB (Ga. Code Ann. § 31-14-13(a); Ga. Comp. R. & Regs. 290-5-16.03) HP attending a person with active TB must examine close contacts (Ga. Comp. R. & Regs. 290-5-16.02). If after interview the LHD has reasonable cause to conclude that a person has a suspected or confirmed case of TB which needs prompt medical evaluation, the LHD shall issue to the person a written order directing him/her to appear at a specified time and place to comply with a written plan of evaluation (Ga. Comp. R. & Regs. 290-5-16.03).
		Reporting		In-patient and out-patient treatment of TB cases must be reported to the Prevention Branch of the DH. Laboratories also must report samples tested positive for TB (Ga. Comp. R. & Regs. 290-5-16-.02). LHD must ensure prompt reporting of TB cases (Ga. Comp. R. & Regs. 290-5-16-.03).
	Management of TB Cases	**Investigation**		LHD must interview all reported or known persons who have a confirmed or suspected case of contagious TB (Ga. Comp. R. & Regs. 290-5-16.03).
		Treatment	**Treatment**	A person willing to follow voluntary treatment shall not be committed (Ga. Code Ann. § 31-14-12). DH (or authorized HA) may seek court orders directed at persons to comply with a prescribed outpatient treatment (Ga. Code Ann. § 31-14-13(a)). A person with active TB who refuses to follow complete course of therapy is a threat to society since such person could develop MDR-TB (Ga. Comp. R. & Regs. 290-5-16.01). LHD shall ensure effective treatment and continuing medical supervision of suspected and diagnosed cases of TB (Ga. Comp. R. & Regs. 290-5-16.03) LHD must ensure that TB treatment is available to residents (Ga. Comp. R. & Regs. 290-5-16.03).
			DOT	LHD is responsible for DOT for patients after they have been discharged (Ga. Comp. R. & Regs. 290-5-16-.05(3)).
		Specific Measures	**Emergency Detention**	DH (or LHA) may request court orders for commitment of noncompliant TB patients (see below, enforcement) (Ga. Code Ann. § 31-14-2). If the court reasonably believes that the person may leave and thus expose others to the disease, it can place the person in custody pending hearing (Ga. Code Ann. § 31-14-5). A court may order commitment for up to two years, upon a showing that (i) the patient has violated rules or regulations, (ii) has not complied with DH orders, (iii) presents a substantial risk of exposing others to an imminent danger of infection, (iv) that there is no less restrictive alternative to involuntary treatment at a HF, (Ga. Code Ann. § 31-14-7(a)). The patient may be released before the commitment period expires if he/she has no longer active TB and there is no likelihood of future non-compliance (Ga. Code Ann. § 31-14-8(a)-(b)). The commitment may be extended for a period longer than two years (a new hearing must be conducted), provided the need for extension is demonstrated (Ga. Code Ann. § 31-14-8.1(a)). If an individual with active TB complies with the rules and regulations, he/she cannot be committed (Ga. Code Ann. § 31-14-12). LDH is authorized to file a petition for confinement under the following circumstances: (i) when patient fails to comply with LDH orders for medical examination; (i) when patient fails to follow prescribed treatment; (iii) when LHD is unable to locate person to be named in the petition; and (iv) when exist an imminent danger to the public health. In the last two cases petitions for commitment may be filed without first issuing an order to the person (Ga. Comp. R. & Regs. 290-5-16.03).
			Quarantine	
			Isolation	If the patient fails to present to the LHD evidence that he/she has complied or intends to comply with the plan of treatment by a specified date, the LHD may in his/her discretion issue a quarantine order against the patient. LHD may also issue a quarantine order if unable to locate the patient (after a good faith effort to do so) or if an imminent danger to the public's health exists, without first issuing an order to the patient. (Ga. Comp. R. & Regs. 290-5-16.03).
			Activities Restricted	A practicing midwife must be free of infectious TB (Ga. Code Ann. § 31-26-2(b)). Private home care providers with active TB are excluded from providing services to clients (Ga. Comp. R. & Regs. 290-5-54.10).
		Enforcement		When a person with active TB violates rules and regulations or does not comply with DH (or other HA) orders, and thereby presents a substantial risk of exposing the public to an imminent danger of infection, the LHA or the DH must submit a petition for commitment to the superior court (Ga. Code Ann. § 31-14-2). If a committed patient leaves HF without being discharged, he/she must be detained and returned to HF (Ga. Code Ann. § 31-14-11). Violations of court orders prescribing outpatient treatment or requiring children exposed to TB to be tested may be punish as for contempt (Ga. Code Ann. § 31-14-13(c)). If a person fails to comply with LHD quarantine orders or court confinement orders, LHD may seek judicial enforcement of actions against the person (Ga. Comp. R. & Regs. 290-5-16.03).
	Safeguarding Rights	**Due Process**		Faced with a petition for forced treatment, examination, or testing, a superior court will set a hearing affording the infected individual the right to counsel, appointment of counsel if unable to pay, right to defend him/herself, cross-examine witnesses, offer evidence, subpoena witnesses, require testimony of physicians before granting a petition for commitment (Ga. Code Ann. § 31-14-3(a), (b)). Court orders for commitment may be appealed (Ga. Code Ann. § 31-14-7(b), -8). The patient (or any interested party), may request (only once every six months) release if he/she is no longer considered infected with active TB or that his/her release does not pose a public risk (Ga. Code Ann. § 31-14-19(a)). Patient (or interested party) can petition for Habeas Corpus (questioning the cause/legality of detention) (Ga. Code Ann. § 31-14-19(b)).
		Confidentiality & Privacy		The TB patient may request the court to exclude the public from the hearing (Ga. Code Ann. § 31-14-3(b)).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		If a prisoner is afflicted with TB, the superior court may order that he/she be sent to a TB treatment facility (Ga. Code Ann. §§ 42-4-6, -5-52).
	Additional TB Provisions			When acting in good faith, HCPs, HO (or any person authorized to do so) are immune from civil liability arising from admitting or discharging patients (Ga. Code Ann. § 31-14-14).

State	Objective	PH Intervention		Legal Authorities
IL	**Prevention of TB Cases**	**TB Control Programs**		A TB Control Plan must be executed for high-risk congregate settings and programs providing alcohol and drug treatment (Ill. Admin. Code tit. 77, § 696.130). DH may establish specific laboratories to detect TB (20 Ill. Comp. Stat. 2305/2(l)).
	Identification of TB Cases	**Screening**		Screening for TB infection: Certain populations may be screened for TB infection using a TB screening test, including: (i) persons who are in close contact with suspected or confirmed cases of TB disease; (ii) employees, volunteers and clients of high-risk congregate settings and programs providing alcohol and drug treatment; (iii) employees, volunteers and clients of other healthcare settings; (iv) employees, volunteers and students in a school or school district; and (v) day care center employees and volunteers (Ill. Admin. Code tit. 77, § 696.140(a)). Screening for TB disease: Screening for TB disease can be done with the use of a checklist of symptoms alone (screening method for persons with a documented prior positive TB screening test and clients admitted to high-risk congregate settings and programs providing alcohol and drug treatment) or with chest radiography or bacteriologic examinations in addition to the checklist of symptoms (screening method for jails, homeless shelters, and single-room-occupancy facilities that house the homeless) (Ill. Admin. Code tit. 77, § 696.140(b)). Applicants for school bus driver permits must be tested for TB (Ill. Admin. Code tit. 92, § 1035.20(h)).
		Examination & Testing		Suspected or confirmed TB cases should undergo Diagnostic Evaluation (Ill. Admin. Code tit. 77, § 696.160).
		Reporting		HCP are required to report suspected and confirmed cases of TB to the local TB control authority or, in its absence, to the TB Control Section of the Department (TB control authority must report to the Department) (Ill. Admin. Code tit. 77, § 696.170).
	Management of TB Cases	**Investigation**		Close contacts to suspected or confirmed cases of TB disease shall obtain a TB screening test to identify infection (Ill. Admin. Code tit. 77, §§ 696.160(c), .140(a)(1)).
		Treatment	**Treatment**	Different types of therapy are directed for different patients. These types of therapy are: (i) preventive therapy; (ii) BCG vaccine and preventive therapy; (iii) DOT for LTBI (patients should be monitored for adverse drug reactions at least monthly during therapy) (Ill. Admin. Code tit. 77, § 696.150). Each county may establish a TB sanitarium district to treat and care for residents (70 Ill. Comp. Stat. 920/0.01 et seq.) A municipality may establish a program for the care and treatment of persons with TB (65 Ill. Comp. Stat. 5/11-29-1) and thereafter the municipality may vote to discontinue existing TB programs (65 Ill. Comp. Stat. 5/11-29-14). If a county or municipality establishes a public tuberculosis sanitarium district, it must provide treatment for residents of the district (70 Ill. Comp. Stat. 920/7; 65 Ill. Comp. Stat. 5/11-29-8.1). City has no legal duty under public health laws to provide for in-patient care and treatment to residents with TB (County of Cook v. City of Chicago, 593 N.E.2d 928 (Ill. App. Ct. 1992)).
			DOT	DOT for individuals with LTBI should be considered where it can be administered by a responsible and trained employee or volunteer (Patients should be monitored for adverse drug reactions at least monthly during therapy) (Ill. Admin. Code tit. 77, § 696.150). Persons with Suspected or Confirmed TB disease. All TB patients should be treated with DOT (Ill. Admin. Code, tit. 77 § 696.160).
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	Infectious TB patients may be confined to their homes (Ill. Admin. Code tit. 77, § 696.160 (b)(1)(B)). Isolation of patients with suspected or confirmed TB disease may be implemented as a precaution in settings serving infectious TB patients (Ill. Admin. Code tit. 77, § 696.160 (b)(1)(A)). Continuous isolation should be considered for patients in in-patient settings with MDR-TB (Ill. Admin. Code tit. 77, § 696.160 (b)(1)(A)(iii)). Persons with suspected or confirmed TB disease considered infectious or likely to become infectious may be ordered in isolation by a directive issued by the TB control authority (see "enforcement" section below). Isolation (and quarantine) of non-compliant TB patients (20 Ill. Comp. Stat. 2305/2).
			Activities Restricted	
		Enforcement		After opportunity for a patient to present information to support his/her position at a hearing, the local TB control authority may issue directives (letters containing information for compliance and consequences for non-compliance) or seek court orders (for diagnostic evaluation, preventive therapy, DOT for LTBI, treatment, isolation and others) "as necessary" for protecting the public's health, safety and welfare. (Ill. Admin. Code tit. 77, § 696.190).
	Safeguarding Rights	**Due Process**		Quarantine and isolation require consent of the TB patient or court authorization within 48 hours and the patient must be given written notice including: (1) right to counsel; (2) right to court-appointed attorney if indigent; (3) reason for order; (4) if not an immediate order, when to begin compliance; and (5) expected duration of order (20 Ill. Comp. Stat. 2305/2(c)). Statute on DH's duty to investigate, quarantine and isolate TB patients (20 Ill. Comp. Stat. 2305/2) implies no private right of action against authorities for violations of statute (*Moore v. Lumpkin*, 630 N.E.2d 982 (Ill. App. Ct 1994)).
		Confidentiality and Privacy		It is the policy of the Illinois Department of Public Health to maintain personal information that would identify individual patients confidential when suspected or confirmed cases of TB are reported (Ill. Admin. Code tit. 77, § 696.170(d)).
		Anti-Discrimination		
		Religious Exemptions		In counties where TB sanitarium districts are established, no resident of a TB sanitarium district may be compelled to take TB test if objection is due to religious convictions, unless there is reasonable cause to believe the person has infectious TB (70 Ill. Comp. Stat. § 920/7; 55 Ill. Comp. Stat. §5/5-23036) Prison inmates may not claim a statutory right to refuse TB test based on religious objection (Cannon v. Mote, 824 N.E.2d 1227 (Ill. App. Ct. 2005)).
	Special Populations	**Considerations for Certain Populations**		Specific considerations are made regarding the screening of nursing home residents, persons who inject non-prescribed drugs, the homeless, long-term inmates in detention centers, among others (Ill. Admin. Code tit. 77, § 696.140).
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
IN	**Prevention of TB Cases**	**TB Control Programs**		DH has a TB control program (Ind. Code § 16-46-9-2; 410 Ind. Admin. Code 2-1-1 et seq.).
	Identification of TB Cases	**Screening**		Certain populations must pass a TB test prior to admission or employment, including: (i) childcare providers and their employees and volunteers (Ind. Code § 12-17.2-3.5-6; 470 Ind. Admin. Code 3-4.7-85); (ii) Foreign students at state universities and residential educational institutions (Ind. Code § 21-40-5-3(b)); (iii) Employees of HFs (410 Ind. Admin. Code 16.2-3.1-14); (iv) Employees of residential care facilities (410 Ind. Admin. Code 16.2-5-12); (v) Children admitted to HFs (410 Ind. Admin. Code 16.2-6-2); (vi) Residents of comprehensive care facilities (410 Ind. Admin. Code 16.2-3.1-18)); (vii) Employees and staff of home health administration facilities (410 Ind. Admin. Code 17-12-1); (viii) Employees and staff at abortion clinics (410 Ind. Admin. Code 26-8-2); (ix) Employees and staff at birthing centers (410 Ind. Admin. Code 27-8-2); (x) Residential staff at community residential facilities for persons with developmental disabilities (431 Ind. Admin. Code 1.1-3-3); (xi) Employees and staff at elderly assisted living centers (460 Ind. Admin. Code 6-15-2); (xii) Children in foster homes and other child caring facilities (465 Ind. Admin. Code 2-9-75, -11-75, -12-73).
		Examination & Testing		All household and close contacts of a reported TB case must take a TB skin test (410 Ind. Admin. Code 1-2.3-106(6)).
		Reporting		LHO must report to DH immediately upon learning of movement of any person with infectious or noninfectious TB into or out of the jurisdiction (410 Ind. Admin. Code 2-1-4). Prison officers must report to DH the release of prisoners known to have infectious TB (Ind. Code 16-41-9-9). A TB patient deemed a threat who leaves HF without authorization must be reported to HO within 24 hours (Ind. Code 16-41-9-7). DH must report and count all cases of TB in the state and disseminate information in annual report (Ind. Code 16-41-3-2).
	Management of TB Cases	**Investigation**		Investigation and case management are responsibilities of the LHO (410 Ind. Admin. Code 1-2.3-106(1)). An investigation by the LHO shall be performed immediately and shall include case management. For individuals with confirmed and suspected cases of pulmonary, laryngeal, or pleural TB, LHO must perform a contact investigation, identifying high and medium priority contacts (410 Ind. Admin. Code 1-2.3-106(1)). For every case of infectious pulmonary TB, LHO must initiate a contact investigation within one business day of reporting and within three business days for noninfectious cases (410 Ind. Admin. Code 1-2.3-106(5)).
		Treatment	**Treatment**	DH may give grants to county clinics, sanatoria, hospitals with outpatient care or in small communities, and private care physicians to treat suspected and confirmed TB patients and contacts. Treatment must include creation of outpatient care centers, provision of drugs, follow-up of suspected cases of TB and their contacts and follow-up of all cases to ensure they are under medical supervision (Ind. Code 16-46-9). LHO shall assure that contacts are appropriately evaluated for TB infection and that a complete course of treatment for latent TB infection is recommended for contacts with evidence of TB infection, regardless of age, unless medically contraindicated. LHO is responsible for recording and reporting to the DH TB Control Program the results of the initial contact investigation within 30 days and post exposure TST within three months and at the completion of treatment (410 Ind. Admin. Code 1-2.3-106(11)). LHO must follow-up with every TB case until full treatment course is completed or until the patient is determined not to have TB (410 Ind. Admin. Code 1-2.3-106(12)). Additional duties of LHO include: requesting laboratory studies, such as AFB smear and cultures as needed for case ascertainment and for determining whether isolation is necessary; requesting drug susceptibility testing of all initial TB isolates as needed; assuring appropriate anti-TB medications are initiated at the appropriate dose; assessing that medication is prescribed; and documenting conversion of sputum and culture to negative for AFB (410 Ind. Admin. Code 1-2.3-106).
			DOT	LHO must follow-up with every TB case until full treatment course is completed, and DOT is the standard of care (410 Ind. Admin. Code 1-2.3-106(12)(E)).
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	Individuals with suspected or confirmed infectious pulmonary TB must be isolated by LHO in a hospital or in the home. In-home isolation requires prohibition of contact with people outside the home unless the individual with TB wears a surgical mask (410 Ind. Admin. Code 1-2.3-106(2)).
			Activities Restricted	LHO must give permission to move infectious patient from one dwelling to another in the jurisdiction (410 Ind. Admin. Code 2-1-3).
		Enforcement		Individuals who intentionally exposes firefighter, police officer, corrections officer or other official emergency staff to bodily fluid infected with TB commit a felony (Ind. Code 35-42-2-6(e); -45-16-2).
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Attending physician or HCP must provide conspicuous notice at time of handling the body of deceased individual with TB (Ind. Code 16-41-13-1). Interjurisdictional Control: LHO must report to DH immediately upon learning of movement of any person with infectious or noninfectious TB into or out of jurisdiction (410 Ind. Admin. Code 2-1-4).HF administrators may transfer nonresident TB patients out-of-state to their legal residence for treatment; costs will be paid by the patient or by DH if patient cannot pay (Ind. Code 16-41-9-10).

