

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF HEALTH

NOTICE OF ADOPTION
OF AMENDMENTS TO ARTICLE 49
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 49 of the New York City Health Code (the “Health Code”) was published in the City Record on March 16, 2012 and a public hearing was held on April 20, 2012. There was no testimony, but four written comments were received. At its meeting on June 12, 2012, the Board of Health adopted the following resolution.

Statement of Basis and Purpose

Statutory Authority

These amendments to the New York City Health Code (the “Health Code”) are issued according to §§556, 558 and 1043 of the New York City Charter (the “Charter”).

- Section 556 of the Charter provides the Department of Health and Mental Hygiene (the “Department” or “DOHMH”) with authority to regulate all matters affecting health in the City of New York.
- Section 558(b) and (c) of the Charter empowers the Board of Health (the “Board”) to amend the Health Code and to include in the Health Code all matters over which the Department has authority.
- Section 1043 of the Charter gives the Department rulemaking powers.

Introduction and Background

The Board of Health is amending Health Code §49.06, repealing required tuberculosis (TB) testing for secondary school new entrants, and as amended will authorize the Commissioner to require testing for TB infection in schools only when testing is necessary for epidemiologic or other public health purposes.

Between 2001 and 2010, the TB case¹ rate among persons 18 years of age and younger in New York City declined 42%, from 4.8 to 2.8 cases per 100,000 persons. As TB rates continue to decline, the Department has found that screening school children is currently not an effective way to identify new cases of active TB or TB infection.

In the 1980s, TB incidence in New York City was rising and high rates of TB were found during voluntary TB screenings. As a result, the Board of Health adopted Health Code §49.06 in 1989 to require that all new school entrants from pre-kindergarten to 12th grade have a tuberculin skin test. In 1996, the

¹ A TB case is a person who shows signs and/or symptoms of active TB disease, as defined in Health Code §11.03 (a). TB infection or latent TB infection (LTBI) occurs in persons who have been exposed to a person with active TB disease, test positive for TB infection on a tuberculin skin test or blood test, and who have become infected with the TB bacillus, but do not show signs and/or symptoms of active TB disease.

Board of Health amended §49.06 to eliminate mandatory TB testing except for new entrants to secondary schools within any public or non-public school system in New York City. Secondary school is defined in the Health Code as including junior high school and higher grade levels. This change was based on data showing that the prevalence of TB infection was low among young school age children but increased with age.

Mandatory TB testing of school children had the following objectives:

- 1) Identify children with TB disease and provide appropriate medication and follow up;
- 2) Identify TB disease through investigation of family contacts that may be the source of infection;
- 3) Identify children with latent TB infection and provide preventive therapy to them; and
- 4) Provide valid data on the prevalence of TB infection in school children.

School Screening and TB Control

In recent years, DOHMH data suggest that the school TB screening requirement has not achieved the first three objectives as stated above. From September 2010 to August 2011, no TB cases were found through the school screening requirement. However, DOHMH identified 32 cases of active TB among persons 10-18 years old in New York City through other means. Twenty persons (63%) were evaluated as a result of symptoms consistent with TB; 10 (31%) had a chest radiograph, a medical evaluation or an incidental laboratory result that led to their TB diagnosis; and 2 (6%) were identified through DOHMH screening of newly arrived immigrants. In 2009, TB preventive therapy was initiated in only 59% of 10-18 year olds with TB infection who were not contacts to active cases and had received a normal chest radiograph in a DOHMH TB clinic.² Only 27% that initiated therapy actually completed therapy.³

The fourth objective of §49.06 has been met. Based on data from the New York City Department of Education (DOE), the overall latent TB infection (LTBI) prevalence for new entrants tested from September to December 2011 was 8% (458 out of 5,643). Prevalence by secondary school grade level did not differ substantially: 7% (42 of 618 persons tested) below 7th grade, 8% (109 of 1,408) for grades 7 and 8; and 8% (307 of 3,617) for 9th through 12th grade. This prevalence rate is much lower than in children who were tested in DOHMH TB clinics between 2002 and 2004, when 21% (2,742 of 13,311) had LTBI, including 6% (177 of 2,918) among US born and 24% (2,565 of 10,569) among foreign born.⁴ This finding is consistent with the decline in the overall TB case rate among persons aged 18 years and younger in New York City.

Resources Saved By Eliminating the TB Testing Requirement

DOHMH TB clinics currently provide TB testing and follow-up evaluation for new secondary school entrants who need to be tested as a result of this Health Code mandate. Every year approximately 3,300 children in the secondary school age group² are referred to one of the clinics for TB testing and follow-up.

