



Centers for Disease Control  
and Prevention (CDC)  
Atlanta GA 30333

TB Notes  
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Dear Colleague:

We note with sadness the passing of four persons who made contributions to TB control. Tina Schein, who served as a TB public health nurse for many years, including 33 years in DTBE, died on July 2, and Dan Reyna, who served as the Director of the Border Health Commission, on July 29. Dr. John Sbarbaro, a world-renowned expert in TB control, passed away August 30. Marilyn Hansen, who contributed to TB control through her important work with the American Thoracic Society, passed away earlier this year; she was responsible for the original development of the *Core Curriculum on Tuberculosis: What the Clinician Should Know* (Core Curriculum). Please see the items on their lives and contributions in this issue of *TB Notes*.

This provides a segue to the next news: staff of the Communications, Education, and Behavioral Studies Branch (CEBSB) have been working for some time on the latest revision of the Core Curriculum. As this important document was last released in 2000, an update was in order. It will be available soon in print format, in limited quantities, and is available now online. An accompanying slide set is also available. This issue of *TB Notes* includes an article about the development of the Core Curriculum.

The first meeting of 2011 of the Advisory Council for the Elimination of Tuberculosis (ACET) was held June 7-8 here in Atlanta. Hazel Dean, ScD, MPH, Deputy Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), served as the ACET designated federal official. The first presenter was Rima Khabbaz, MD, Director, Office of Infectious Diseases, CDC. Dr. Khabbaz reported that CDC's FY2011 budget reflects a reduction of 11% below the FY2010 budget. A summary of CDC's budget is available at [www.cdc.gov/fmo/](http://www.cdc.gov/fmo/). Despite these extensive budget cuts, CDC is committed to maximizing public health impact, maintaining the focus on national priorities, and sustaining critical programs.

After Dr. Dean gave the NCHHSTP Deputy Director's report, I provided the DTBE Director's report. For the benefit of the new members, I explained that these reports typically provide brief updates on recent activities conducted by DTBE and its branches. However, this report would focus on DTBE's challenge to ACET, "How should the national tuberculosis program (NTP) be configured to accomplish its elimination goal?"

To provide background, I outlined DTBE's past strategies for TB elimination, including the 1989 strategic plan to eliminate TB from the United States, the 2000 Institute of Medicine report *Ending Neglect*, and the 2010 TB Elimination Plan from Stop TB USA. The 1989 strategic plan had established a TB elimination goal of  $\leq 1$  TB case per million population by 2010, but this goal was not met. In 2010, Stop TB USA estimated that

eliminating TB by 2035 would result in 253,000 fewer TB cases, 15,200 fewer TB-related deaths, and a \$1.3 billion reduction in TB treatment costs (in 2006 dollars). After explaining the challenges and opportunities for the national TB program, I charged ACET with revising and updating the TB elimination targets and measures of success for FY2011 and FY2012.

José Becerra, MD, MPH, Chief, Data Management and Statistics Branch, DTBE, used DTBE recent modeling data to report on U.S. TB trends. The U.S. annual percentage rate change of TB incidence decreased from 7.3% in 2000 to 3.8% in 2008. Given a continued 3.8% percentage change, it would take 100 years to achieve the TB elimination goal of 1 case per 1 million persons. To eliminate TB by 2050, we would need a percentage change of 8.8% plus new diagnostic tools, new and shorter treatment, and a new TB vaccine. Dr. Becerra concluded by asking ACET to provide advice on three key questions: Is a TB elimination target date of 2050 feasible and realistic? Should we consider incidence targets other than 1 case per million for different subgroups (e.g., U.S.-born versus foreign-born persons)? Finally, should we set interim goals, now that we are able to detect TB clusters and recent transmission?

Next, Terence Chorba, MD, MPH, DSc, Chief, Field Services and Evaluation Branch, DTBE, reported on CDC's cooperative agreements (CoAgs) and the National TB Indicators Project (NTIP). DTBE uses CoAgs to allocate categorical funding to 68 U.S. TB programs and four Regional Training and Medical Consultation Centers (RTMCCs). He noted the most significant challenges in national TB program capacity: the erosion of federal and state TB budgets, losses in human resources and proficiency, a smaller workforce of private providers and public health staff, and fiscal constraints. He then discussed the National TB Indicators Project (NTIP), a web-based performance monitoring system based on existing data sources. Indicator reports reflect progress toward national objectives in 15 high-priority categories; focus program evaluation efforts; and provide performance targets as benchmarks for assessment.

Wanda Walton, PhD, Chief, Communications, Education, and Behavioral Studies Branch, DTBE, reported on the four CDC-funded RTMCCs: the New Jersey Medical School Global TB Institute, the Southeastern National TB Center, the Heartland National TB Center, and the Curry International TB Center. Since 2005, RTMCCs have provided >4,400 hours of training to 44,484 participants with in-person or web-based formats, 152 mini-fellowships, and 12,619 medical consultations. They also develop educational products for both regional and national audiences. The products are accessible in various formats and are available free of charge whenever possible. The RTMCC Products Page at <http://sntc.medicine.ufl.edu/RTMCCProducts.aspx> provides access to 164 TB products and archived webinars. Dr. Walton asked ACET to help CDC clearly define the future role of RTMCCs in light of funding constraints.