State	Objective	PH Intervention		Legal Authorities
KS	**Prevention of TB Cases**	**TB Control Programs**		SHA has power to implement state TB control, treatment and care programs (Kan. Stat. Ann. § 65-116a et seq.).
	Identification of TB Cases	**Screening**		Certain populations shall have a record of a negative TB test or x-ray, including: (i) staff and regular volunteers at day care facilities (Kan. Admin. Regs. §§ 28-4-126, -188); (ii) employees of health care facilities (Kan. Admin. Regs. § 28-4-291); (iii) employees and volunteers at family foster homes (Kan. Admin. Regs. §§ 28-4-333, -337); (iv) youth in foster care facilities (Kan. Admin. Regs. § 28-4-341); (v) youth, employees and volunteers at youth detention centers (Kan. Admin. Regs. §§ 28-4-353, -353b, -356); (vi) staff and volunteers in infant-toddler service agencies (Kan. Admin. Regs. § 28-4-590); (vii) personnel in food and drug establishment (production, packing, manufacturing, etc) (Kan. Admin. Regs. § 28-23-12); (viii) residents and employees of adult care homes (Kan. Admin. Regs. §§ 28-39-161, -163); (ix) residents and employees at care homes for the mentally retarded (Kan. Admin. Regs. §§ 28-39-249, -253, -284); and (x) employees of the school district who are regularly in contact with pupils (Kan. Stat. Ann. § 72-5213).
		Examination & Testing		Any HO that has reasonable grounds to suspect a case of TB must order examination by primary care physician or HF (Kan. Stat. Ann. § 65-116b). Prophylactic treatment and follow-up must be provided to staff or volunteers of daycare facilities exposed to TB (Kan. Admin. Regs. § 28-4-126).
		Reporting		Licensed healthcare professionals must report cases or suspected cases of active TB within 4 hours by telephone to SHA and latent cases within 7 days (Kan. Admin. Regs. § 28-1-2). Laboratories must report positive tests for TB bacteria within 48 hours (Kan. Admin. Regs. § 28-1-18).
	Management of TB Cases	**Investigation**		Whenever it has been determined that any person has active TB or TB in a communicable form, and such person is not immediately admitted as a patient in a HF for treatment of TB, the HO shall instruct such person of the precautions necessary to prevent the spread of TB (to members of household and community), and it shall be the duty of the individual with TB to prevent the spread of TB. HO also has duty to investigate periodically to ensure precautions are being followed (Kan. Stat. Ann. § 65-116c).).
		Treatment	**Treatment**	Individuals with active TB or TB in a communicable form shall admit themselves into a HF for treatment. If HO determines that the individual poses no danger to the public or other individuals, he/she may receive treatment on an outpatient basis (Kan. Stat. Ann. § 65-116b). Treatment and ongoing monitoring will be provided to TB patients (Kan. Stat. Ann. § 65-129e(b)). Patients have a duty to take necessary precautions to prevent the spread of TB (Kan. Stat Ann. § 65-116c).
			DOT	
		Specific Measures	**Emergency Detention**	Court may order hospital detention for individuals who fail to report for examination and testing or who fail to take precautions necessary to prevent the spread of TB (Kan. Stat. Ann. § 65-116d).
			Quarantine	
			Isolation	HO shall isolate individuals with pulmonary TB until three sputa obtained on consecutive days are negative by microscopic examination (Kan. Admin. Regs. § 28-1-6(22)).
			Activities Restricted	Patient in violation of Kan. Stat. Ann. § 65-116d (a) and (b) shall be committed to HF, HO may direct HF to isolate (Kan. Stat. Ann. § 65-116e).
		Enforcement		If suspected TB patient fails to report for examination and testing or fails to take precautions to prevent spread of TB as ordered, HO shall file notice to county or district attorney to bring criminal proceedings against that patient (Kan. Stat. Ann. § 65-116d).
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		School personnel may waive TB skin test requirement based on religious beliefs by presenting an alternative certification of health (certificate by licensed physician, assistant or nurse practitioner stating that freedom from TB of the employee has been established) (Kan. Stat. Ann. § 72-5213).
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Interjurisdictional Control: SHA has power to return any person who has not been a KS resident for at least one year prior to being admitted for treatment of TB in state HF (Kan. Stat. Ann. § 39-110).

