

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF HEALTH

NOTICE OF ADOPTION  
OF AMENDMENTS TO ARTICLE 11 OF THE NEW YORK CITY HEALTH CODE

In compliance with §1043(b) of the New York City Charter (the “Charter”) and pursuant to the authority granted to the Board of Health by §558 of said Charter, a notice of intention to amend Article 11 (Reportable Diseases and Conditions) of the New York City Health Code (the “Health Code”) was published in the City Record on March 23, 2010, and a public hearing was held on April 28, 2010. Two comments were received, and in response to one of the comments, the proposal has been amended. At its meeting on June 15, 2010, the Board of Health adopted the following resolution.

**STATUTORY AUTHORITY**

These amendments to the Health Code are promulgated pursuant to §§ 556, 558 and 1043 of the Charter. Section 556 of the Charter provides the Department of Health and Mental Hygiene (the “Department”) with jurisdiction to regulate all matters affecting the health in the City of New York. Section 558(b) and (c) of the Charter empower the Board of Health to amend the Health Code and to include in the Health Code all matters to which the Department’s authority extends. Section 1043 of the Charter grants the Department rulemaking powers.

**STATEMENT OF BASIS AND PURPOSE**

The Board of Health, at its meeting on September 17, 2008 adopted a resolution repealing and reenacting Article 11 of the Health Code. The provisions relating to tuberculosis control were renumbered, from §11.47 to §11.21, but were otherwise unchanged. The Department has requested the Board to amend subdivision (a) of § 11.21 (Tuberculosis; reporting, examination, exclusion, removal and detention) to require attending physicians who treat newly diagnosed cases of tuberculosis (TB) and persons in charge of hospitals where newly diagnosed cases of TB are treated to submit proposed treatment plans to the Department for review, and to require physicians and persons in charge of hospitals who report infectious TB cases to obtain consultation with and consent of the Department at least 72 hours prior to discharging such cases from inpatient care.

Under the New York Public Health Law (PHL), the Health Code and the State Sanitary Code, the Department has the duty in New York City of investigating cases, ascertaining sources of infection, seeking out contacts, and taking other steps to reduce morbidity and mortality from TB and other communicable diseases. Article 22 of the PHL imposes specific TB control duties upon physicians and, in the absence of an attending physician, upon the local health officer, i.e., in the City of New York, the Commissioner or designee. The physician or local health officer has a duty to take proper precautions and provide for the safety of all individuals occupying the same house or apartment of a TB patient. PHL §2222 (1). Physicians are required by State law to report the recovery of a TB patient to the “proper health officer.” PHL §2225. The State Sanitary Code requires the local health officer, upon receiving a report of a TB case, to “take such further measures as may be indicated ...if such a person has been reported to him previously by a physician as one suffering from pulmonary tuberculosis, the State or local health officer concerned shall ascertain promptly whether such physician is maintaining proper sanitary supervision.” 10 NYCRR §2.7 (a). State Department of Health rules authorizing State aid and reimbursement for care of TB cases and suspect cases define the “local health officer” as the individual responsible for providing or securing tuberculosis care and treatment pursuant to Public Health Law §2202 (1) and make this person responsible for providing or securing health care services needed for all

cases and suspects. 10 NYCRR §§43-1.1 (e) and 43-1.2. Providers of health care services to TB patients are already required to submit initial and monthly written progress reports detailing care provided to TB patients, and to follow “prevailing standards of care” in the services they provide. 10 NYCRR §§ 43-1.4 and 43-1.6. However, no State law or rule currently requires that the local health officer review TB cases’ treatment plans or infectious TB cases’ hospital discharge plans.

The Department has been successful in reducing the incidence of TB in New York City, from 1,140 newly reported cases in 2003, when amended Health Code §11.47 (the predecessor of §11.21) became effective, to 760 in 2009.