Thomas Navin, MD, Chief, Surveillance, Epidemiology, and Outbreak Investigations Branch, DTBE, reported on recent scientific advances that will support early outbreak detection. The first advance is genotyping, which allows for the identification of genetically related organisms, which in turn allows the identification of genotype clusters of TB cases. The second development is the linkage between genotyping data and

surveillance data; as of March 2011, the TB Genotyping Information Management System (TB GIMS) contained >55,000 patient records with genotype and surveillance results. The third advance is the use of genotype and surveillance data to predict, detect, and analyze TB outbreaks. DTBE tested a future outbreak detection algorithm by using TB GIMS data from an actual outbreak in a homeless shelter; the local TB program noted the problem in 2009 after case 7, but TB GIMS would have signaled an alert in 2008 after case 3. Several principles will guide DTBE's updated TB outbreak response plan: Actions will be in line with CDC's core values of accountability, respect, and integrity; DTBE will acknowledge its role as a guest of host jurisdictions; collaborations will be fostered and expertise will be built within and outside of CDC; and surge capacity will be provided when requested.

Bonnie Plikaytis, MS, Deputy Chief, Laboratory Branch, DTBE, reported on her branch's activities. DTBE has identified several laboratory mandates for NTP: accurate, reliable, and prompt TB services must be provided; laboratory services must be coordinated with private providers and public health staff caring for TB patients; policy guidance must be available to help TB control staff make prompt, informed case management decisions and eliminate transmission of TB disease; and new tools must be developed. Current challenges include existing regulations that add complexity in terms of providing services in certain areas. Also, laboratory infrastructure and logistics can be expensive, particularly the requirement to maintain a BSL-3 facility in each TB laboratory and the need to transport specimens to public health laboratories; the laboratory network depends on rapid referral of specimens and timely requests from local laboratories and providers. Ms. Plikaytis noted that elimination of funding for lab services would in some cases result in a disruption of services, and stated that data-driven guidance is needed in regard to funding and organization of public health laboratories.

I presented an update on behalf of Dr. Eugene McCray, Chief of the DTBE International Research and Programs Branch. CDC follows the "2011-2015 Global Plan to Stop TB" that was developed and published by the Global Stop TB Partnership. In addition, I represent CDC on the Federal TB Task Force's U.S. Government Workgroup to Address Global TB, the Global Stop TB Partnership Coordinating Board, and the WHO TB Technical Advisory Group. I noted that Dr. Frieden is interested in CDC developing a unified policy to address global TB and has designated a TB Coordinator to make recommendations on investing resources in CDC's global TB agenda; Dr. Harold Jaffe has been appointed the Acting CDC Global TB Coordinator. At the division level, DTBE collaborates with partners to reduce the importation of TB from other countries and also to address HIV-associated TB in sub-Saharan Africa. DTBE also provide operational research training, and with resources from its global partners, deploys CDC staff to China, India, Kenya, and Thailand. DTBE also provides technical support to implement infection control precautions and improve capacity in this area at the global level. Overall, CDC is interested in aligning its domestic and global TB activities for mutual benefit and welcomes guidance from ACET in achieving this goal.

Elsa Villarino, MD, MPH, Tuberculosis Trials Consortium Project Officer, DTBE, presented an update on CDC's TB research conducted by the Tuberculosis Trials Consortium (TBTC). TBTC was initially funded in 1993 to conduct one trial and was

formally reorganized in 1997; funding was renewed in 2009 for a 10-year period and will decrease by 22% in 2011. TBTC has made several notable accomplishments to date. Its 9 major clinical trials and 15 sub-studies have enrolled >12,000 patients and volunteers. Its studies have resulted in 25 publications in peer-reviewed journals and >100 presentations, posters, and abstracts at national and international conferences. *Nature Medicine* cited TBTC Study 27 as one of the 20 most important TB papers published in the past 3 years. Dr. Villarino concluded that investments in TB research should be continued and strengthened so that these research advances can continue.

Thomas Navin, MD, Chief, Surveillance, Epidemiology and Outbreak Investigations Branch, DTBE, presented an update on CDC's other TB research initiatives. One research area is the Tuberculosis Epidemiologic Studies Consortium (TBESC). The first 10-year cycle of TBESC was recently completed; of the 32 studies conducted, 2 were cancelled and 30 completed data collection by September 2011. TBESC will focus on LTBI in its next 10-year cycle, with its major study being a prospective comparison of tuberculin skin tests (TSTs) and interferon gamma release assays (IGRAs) in detecting LTBI and predicting progression from LTBI to TB disease. The second research area is NHANES. DTBE and CDC's National Center for Health Statistics signed an agreement in August 2010 to utilize NHANES data for TB research for the period January 2011 to December 2012. DTBE incorporated 10 TB questions into NHANES and added TST and IGRA questions to the laboratory portion of the survey. The third research area is laboratory research. Studies seeking more accurate and rapid ways to detect TB drug resistance account for 50% of lab research. DTBE is also conducting research to improve genotyping. As the field of DNA sequencing continues to evolve and provide alternative approaches to genotyping, there will continue to be a critical need for operational research and for data analysis and interpretation.

Philip LoBue, MD, FACP, FCCP, Associate Director for Science, DTBE, discussed the development of evidence-based TB guidelines. He noted that ACET's role in TB guidelines has ranged across a spectrum including no involvement, endorsing a product solely developed by CDC, actively participating in and endorsing a product developed by CDC, and developing and endorsing a product via a joint CDC/ACET workgroup. In addition, no criteria have been clearly defined as to which entities should develop TB guidelines. Historically, professional societies have led the development of clinically based guidelines; the development of other guidelines appears to be based on legacy. DTBE's methodology for evaluating evidence and grading recommendations is also variable and does not use a standardized system. Dr. LoBue asked ACET to provide advice to DTBE during a future meeting on important issues that should be addressed in the development of evidence-based TB recommendations and guidelines.