State	Objective	PH Intervention		Legal Authorities
KY	**Prevention of TB Cases**	**TB Control Programs**		SHA is compelled to maintain a TB control program in cooperation with other states' departments (Ky. Rev. Stat. Ann. § 215.520).
	Identification of TB Cases	**Screening**		The following populations must be screened for TB: (i) all private and public school children prior to entry to school (as requested by LHD) (Ky. Rev. Stat. Ann. § 214.034(2); 902 Ky. Admin. Regs. 2:090); (ii) entering residents of nursing homes and long-term care facilities (when entering and annually thereafter) (902 Ky. Admin. Regs. 20:200(3)) and also employees (902 Ky. Admin. Regs. 20:048); (iii) school employees if they are at high risk for TB (all school employees must undergo a TB risk assessment) (704 Ky. Admin. Regs. 4:020); staff members of HCFs (hospitals) (before employment, or soon after starting, and annually thereafter) (902 Ky. Admin. Regs. 20:016, :200); (iv) employees and patients of skilled nursing facilities (902 Ky. Admin. Regs. 20:026); (v) employees and patients of personal care homes (902 Ky. Admin. Regs. 20:036); (vi) employees of adult health and day care programs (902 Ky. Admin. Regs. 20:066); (vii) staff of outpatient health care center (902 Ky. Admin. Regs. 20:074); (viii) staff of rehabilitation centers (902 Ky. Admin. Regs. 20:240); (ix) employees of Alzheimer's nursing homes (902 Ky. Admin. Regs. 20:291); (x) employees and volunteers of residential hospice facilities (902 Ky. Admin. Regs. 20:380); (xi) adults living in family child care homes (922 Ky. Admin. Regs. 2:100); (xii) staff at daycare facilities (922 Ky. Admin. Regs. 2:110).
		Examination & Testing		No person diagnosed with active TB may refuse to submit to further examination if reasonably requested by DH or LHO (Ky. Rev. Stat. Ann. § 215.550(2)). All HCPs must order drug-susceptibility tests for patients with active TB (Ky. Rev. Stat. Ann. § 215.531). Local health department may require testing for suspected case of TB in students (Ky. Rev. Stat. Ann. § 214.034(2)). School employees exposed to TB must be tested (704 Ky. Admin. Regs. 4:020).
		Reporting		HFs and HCPs must report known cases of active TB to LHD (Ky. Rev. Stat. Ann. § 215.590(1)). HFs and HCPs must report results of drug-susceptibility tests and all cases of drug-resistant TB to LHD (Ky. Rev. Stat. Ann. § 215.590(2)). HFs and HCPs must notify DH or LHA within one business day if there is a reasonable belief that a patient has TB (902 Ky. Admin. Regs. 2:020). Nursing homes and long-term care facilities must report all positive tests for TB in residents and staff to LHD (902 Ky. Admin. Regs. 20:200(10)). HCFs shall report to LHA if an employee tests positive for TB (or if TB infection is suspected) (902 Ky. Admin. Regs. 20:016, 20:086).
	Management of TB Cases	**Investigation**		See enforcement section (investigations initiated after person submits affidavit)
		Treatment	**Treatment**	Active TB patients found by court to be noncompliant will first receive probation and be ordered into inpatient TB facility or other treatment program (Ky. Rev. Stat. Ann. § 215.570). No person diagnosed with TB may refuse to follow treatment if DH or LHO determines it is needed (Ky. Rev. Stat. Ann. § 215.550(2)). See enforcement section for additional treatment orders (investigations initiated after person submits affidavit). Parents of children infected with TB must have their children examined and treated for TB (Ky. Rev. Stat. Ann. § 214.034).
			DOT	
		Specific Measures	**Emergency Detention**	See enforcement section (investigations initiated after person submits affidavit).
			Quarantine	
			Isolation	See enforcement section (investigations initiated after person submits affidavit).
			Activities Restricted	Nursing homes and long-term care facilities may not admit a patient being treated for pulmonary TB unless shown to be non-infectious (902 Ky. Admin. Regs. 20:200(2)).
		Enforcement		Individuals with active TB have a legal duty to the public to take reasonable precautions to prevent the spread of TB; a violation will result in a misdemeanor with a minimum fine of $500 or minimum jail time of 6 months (Ky. Rev. Stat. Ann. § 215.570). Individuals may sign an affidavit addressed to the DH when they suspect that someone has willingly failed to comply with treatment and other requirements, in which case LHO must conduct an investigation and, if appropriate, issue an order for isolation, quarantine, examination, treatment or other necessary orders (Ky. Rev. Stat. Ann. §215.560).
	Safeguarding Rights	**Due Process**		If DH files a petition against noncompliant TB patient, defendant has right to be represented by counsel and case will be treated as a civil case. Standard is preponderance of the evidence that TB patient has not complied (Ky. Rev. Stat. Ann. §215.560(2)).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		Immunization and testing of a child may be waived based on the parents' religious beliefs (Ky. Rev. Stat. Ann. §§ 214.036, .034).
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
LA	**Prevention of TB Cases**	**TB Control Programs**		SHA must maintain TB Control Program (La. Rev. Stat. Ann. § 40:4).
	Identification of TB Cases	**Screening**		Certain populations must be tested for TB prior to employment or admittance, including: (i) Applicants to nursing homes (La. Rev. Stat. Ann. § 40:1300.31; La. Admin. Code tit. 51, Part II § 505); (ii) Employees, volunteers and residents of medical or 24-hour residential facilities (La. Admin. Code tit. 51, Part I, §503); (iii) Prison inmates being admitted for more than 48 hours (La. Admin. Code tit. 51, Part XVIII, § 301); (iv) Persons with AIDS or infected with HIV when receiving treatment for such conditions (La. Admin. Code tit. 51, Part I, § 503); (v) Students in health care professions (La. Admin. Code tit. 51, pt. XVII, § 501).
		Examination & Testing		DH may establish free diagnostic clinics in the state (La. Rev. Stat. Ann. § 40:28).
		Reporting		When an individual with infectious TB disease, is a patient in a hospital, and refuses treatment, HCP shall contact SHA (La. Rev. Stat. Ann. § 40:17 B(2)). When emergency services workers (*e.g.* firefighters, paramedics, etc) come into direct contact with a patient who is subsequently diagnosed as having untreated pulmonary TB, the HCF shall notify the appropriate department (La. Rev. Stat. Ann. § 40:1099).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	Persons with TB are encouraged to seek voluntary treatment (La. Rev. Stat. Ann. § 40:31.21). A person committed into a treatment facility may receive medication and treatment without his/her consent (La. Rev. Stat. Ann. § 40:31.22). Indigent persons may be admitted to state-operated hospitals for TB treatment (La. Rev. Stat. Ann. § 40:1172). HCF directors may discharge TB committed persons, upon the recommendation of the SHO or his designee (La. Rev. Stat. Ann. § 40:31.28). HCFs (and nursing homes) shall treat persons with TB in a communicable state or suspected of having TB in a communicable state in 'isolation rooms with negative air pressure' (La. Admin. Code tit. 51, Part XIX, § 103, Part XX, § 105).
			DOT	HCP and TB patient negotiate the time and place of DOT as part of the 'voluntary patient compliance agreement' (La. Admin. Code tit. 51, Part II, § 121). Non-compliance with the voluntary agreement authorizes SHO to issue quarantine orders for DOT (La. Admin. Code tit. 51, Part II, § 121).
		Specific Measures	**Emergency Detention**	If SHA believes a person with active TB is a public health risk, he/she has the power to file for a protective custody order to bring the person into a HF within 72 hours (La. Rev. Stat. Ann. § 40:31.24). Involuntary Detention: If an individual with active TB is admitted to HCF for treatment and refuses to execute the informed consent documents, he/she can be involuntarily admitted (La. Rev. Stat. Ann. § 40:31.23). If there are grounds to believe that a patient will not comply with treatment, SHO may request that DA issue a hospitalization order (La. Admin. Code tit. 51, Part II, §121).
			Quarantine	
			Isolation	SHA may order active TB patient into isolation for failing to seek voluntary treatment or comply with quarantined directly observed treatment (La. Rev. Stat. Ann. § 40:31.21). See DOT (above) for quarantine orders related to DOT. If, after quarantine orders for DOT, the TB patient still does not comply, SHO may issue quarantine order for hospitalization (La. Admin. Code tit. 51, Part II, §121).
			Activities Restricted	Midwives cannot aid women who have TB disease (51 LA ADC Pt XLV, §5361). No individual with evidence of active TB shall be admitted to a nursing home unless the examining physician states that the resident is on an effective drug regimen, is responding to treatment, and presents no imminent danger to other patients or employees, or unless the facility has been specifically cleared by the Office of Public Health and the Department of Health and Hospitals to house patients with active TB (La. Admin. Code tit. 51, Part II, § 505).
		Enforcement		Criminal charges may be filed if patient refuses to adhere to court-ordered quarantine/isolation (La. Admin. Code tit. 51, Part II, § 121).
	Safeguarding Rights	**Due Process**		A person with active TB may not be held involuntarily without opportunity for a hearing (La. Rev. Stat. Ann. § 40:31.21). A person admitted to TB HF must be informed in writing of procedures for release and availability of counsel (La. Rev. Stat. Ann. § 40:31.22(c)). Active TB patients under protective custody may not be held more than 12 hours without being brought to a treatment facility (La. Rev. Stat. Ann. § 40:31.24(c)). Within 7 days of involuntary admission into HF, HO must file a petition in court to keep TB patient admitted (La. Rev. Stat. Ann. § 40:31.25). Detained TB patient has: (i) right to counsel or court-appointed counsel if indigent; (ii) right to be present at and participate fully in hearing (through telecommunication); (iii) right to present evidence; (iv) right to seek additional medical opinion to counter SHA's assessment of public health risk (La. Rev. Stat. Ann. § 40:31.25). Court must find by clear and convincing evidence that patient is a public health risk in order to continue detention (La. Rev. Stat. Ann. § 40:31.26) All judicially committed patients will have their cases reviewed annually (La. Rev. Stat. Ann. § 40:31.27(b)). Every 90 days, there must be a written report by HF on reasons for continued involuntary treatment. Right of habeas corpus shall not be denied (La. Rev. Stat. Ann. § 40:31.27(e)). Right to appeal shall be granted (La. Rev. Stat. Ann. § 40:31.27(c)).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
MD	**Prevention of TB Cases**	**TB Control Programs**		When requested by HO or physician, the Sec'y shall provide printed instructions and supplies necessary to prevent or control the spread of TB (Md. Code Ann., Health-General § 18-323). The CDC's 1994 "Guidelines for preventing the transmission of *Mycobacterium tuberculosis* in health-care facilities" (MMWR 1994;43 (No.RR-13)) are incorporated into the regulations for comprehensive & extended care facilities (Md. Code Regs. 10.07.02.01-1, .21-1, .21-2); such facilities shall have policies & procedures for TB surveillance of residents (Md. Code Regs. 10.07.02.09A(14)). Licensed child care programs shall comply with the CDC's guidelines for the prevention of TB (Md. Code Regs. 14.31.06.13I).
	Identification of TB Cases	**Screening**		Maryland laws and regulations establish a comprehensive list of employees, staff or patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) residents and employees of comprehensive/extended care facilities (Md. Code Regs. 10.07.02.09A(16), .21-2); (ii) new residents in assisted living arrangements (Md. Code Regs. 10.07.14.09B(5)); (iii) licensed HCPs at nursing referral agencies (Md. Code Ann., Health-Gen. § 19-4B-03; Md. Code Regs. 10.07.07.08B(1)(c)); (iv) employees of child care centers (Md. Code Regs. 13A.14.02.48, .05.38); (v) employees of licensed child placement agencies (Md. Code Regs. 07.05.01.13C); (vi) patients at psychiatric day treatment centers (Md Code Regs 10.21.02.03C); (vii) inmates at community adult rehabilitation centers (Md. Code Regs. 12.02.03.08a(7)(c)); (viii) employees supervising children at state-run residential education facilities (Md Code Regs 14.31.07.04); (ix) staff at community non-residential youth programs (Md. Code Regs. 16.17.05.04); (x) personnel at drug and alcohol treatment programs (Md Code Regs 10.47.01.03C(3)(i)); (xi) households of foster family applicants (Md. Code Regs. 07.02.25.05D(3)); (xii) households of individuals seeking foster parent certification (initially and every 2 years) (Md. Code Regs. 07.05.02.06); (xiii) staff members at residential treatment centers for emotionally disturbed children (initially and annually) (Md. Code Regs. 10.07.04.14); (xiv) volunteers at comprehensive/extended care facilities are urged to accept TB testing as considered necessary by the facility (Md. Code Regs. 10.07.02.21-3).
		Examination & Testing		Sec'y or HO may have an individual examined if Sec'y or HO knows or is notified that the individual is suspected of having TB (Md. Code Ann., Health-Gen. § 18-324(a)). The Sec'y may not require a physical examination other than a chest X ray and the rendering of sputum samples (Md. Code Ann., Health-Gen. § 18-324(c)). HO shall direct TB testing for contacts of patients with communicable TB (Md Code Regs 10.06.01.21B).
		Reporting		Laboratories must report TB cases to LHO; out-of-state laboratories testing a specimen from a person in the state must report evidence of TB to the Sec'y (Md. Code Ann., Health-Gen. § 18-205). Residential Treatment Centers for emotionally disturbed children must file reports of annual TB exams of staff with LHO (Md Code Regs 10.07.04.14H). HCPs, HCFs, laboratories and other persons shall report confirmed or suspected TB cases to HO or Sec'y (Md. Code Regs 10.06.01.03).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	Sec'y or HO may order medical care for a person with TB whose condition endangers, or may endanger, the public health of the community (Md. Code Ann., Health-Gen. § 18-324(b)(1)). HCP shall follow national and State standards of care for TB treatment (Md. Code Regs. 10.06.01.21A(3)). HO shall monitor to determine appropriate treatment (Md. Code Regs. 10.06.01.21A(4)). HO may require supervision of individuals with noncommunicable TB if adequate treatment is refused (Md. Code Regs. 10.06.01.21A(6)).
			DOT	
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	An HO or HCP shall isolate a patient with communicable TB (Md. Code Regs. 10.06.01.21A(1)). The Sec'y or HO may order medical quarantine at home, in a HF, or in another medically appropriate living arrangement for an individual who fails to comply with a treatment order (Md. Code Ann., Health-Gen. § 18-324(b)(2)). The Sec'y or HO may impose other conditions necessary to protect the health of the public or of the patient (Md. Code Ann., Health-Gen. § 18-324(b)(3)).
			Activities Restricted	Persons with TB in a communicable stage may not work in public/private/parochial schools; employees may be required to furnish TB certification (Md. Code Ann., Educ. § 7-406); Active TB is grounds for denial of foster home approval (Md. Code Regs. 07.02.25.05D(3)); Motorcycle safety instructors must be free from TB (Md. Code Regs. 11.20.01.26B(4)).
		Enforcement		An individual ordered to be quarantined may not refuse to comply with the order, behave in a disorderly manner, or leave placement before discharge (Md. Code Ann., Health-Gen. § 18-325(a)-(b)). Violation of these provisions is a misdemeanor. Upon conviction, a person shall be imprisoned in a penal institution with TB treatment facilities until the Sec'y or DH of Baltimore City find the condition no longer endangers community health or the Sec'y obtains a court order moving the individual to a less restrictive treatment setting (Md. Code Ann., Health-Gen. § 18-325(c)).
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		Laboratory reports are confidential (Md. Code Ann., Health-Gen. § 18-205(i)). The Sec'y must keep a confidential register of individuals with TB (Md. Code Ann., Health-Gen. § 18-322). Where a public servant is notified of TB exposure (see below), it should be in a manner that will protect the patient's and the public servant's confidentiality (Md. Code Ann., Health-Gen. § 18-213 & 213.1-.2).
		Anti-Discrimination		
		Religious Exemptions		An individual has the right to select a treatment method if she/he relies on spiritual means through prayer for healing and complies with laws/rules/regulations relating to sanitation and quarantine for infectious/contagious/communicable diseases (Md. Code Ann., Health-Gen. § 18-324(c)).
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Certain public servants (*e.g.*, fire marshals, fire fighters, law enforcement & correctional officers, paramedics) who come into contact with a patient subsequently diagnosed with TB shall be notified by the HF of exposure (Md. Code Ann., Health-Gen. § 18-213 to -213.2).

State	Objective	PH Intervention		Legal Authorities
MA	**Prevention of TB Cases**	**TB Control Programs**		DPH must conduct TB control (and eradication) programs (Mass. Gen. Laws ch. 111, § 81). District HOs must gather and disseminate relevant TB information and after consultation with DPH and LHA work on TB eradication (Mass. Gen. Laws ch. 111, § 18).
	Identification of TB Cases	**Screening**		Massachusetts laws and regulations require the establishment of a comprehensive list of employees, staff or patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) inmates of state correctional facilities (Mass. Gen. Laws ch. 127, § 16; 103 Mass. Code Regs. 932.07; 105 Mass. Code Regs. 205.200); (ii) staff of child placement and adoption services centers (102 Mass. Code Regs. 5.08); (iii) staff assigned to maternal and newborn areas in hospitals (105 Mass. Code Regs. 130.626); (iv) staff of birth centers (105 Mass. Code Regs. 142.520); (v) patients in medical centers for substance abuse detoxification (105 Mass. Code Regs. 160.405, 162.401); (vi) employees of residential drug free programs (105 Mass. Code Regs. 750.700); (vii) staff of adult day health services (130 Mass. Code Regs. 404.408); (viii) staff and caregivers of adult foster care (130 Mass. Code Regs. 408.433–.434); (ix) employees of long term care facilities (105 Mass. Code Regs. 150.002); (x) personnel of alcohol treatment programs from operating under the influence (105 Mass. Code Regs. 166.062).
		Examination & Testing		LBHs, institutions, schools, and colleges may not require a chest X ray examination to show freedom from TB in a communicable form, unless the recipient of such X ray tests positive for TB. Any required report showing freedom from TB in a communicable form shall be based upon a negative intradermal tuberculin test that is administered and interpreted in a manner approved by the commissioner. In the case of a person whose tuberculin test is positive, a statement by a physician, based upon the results of a standard chest x-ray film shall be required, and such other laboratory and clinical examinations as may be necessary for the exclusion of TB in a communicable form. (Mass. Gen. Laws ch. 111, § 81A)
		Reporting		HCPs (or other institution) shall report LHA confirmed (or suspected –as defined in 105 Mass. Code Regs. 365.004)) TB cases directly to the DPH (Mass. Gen. Laws ch. 111, § 111; 105 Mass. Code Regs. 365.500; 105 Mass. Code Regs.). HCPs, laboratories, HCFs must report confirmed or suspected active TB cases to the DPH (Division of TB Control) (105 Mass. Code Regs. 300.180(A)) & HCPs and HCFs must report cases of latent TB infection to the DPH (105 Mass. Code Regs. 300.180(B)). HCPs must notify LBH or DTBC of suspected or confirmed cases of infectious TB who are unwilling or unable to receive proper care (105 Mass. Code Regs. 365.300).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	DPH must establish a state TB treatment center (a facility with adequate safeguards to prevent the escape of patients who have been compulsorily hospitalized –see below) (Mass. Gen. Laws ch. 111, § 94). DPH must provide hospital care and treatment to MA residents suffering from TB and who need such hospital care (Mass. Gen. Laws ch. 111, § 77). DPH may issue regulations regarding the care and treatment of TB patients (Mass. Gen. Laws ch. 111, § 78). DPH may admit patients with extra-pulmonary TB to Lakeville Hospital, provided that preference is given to MA citizens (Mass. Gen. Laws ch. 111, § 65A).[3] PH commissioner and PH council may issue regulations regarding outpatient TB treatment and methods for determining active TB (Mass. Gen. Laws ch. 111, §94H). TB treatment shall be completed according to the standards of the CDC and the American Thoracic Society (105 Mass. Code Regs. 365.200, .300(A), .400).
			DOT	HCPs or individuals identified by the LBH shall employ DOT when there is an identified risk of nonadherence to treatment. (105 CMR 365.200(C)(6)(d)).
		Specific Measures	**Emergency Detention**	Compulsory hospitalizations include a short-term observation period and a long-term court commitment (Mass. Gen. Laws Ann. ch. 111 § 94A) (see above). Compulsory hospitalization processes start when a person: (i) is afflicted with active TB, (ii) is unwilling or unable to receive proper medical treatment, and (3) is thereby a serious danger to the public health. (Mass. Gen. Laws ch. 111, § 94A(a)) The commissioner may issue regulations governing this process (Mass. Gen. Laws ch. 111, § 94H). If the above three criteria are met, the commissioner shall file a petition in district court for an order of compulsory hospitalization. If the person refuses examination or the commissioner determines that immediate hospitalization is needed, he/she may order immediate hospitalization for an observation period (max. 15 days) (Mass. Gen. Laws ch. 111, § 94A(b)-(c)). At the end of the observation period, patient must be released or HA must file a court petition to extend hospitalization; the patient may be detained pending the court's decision (Mass. Gen. Laws ch. 111, § 94A(e)). If the patient wants to leave facility against medical advice, and it is determined that his/her release would be a serious danger to the public health, the superintendent may: (1) detain the patient and file a court petition for prolonged hospitalization, or (2) transport the patient to the state TB treatment center, (where the patient will be detained for the observation period) (Mass. Gen. Laws ch. 111, § 94B). If after the hearing (see "Due Process" below) it is determined that the patient has TB and is unwilling to accept treatment, and thus he/she is a danger to the public health, the court shall commit the individual to the TB treatment center. (Mass. Gen. Laws ch. 111, § 94C).
			Quarantine	
			Isolation	DH and LBH are authorized to order isolation of individuals with confirmed or suspected pulmonary or laryngeal TB, until bacteriologically negative based on three consecutive negative sputum smears, submitted within a time period specified in the most current recommendations of the U.S. Centers for Disease Control and Prevention; or until 14 days after the initiation of appropriate effective chemotherapy, provided therapy is continued as prescribed, and there is demonstration of clinical improvement. (105 CMR 300.200).
			Activities Restricted	Persons with active TB are not considered appropriate candidates for Halfway houses for alcoholic recovery (105 Mass. Code Regs. 165.500).
		Enforcement		See "Treatment" above.
	Safeguarding Rights	**Due Process**		Patient subject to compulsory hospitalization: (i) must be informed of his/her right to a hearing; (ii) if excluded from being present at hearing (due to physician advice), must be informed of his/her right to have counsel and witnesses present at the hearing; (iii) must be informed of his/her right to a court-appointed attorney if he/she does not have one. (Mass. Gen. Laws ch. 111, § 94C). Person committed may file a court order for release. If the petition is denied, the person cannot file another petition until at least 6 months after the date of denial (Mass. Gen. Laws ch. 111, § 94G).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		Inmates of public charitable institutions and prisoners in penal institutions who have TB must be treated, and, if determined necessary, isolated. Before releasing inmates with TB, the institution must notify the department of public welfare and keep the prisoners in treatment in the institution until the department provides for their care and treatment (Mass. Gen. Laws ch. 111, § 121; Mass. Gen. Laws ch. 127, § 151).
	Additional TB Provisions			Health education curriculum for all students in public schools must include instruction on TB and its prevention. (Mass. Gen. Laws ch. 71, § 1).