The steady decline in the incidence of TB may have unintended negative effects on TB control in that TB expertise will become more scarce as practitioners try to manage an increasingly rare disease. In New York City, approximately 50% of TB patients are treated—partly or completely—in the private sector.

Numerous studies around the world have shown that private practitioners tend to deviate from recommended TB management practices and guidelines, and this tendency seems to be directly related to how many TB patients a practitioner sees in his or her practice: the fewer patients one sees, the more likely one is to deviate from accepted standards of care. In TB care such deviations include not using sputum culture to monitor treatment response and prescribing inappropriate drug regimens, often with incorrect combinations and inaccurate doses for the wrong duration. Without a framework for oversight, these deviations can have deleterious public health effects for TB control. Treatment failure often leads to drug resistance, which decreases the chances for cure and greatly increases treatment costs through prolonged hospitalizations, and may increase the risk of transmission of the disease to others. Successful treatment of tuberculosis is a societal imperative as well as a benefit to an individual's health. The Department, through the Bureau of Tuberculosis Control (“the Bureau”), should be able to influence and guide TB care practices so that those practices more closely conform to accepted standards. The Bureau’s ability to influence practices is likely to be enhanced if the government's role in TB care were more clearly defined and strengthened through this proposed amendment to the Health Code. On-going communication between the private practitioners and the Bureau beyond the initial reporting of a case would be greatly enhanced if practitioners provided the Department with a written plan of management for TB patients soon after TB is diagnosed, ideally within two months of TB diagnosis (treatment for TB lasts a minimum of six months). This amendment to Health Code §11.21 (a) requires communication between the providers and the Department beyond case reporting. Relying on practitioners’ good faith to share information with the Department has always been suboptimal. Since the private medical sector varies considerably in terms of size and composition of the practice, level of organization, types of services delivered, and socioeconomic groups served, a regulatory approach would be the most consistent and fair way of ensuring compliance among practitioners. One comment on the proposed amendment stated that the written plan of management should be submitted within one month of TB diagnosis, since treatment errors might have already occurred. The Department agrees that one month would be more appropriate and has amended the proposal accordingly.

Timely submission of such a treatment plan to the Bureau would strengthen the Bureau’s ability to provide support for activities that are integral to TB control but that are generally not carried out by private providers. These activities include locating TB patients who do not keep physical examination or directly observed therapy (DOT) appointments, application of legal action for persistently non-compliant/non-adherent, infectious TB patients, and provision of DOT, the standard of care for TB. Having treatment plans for all TB patients would also help the Bureau better plan and allocate resources for each TB case in the face of a shrinking TB public health workforce.

The Department received a further comment expressing concern that the 72 hours prior notice to the Department before an infectious TB patient may be discharged could prolong the patient's length of stay. Although this is possible, the risk of a prolonged stay is substantially outweighed by public health concerns that infectious patients will receive appropriate care on discharge and thereby minimize transmission of TB to uninfected persons, which is consistent with the Department's and physicians' obligations.

New York City would not be the first jurisdiction to take this approach. Colorado and Connecticut require approval of treatment plans before a patient is discharged from the hospital, and except for California, have a requirement for the TB treatment plan to be approved by public health authorities. 6 CCR 1009-1(I); Conn. Gen. Stat. §§ 19a-265(7)(b). Virginia requires the treating physician to develop a detailed treatment plan for a TB patient and submit the treatment plan to the Health Department upon request. Virginia Code § 32.1-50.1(B) ; 12 Virginia Admin. Code § 5-90-225. Oklahoma authorizes the state health commissioner to review TB treatment regimens for persons with confirmed or suspected active TB, make recommendations for change, and establish length of therapy. Oklahoma Admin. Code § 310:521-3-3. Completion of TB therapy occurs when therapy has been taken for an adequate length of time, as determined by the Commissioner. Oklahoma Admin. Code § 310:521-3-4. Consultation with the TB control officer must be established and maintained during the treatment regimen. Oklahoma Admin. Code § 317:30-5-1159. California law provides that health care facilities may not discharge suspected or confirmed TB patients until prescribing a written treatment plan and notifying local health officers. California Health & Safety Code §§ 121361(e), 121365(b).