Stuart Berman, MD, ScM, presented an update on NCHHSTP's recent activities related to prevention through healthcare. TB, HIV, STDs, and viral hepatitis account for substantial healthcare spending. Thus, anticipated U.S. health reform may allow advancement of NCHHSTP priorities. Dr. Berman noted an NCHHSTP consultation set for June 20-21, 2011, in Atlanta. The impact of changes in the healthcare system on service delivery were to be discussed. We will share the implications of these changes

for state and local health departments related to TB prevention as they become available.

Ann Cronin, Associate Director for Policy and Issues Management, DTBE, noted that many TB programs do not take advantage of the Omnibus Budget Reconciliation Act of 1993 that expands eligibility of services to TB patients. Congress enacted the legislation during the TB resurgence to eliminate all barriers to TB treatment. In states where the TB option is implemented, TB programs can bill Medicaid for prescribed drugs; case management and other services to encourage completion of therapy, including DOT services; and physician, x-ray, laboratory, and clinical services. The law excludes room and board of TB patients. Only nine states are implementing the TB option. CDC hopes to collect solid data and demonstrate the cost benefits of implementing the TB option.

At the business session, ACET discussed and made formal actions on a number of issues. The next ACET meeting will be held in early December 2011.

As I reported in the last *TB Notes Dear Colleague* letter, DTBE and colleagues in TB control gathered in Atlanta in June for the 2011 National TB Conference. In this issue we have the winners of the National TB Controllers Association (NTCA) poster competition, as well as winners of the second annual special awards for Exemplary Performance and Service in TB Prevention and Control. These awards provide an opportunity for us to recognize some of the amazing and dedicated individuals working among us in TB prevention and control. I hope you will take a look and read about their impressive accomplishments.

Kenneth G. Castro, MD  
Assistant Surgeon General, USPHS, &  
Commanding Flag Officer  
CDC/ATSDR Commissioned Corps  
Director, Division of Tuberculosis Elimination  
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## HIGHLIGHTS FROM STATE AND LOCAL PROGRAMS

### North Carolina TB and Respiratory Disease Meeting Summary

The 61<sup>st</sup> Annual Tuberculosis and Respiratory Disease (TB/RD) Institute meeting was held in Raleigh, North Carolina, July 27-29, 2011. It is affectionately known to many as the “Black Mountain Conference,” a reference to a long history of having the conference in the mountains not far from the old Black Mountain Sanatorium outside Asheville, NC. The TB/RD Institute brings together nurses, physicians, and other allied health professionals for the purpose of providing education and training about current trends in TB treatment and management. Past programs have explored TB research, including vaccine development and genetic sequencing, new laboratory testing methods, and the threat of multidrug-resistant (MDR) TB.

Officially kicking off the conference was the Herman F. Easom Distinguished Guest Lecture. The key note speaker for this session was Dr. John Hamilton from Duke University Medical Center. Dr. Hamilton provided attendees with a timeline illustrating events and persons responsible for the development of TB research and support at Duke University. A returning favorite, Dr. Eric Brenner, steered participants through a short course entitled “*Epidemiological Aspects of Tuberculosis and TB Control*” in which he challenged them to think critically about how epidemiological studies inform public health practice. One of the meeting highlights was the presentation of “difficult” cases by local TB nurses and clinicians. These presentations emphasize the diversity of experience that

working a TB investigation can bring to public health. This year’s presentations included a large investigation in an urban homeless shelter; a multilayered prison investigation with delayed diagnosis contributing to ongoing transmission; and MDR TB in a foreign adoptee. The presentations underscored the need for rapid, accurate diagnostics; consultation with treatment experts; and enhanced communication between all concerned parties to ensure successful outcomes.

The planning committee members from North Carolina and South Carolina, the Southeastern National TB Center, and CDC collaborated with Martha Bogdan, President and CEO of the ALA of the Southeast, and her “right-hand woman” Candy Holloway, Director of Medical Education. Without the support of ALA of the Southeast, the meeting would not have been possible. The speakers delivered wonderful information on topics including *Tuberculosis in Internationally Adopted Children and Refugees*, *Pharmacokinetics Studies of Levofloxacin in Children Exposed to MDR TB*, *Radiographic Manifestations of Tuberculosis*, and CDC’s *DGMQ Do Not Board Process* among others.

The 78 attendees were from North Carolina, South Carolina, Florida, Georgia, and Puerto Rico. While budget cuts definitely had an effect on overall attendance, those able to join the meeting professed themselves very satisfied overall with the quality of the learning experience.

—By Elizabeth Zeringue, RN, BSN, MPH  
NC TB Control Program

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### **Cluster Investigation on TB Row: Field Investigations and TB-GIMS Converge in Detroit**

#### *Background*

From the mid 1960s to late 2010, the Detroit TB program managed a cluster of *M. tuberculosis* case patients and contacts with latent TB infection (LTBI) known as "TB Row." This name was given by the Senior Public Health Nurse, who has served for many years as the case manager and field investigative historian for the TB control program. She has provided directly observed therapy (DOT), contact investigations, treatment and care, and follow-up services since 2001. During this time, the TB program has experienced many changes in field contact investigation protocols and procedures. In the past 2 years, a focus has been placed on finding missed contacts from previous field efforts. Several generations of TB cases and suspects were identified from the main cluster. In 2010 the "TB Row" cluster was identified through the

Tuberculosis Genotyping Information Management System (TB-GIMS) as a high-level concern for investigation. This particular cluster yielded eight historic multidrug-resistant cases, as well as 43 drug-sensitive cases among a local family and their contacts during the period of 1998 through 2009.