State	Objective	PH Intervention		Legal Authorities
MI	**Prevention of TB Cases**	**TB Control Programs**		
	Identification of TB Cases	**Screening**		Michigan requires some populations to be tested for TB (before employment or admission, as applicable), *e.g.*: (i) individuals admitted to homes for the aged (and annually thereafter) ((Mich. Admin. Code R. 325.2056); (ii) employees of homes for the aged (Mich. Admin. Code R. 325.20402); (iii) employees of nursing homes (annually thereafter) (Mich. Admin. Code R. 325.20402; (iv) staff of adult foster care family homes (Mich. Admin. Code r. 400.1405, Mich. Admin. Code r. 400.14205 and Mich. Admin. Code r. 400.15205); (v) staff of family and group child care homes (Mich. Admin. Code r. 400.1906); (v) staff and employees of child care institutions (Mich. Admin. Code r. 400.4114) & (Mich. Admin. Code r. 400.5104b); (vi) employees and volunteers at juvenile facilities (Mich. Admin. Code r. 400.10115); (vii) inmates in jails and prisons (Mich. Admin. Code r. 791.732).
		Examination & Testing		
		Reporting		Physicians must report diagnosis or discovery of TB to the appropriate health department (Mich. Admin. Code r. 325.173). If residents of nursing homes and nursing care facilities test positive for TB, the LHD must be notified and the patient must be evaluated (Mich. Admin. Code r. 325.20506).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	LHD must immediately provide the necessary care for individuals known to have TB. LHD must issue an order authorizing the care. The LHD must promptly report the action taken to the county department of social services of the individual's domicile (Mich. Comp. Laws Ann. 333.5117). The county where TB patient has a domicile is charged with his/her care (Mich. Comp. Laws Ann. 333.5301). An individual receiving medical treatment as an inpatient for TB may receive medical services under the Social Welfare Act (Mich. Comp. Laws Ann. 400.109). Any person afflicted with TB may be admitted to the sanatorium on a certificate of the LHO. The board of trustees may accept TB patients who are not residents of the county establishing and maintaining the sanatorium. On the first day of each month the board of trustees of the sanatorium shall report to the department of community health the number of patients treated during the preceding month (Mich. Comp. Laws Ann. 332.159). The board of trustees of TB sanatoria may admit patients for the treatment of diseases other than TB (Mich. Comp. Laws Ann. 332.159a). The board of supervisors of any county in the state having a population of more than 30,000 must establish, maintain and operate a hospital or sanatorium for the treatment of TB (Mich. Comp. Laws Ann. 332.151, see also . Mich. Comp. Laws Ann. 400.151). Public-owned TB sanatoria may use their facilities only for the treatment of TB patients and may not convert excess beds to treatment of patients afflicted with other diseases; but TB hospitals established and operating under the authority of other statutes may convert excess beds if the statutes do not prohibit such conversion and proper steps are taken by the governing body of the institutions concerned (Op.Atty.Gen.1955-56, No. 2578, p. 776). There shall be routine instruction for patients and orientation for employees in hospitals to inform them of the hazards of TB (Mich. Admin. Code r. 325.1060).
			DOT	
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	
			Activities Restricted	An individual requiring special treatment for TB shall not be admitted or retained for care in a nursing home unless the home is able to provide an area and a program for such care (Mich. Comp. Laws Ann. 333.21717. See also Mich. Comp. Laws Ann. 400.58).
		Enforcement		
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		Jails and lock ups: an inmate diagnosed with contagious TB shall be removed from the facility or quarantined in well-ventilated quarters and separated from other inmates. In a case of suspected contagious TB, the administrator must consult with the facility's health authority or the local health department. If the inmate needs hospitalization, the administrator must transport him/her to the hospital (Mich. Admin. Code r. 791.732).
	Additional TB Provisions			In accordance with written facility policies and the orders of the physician in charge, patients in a tuberculosis nursing facility (nursing homes and nursing care facilities) shall be permitted to visit other patients in the tuberculosis nursing facility and receive visitors (Mich. Admin. Code r. 325.21806).

State	Objective	PH Intervention		Legal Authorities
MS	**Prevention of TB Cases**	**TB Control Programs**		
	Identification of TB Cases	**Screening**		Mississippi requires some populations to be tested for TB, *e.g.*: (i) offenders in (and employees of) state and private correctional facilities (Miss. Code Ann. § 41-23-1(10)) & (15-2-11 Miss. Code R. § 117.02(2)) ((15-2-11 Miss. Code R. § 117.02(5)) (15-2-11 Miss. Code R. § 117.02(6))) (15-2-11 Miss. Code R. § 117.02(9) (for inmates), § 117.02(10) (for employees), and § 117.02(14) (for both); (ii) all staff of and those applying for residency in adult care foster facilities (15-3(01)-83 Miss. Code R. §§ 110.05 & 111.03); (iii) all hospice employees who have contact with patients (15-3(01)-01 Miss. Code R. § 111.04); (iv) all staff and residency applicants of institutions for the aged or infirm (15-3(01)-45 Miss. Code R. §§ 115.05 & 119.01-.02); all staff and residency applicants of personal care facilities (15-3(01)-47 Miss. Code R. §§ 110.07 & 111.03, & 15-3(01)-48 Miss. Code R. §§ 110.07 & 111.03).
		Examination & Testing		LHO must request that persons suspected of having active TB submit to a medical examination (Miss. Code Ann. § 41-33-15). Hospitals and physicians and employees thereof may conduct a TB test without the consent of the patient if they determine it to be necessary to provide appropriate treatment to the patient or to protect the health of other patients or those providing treatment (Miss. Code Ann. 41-41-16).
		Reporting		TB is declared a reportable disease (15-2-11 Miss. Code R. §§ 100.01 & 116.15(1) app. A). TB infection in children less than 15 years of age must "be reported [to DH]" (15-2-11 Miss. Code R. app. A). Laboratories must report findings related to TB (15 Miss. Code R., pt. II, subpt. 11, app. C.). "Significant tests" administered in correctional facilities must be reported to the DH (15-2-11 Miss. Code R. § 117.02(5)). Employees of correctional facilities that have tested positive for TB must be reported to DH (15-2-11 Miss. Code R. § 117.02(13)).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	Physicians treating TB patients who are detained pursuant to Miss. Code Ann. §§ 41-33-3 and 41-33-9 (see below) may discharge such patients to home care with the approval of the LHO (Miss. Code Ann. § 41-33-11). LHOs are charged with prescribing TB treatment (15-2-11 Miss. Code R. § 116.15(2)). In correctional facilities, "latent therapy, active treatment and treatment follow-up of inmates and employees for [TB]" must be conducted in accordance with the *Tuberculosis Manual of the MDH* (15-2-11 Miss. Code R. § 117.02(6)). The facility's medical director is authorized to issue TB treatment procedures (15-2-11 Miss. Code R. § 117.02(7)(d)).
			DOT	
		Specific Measures	**Emergency Detention**	Individuals with active TB who do not adhere to HO's "minimum precautions" for prevention may be committed to a hospital or state detention facility equipped to isolate TB patients (Miss. Code Ann. § 41-33-3). If a person quarantined does not comply with restrictions prescribed by LHO, LHO may request approval from DH to initiate judicial proceedings to commit the person. (*See* "Due Process" below) (15-2-11 Miss. Code R. § 116.15(2)).
			Quarantine	In correctional facilities, the medical director may place inmates in quarantine for containment or screening purposes (15-2-11 Miss. Code R. § 117.02(7)(a)).
			Isolation	If a person fails to comply with isolation as prescribed by the LHO, the LHO must quarantine the person (15 Miss. Code R., pt. II, subpt. 11, § 116.15(2). Inmates experiencing symptoms of TB must be placed in isolation until TB is ruled out (15-2-11 Miss. Code R. § 117.02(5)). Residents of institutions for the aged or infirm, or residents of personal care homes (*e.g.*, assisted living), suspected of TB infection must be isolated (15-3-1(45) Miss. Code R. §119.04; 15-3-01(47) Miss. Code R. § 111.05).
			Activities Restricted	Persons with infectious TB are prohibited from employment in all schools within the state (public or private) (Miss. Code Ann. § 37-11-13). Children suspected of or diagnosed with TB must obtain written permission from the DH Tuberculosis Control Program in order to return to a child care facility (15-3-55(01) Miss. Code R. app. I-18, & ch. 02, app. I-18 or to school (MDH, *Return to School Guidelines*, at 9 (3d ed., 2000)).
		Enforcement		Refusal to submit to a medical examination is a misdemeanor (Miss. Code Ann. § 41-33-15).
	Safeguarding Rights	**Due Process**		LHOs must obtain approval from the executive officer of the state board of health to pursue a court order for the detention of a person with active TB. The LHO's request must state the reasons justifying detention (Miss. Code Ann. § 41-33-5). If judicial proceedings are initiated, the person whose detention is sought is entitled to a public hearing and "counsel of his own selection." (Miss. Code Ann. § 41-33-7). LHOs must have "reasonable grounds" to believe that a person has active TB before requiring submission to a medical examination (Miss. Code Ann. § 41-33-15). Court decision: Prison officials and healthcare workers do not violate pretrial detainee's right to due process in refusing his request for a TB test when such tests were being administered only to inmates who were known to have contact with an individual with active TB or who were symptomatic *(See Gibbs v. Grimmette*, 254 F.3d 545 (5th Cir. 2001)).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Deceased persons with TB must be marked with a warning tag reading "blood/body fluid precautions required" (Miss. Code Ann. § 41-39-13(2)). Insurance policies issued after Aug. 6, 1968 that cover TB may not exclude hospitalization benefits for patients treated in tax-supported state, country, or municipal institutions. (Miss. Code Ann. § 83-9-7).

State	Objective	PH Intervention		Legal Authorities
MO	**Prevention of TB Cases**	**TB Control Programs**		The DH must maintain a bureau of TB control (Mo. Ann. Stat. § 192.050). The DH shall also have jurisdiction over the accounts of TB hospitals (Mo. Ann. Stat. § 192.010).
	Identification of TB Cases	**Screening**		Missouri laws and regulations establish a comprehensive list of employees, staff, or patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) health care workers and volunteers in nursing homes (Mo. Ann. Stat. § 199.350); (ii) child care service providers (Mo. Code Regs. Ann. tit. 13, § 40-32.020. See also Mo. Ann. Stat. § 210.027); (iii) private duty nursing: before contact with clients (Mo. Code Regs. Ann. tit. 13, § 70-95.010); (iv) child care providers and children in license-exempt child care facilities (Mo. Code Regs. Ann. tit. 19, § 30-60.060); (v) residents and staff of residential care and assisted living facilities (Mo. Code Regs. Ann. tit. 19, § 30-86.042); (vi) residents and staff of long-term care facilities and state correctional centers (Mo. Code Regs. Ann. tit. 19, § 20-20.100); (vii) patients of alcohol and drug abuse programs (Mo. Code Regs. Ann. tit. 9, § 30-3.132); (viii) staff of community residential facilities (Mo. Code Regs. tit. 9, § 40-6.075); (ix) all children in social services must be tested for TB (Mo. Code Regs. Ann. tit. 13, § 40-71.060); (x) private duty nursing care providers (Mo. Code Regs. Ann. tit. 13, § 70-95.010); (xi) employees, volunteers and residents of long term care facilities (Mo. Code Regs. Ann. tit. 19, § 20-20.100); (xii) foster families (if determined by physician) (Mo. Code Regs. Ann. tit. 13, § 35-60.030).
		Examination & Testing		The DH shall develop educational materials recommending that infants and young children be tested for TB (Mo. Ann. Stat. § 192.072).
		Reporting		Laboratories are required to report TB to the DH (Mo. Code Regs. Ann. tit. 19, § 20-20.080). TB is a reportable disease and must be reported to the LHA or to the DH within 24 hours of first knowledge or suspicion (Mo. Code Regs. Ann. tit. 19, § 20-20.020).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	A person found to have TB must follow the instructions of the local board, obtain the required treatment, and minimize the risk of infecting others with TB (Mo. Ann. Stat. § 199.180). No person committed to a facility designated by the curators of the University of Missouri under V.A.M.S. 199.170 to V.A.M.S. 199. 270 is required to submit to medical or surgical treatment without his/her consent (Mo. Ann. Stat. § 199.240).
			DOT	
		Specific Measures	**Emergency Detention**	If the board determines that a person with active TB, or a person who is a potential transmitter, poses an immediate threat to other persons, the board may file an ex parte petition for emergency temporary commitment (Mo. Ann. Stat. § 199.180). If the petition is granted, the individual named in the petition must be confined in a designated facility until a full hearing is held (Mo. Ann. Stat. § 199.200). If the court finds that the person named in the petition is a potential transmitter and is a danger to public health, it shall issue an order committing the person to a facility. (Mo. Ann. Stat. § 199.210).
			Quarantine	
			Isolation	
			Activities Restricted	
		Enforcement		
	Safeguarding Rights	**Due Process**		The court shall appoint legal counsel for the individual named in the petition for emergency temporary commitment (if requested to do so or if such individual is unable to employ counsel) (Mo. Stat. Ann. § 199.200). The individual named in the order also has the right to confront and cross-examine witnesses and to present witnesses and evidence in his/her own behalf (Mo. Stat. Ann. § 199.210). The individual may appeal the order of commitment (Mo. Stat. Ann. § 199.220).
		Confidentiality and Privacy		Names of: (i) the person who has suffered TB exposure and (ii) the person determined to have TB must be kept confidential. A person who violates this confidentiality is guilty of a misdemeanor and is subject to fine or jail term (Mo. Code Regs. Ann. tit. 19, § 40.047(c)).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		All persons delivered to the department of corrections and who are released from correctional facilities shall undergo TB testing without the right of refusal (Mo. Ann. Stat. § 191.659).
	Additional TB Provisions			The body of any person having died of TB cannot be offered to or accepted by any common carrier for transportation, unless it has been thoroughly embalmed by arterial and cavity injection with a disinfecting fluid, or encased in an airtight metal or metal-lined burial case, coffin, casket or box that is closed and hermetically sealed (Mo. Ann. Stat. § 194.090). State's allegations that nursing home left patient with TB in general population, thereby causing serious physical injury to patient and subjecting other residents to danger, were sufficient to state claim for violation of Omnibus Nursing Home Act provision authorizing immediate additional civil penalties for violation of Act resulting in serious physical injury (*State, Dept. of Social Services, Div. of Aging v. Carroll Care Centers, Inc.* (App. W.D. 2000) 11 S.W.3d 844).