In addition, two DOHMH bureaus, Bureau of TB Control (BTBC) and Bureau of School Health (BSH), and the DOE oversee compliance with this mandate in schools. At the beginning of each school year, DOE staff identifies eligible entrants in public schools and informs parents of the mandate. School principals are required to follow up on TB testing, reading TB tests, and chest x-ray results of identified

² DOHMH TB clinic data do not specifically capture the school entry requirement as a reason for obtaining a TB test or chest radiograph, but it can be assumed that children who are not contacts come to the clinic for this reason.

³ This includes all children in the age group that were started on isoniazid (INH) preventative treatment regardless of TB test or chest radiograph result.

⁴ Li, J, Munsiff, SS, Agerton, T. Prevalence of tuberculin skin test positivity in clinical population in New York City. J Immigr Minor Health. 2010. 12(6):816-22

students, and then report results back to DOE. DOE collects the data, enters it into an electronic system, and submits follow-up reports to the DOHMH and BSH on a monthly basis. BTBC also mails packets of information about the TB testing requirement and copies of the reporting forms to hundreds of private, parochial, and charter schools. After schools submit their reporting forms to DOHMH, data are compiled and entered into a database.

Over the past several years, DOE's compliance with this provision of the Health Code improved from 30% to 90% for public schools. Obtaining compliance, however, is extremely resource intensive for both DOE and DOHMH. Moreover, children who visit DOHMH clinics are missing school and their parents or guardians are missing work to comply with the testing requirement.

Children and adolescents are considered to be at low risk for exposure to TB and should be tested only if one or more risk factors⁵ are present. Since the mid 1990's, mandated TB testing for low risk school entrants has not been recommended by both the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics in the absence of risk factors.⁶

Conclusion

Mandatory testing of new entrants in secondary schools consumes substantial resources while contributing little to TB prevention and control in New York City. Eliminating this mandate will allow DOHMH to direct increasingly limited resources to screen, identify and treat TB among persons at highest risk, and allow the DOE to focus its resources on higher priority adolescent health issues.

Instead of mandatory testing of all new entrants in secondary schools, the provision in current subdivision (g) of this section has been amended to authorize the testing of persons in a school only when such testing is considered by the Department as necessary for epidemiologic and other public health purposes, such as in an investigation to determine if any students or staff may have had contact with a TB case in a school.

Although the proposal was circulated to many NYC pediatricians, the Department received only four e-mail comments, including one in favor of and two opposed to the amendment. One comment indicated it was too soon for the requirement to be repealed, without stating more, and another indicated that without the mandate, children would not return for readings of TB tests. The Department, as noted above, has found that although compliance with the TB testing requirement has been fairly high, at over 90% of eligible students, the numbers and percent of cases of TB infection and active disease identified has been very low, and do not justify maintaining the testing requirement. With increasingly limited resources, it is important that the Department focus its efforts on individuals who are at highest risk for infection and developing active disease, including people who are contacts of cases of active disease, or who have become recently infected and are likely to develop active disease. Accordingly, no change has been made in the resolution.

⁵ Risk factors for TB disease and latent TB infection: Contact to a TB case; immigrated in the past 5 years from high TB incidence areas; prolonged stay in high TB incidence areas; work in clinical or institutional settings such as nursing home or homeless shelters; individuals with certain clinical conditions, i.e. HIV, cancer, etc. and children/adolescents exposed to adults in high-risk categories.

⁶ Centers for Disease Control and Prevention. 2000. Targeted tuberculosis testing and treatment of latent tuberculosis infection. *MMWR* 49(No. RR-6): 7-10; Pediatric TB Collaborative Group. Targeted tuberculin skin testing and treatment of latent TB infection in children and adolescents. *Pediatrics*. 2004;114:1175-1201.

The resolution is as follows.

New matter is underlined; Deleted matter appears in [brackets].

RESOLVED, that of §49.06 (Mandatory tuberculosis examination for students) of Article 49 (Schools) of the New York City Health Code, found in Title 24 of the Rules of the City of New York, is repealed and recodified, to be printed together with explanatory notes to read as follows:

§49.06 **Test for tuberculosis infection.** The Department may require testing for tuberculosis of any persons in a school when such testing is considered by the Department as necessary for epidemiological or other public health purposes.

Notes: Section 49.06 (Mandatory tuberculosis examination for students) was repealed and recodified by resolution of the Board of Health adopted June 12, 2012, after an analysis of incidence data showed that routine mandatory testing of all children newly admitted to secondary schools was ineffective in identifying new tuberculosis cases occurring in persons under 18 years of age. As amended, this section now authorizes the Department to require testing of any persons in a school when such testing is considered by the Department as necessary for epidemiological or other public health purposes.