#### *Purpose of Activity*

The concept of incorporating TB-GIMS data into proactive case management was the main objective for this investigation. The idea of utilizing TB-GIMS to highlight what the program *did not* already know about the current cases was not the only challenge. More important was the idea that TB-GIMS could help confirm what we already suspected from the field in regard to epi-links. While the epi-links could provide clues as to where to direct and focus our contact investigation in the field, this tool would help us determine how the cluster investigation would be applied. TB-GIMS and active case management would help determine the extent of continued transmission, identify risk factors, and show negative factors that prevent the completion of therapy. The most important purpose of this investigation was to identify the positive outcomes in field contact investigation work. We also wanted to investigate the level of effort required to conduct a good cluster investigations. We had to be sure not to exceed the capacity of the TB program while performing the investigations.

#### *Description of Program and Progress*

Step 1: Evaluate and review both TB-GIMS and individual medical health records for completeness and missing variables for locating contacts. Field staff used genotyping PCR or ID numbers to make a positive match for all cases within the identified cluster. We followed up to find any missing variables from each case contact roster. This would include data on first and second skin test results, starting or stopping treatment, treatment completion, and loss to follow-up. Demographic data were reviewed and

verified to locate persons who could assist in our interviews, usually family and friends.

Step 2: Scrutinize common contacts found on each contact roster. This data would show any obvious epi-links between cases and add to what we already suspected with the DNA match.

Step 3: Identify contacts to all epi-linked persons via phone and/or field visit for associate interviews. Field staff solicited any information that would link additional associates, contacts, high-risk persons, family or friends – generally, anyone who would benefit from a TB skin test. The associate interviews would elicit the names and locations of persons with a history of TB. Education and training on TB signs and symptoms from the Public Health Field Nurses and Disease Intervention Specialists would help the contacts identify possible missed persons for testing.

Step 4: Perform a field tour with the contact to show staff where missed at-risk contacts reside or hang out. The field staff would also elicit any nicknames or other information that would help locate the at-risk persons.

Step 5: Provide incentives and enablers to contacts and cluster interviewees for their help in locating and providing demographic data for potential at-risk contacts. Incentives and enablers included gift cards, bus tickets, clothes, shoes, and food. And a simple “Thank you! We really appreciate your help” further ensured that the health department developed a good rapport and credibility in the community.

Step 6: Provide verbal feedback to all persons involved in the associate interview process. Maintain the standard of care for persons with TB disease and latent TB infection as recommended.

#### *Results of Activity*

The cluster investigation involved 43 persons who had active TB diagnosed during the time

period of 1966-2010. Most persons were members of one extended family, their close contacts, or neighbors. Others resided in nearby homeless shelters or lived on the local area streets. Of the 43 cases, 13 were identified using traditional “gum-shoe epi”; an additional 25 cases were linked using TB-GIMS genotyping data; and 5 cases were linked by both methods. The cluster investigation found 15 infected contacts to known TB cases that otherwise would have been missed in traditional contact investigations. All persons were evaluated for disease and symptom history, and recommended for LTBI treatment if appropriate.

The cohort of 43 patients in this cluster consisted of U.S.-born African Americans. Following are additional demographic data:

Male = 26 (60.5%)  
 History of homelessness = 13 (30.2%)  
 History of drug use = 17 (39.5%)  
 History of alcohol use = 19 (44.2%)  
 HIV infected = 10 (23.3%)  
 Multidrug-resistant TB = 10 (23.3%)  
 Required court commitment to complete treatment = 5 (11%)

#### *Lessons Learned*

Transmission of tuberculosis in this cluster remained localized for many generations. Multigenerational and neighborhood transmission yielded several missed opportunities for prevention among this high-risk population. Homelessness, drug use, alcohol use, HIV infection, and male social gathering rituals appear to be overwhelming factors for the propagation of TB, not to mention high unemployment! Real-time case management, surveillance, contact investigations, and proper treatment of persons with active TB and latent infections are keys to reducing transmission. Although the overall field investigations were conducted well, the use of TB-GIMS and DNA fingerprinting did help to bridge a wide gap and provides another realistic tool for TB control and prevention. The use of DOT for high-risk persons

with LTBI (e.g., children, homeless, medically complicated patients, HIV-infected and other immune-compromised persons) all assist to increase completion of therapy rates and to reduce the future risk of TB disease.

#### *Future Plans*

Plans include the following: Incorporate active surveillance, DNA genotyping data, and focused contact investigations as a daily case management plan. Develop a reproducible protocol for evaluating cluster investigations for the future. Use the resources stated to help “lessen the sting” of reduced funding and staffing woes as we become more efficient with new technologies. Continue the progress towards DOT for not only high-risk persons with LTBI, but for all contacts that start LTBI treatment. Consider the implementation of a 4-month rifampin regimen with DOT as an effective programmatic protocol for contacts with LTBI.