State	Objective	PH Intervention		Legal Authorities
MT	**Prevention of TB Cases**	**TB Control Programs**		It is the duty of the State to protect the public from TB and to maintain a comprehensive prevention program (Mont. Code Ann. § 50-17-101). DPH controls spending for TB control and adopts rules for TB control (Mont. Code Ann. § 50-17-103).
	Identification of TB Cases	**Screening**		Certain populations must be screened for TB, including: (i) adult day care center employees (before employment and yearly thereafter) (Mont. Admin. R. 37.106.2609(1)); (ii) clients of adult day care centers (before being admitted to the center and yearly thereafter) (Mont. Admin. R. 37.106.2609(2)); (iii) public and private school employees (Mont. Admin. R. 37.114.1010).
		Examination & Testing		When an individual is reasonably suspected of having TB or having been exposed to TB, HCP, DPH, or LHO, DPH (or LHA) may request circuit court to order examination for TB (Mont. Code Ann. § 50-17-105). Diagnosis and testing standards are established by regulation (Mont. Admin. R. 37.114.1001). DPH or LHO may require close contacts of individuals with TB to be tested for TB infection (Mont. Admin. R. 37.114.1005(2)).
		Reporting		LHO must report (send a specimen to) to the DPH if a TB case is found (Mont .Admin. R. 37.114.313). Every three months, LHO must report to the DPH documented information of the prescribed treatments for individuals with TB in his/her jurisdiction (Mont. Admin. R. 37.114.1015). Laboratories and HCPs must send TB-positive specimens to the DPH (Mont. Admin. R. 37.114.1016).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	The DPH or LBH may apply for an order for completion of an approved course of treatment from the district court if a person is reasonably suspected to have or to have been exposed to TB, upon request of a HCP, DPH, or LHO (Mont. Code Ann. § 50-17-105). When committed, the patient's consent is required for treatment (Mont. Code Ann. § 50-17-110(1)). If deemed necessary, the committed person may be transferred to another facility (Mont. Code Ann. § 50-17-111). Regulations establish the correct standard of treatment (Mont. Admin. R. 37.114.1006). LHO must ensure that each case of TB within his/her jurisdiction obtains follow-up tests, treatment, and monitoring (Mont. Admin. R. 37.114.1015).
			DOT	DOT is under the supervision of a LHO (or other HCP or HA) and will be ordered by the court when there is noncompliance with original treatment order (see bellow, enforcement) (Mont. Code Ann. § 50-17-108(2)).
		Specific Measures	**Emergency Detention**	DPH or LBH may apply for an order for completion of an approved course of treatment from the district court if a person is reasonably suspected to have or to have been exposed to TB, upon request of a HCP, DPH, or LHO (Mont. Code Ann. § 50-17-105). If the attending physician and the DPH or LBH that requested commitment concur that a person either does not have TB or has completed an approved course of treatment, the person must be released from the hospital or treatment location (Mt. Code Ann. § 50-17-113). If a physician, the DPH, or LHO reasonably believes that a person has TB and that person is likely to attempt to leave the jurisdiction to avoid a hearing on commitment, the physician, DPH, or LHO shall notify the sheriff of the county in which the person is found, who shall cause the person to be detained in a hospital.. An application for court hearing must be filed by the next following business day (Mt. Code Ann. 50-17-115).
			Quarantine	
			Isolation	Patients with communicable TB must be isolated until TB is no longer communicable (Mont. Admin. R. 37.114.1005(1)).
			Activities Restricted	Midwives cannot aid women who active TB at the onset of labor (Mont. Admin. R. 24.111.610). Public and Private schools cannot employ individuals with communicable TB (Mont. Admin. R. 37.114.1010).
		Enforcement		When a patient fails to comply with court's TB examination order, the court must order commitment for examination purposes (Mont. Code Ann. § 50-17-108(1)). Non-compliance with court orders prescribing treatment shall result in the court ordering the individual to be committed to a treatment location for treatment under the supervision of a LHO (or other HCP or HA) (Mt. Code Ann. § 50-17-108(2)) (Warrants for commitment orders - requirements (Mont. Code Ann. § 50-17-109)).
	Safeguarding Rights	**Due Process**		Examination, treatment, and confinement orders must be granted by district court provided that (i) the person is reasonable suspected of having TB or having been exposed to TB and refuses to be examined; or (ii) the person has TB and refuses to be treated or to complete an approved course of treatment (Mont. Code Ann. § 50-17-105). Hearings granting such orders must comply with certain notice requirements (Mont. Code Ann. § 50-17-106). The committed person may request release from commitment (after at least 180 days have passed from the start of the commitment), in which case the court shall schedule a hearing to decide the request (Mont. Code Ann. § 50-17-112).
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
NY (State)	Prevention of TB Cases	TB Control Programs		SHA is compelled to maintain a TB control program (N.Y. Pub. Health Law § 2200 et seq). LHO is responsible for TB care and treatment for suspects and cases in his/her jurisdiction, for preventive measures in his jurisdiction, and for cooperation with other LHOs (N.Y. Comp. Codes R. & Regs. tit. 10, § 43-1.2).
	Identification of TB Cases	Screening		Certain populations must be screened using a tuberculin skin test, including: (i) hospital employees (tested annually) (N.Y. Pub. Health Law § 206(1)(m)) & (N.Y. Comp. Codes R. & Regs. tit. 10, § 405.3); (ii) children entering juvenile detention (N.Y. Comp. Codes R. & Regs tit. 9, § 180.9); (iii) police officer candidates (N.Y. Comp. Codes R. & Regs. tit. 9, § 6000.6); (iv) employees of service agencies for the elderly (N.Y. Comp. Codes R. & Regs. tit. 9, § 6654.17) and nursing home employees (N.Y. Comp. Codes R. & Regs. tit. 10, § 405.3); (v) home care employees (N.Y. Comp. Codes R. & Regs. tit. 10, § 763.13); (vi) patients at alcohol and substance abuse centers (N.Y. Comp. Codes R. & Regs. tit. 14, §817.2); (vii) patients at substance abuse centers for youth (N.Y. Comp. Codes R. & Regs. tit. 14, § 817.4); (viii) applicants to adopt children (N.Y. Comp. Codes R. & Regs. tit. 18, § 421.16); (ix) potential foster parents (N.Y. Comp. Codes R. & Regs. tit. 18, § 443.2); (x) employees of adult-care facilities (N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.9, 488.9, & 490.9).
		Examination & Testing		
		Reporting		Physicians must report accurate information to SHA on TB patients and precautions taken (N.Y. Pub. Health Law § 2224). If a TB patient dies or is removed from premises, physician (or in the absence of a physician any other person in the premises) must report this to LHO (N.Y. Pub. Health Law § 2226). If a TB patient recovers, physician has a duty to report this to LHO (N.Y. Pub. Health Law § 2225). SHA or LHO must disclose TB results and identity of person to medical examiner of the induction center of armed forces (N.Y. Comp. Codes R. & Regs. tit. 10, § 1.30).
	Management of TB Cases	Investigation		HO is required to investigate all reports by a physician of a patient with TB (N.Y. Pub. Health Law § 2120)
		Treatment	Treatment	SHA must provide for the care, diagnosis, and treatment of individuals suffering from TB or suspected of having TB (N.Y. Pub. Health Law § 2202). Physician or LHO must give proper instructions to TB patients and advise family and household of precautions to prevent risk of TB infection (N.Y. Pub. Health Law § 2222). If physician only suspects that patient may have TB (*i.e.* he/she has not confirmed the infection), physician has no duty to warn household to take precaution (*Ellis v. Peter*, 627 N.Y.S.2d 707 (N.Y. App. Div 1995)). Hospitals must provide care for TB patients (including detainees) that meets minimum standards (N.Y. Comp. Codes R. & Regs. tit. 10, § 405.22 (j),(k)).
			DOT	
		Specific Measures	Emergency Detention	
			Quarantine	
			Isolation	If LHO deems TB patient (or TB carrier) a threat, he/she may ask magistrate to commit person to TB institution or ward (N.Y. Pub. Health Law § 2120).
			Activities Restricted	
		Enforcement		
	Safeguarding Rights	Due Process[4]		Magistrate may commit TB patient or carrier only after due notice and hearing (N.Y. Pub. Health Law § 2120).
		Confidentiality and Privacy		Reports of TB patients and records of examination are open only to SHA LHAs and they may not disclose identity of patients unless authorized by statute (N.Y. Pub. Health Law § 2221). SHA or LHO may disclose TB cases only if in best interest of patient, family or public health (N.Y. Comp. Codes R. & Regs. tit. 10, § 2.17).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	Considerations for Certain Populations		
	Additional TB Provisions			Interjurisdictional Provisions: SHA may provide transportation to send TB patient to another state or country if willing relatives or friends are there to care for him/her, and may also designate nurses/attendants to accompany patient (N.Y. Pub. Health Law § 2204). SHA may make reciprocal arrangements with other states regarding transfer of patients (N.Y. Pub. Health Law § 2205). TB patients must take care to dispose of saliva and bodily fluids so as not to offend or endanger neighbors (N.Y. Pub. Health Law § 2223).