#### **Statement Pursuant to Charter § 1043**

This proposal was not included in the Department's regulatory agenda because the need for the amendment became known after publication of the regulatory agenda.

The amendment is as follows:

Matter underlined is new

Matter to be deleted is indicated by [brackets].

**RESOLVED**, that §11.21 of Article 11 of the New York City Health Code, set forth in Title 24 of the Rules of the City of New York be, and the same hereby is, amended, to be printed together with explanatory notes to read as follows:

#### **§11.21 Tuberculosis; reporting, examination, treatment, exclusion, removal and detention.**

(a) *Reports; treatment plan review; approval of hospital discharges; and contact examination.*

(1) *Reports.* A physician who attends a case of active tuberculosis, or the person in charge of a hospital, dispensary or clinic giving out-patient treatment to such a case, shall report to the Department at such times that the Department requires. The report shall state whether the case is still under treatment, the address of the case, the telephone contact number(s) of the case, the stage, the clinical status and treatment of the disease and the dates and results of sputum and X-ray examinations and any other information required by the Department.

(2) Submission of treatment plans for review. The physician who attends a person for whom treatment for newly diagnosed active tuberculosis is being initiated, or the person in charge of a hospital or other health care facility where such newly diagnosed case is or will be receiving treatment for active tuberculosis, shall submit to the Department for review the treatment plan proposed for such case within one month of initiation of treatment. The plan shall be submitted in writing on a form provided or approved by the Department and shall include the name of the medical provider who has assumed responsibility for treatment of the patient, names and duration of prescribed anti-tuberculosis drugs, anticipated date of treatment completion, and a plan for promoting adherence to the prescribed treatment.

(3) Report required when treatment ceases. The physician who attends the case or the person in charge of a hospital, dispensary or clinic giving out-patient care to such a case shall report promptly to the Department when the case ceases to receive treatment and the reason for the cessation of treatment.

(4) Department approval of hospital discharge of infectious cases. The physician who attends a case of infectious tuberculosis in a hospital or the person in charge of a hospital or other health care facility where such case has been admitted shall notify the Department in writing on a form provided or approved by the Department and shall consult with the Department at least 72 hours before planned discharge of such case from in-patient care, and shall discharge such patients only after the Department has determined that discharge of such person will not endanger the public health. The Department shall make its discharge determination and respond to the attending physician or the person in charge of a hospital or other health care facility within one business day from the date of the consultation.

(b) Contacts. A physician who attends a case of active tuberculosis shall examine or cause all household contacts to be examined or shall refer them to the Department for examination. The physician shall promptly notify the Department of such referral. When required by the Department, non-household contacts and household contacts not examined by a physician shall submit to examination by the Department. An examination required by this section shall include such tests as may be necessary to diagnose the presence of tuberculosis, including but not limited to tuberculin tests, serologic tests for tuberculosis infection, and where indicated, laboratory examinations, and x-rays. If any suspicious abnormality is found, steps satisfactory to the Department shall be taken to refer the person promptly to a physician or appropriate medical facility for further investigation and, if necessary, treatment. Contacts shall be re-examined at such times and in such manner as the Department may require. When requested by the Department, a physician shall report the results of any examination of a contact.

(c) Exclusion. A person with active tuberculosis that is infectious shall be excluded from attendance at the workplace or a school. Such person may also be excluded from such other premises or facilities as the

Department determines cannot be operated or maintained in a manner adequate to protect others against spread of the disease.

Notes: Subdivision (a) of §11.21 was amended, and subdivisions (b) and (c) were provided with subheadings, by resolution adopted on June 15, 2010 to reflect new requirements pertaining to management of newly diagnosed cases of active tuberculosis and discharge from hospital of cases of active infectious tuberculosis.