—Reported by Vernard D. Green, MSPH  
CDC SPHA, Lansing, Michigan

## **News from the 2011 National TB Conference**

### **National TB Conference Poster Contest Winners**

This year, for the National TB Conference fifth annual poster contest, 58 posters were developed and submitted by TB program staff from throughout the country, and were available for viewing during most of the meeting. A panel of judges reviewed and rated the posters on three criteria areas.

#### *Relevance to TB control or elimination*

Topic provides information that can potentially be transferred to another program; addresses or identifies high priority area of TB program or problematic area; provides strategy for better use of resources.

#### *Clarity of information*

Information is clearly written, short sentences, bulleted points to enhance readability; adequate amount of information provided to understand project, but not a complete journal article!

#### *Graphic presentation*

Graphics utilized to clearly present information (photographs to demonstrate or model, graphs and charts to display data); graphics are appealing to the viewer (not crowded, colors are used appropriately).

The poster judges for this year were Pennan Barry, Dawn Farrell, Roque Miramontes, Wanda Walton, Jon Warkentin, and Mark Wolman. A special thanks to them for their diligence.

This year the judges gave one first-place, one second-place, and two third-place awards because of ties among the entrants.

The first-place award was given to

#### **Deborah Lee**

CDC/DGMQ

“U.S. Destinations of Newly Arriving Immigrants and Refugees with TB Classifications for 2009 and 2010”

The second-place winner was

#### **Ann Scarpita**

Wisconsin State Department of Health Services  
“Costs and Challenges Associated with Management of a Multidrug-Resistant TB Patient in Wisconsin”

The two third-place winners were

#### **Bianca R. Perri, MPH**

NYC Department of Health and Mental Hygiene  
“Using TB Cluster Investigation to Identify High-Risk Populations – A New York City Example”

#### **Brian Baker, MD**

CDC/DTBE

“Evaluation of Tuberculosis Genotyping and the Tuberculosis Genotyping Information

Management System in State and Local Health Departments – United States, 2010”

Congratulations to the winners of this year’s competition, and thank you to all submitters for sharing your data, experiences, and excellent solutions!

—Reported by Regina Bess  
Div of TB Elimination

### Recipients of 2011 NTCA Awards

On June 15, the National TB Controllers Association (NTCA) presented awards for Exemplary Performance and Service in TB Prevention and Control. The winners of the 2011 awards were as follows.

The President’s Award is given at the discretion of the NTCA President to acknowledge special accomplishments of an individual or organization who has contributed to the NTCA or the TB community in general. This year *Sue Etkind, RN, MS* (below), Director of the Massachusetts Division of TB Prevention and Control, was selected to receive the President’s Award by Kim Field, who served until May 2011 as the President of the NTCA. The nomination cites over 25 years of prodigious TB work, including serving as an officer in numerous TB control groups, participating on various writing committees and projects, and steering the Massachusetts TB Division through challenges



related to health care coverage and access, decline of public health infrastructure, retirement of staff, and other issues. Sue also actively

mentors the next generation of the public health workforce. In her remarks on selecting Sue for the President’s Award, Kim wrote: “I first knew of Sue at my first National TB Controllers Meeting in Atlanta. Sue and Massachusetts [TB control] held nationally recognized TB standards and policies and educational tools. I knew I was to keep working in leadership and advocacy for TB when Sue, along with Carol Pozsik, approached me in 2003 at a National TB Controllers meeting and stated, ‘You should be on the NTCA Board and consider the President Elect position.’ Thank you, Sue, for all of your dedication, leadership, and advocacy for TB elimination and control. Your career continues to lead the way. I am so proud to be able to recognize you with this award.”



The Carol Pozsik Nursing Award was presented to *Mary Younge, RN, CIC* (photo, center). Mary has been the TB Outreach Coordinator at NY State’s Monroe County Dept. of Public Health since 1993. As her nominators attest, she provides exemplary clinical care. In Monroe County, new TB cases are presented at Pulmonary Physician Rounds; Mary always presents the most complicated cases and never misses a clinical detail in her history. She is dedicated to TB control. In April 2011, the health department investigated an exposure at a daycare center that involved over 100 children and staff. She was there every morning at 6 am and was there every evening, talking to parents. Mary is also committed to serving the poor and needy. She has served on a hospice unit in a nursing home and in two homeless shelters. At the TB program, she provides individualized,

patient-centered care for the most difficult patients. And she is a leader in nursing. She has converted numerous young nurses to be fanatical fans of TB control, and has inspired many young students to consider a career in community health.



The William Stead Clinician Award was given to *Dr. Lee Reichman* (photo, right). This award recognizes outstanding commitment and performance by a clinician providing TB care, leadership, or mentoring. Dr. Reichman was the Director of the Bureau of Tuberculosis in the New York City Health Department from 1971 to 1973 and the Director of the Pulmonary Division of the New Jersey Medical School - Newark from 1974 to 1993. He is presently a Professor of Medicine and Professor of Preventive Medicine and Community Health at the same institution. He serves as the Executive Director of the Global Tuberculosis Institute at the NJ Medical School. He has been involved since 1982 with the International Union Against Tuberculosis and Lung Disease. He is an author of over 100 journal articles, as well as numerous other publications; his CV is 78 pages long! For nearly 50 years, Dr. Reichman has worked tirelessly towards the control and elimination of TB around the globe. He has been actively involved in patient care and in the mentoring of innumerable students, and he is a relentless advocate for TB care everywhere on the globe.