Juris.	Objective	PH Intervention		Legal Authorities[5]
NYC	**Prevention of TB Cases**	**TB Control Programs**		
	Identification of TB Cases	**Screening**		Certain populations must be screened, either with a skin test or FDA approved blood-based test, including: (i) employees of child daycare (annually) (New York, N.Y., tit. 24, Health Code § 47.27); (ii) motion picture theatre matrons (New York, N.Y., tit. 24, § 8-03); (iii) school staff, including teachers, volunteers, kitchen workers, and Dept. Of Parks and Recreation employees (New York, N.Y., tit. 24, § 45-09); (iv) all new entrants to a secondary school (junior high or high school), both public and private (New York, N.Y., tit. 24, Health Code §49.06(f)).
		Examination & Testing		See "Emergency Detention" (below (New York, N.Y., tit. 24, Health Code § 11.47(d)(1))).
		Reporting		HCPs and labs must report suspected or confirmed diagnoses within 24 hours to LHA (New York, N.Y., tit. 24, Health Code § 11.03, §11.05, §11.47(a) and §13.03). MPs, when requested by DH, must report all information on evaluation, testing and treatment of individuals who have been in contact with a person with active TB (New York, N.Y., tit. 24, Health Code § 11.47(b)). Secondary school principals must report twice a year on number of new students, number exempt for religious or medical reasons, number evaluated and number with positive test results (New York, N.Y., tit. 24, Health Code § 49.06(f)).
	Management of TB Cases	**Investigation**		The City (and DH) may not be liable for the way it conducts investigation into possible outbreaks of tuberculosis in schools to the extent that it failed to act (*Abraham v. City of New York*, 828 N.Y.S.2d 502 (N.Y. App. Div. 2007)).
		Treatment	**Treatment**	LHO may order individuals with active TB to complete appropriate course of medication (New York, N.Y., tit. 24, Health Code § 11.47(d)(2)). Forcible administration of any medication is not permitted without a prior court order (New York, N.Y., tit. 24, Health Code § 11.47(i)).
			DOT	LHO may order directly observed therapy for individuals with active TB who are unable or unwilling to complete course of medication (New York, N.Y. tit. 24, Health Code § 11.47(d)(3)).
		Specific Measures	**Emergency Detention**	LHO may order the detention of an individual who has, or is suspected of having active TB, and who is unwilling or unable to submit voluntarily to examination (New York, N.Y., tit. 24, Health Code § 11.47(d)(1)). LHO may order detention for individuals who have or are substantially likely to have infectious active TB when if there is a substantial likelihood that the person may transmit TB to others based on his/her inadequate separation from others (New York, N.Y., tit. 24, Health Code § 11.47(d)(4)). LHO may order detention for a person who has active TB, or who has been reported to the DH as having active TB with no subsequent report to the DH of completion of an appropriate prescribed course of medication for TB; and (ii) where there is a substantial likelihood, based on such person's past or present behavior, that he or she can not be relied upon to participate in and/or to complete an appropriate prescribed course of medication for TB and/or, if necessary, to follow required contagion precautions for TB (New York, N.Y., tit. 24, Health Code § 11.47(d)(5)). LHO has broad authority to detain suspected or confirmed TB patients (New York, N.Y., tit. 24, Health Code § 11.47(e)): (i) without prior court order, but must file court authorization within 3 days of requested release; (ii) up to 60 days if patient does not request release; and (iii) court order must be reviewed by issuing court every 90 days.
			Quarantine	
			Isolation	
			Activities Restricted	An individual with active infectious TB must be excluded from attendance at the workplace and school (New York, N.Y., tit. 24, Health Code § 11.47(c)).
		Enforcement [6]		
	Safeguarding Rights	**Due Process**		LHO must request a court authorization within 3 days of detainee requested release (New York, N.Y., tit. 24, Health Code § 11.47(e)). LHO must provide clear and convincing evidence that individual is a threat to public health and detention is the last resort (*City of New York v. Doe*, 205 A.D.2d 469 (N.Y. App. Div. 1994)). Detained patients have the right to representation by private or city-appointed counsel, notice of the right to request release, and right to request LHO to notify patients' friends and family of detention (New York, N.Y., tit. 24, Health Code § 11.47(f)) "These procedural safeguards are similar to those applicable to the detention of non-adherent psychiatric patients. Health Code § 11.47 has been upheld by the courts. See City of *New York v. Doe*, 205 A.D. 2d 469, 614 N.Y.S.2d 8 (1994); See also *City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008 (1995)".
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		Children may be exempted from school-required TB tests if contrary to their religious beliefs (New York, N.Y., tit. 24, Health Code § 49.06(d)(2)).
	Special Populations	**Considerations for Certain Populations**		Where necessary, language interpreters and persons skilled in communicating with vision and hearing impaired individuals shall be provided in accordance with applicable law (New York, N.Y., tit. 24, Health Code § 11.47(h)).
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
OK	**Prevention of TB Cases**	**TB Control Programs**		TB control and treatment is specifically delegated to the SHD (Okla. Stat. Ann. tit. 63, § 1-401).
	Identification of TB Cases	**Screening**		Oklahoma laws and regulations establish a list of employees, staff, or patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) all employees (physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory and pharmacy workers, hospital volunteers, and administrative staff, including food service workers) in hospitals (Okla. Admin. Code § 310:667-5-4); (ii) residents of health care facilities (Okla. Admin. Code § 310:675-7-17.1; (iii) personnel of residential child care facilities (Okla. Admin. Code § 340:110-3-153.1); (iv) staff of secure juvenile detention centers and Community intervention centers (Okla. Admin. Code § 377:3-13-43 and Okla. Admin. Code § 377:3-13-88). DH personnel perform TB screening tests of contacts to all TB cases (and likely TB suspect cases), high risk population groups and nursing home residents. (Okla. Admin. Code § 317:30-5-1159).
		Examination & Testing		When LHO believes a person has active or communicable TB, who will not voluntarily seek a medical examination, LHO must order such person to undergo an examination. If it is determined that the person has active or communicable TB, such person must arrange for admission in a hospital for TB treatment or to receive treatment at home when there is no danger to the public upon Commissioner's approval (Okla. Stat. Ann. tit. 63, § 1-402).
		Reporting		HCPs, labs, and hospitals must report cases of TB to the DH within 1 business day of positive test or diagnosis. (Okla Admin. Code § 310:515-1-4).
	Management of TB Cases	**Investigation**		The Commissioner must establish surveillance to identify all cases of TB. All individuals with suspected TB must be investigated by public health authorities to establish or exclude the diagnosis of TB (Okla. Admin. Code § 310:521-3-3).
		Treatment	**Treatment**	Commissioner reviews TB treatment regimen for persons with confirmed or suspected active TB, makes recommendations for change, and establishes the length of therapy (Okla. Admin. Code § 310:521-3-3). Individuals have the right to select the mode of treatment (Okla. Stat. Ann. tit. 63, § 1-405). Completion of TB therapy occurs when therapy has been taken for an adequate length of time, as determined by the Commissioner (Okla. Admin. Code § 310:521-3-4). Consultation with the TBCO must be established and maintained during the treatment regimen (Okla. Admin. Code § 317:30-5-1159). When a person has TB in an active stage or a communicable form and is not immediately admitted to a hospital, the LHO shall instruct such person of the precautions to be taken to protect the others from infection. It is the duty of the person with TB not to expose others. LHO shall investigate periodically if he/she is following (Okla. Stat. Ann. tit. 63, §1-403). Immunocompromised patients with TB should be placed in a room especially designed to maintain positive air pressure for the patient (Okla. Admin. Code § 310:667-49-2). In child care centers for sick children, separate outside ventilation is required when care is provided for children diagnosed with TB. (Okla. Admin. Code § 340:110-3-33.2).
			DOT	DOT shall be the standard of therapy for TB treatment. Exceptions may be granted by the Commissioner. TB treatment shall continue by DOT until an accepted course of therapy has been completed (Okla. Admin. Code § 310:521-3-3) CHD/CCHD service limitations are: TB case management and DOT (Okla. Admin. Code § 317:30-5-1154). Clinic visits may include the direct observation of the intake of prescribed drugs to treat TB (Okla. Admin. Code § 317:30-5-1158). DOT provider delivers medication to the patient and records the patient's ingestion of medication. DOT provider is responsible for monitoring side effects of medication and the collection of sputum samples (Okla. Admin. Code § 317:30-5-1159).
		Specific Measures	**Emergency Detention**	When the Commissioner believes that a person has active or communicable TB, he/she may require hospitalization or other confinement for treatment of such person. If a person is convicted for a violation of any of provisions relating to exposure or treatment, such person shall be committed by the judge of the district court for confinement and treatment as designated by the Commissioner (Okla. Stat. Ann. tit. 63, §1-410).
			Quarantine	
			Isolation	Persons with contagious TB will remain in isolation until non-contagious criteria are met (Okla. Admin. Code § 310:521-3-3).
			Activities Restricted	No person with TB in a transmissible stage is permitted in any room or compartment where exposed or unpacked edible products are prepared, processed, or handled (Okla. Admin. Code § 35:37-9-58).
		Enforcement		Compliance orders must be issued to TB patients to establish behavioral expectations in regard to treatment, isolation and monitoring. Non-compliant behavior in regard to treatment, isolation or patient monitoring must be reported to the Commissioner. Action will be taken to eliminate the non-compliant behavior when possible or to pursue enforcement action, as is appropriate (Okla. Admin. Code § 310:521-3-3).
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		Commissioner or LHO may not require physical examination or treatment of a patient who, in good faith, relies upon spiritual means or prayer for healing (Okla. Stat. Ann. tit. 63, § 1-405).
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Interjurisdictional Control: the Commissioner may enter into a reciprocal agreement with another state providing for care and treatment, in a sanatorium of one of the states, of persons having active TB who are residents of the other state, or for the transportation or return of any such nonresident person from one of the states to the other state of which he is a resident (Okla. Stat. Ann. tit. 63, § 1-409).

State	Objective	PH Intervention		Legal Authorities
OR	**Prevention of TB Cases**	**TB Control Programs**		
	Identification of TB Cases	**Screening**		Oregon laws and regulations establish a comprehensive list of employees, staff and patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) all persons admitted to or personnel working in any hospital, nursing home or health care facility shall be screened for TB (Or. Admin. R. 333-026-0010. See also Or. Admin. R. 333-071-0057); (ii) staff of and residents admitted to residential care facilities for mentally or emotionally disturbed persons (Or. Admin. R. 309-035-0120; Or. Admin. R. 309-035-0310) & (Or. Admin. R. 309-035-0175; Or. Admin. R. 309-035-0440); (iii) staff of ambulatory surgery centers (Or. Admin. R. 333-076-0125); (iv) personnel and admitted persons to nursing homes for the mentally retarded (Or. Admin. R. 333-092-0075); (v) employees working in a health care facility (Or. Admin. R. 333-505-0040); (vi) employees of residential care and assisted living facilities (Or. Admin. R. 411-054-0065); (vii) patients seeking admittance to outpatient synthetic opiate treatment programs (Or. Admin. R. 415-020-0025); (viii) international students attending Western Oregon University (Or. Admin. R. 574-035-0005). All health care facilities and residential facilities (correctional facilities, long term care facilities for the elderly, homeless shelters) must follow TB screening recommendations as established in corresponding guidelines published by the Centers for Disease Control and Prevention, and assess the risk of TB transmission among staff, residents and patients at least annually (Or. Admin. R. 333-019-0041).
		Examination & Testing		
		Reporting		Any person who knows of a TB case must immediately report it to the DHS. Names and addresses of all persons reported as having pulmonary TB are recorded in the office of the department (Or. Rev. Stat. § 437.010. See also Or. Admin. R. 333-018-0000 and Or. Admin. R. 333-018-0005).
	Management of TB Cases	**Investigation**		If communicable TB is diagnosed in an employee or patient of a HCF, the facility must conduct an investigation to identify contacts. The LHD shall assist in the investigation (Or. Admin. R. 333-505-0040) (Or. Admin. R. 333-071-0057). Upon receiving a report of a person having TB, the DHS shall investigate to determine whether or not the person has communicable TB. Upon confirming communicable TB, DHS shall exert control over the affected person and contacts with other persons for the protection of the public health, for which it may make rules governing such person's conduct as necessary to prevent the spread of the disease. (Or. Rev. Stat. § 437.030). LHO must investigate each report of TB using the procedures set forth in DHS's Investigative Guidelines or other DHS-approved procedures. (Or. Admin. R. 333-19-0000).
		Treatment	**Treatment**	
			DOT	
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	If TB is diagnosed, patient must be cared for in accordance with AFB isolation: in health care facilities, cases of diagnosed pulmonary TB are placed in AFB isolation until deemed non-infectious by the infection control officer or LHO (Or. Admin. R. 333-071-0057).
			Activities Restricted	Persons who attend or work at schools or other facilities (Child Care Facilities, Health Care Facilities or Food Service Facilities) shall not attend or work at these facilities if they have communicable TB (Or. Admin. R. 333-019-0010). A person diagnosed with TB may not engage, as long as he/she is communicable, in any occupation in which she/he provides personal care to or has direct contact with patients in a subject HCF (Or. Admin. R. 333-505-0040).
		Enforcement		
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		Admin. Law Judge may require a prison to turn over medical records of inmates testing positive for TB for inspection by a workers' compensation claimant alleging he contracted TB through exposure while working as a prison guard, even though the statute governing the records provides they are not to be provided except in response to an order of a "court of competent jurisdiction" (Or. Rev. Stat. §§ 179.495, 656.732. Coman v. Corrections Dept., 1998, 327 Or. 449, 960 P.2d 383).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Human remains of someone who has died from TB shall be thoroughly embalmed with disinfectant solution; all orifices shall be closed with absorbent cotton and the body shall be washed. If religious custom prohibits embalming, human remains are placed in a sealed metal casket enclosed in a strong transportation case or in a sound casket enclosed in a sealed metal or metal lined transportation case (Or. Admin. R. 830-030-0070).