*Dr. Timothy Sterling* won the Robert Koch TB Researcher Award. His nomination states that when he taught at Baltimore's 3-day "TB Today" program, Dr. Sterling was an immediate favorite

of the students, able to make the treatment of TB and the interactions of medications not only understandable to novices, but enjoyable. His interest in research and his commitment to the patients whose care he directed were evident to everyone. Moving on to Vanderbilt, he remained a strong advocate for TB and HIV research, working with both the TB Trials Consortium (TBTC) and the TB Epidemiologic Studies Consortium (TBESC). As chair of TBTC Study 26 (the PREVENT TB study) he guided that large and important study to its successful completion. He is known for his generosity in sharing his knowledge, his sense of humor, and his commitment to the patients he sees, the people he teaches, and those with whom he works to eliminate TB in the world. Dr. Sterling was not at the conference.

The Dixie Snider Award was presented to *Dr. Thomas Navin* (photo, right). This award is bestowed on a CDC employee who has rendered outstanding support, through partnership, to the state or local level TB community in the interest of improving TB control and prevention programs. Dr. Navin is the Chief of the Surveillance, Epidemiology, and Outbreak Investigations Branch, DTBE, CDC. He oversees the epidemiologic and surveillance research agenda for preventing TB in the United States, the National TB Surveillance System, and the conduct of TB outbreak investigations. The nominator wrote, "Dr. Navin does render outstanding support to the state and local TB community through partnership. I have witnessed and had the experience of Dr. Navin coming to



the state/local level to really understand the challenges the state and local staff face in the day-to-day work of TB prevention and control. I have also always felt that Dr. Navin addresses each individual as a peer and that we are all on the same team, fighting the battle of sustaining and maintaining TB prevention and control battle. I most admire the support he has given to his scientists regarding advancement and application of genotyping to TB prevention and control.”

The Charles DeGraw Advocacy Award was won by *Cynthia Tschampl*. This award is given to an organization or individual who has rendered outstanding efforts and achievements in advocating for increased support of TB prevention and control efforts. She is a doctoral student and teaching assistant at the Heller School for Policy and Management at Brandeis University. She is also a research consultant for the Crittenden Women’s Group, and the Boston global group leader for RESULTS. Cynthia has received awards including training fellowships, scholarships, and the RESULTS Grass Roots Service Award. Her nominators write that “She is an absolute dynamo, whose passion is domestic and global TB and grass roots advocacy. She schedules legislative visits each year and arms herself (and her students) with targeted lobbying materials and that same passion to move mountains that gets results. Largely through her efforts, key members of the Massachusetts Senate and House receive TB and public health messages, and those efforts have resulted in increases in the state budget for TB control when economic times have been lean. She is the advocate that we in TB control all dream of having. Her advocacy work has had an impact on TB patients, the Massachusetts TB Prevention and Control Program, students, legislators, the media, and the public at large.” Cynthia was not at the meeting to receive the award.

*Ken Jost* (photo, right) of DTBE’s Laboratory Branch won the Ed Desmond Lab Award. This award is given to a TB laboratorian for outstanding TB laboratory services. As the



previous Manager of the Mycobacteriology Laboratory and the current Tuberculosis Applications Scientist for the Texas Department of State Health Services Mycobacteriology Laboratory, he helps ensure the provision of excellent service and diagnostic capacity of the laboratory. His nomination states, “He has a long history of providing extraordinary service to health care providers and public health workers in the state of Texas in their care of TB patients and contacts. He works diligently, including working long and late hours when needed, to ensure that providers have the most rapid access to lab services possible. He takes a sincere interest in TB patients and their outcomes. He has an impressive understanding of TB, and the approach that health care providers take to manage it. He understands the impact of a diagnosis of active TB, drug resistance, or treatment failure. He cares about the service the lab provides, understands how important it is, and is willing to provide that help even when it means going the extra mile to get lab results. He is known nationally for his dedication and leadership as evidenced by his participation on numerous workgroups.” Please note, Ken’s write-up and photo also appear in an article from the Laboratory Branch in this issue.

The TB Controller of the Year Award was won by *Kim Field*, Washington State TB Controller until her recent retirement in May 2011. The award recognizes an outstanding contribution and impact on TB prevention and control. Kim has had a 35-year career in public health, with the last 18 devoted to TB prevention and control at the state and national levels. Kim’s TB experience began in rural San Diego County

where she administered streptomycin and hearing tests to immigrants and ranch hands. Her stellar career culminated with her recognition as a nationally known leader, educator, and advocate for TB programs. During her tenure in the Washington State TB Program, Kim faced many challenges, including three complex and large outbreaks. Under her leadership, she and her staff met these challenges in an open and collaborative manner. In addition, Kim implemented cohort review in her state as a way to improve case management outcomes, and tirelessly educated many other state staff in the cohort review process. Kim's passion for sharing and mentoring resulted in her teaching many courses for the Francis J. Curry International TB Center and providing numerous guest presentations at national and regional TB meetings. Kim also actively participated in many state and national TB workgroups and committees, including serving as President of NTCA twice. It is truly fitting that Kim's passionate and tireless advocacy for TB programs and patients everywhere be recognized through NTCA's highest award. Kim was not at the meeting to receive this honor.