State	Objective	PH Intervention		Legal Authorities
SC	**Prevention of TB Cases**	**TB Control Programs**		DH must provide consultation services to state institutions (educational, correctional, medical) regarding TB control (SC ST § 44-31-30). Each hospital and institutional general infirmary shall designate a person to coordinate TB control activities (SC ADC 61-16 Ch 2). DH must distribute information on TB control (SC ADC 61-108).
	Identification of TB Cases	**Screening**		The following populations must be screened for TB (before employment or before admission as applicable): (i) applicants for positions or employees of public or private school, kindergarten, nursery or day care center for infants and children (SC ST § 44-29-150), (SC ST § 44-29-160), (SC ADC 43-207), (SC ADC 43-237.1) & (SC ADC 61-22); (ii) employees of hospitals and institutional general infirmaries (SC ADC 61-16); (iii) licensed midwifes (before applying for license and annually thereafter) (SC ADC 61-24); (iv) staff and volunteer of HFs that have contact with patients (SC ADC 61-77); (v) employees of renal dialysis facilities (SC ADC 61-97); (vi) personnel for recreational camps for mentally retarded persons (SC ADC 88-335); (vii) staff of residential group care facilities for children (upon applying for licensing) (SC ADC 114-590).
		Examination & Testing		When the county supervisor or sheriff have reasons to suspect a prisoner has TB, he/she shall have the prisoner examined and tested (SC ST § 44-31-320). The jailer, keeper, or warden shall have prisoners and inmates suspected of having TB examined within 5 days after being committed (SC ST § 44-31-330).
		Reporting		HCPs must report to the DH known cases of TB (SC ST § 44-31-10). Laboratories shall report TB cases to DH (SC ST § 44-31-20).
	Management of TB Cases	**Investigation**		Authorized personnel of the DH may inspect medical records of HCPs where TB patients are treated (SC ST § 44-31-30). County HO shall investigate cases of TB when there is likelihood individual with TB is unable or unwilling take measures not to infect others. If, after investigating, LHO determines that the person has active pulmonary TB and a menace to others, he/she shall file a complaint in Court. When there is no LHO or he/she fails to act, individuals may file a complaint in court (SC ST § 44-31-110).
		Treatment	**Treatment**	Compulsory treatment shall be ordered only after two licensed physicians (one appointment by the patient) or county/district HO, certify that the person has contagious TB and that he/she constitutes a menace to others unless treated (SC ST § 44-31-170) Commitment alone, without forced compulsory treatment, does not require testimony by two physicians. See SC ST §§ 44-31-110 and 120.
			DOT	
		Specific Measures	**Emergency Detention**	Probate judges are entitled to inquire into and authorize involuntary commitment of individuals with active pulmonary TB (SC ST § 14-23-1150) (SC ST § 44-31-120).
			Quarantine	
			Isolation	If a person committed to the State Park Health Center behaves in a way that may harm others or leaves without permission, the director of the Center is empowered to isolate and forcibly detain him/her (SC ST § 44-31-140).
			Activities Restricted	Individuals with active TB and who are not under treatment may not practice as licensed massage practitioners (SC ADC 77-140).
		Enforcement		See court-issued commitment orders in 'Treatment' and 'Emergency Detention' (above) and 'due process' (below). If a person leaves State Park Health Center without authorization, the director of the HF shall report this to the probate judge so who can take all the necessary steps to insure the patient's return (SC ST § 44-31-160). Violations of HA orders or court orders is a misdemeanor (SC ST § 44-31-360).
	Safeguarding Rights	**Due Process**		Courts must hold a hearing before committing persons against their will for TB treatment (SC ST § 44-31-120). Courts orders for commitment may be appealed (SC ST § 44-31-130).
		Confidentiality and Privacy		Laboratories' records of TB are confidential (SC ST § 44-31-20).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		Correctional facilities must keep inmates infected with TB separate from other inmates (SC ST § 44-31-310), (SC ST § 44-31-320) & (SC ST § 44-31-340).
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
TN	**Prevention of TB Cases**	**TB Control Programs**		DH may exercise all the rights, powers and duties related to TB control (TN ST § 4-3-1803). DH may create a TB control division that will direct diagnosis, prevention, treatment and cure of TB (Tenn. Code § 68-9-102). The following institution/facilities for mental retardation must have a TB control program: (i) adult rehabilitation day facilities (Tenn. Comp. R. & Regs. 0940-5-20.01); (ii) preschool facilities (Tenn. Comp. R. & Regs. 0940-5-21.01); (iii) institutional habilitation facilities (Tenn. Comp. R. & Regs. 0940-5-23.01); (iv) boarding homes facilities (Tenn. Comp. R. & Regs. 0940-5-25.01); (v) placement services facilities (Tenn. Comp. R. & Regs. 0940-5-26.01); (vi) care services facilities (Tenn. Comp. R. & Regs. 0940-5-27.01).
	Identification of TB Cases	**Screening**		Tennessee laws and regulations list employees, staff, and patients that must be tested for TB prior to employment or admittance, *e.g.*: (i) school children and employees of the board of education when there is reason to believe they may be infected (Tenn. Code § 49-2-203); (ii) employees of group care homes or family board homes (Tenn. Comp. R. & Regs. 0250-4-2.05); (iii) employees of residential child care agencies (Tenn. Comp. R. & Regs. 0250-4-5.05); (iv) employees of maternity homes (Tenn. Comp. R. & Regs. 0250-4-7.06); (v) personnel and employees of the following facilities for mental retardation: adult habilitation day facilities (Tenn. Comp. R. & Regs. 0940-5-20.03); preschool facilities (Tenn. Comp. R. & Regs. 0940-5-21.03); diagnosis and evaluation facilities (Tenn. Comp. R. & Regs. 0940-5-22.05); institutional rehabilitation facilities (Tenn. Comp. R. & Regs. 0940-5-23.03); (vi) foreign-born children admitted to mental retardation health therapeutic nursery program facilities (Tenn. Comp. R. & Regs. 0940-5-31.08); (vii) employees and volunteers at child care centers (Tenn. Comp. R. & Regs. 1200-8-2.04); (viii) foreign-born children admitted to child care centers (Tenn. Comp. R. & Regs. 1200-8-2.10); (ix) employees of ALL facilities of the alcohol and drug abuse programs, *e.g.*: residential (Tenn. Comp. R. & Regs. 1200-8-17.04) and non-residential (Tenn. Comp. R. & Regs. 1200-8-18.04) rehabilitation treatment facilities; DUI schools (Tenn. Comp. R. & Regs. 1200-8-19.04). Screening is recommended, but not mandatory for child care employees who are: (i) recent immigrants; (ii) HIV positive; (iii) exposed to TB (Tenn. Comp. R. & Regs. 0520-12-1.10). Screening is not required for children attending childcare centers (only required when symptomatic) (Tenn. Comp. R. & Regs. 1200-8-2).
		Examination & Testing		Commissioner, or any authorized HA, may order examination of persons suspected of having infectious TB (Tenn. Code § 68-9-202). *See* "Enforcement" below for examination order by court. Examination must be made by HO or licensed physician (Tenn. Code § 68-9-206(a)(4)). If physicians are not in agreement regarding TB diagnosis, court shall order a hearing (Tenn. Code § 68-9-206(a)(5)). If exposed to TB, emergency worker may request TB testing (Tenn. Code § 68-10-117(a)). TB testing is included as part of the infection control procedures (Tenn. Code § 68-140-520).
		Reporting		Commissioner of health may establish procedures for reporting TB cases (Tenn. Code § 68-9-104). DH shall maintain a TB registry system in the state (Tenn. Code § 68-9-106). If physician or HCP believes a TB patient is behaving in a way that may infect others he/she must notify the SHA or LHA (Tenn. Code § 68-9-201). See "Additional TB provisions" below for interjurisdictional control reporting. Alcohol and drug abuse non-residential narcotic treatment facilities must report TB cases (Tenn. Comp. R. & Regs. 1200-8-21.06). LHD shall report changes of address of TB patients to SHD (Tenn. Comp. R. & Regs. 1200-14-1.04).
	Management of TB Cases	**Investigation**		DHS may be required to conduct field investigations (Tenn. Code § 68-9-112).
		Treatment	**Treatment**	TB division may establish field treatment clinics (Tenn. Code § 68-9-107). Hospitalization for treatment purposes must be available and provided by the DH (Tenn. Code § 68-9-111). TB treatment for residents can be provided without cost (Tenn. Code § 68-9-112). Court may order treatment (see "Enforcement") (Tenn. Code § 68-9-206(a)(6)).
			DOT	
		Specific Measures	**Emergency Detention**	See enforcement section for commitment in detention facilities.
			Quarantine	See isolation below.
			Isolation	Commissioner of health may establish procedures for quarantine (and isolation) of individuals with infectious TB (Tenn. Code § 68-9-104). Only the commissioner, state, local or authorized HAs may order (and terminate) quarantine (or isolation) of individuals having or reasonably suspected of having infectious TB (Tenn. Code § 68-9-202) & (Tenn. Code § 68-9-204(a)-(b)). Specific details about the quarantine (or isolation) order (length of time, place and special conditions) must be determined by the HO imposing the measure (Tenn. Code § 68-9-203). Release shall be made (only by authorized HA) when TB in patient is no longer communicable (the commissioner shall establish specific requirements for testing) (Tenn. Code § 68-9-204(c)-(d)). Quarantine (or isolation) may also be terminated if commissioner of health or HO believes the person is fit for release as a voluntary patient in any hospital for the treatment of TB (Tenn. Code § 68-9-207(a)).
			Activities Restricted	Individuals with communicable TB may not be employed in egg plants (Tenn. Comp. R. & Regs. 0080-5-4.21). Persons with infectious TB may not attend work (if there is chance of contact with others) or teach in public or private schools (Tenn. Comp. R. & Regs. 1200-14-1.08).
		Enforcement		When an individual is suspected of having infectious TB and he/she refuses to be examined or comply with orders of HA, the commissioner may request a court to issue an arrest warrant (Tenn. Code § 68-9-206(a)(1)). When a TB patient violates isolation and/or quarantine orders, LHO may use all legal processes to enforce the isolation or quarantine orders (Tenn. Code § 68-9-206(a)(9)). If a person committed for quarantine pursuant to court order violates such order (or refuses to comply with the rules of the institution), the commissioner may seek a court order for commitment to a detention facility (Tenn. Code § 68-9-206(b)). If persons released from quarantine or isolation to follow voluntary treatment refuse to comply with voluntary treatment, enforcement provisions described above shall apply (Tenn. Code § 68-9-207(b)).
	Safeguarding Rights	**Due Process**		When an arrest warrant is requested due to non-compliance, the court shall only issue the warrant if there is reasonable cause (supported by clinical and epidemiological evidence) that the individual has infectious TB (Tenn. Code § 68-9-206(a)(2)-(3)). No appeal or certiorari from the decision of the court committing the person to the place of isolation shall stay the commitment, nor shall any court have the power to supersede the order. Individuals shall remain committed to the detention facility until released by the commissioner or the HO as no longer communicable, or released by order of court. Any person committed under the provisions of this chapter may appeal from the judgment of the magistrate or court (Tenn. Code § 68-9-206(a)(7)-(8)).
		Confidentiality and Privacy		Information about TB patients received by HO must be kept confidential and disclosed only for TB control purposes (Tenn. Code § 68-9-201). Residential rehabilitation treatment facilities for alcohol and other drug abuse must keep TB status of patient confidential (Tenn. Comp. R. & Regs. 1200-8-17.06).
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			Interjurisdictional Control: LHO, SHO or any HO involved in TB control must notify appropriate health authorities when an individual with infectious TB or receiving treatment for TB disease relocates from TN into other jurisdiction (Tenn. Code § 68-9-201). Commissioner of health is authorized to notify the appropriate TB infection control staff of TN or another state of an individual's TB infection for the sole purpose of containing a potential threat to the public health and welfare or to assure completion of proper treatment of the diseased person (Tenn. Code § 68-9-201).

State	Objective	PH Intervention		Legal Authorities
TX	**Prevention of TB Cases**	**TB Control Programs**		DH has a TB control program (Tex. Health & Safety Code § 13.005 et seq.). There is also a TB control program for prison inmates (97 Tex. Admin. Code § 171 et. seq). Mental Retardation Authority must have infection control plan to prevent TB infections among staff, providers and patients (40 Tex. Admin. Code § 2.363).
	Identification of TB Cases	**Screening**		DH must test all children entering facilities regulated by children's welfare and protective services dept (Tex. Hum. Res. Code § 42.043). All prison employees and volunteers must be tested for TB (Tex. Health & Safety Code § 89.001). All prison inmates who will be in jail for more than 7 days must be tested for TB (Tex. Health & Safety Code § 89.051 & 25 Tex. Admin. Code § 97.173). There are jail standards for TB Screening (37 Tex. Admin. Code § 273.7). Prisons must certify TB screening before accepting out-of-state inmates on contract (Tex. Gov't Code § 511.0092). Court may order any person charged with criminal offense to be tested for TB (Tex. Code Crim. Proc. Ann. Art. 21, 31). Narcotics Treatment Programs must test patients and employees for TB, and must periodically retest immunosuppressed groups such as HIV positive patients (25 Tex. Admin. Code § 229.148(9)). Employees and residents of Community Corrections Facility (halfway houses) must be tested for TB (37 Tex. Admin. Code § 163.39). Nursing home and assisted-living facility employees and residents must be screened for TB (40 Tex. Admin. Code § 19.1601). Maternity home residents, volunteers and employees must be screened for TB (40 Tex. Admin. Code § 727.203).
		Examination & Testing		Emergency responders (State employees such as law enforcement officers, firefighters, paramedics, etc.) must be tested within 10 days of suspected exposure to TB or they risk losing health benefits (28 Tex. Admin. Code §122.3).
		Reporting		In prisons, suspected cases of TB must be reported to DH within three days of detection. Screening test results in prisons must be reported to DH monthly (Tex. Health & Safety Code §§ 89.051, 89.071, 25 Tex. Admin. Code § 97.178). Corrections facilities must report the release of any inmate being treated for TB to DH and must arrange for continued care of inmate after release (Tex. Health & Safety Code § 89.102 & 37 Tex. Admin. Code § 273.4). Hospitals are required to notify LHA when an emergency medical service employee, peace officer, detention officer, county jailer, or fire fighter may have been exposed to pulmonary or laryngeal TB during the course of duty from a person delivered to the hospital under conditions that were favorable for transmission (25 Tex. Admin. Code § 97.11 & 28 Tex. Admin. Code § 122.3).
	Management of TB Cases	**Investigation**		
		Treatment	**Treatment**	DH shall set standards of treatment for patients in state chest hospitals (Tex. Health & Safety Code § 13.031 et seq). Prison inmates must receive treatment for TB (97 Tex. Admin. Code § 171). Texas DMH and Mental Retardation may transfer, without consent, any patient (mentally ill or retarded) infected with TB to the Texas Center for Infectious Disease for treatment (Tex. Health & Safety Code § 13.004). Corrections facility must arrange with DH for continued care and treatment when an inmate being treated for TB while in detention is released (Tex. Health & Safety Code § 89.102). Prison inmates, volunteers and employees must receive treatment for TB (25 Tex. Admin. Code § 97.176).
			DOT	
		Specific Measures	**Emergency Detention**	
			Quarantine	
			Isolation	Prison inmates suspected of having TB shall be placed in respiratory isolation until they are no longer infectious. Inmates who are cases or suspects shall be released from isolation only after infectiousness has been ruled out (25 Tex. Admin. Code § 97.177).
			Activities Restricted	No licensed optometrist may practice while knowingly suffering from contagious or infectious TB (22 Tex. Admin. Code § 279.15). Children must be excluded from child-care facilities or school if suspected to have TB until treatment is started and a physician's certificate or health permit is obtained (25 Tex. Admin. Code § 97.7). Prison volunteers and employees with infectious pulmonary or laryngeal TB shall be excluded from work until adequate treatment is instituted, cough is resolved, sputum is free of bacilli on three consecutive smears, and they have received a release for work signed by their physician or the LHA (25 Tex. Admin. Code § 97.177).
		Enforcement		
	Safeguarding Rights	**Due Process**[7]		
		Confidentiality and Privacy		
		Anti-Discrimination		A state chest hospital may not discriminate against a patient and must provide equal facilities, attention, and treatment, but care may differ depending on the condition of patient (Tex. Health & Safety Code § 13.042). No patient may offer a gratuity to hospital employees or staff (Tex. Health & Safety Code § 13.043).
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		LHA may establish a separate school for education and care of children with TB (Tex. Health & Safety Code § 263.051).
	Additional TB Provisions			Interjurisdictional Control: DH may return nonresident TB patients to the patient's home state and may enter into reciprocal agreements with other states for returning patients (Tex. Health & Safety Code § 13.041). DH may enter into agreements with another state's health agency to care for their TB patients in Texas chest hospitals (Tex. Health & Safety Code § 13.046).

State	Objective	PH Intervention		Legal Authorities
VA	**Prevention of TB Cases**	**TB Control Programs**		Corrections facilities shall develop written practices for identification and treatment of TB (6 Va. Admin. Code § 15-31-230), for the management of TB (6 Va. Admin. Code § 15-45-1420).
	Identification of TB Cases	**Screening**		The following populations must be screened for TB (before employment or admission as applicable): (i) school employees (Va. Code § 22.1-300); (ii) residents (before admission) of family group homes (6 Va. Admin. Code § 35-140-370); (iii) school bus drivers (8 Va. Admin. Code § 20-70-330); (iv) personnel of home and community-based services for individuals with AIDS (yearly) (12 Va. Admin. Code § 30-120-165); (v) companion services, and personal assistance (health care providers) (12 Va. Admin. Code § 30-120-223) & (12 Va. Admin. Code § 30-120-233); (vi) employees, students or volunteers in substance abuse outpatient or substance abuse residential treatment (12 Va. Admin. Code § 35-105-510); (vii) staff and independent contractors of childcare centers (22 Va. Admin. Code § 15-30-180); (viii) employees of adult day care centers (22 Va. Admin. Code § 40-60-235); (ix) adult day care patients will be screened after exposure or onset of symptoms (22 Va. Admin. Code § 40-60-610); (x) employees and patients of assisted living facilities (Department of Social Services) (22 Va. Admin. Code § 40-72-290) & (22 Va. Admin. Code § 40-72-350); (xi) staff and children accepted to child care facilities (22 Va. Admin. Code § 40-100-80) & (22 Va. Admin. Code § 40-100-200); (xii) employees and members of family day care facilities (22 Va. Admin. Code § 40-110-1090); (xiii) employees and volunteers of family day care systems (22 Va. Admin. Code § 40-120-40); (xiv) children in foster care services and members of foster homes (22 Va. Admin. Code § 40-130-220) & (22 Va. Admin. Code § 40-130-270); (xv) members of independent foster homes (22 Va. Admin. Code § 40-141-80); and (xvi) employees and members of family day homes (22 Va. Admin. Code § 40-180-40).
		Examination & Testing		LHD may order a person suspected of having TB to be examined (Va. Code § 32.1-50(A)).
		Reporting		TB is included in the list of reportable diseases (Va. Code § 32.1-49). HCPs, HCFs and any health care professional must report confirmed and suspected cases of TB to the LHD, and when patient ceases treatment for TB disease (Va. Code § 32.1-50(B)-(C)) & (12 Va. Admin. Code § 5-90-225). HCFs and physicians must also complete a more detailed report (simultaneously or within two weeks of initial report) in which they must include *inter alia* the following information: date and results of TB test, follow-up examination and testing, treatment regime, date and results of drug susceptibility testing, HIV status and contact screening information (12 Va. Admin. Code § 5-90-225 A(2)). Laboratories must report specimens positive for TB to LHD (Va. Code § 32.1-50(E)), (12 Va. Admin. Code § 5-90-90) & (12 Va. Admin. Code § 5-90-225). See Enforcement, below.
	Management of TB Cases	**Investigation**		When informed of TB cases, LHD shall perform contact tracing (12 Va. Admin. Code § 5-90-100)
		Treatment	**Treatment**	Treating physician shall develop a detailed treatment plan for a TB patient (Va. Code § 32.1-50.1(A)). Upon request, HCP must submit the treatment plan to the LHD (Va. Code § 32.1-50.1(B)) & (12 Va. Admin. Code § 5-90-225). The Commissioner shall have the authority to resolve any dispute regarding appropriate treatment between HCP and LHD (Va. Code § 32.1-50.1(B)). Written documentation of patient's adherence to treatment plan shall be submitted to the LHD upon request (Va. Code § 32.1-50.1(C)). Health Board may construct and operate hospitals for the diagnosis and treatment of TB (Va. Code § 32.1-53).
			DOT	
		Specific Measures	**Emergency Detention**	When a person with communicable TB poses a risk to others, the Commissioner may order the person to be detained immediately (for a period that cannot exceed 48 hours) for examination and treatment if the person has failed or refused to comply with treatment order, has history of noncompliance, or there is risk of noncompliance (Va. Code § 32.1-48.02).
			Quarantine	
			Isolation	Complete isolation must be used for individuals with TB disease who are engaging in behavior that places others at risk for infection (12 Va. Admin. Code § 5-90-100).
			Activities Restricted	As a condition of employment, school employees must present a certificate stating that such employee is free of communicable TB (Va. Code § 22.1-300). Assisted living facilities shall not admit persons with communicable TB (Va. Code § 63.2-1805). Employees, contractors, students or volunteers in facilities providing outpatient or residential substance abuse treatment services who are suspected of having active TB shall not return to work or have contact with employees, contractors, students, volunteers or individuals receiving services until a physician has determined that the person is free of active TB (12 Va. Admin. Code § 35-105-510). Assisted living facilities shall not admit individuals with communicable TB (22 Va. Admin. Code § 40-72-340). Independent foster home providers, assistants, and household members who, upon examination or as a result of tests, shows indication of communicable TB, shall be removed from contact with children and, where indicated, from food served to children until a licensed physician certifies that the risk to children has been eliminated or substantially reduced (22 Va. Admin. Code § 40-141-80).
		Enforcement		In cases of inpatient treatment, if the TB patient indicates an unwillingness to comply with his/her treatment plan upon release or exhibits behavior that indicates noncompliance, HCP and LHD may request Commissioner to issue an emergency detention order or other applicable order (Va. Code § 32.1-50.1(D)). All state and local law-enforcement officers are authorized to take custody of individuals who are issued an emergency order immediately upon issuance of the emergency order by the Commissioner (Va. Code § 32.1-48.02).
	Safeguarding Rights	**Due Process**		
		Confidentiality and Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	**Considerations for Certain Populations**		
	Additional TB Provisions			