In addition, *Dr. Richard Brostrom* (photo, left) was recognized for having been selected for the 2010 Harriet Hylton Barr Distinguished Alumni Award from the UNC (Chapel Hill) Gillings School of Global Public Health. Established in 1975, the Barr award is presented to an outstanding alumnus who is working full time in public health. Dr. Brostrom was named the Barr Award winner in April 2010 but was living in Saipan at the time;

he received the award in June 2011 at the National Tuberculosis Conference. Dr. Brostrom earned a Master of Science in Public Health degree in 1987 from UNC's public health school and medical degree in 1991 from UNC's School of Medicine. In 1996 he relocated to Saipan, capital of the U.S. Commonwealth of the Northern Mariana Islands (CNMI). He served as medical director of the Division of Public Health for the CNMI until 2010 when he moved to Hawaii to become DTBE's Pacific Region TB Field Medical Officer and the TB Control Branch Chief with the Hawaii Department of Health. Some of his most groundbreaking work has been with diabetes and multidrug-resistant (MDR) TB. "Dr. Brostrom was one of the first people to sound the alarm of this emerging problem of MDR TB on the island state of Chuuk," said Sapna Bamrah, MD, a DTBE medical epidemiologist. At the conference, the Barr award was presented to Dr. Brostrom by Dr. Terry Chorba, Chief, FSEB, who is also an alumnus of the UNC School of Global Public Health.

—By Carol Pozsik and Denise Ingman, NTCA  
and Ann Lanner, DTBE

## TB EDUCATION AND TRAINING NETWORK UPDATE

### *Medecins Sans Frontiers* Launches Blogging Project for MDR TB Patients

*Medicins Sans Frontiers (MSF)*, also known as *Doctors without Borders*, recently launched a blogging project for patients with MDR TB. [TB&ME](#) is a collaborative project by and for patients being treated for multidrug-resistant tuberculosis (MDR TB) in locations all around the world. TB&ME was launched to give MDR TB patients a forum for sharing with the world, in their own words, what it's like to have this disease and how treatment and services could be improved.

As possibly the first blog of its kind, TB&ME could provide an excellent opportunity for TB

care providers and educators to learn from patients about the real-life experience of MDR TB and MDR TB treatment. Patients who choose to participate in the TB&ME project do so on a voluntary basis, having been identified by MSF field staff as people who might be interested in sharing their stories. Patients may choose to leave the project at any time without affecting their care.

Members write about their experiences of living with MDR TB and the treatments that they receive. Stories from patients who do not have access to computers or the internet are transcribed and, if necessary, translated and posted by MSF. When such patients wish to respond to questions or comments to their blog posts, these are also transcribed and posted (unedited other than spelling and grammar) by MSF.

So far the site has bloggers from Uganda, Swaziland, the Philippines, and Australia, with a range of ages and backgrounds. Visitors to the site can interact with the bloggers by posting questions or comments. One of the project's bloggers is Christiaan Van Vuuren, a young man from Australia who was diagnosed with MDR TB in 2010. During the nearly 7 months he spent in isolation, Christiaan (aka the Fully Sick Rapper) made a name for himself and created quite a stir after writing, directing, and posting two rap videos on YouTube describing his situation. Christiaan recently completed 18 months of treatment for MDR TB, and his recent posts describe the relief and sense of accomplishment he feels about that. To read their blogs, and those of other MDR TB patients, visit [TB&ME](#).

Individuals wishing to reach MSF about TB&ME can do so by contacting [pete.masters@london.msf.org](mailto:pete.masters@london.msf.org) or via twitter ([http://twitter.com/msf\\_field](http://twitter.com/msf_field)).

—Submitted by Linette McElroy  
TB ETN Membership Development Work Group

## TB PROGRAM EVALUATION NETWORK UPDATE

### Assessing TB Program Evaluation Capacity and Focal Point Training Needs

The TB Program Evaluation Network (TB PEN) Steering Committee is committed to assisting the Program Evaluation Focal Points (EFPs) in having their voices heard and communicating any issues and needs related to program evaluation (PE) to CDC. In January 2011, the Steering Committee, with input from the TB PEN Training and Tools Teams, determined that a needs assessment of the EFPs would be the most effective mechanism for eliciting feedback regarding evaluation issues. The Steering Committee's goals were to 1) gain insight into the needs of focal points in their respective program areas; 2) assess current capacity for program evaluation; and 3) identify where tools, training, and technical assistance are needed.

The Southeastern National Tuberculosis Center (SNTC) provided the Steering Committee with technical support in the form of question development and use of their web-based survey technology. The SNTC worked with the Steering Committee through several iterations of the assessment and offered their expertise in the creation of the final 48-item assessment tool and transfer into the web-based survey platform.

Focus areas of the assessment included:

- Demographics of focal points to better understand their current role in TB; length of time working in TB and as an EFP; barriers to fulfilling job duties; and time allotted to program evaluation;
- Program evaluation activities conducted such as development of goals and objectives, action plan, timeline and evaluation focus areas;
- Dissemination of evaluation findings;

- Current level of training in evaluation and training needs; preferred training formats; and
- Use of TB program evaluation resources.

The Steering Committee consulted with the National TB Controllers Association to identify viable survey launch dates to increase the response rate and minimize burden and overlap with other surveys being distributed to TB programs. An online URL for the needs assessment was distributed to the EFPs and the Steering Committee members. The assessment was launched on April 21, 2011, and remained open for responses for 2 weeks until it closed on May 6, 2011. Completion time of the assessment was estimated as 15-20 minutes. Responses and comments provided by the focal points remained anonymous.