State	Objective	PH Intervention		Legal Authorities
WI	Prevention of TB Cases	TB Control Programs		DH may promulgate rules for the administration and regulation of TB control, including measures for screening (Wis. Stat. Ann. § 252.07(11)).
	Identification of TB Cases	Screening		The following populations must be screened (before admission or employment as applicable) for TB: (i) school employees (Wis. Stat. Ann. § 118.25); (ii) group foster care personnel (Wis. Admin. Code HFS § 57.17); (iii) staff of community substance abuse services (Wis. Admin. Code HFS § 75.03); (iv) employees of community-based residential facilities (Wis. Admin. Code HFS § 83.13); (v) licensee and service providers in adult family homes (Wis. Admin. Code HFS § 88.04); (vi) new residents of adult family homes (Wis. Admin. Code HFS § 88.06); (vii) employees of nursing homes (Wis. Admin. Code HFS § 132.42); (viii) patients before admission to nursing homes (Wis. Admin. Code HFS § 132.52); (ix) employees of home health agencies (Wis. Admin. Code HFS § 133.06); (x) employees of facilities serving people with disabilities (Wis. Admin. Code HFS § 134.44); (xi) before admission, patients of facilities serving people with developmental disabilities (Wis. Admin. Code HFS § 134.70); (xii) day care providers. (Wis. Admin. Code HFS § 145.10(6)(a)). DH must identify risk groups and develop/recommend protocols for the screening of such groups (Wis. Stat. Ann. § 252.07(2)).
		Examination & Testing		Medical evaluation may be ordered as an enforcement mechanism in cases of non-compliance (see enforcement bellow) (Wis. Stat. Ann. § 252.07(5)). LHO or DH may order medical evaluation of a person (Wis. Admin. Code HFS § 145.10(6)(a)). LHO and DH may order examination (and reexamination) of contacts of TB infected persons (Wis. Admin. Code HFS § 145.10(12)).
		Reporting		HCPs and laboratories must report TB cases to LHO and DH (Wis. Stat. Ann. § 252.07; Wis. Admin. Code HFS § 145.09). HCPs must inform LHO when a patient fails to comply with treatment or control measures (Wis. Admin. Code HFS § 145.10(4)(b)), upon receiving such notification, LHO must investigate (see below) and notify DH (Wis. Admin. Code HFS § 145.10(5)).
	Management of TB Cases[8]	Investigation		Upon receiving report of individuals with confirmed or suspected infectious TB, LHO must investigate and issue necessary orders (Wis. Stat. Ann. § 252.07(5)). LHO shall immediately investigate upon receiving notice that a patient failed to complete or follow treatment or control measures (Wis. Admin. Code DWD § 55.08).
		Treatment	Treatment	Specific treatment shall be prescribed by physician (if possible considering American Thoracic Society statements) (Wis. Admin. Code HFS § 145.10(3)(4)).
			DOT	DOT may be ordered when patient does not comply with LHO orders voluntarily (Wis. Stat. Ann. § 252.07(5)). LHO/DH may order DOT (Wis. Admin. Code HFS § 145.10(6)(b)).
		Specific Measures	Emergency Detention	Prior to obtaining court order, LHO may order confinement to a facility for an individual with confirmed or suspected infectious TB. To obtain a court order, LHO must provide: 1) a written statement from a physician or advanced practice nurse prescriber that the individual has infectious TB or suspect TB; 2) evidence that the patient did not comply with treatment, or, in the case of an individual suspected to have TB, that he/she refused examination; or 3) a written statement that, in the case of an individual with a confirmed diagnosis of infectious TB, the DH or LHO determines that the individual poses an imminent and substantial threat to himself or herself or to the public health (Wis. Stat. Ann. § 252.07(8)(a)). Confinement order issued by a court will end when the DH or LHO determines that the treatment is complete or that the individual is no longer a substantial threat to himself or herself or to the public health (Wis. Stat. Ann. § 252.07(9)(c); Wis. Admin. Code HFS § 145.10(11)). LHO or DH may order confinement of a person if they deem it necessary and if it complies with certain requirements (*i.e.*, court order, evidence, etc) (Wis. Admin. Code HFS § 145.10(6)(d)).
			Quarantine	
			Isolation	DH shall make the arrangements for 'segregation' of TB patients when admitted to state-operated facilities (Wis. Stat. Ann. § 51.65). In-home isolation may be ordered as an enforcement mechanism in cases of non-compliance (see enforcement bellow) (Wis. Stat. Ann. § 252.07(5)). LHO/DH may order a person to be isolated (Wis. Admin. Code HFS § 145.10(6)(c)). LHO/DH shall release a person from isolation or confinement if an adequate course of chemotherapy has been administered for a minimum of 2 weeks and there is clinical or other medical evidence of improvement, the person is no longer infectious, arrangements have been made for post-isolation (port-confinement) care, and the person is no longer a threat to the public and is likely to comply with the remainder of the treatment regimen (Wis. Admin. Code HFS § 145.11).
			Activities Restricted	School employees and drivers of vehicles owned by the school district must be free from communicable TB (Wis. Stat. Ann. §§ 118.25, 121.52). Employees of group childcare centers must be free from communicable TB (Wis. Admin. Code HFS § 46.05). Persons with confirmed or suspected infectious TB must be excluded from work, school and other premises (determined by LHO) (Wis. Admin. Code HFS § 145.10(2)). Midwives cannot aid persons with active TB (Wis. Admin. Code RL § 182.03).
		Enforcement		LHO and DH may order evaluation, DOT and isolation for individuals who do not voluntarily comply with LHO orders (Wis. Stat. Ann. § 252.07(5)).
	Safeguarding Rights	Due Process		See enforcement section above for requirements to grant confinement orders. Confinement orders granted without a court hearing may not exceed 72 hours (Wis. Stat. Ann. § 252.07(8)(c); Wis. Admin. Code HFS § 145.10(6)(f)). In the hearing petition, the LHO or DH shall demonstrate: (i) that the individual has infectious TB or is suspected of having infectious TB; (ii) that he/she failed to comply with treatment (or that the TB disease is resistant to treatment); (iii) that all other means to assure voluntary compliance have been exhausted and there are no "less restrictive alternatives available", and; (iv) that the individual poses a threat to himself or to others (Wis. Stat. Ann. § 252.07(9)(a); Wis. Admin. Code HFS § 145.10(7)). DH or LHO shall follow some requirements when informing the individual about the details of the hearing (Wis. Stat. Ann. § 252.07(9)(b)). In cases of confinement, if the individual must be confined for more than 6 months, the court must review the confinement every six months (Wis. Stat. Ann. § 252.07(9)(c)). Individuals subject to hearings have the right to appear at the hearing, defend themselves, present evidence, cross-examine witnesses, etc (Wis. Stat. Ann. § 252.07(9)(d), Wis. Admin. Code HFS § 145.10(8)). Court orders may be appealed (Wis. Stat. Ann. § 252.07(9)(e), Wis. Admin. Code HFS § 145.10(9)).
		Confidentiality & Privacy		
		Anti-Discrimination		
		Religious Exemptions		
	Special Populations	Considerations for Certain Populations		
	Additional TB Provisions			In terms of admission, community substance abuse services shall give priority to TB patients (Wis. Admin. Code HFS § 75.15).

[1] *Jones v. Czapkay*, 6 Cal. Rptr. 182 (Cal. Ct App. 1960).
[2] In *Moore v. Draper*, 57 So. 2d 648 (Fla. 1952), the Florida Supreme Court discusses in detail the interactions between the state's police powers (when used to protect the public's health) and the due process clause of the 14th Amendment to the United States Constitution.
[3] As per communication with Massachusetts officials, Lakeville Hospital has long been closed. However, since this provision has not been repealed and thus it is still part of Massachusetts law, we nonetheless included it in the survey table.
[4] *Bradley v. Cromwell*, 694 N.Y.S.2d 176 (N.Y. 1999).
[5] New York State express TB control laws have applied to New York City since the provision that exempted state laws from applying in New York City was repealed in 1981.
[6] *City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008 (N.Y. 1995); *City of New York v. Doe*, 614 N.Y.S.2d 8 (N.Y. 1994).
[7] *L.G. v. State*, 775 S.W.2d 758 (Tex. App. 1989).
[8] *In re Washington*, 735 N.W.2d 111 (Wis. 2007).

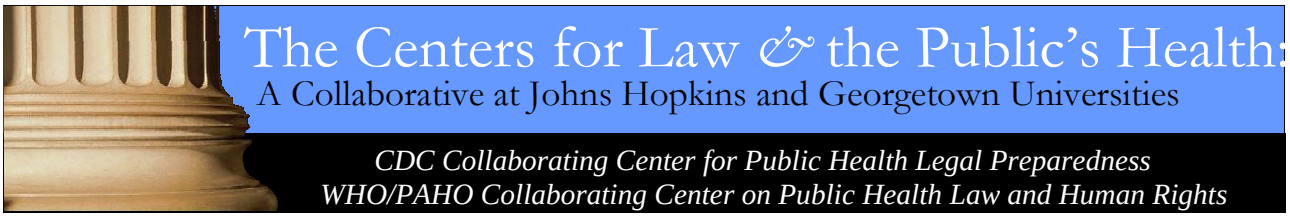


Table 2:
Characterizing Express Laws Regarding the Control of Tuberculosis in Selected U.S. Jurisdictions: Summary of Findings

The table below provides a brief summary of the findings from Table 1 as of May 1, 2008. Marking a specific category with an 'x' implies that the jurisdiction appears to feature express TB control laws for that public health intervention or sub-category. Table 2 uses the same categories of express TB control laws as used in Table 1.

Disclaimer *– Information in this document does not represent the official legal positions of the U.S. Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention/HHS, or state or local governments, and is not meant to provide specific legal guidance or advice. Thus, users of this report, including state and local officials, should consult with their state and local attorneys and legal advisors for a more complete review of laws and policies pertaining to tuberculosis control.*

Objective	PH Intervention	States																									
		AZ	CA	CO	FL	GA	IL	IN	KS	KY	LA	MA	MD	MI	MO	MS	MT	NY	NYC	OK	OR	SC	TN	TX	VA	WI	TOTAL
Prevention of TB Cases	TB Control Programs	x	x	x	x	x	x	x	x	x	x	x	x		x		x	x		x		x	x	x	x	x	21 (84%)
Identification of TB Cases	Screening	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	25 (100%)
	Examination & Testing	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x		x	x		x	x	x	x	x	22 (88%)
	Reporting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	25 (100%)
Management of TB Cases	Investigation	x	x	x	x	x	x	x	x	x								x	x	x	x	x	x		x	x	17 (68%)
	Treatment: Treatment	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	24 (96%)
	Treatment: DOT	x	x	x	x	x	x	x			x	x					x		x	x						x	13 (52%)
	Specific Measures: Emergency Detention	x	x		x	x			x	x	x	x			x	x	x		x	x		x	x		x	x	17 (68%)
	Specific Measures: Quarantine															x											1 (4%)
	Specific Measures: Isolation	x	x	x	x	x	x	x	x	x	x	x	x			x	x	x		x	x	x	x	x	x	x	22 (88%)
	Specific Measures: Activities Restricted	x	x		x	x		x		x	x	x	x	x		x	x		x	x	x	x	x	x	x	x	20 (80%)
	Enforcement	x	x	x	x	x	x	x	x	x	x	x	x			x	x			x		x	x		x	x	19 (76%)
Safeguarding Rights	Due Process	x	x	x	x	x	x			x	x	x			x	x	x	x	x			x	x			x	17 (68%)
	Confidentiality and Privacy	x		x	x	x	x						x		x			x			x	x	x				11 (44%)
	Anti-Discrimination			x																				x			2 (8%)
	Religious Exemptions	x	x	x			x		x	x			x						x	x							9 (36%)
Special Populations	Considerations for Certain Populations	x	x		x	x	x					x		x	x				x			x		x			11 (44%)
Additional TB Provisions		x		x		x		x	x			x	x	x	x	x		x		x	x		x	x		x	16 (64%)
TOTAL		16	14	14	14	15	13	11	11	12	11	13	11	6	10	11	11	9	11	13	7	13	14	10	10	13	