Preliminary results have been shared with the TB PEN Steering Committee. Completed responses were received from 50 of 88 (57%) people contacted. The survey gathered considerable useful information and helped express the needs of the focal points for more resources. A final report of the needs assessment will be provided to the TB PEN focal points through a future *TB Notes* article.

—Reported by Stephen E. Hughes, Ph.D.  
TB PEN Co-Chair, NY State Department of Health

## COMMUNICATIONS, EDUCATION, AND BEHAVIORAL STUDIES BRANCH UPDATE

### Revised and Updated *Core Curriculum on Tuberculosis: What the Clinician Should Know*

#### Background

For the U.S. to reach the goal of TB elimination, clinicians and other public health professionals must have access to current TB control and

prevention information. To help address this need, the *Core Curriculum on Tuberculosis: What the Clinician Should Know* (Core Curriculum) was originally developed in 1989. Last updated in 2000, the Core Curriculum required updating to reflect new guidelines for TB prevention, treatment, testing, diagnosis, and patient management and public health practice. A multiphased, systematic process was utilized for this update.

Beginning in 2007, a needs assessment was conducted with TB experts from several state and local TB agencies who provided guidance on how to improve the Core Curriculum. This was followed by an extensive update of the Core Curriculum content using the latest CDC guidelines for TB prevention, treatment, testing, diagnosis, patient management, and public health practice. The topic layout, formatting, and study question design were revised by an instructional design expert. TB subject matter experts from CDC and state and local TB agencies reviewed the updated materials for scientific accuracy.

*Two-Phase Pilot Test with Target Audience*  
A two-phase pilot test was conducted with the target audience to evaluate the accuracy and clarity of the content and the effectiveness of the instructional design. The target audience included a small (5-person) focus group facilitated by CDC and a larger (64-person) national group who completed the pilot test on their own.



Participants from Phase I pilot test discussing materials.

*Pilot Test Phase 1 – Focus Group*

We recruited five health professionals with varied TB training and experience from Atlanta, Georgia. The pilot test was conducted over 2.5 days in a controlled classroom setting. The participants worked continuously through the pilot test materials at their own pace and participated in group discussions. Evaluators observed participants working through materials, facilitated discussions, and administered pretests and posttests.

*Pilot Test Phase 2 – Nationwide Group*

We then recruited 64 clinicians and other public health professionals with varied TB training and experience from several state, local, and island jurisdictions. The pilot test materials were sent to each participant, and the pilot test was conducted over a 1-month period in realistic conditions at each participant’s work or home. Participants worked through the materials at their own pace and returned the completed materials to CDC.

*Results*

Clinicians and other public health professionals participating in the pilot test gained an increase in TB knowledge as demonstrated by pretest and posttest scores. Additional results are below.

*Increase in Pretest and Posttest Knowledge Scores*

<b>Pilot Test Group</b>	<b>% Increase</b>
<b>Phase 1 Focus Group</b>	11.5% increase in score
<b>Phase 2 Nationwide Group</b>	13.4% increase in score

*Selected Pilot Test Objective Evaluation Results*

<b>Evaluation Questions</b>	<b>% Answer</b>
<b>Does the Core Curriculum meet stated objectives?</b>	100%: <b>Yes</b>
<b>How do you rate the level of the content for the target audience (doctors, nurses, and other health care staff)?</b>	90.5%: <b>Just right</b>
<b>Overall, how confident are you that the target audience can learn about TB after having worked through the Core Curriculum?</b>	95.3%: <b>Confident</b>

*Summary of Comments from Reviewers and Pilot Test Participants:*

The content was clear, easy to understand, in-depth, and relevant to public health; the writing was clear, easy to follow, concise, and to the point; the study questions reinforce material, are challenging, create interactivity; the tables clarify content. Comments on the educational aspect: Fantastic resource, comprehensive. General comment: Excellent work.

*Target Audience*

The Core Curriculum is intended for clinicians and other public health professionals who care for persons with or at high risk for TB disease or infection.

*Sections of the 2011 Core Curriculum*

The Core Curriculum can be used as a self-study guide or reference manual and includes the following sections:

- Introduction to the Core Curriculum
- Chapter 1: Overview of TB Epidemiology in the United States
- Chapter 2: Transmission & Pathogenesis of TB
- Chapter 3: Testing for TB Infection and Disease
- Chapter 4: Diagnosis of TB Disease
- Chapter 5: Treatment for Latent TB Infection
- Chapter 6: Treatment of TB Disease
- Chapter 7: TB Infection Control
- Chapter 8: Community TB Control

The manual also includes a glossary, answers to the study questions, and copies of the PowerPoint slide set that accompanies the Core Curriculum.

To view the Core Curriculum, please visit [www.cdc.gov/tb/education/corecurr/](http://www.cdc.gov/tb/education/corecurr/)

To view or download the *Core Curriculum* slide set, please visit [www.cdc.gov/tb/publications/slidesets/corecurr/default.htm](http://www.cdc.gov/tb/publications/slidesets/corecurr/default.htm)

Continuing education (CE) credits are offered free of charge for various professions. More information about CE credits is available at [www.cdc.gov/tb/education/CE/default.htm](http://www.cdc.gov/tb/education/CE/default.htm)

Print copies of the Core Curriculum will be available for ordering by the end of October.

—Reported by Cheryl Tryon and Peri Hopkins  
Div of TB Elimination

## INTERNATIONAL RESEARCH AND PROGRAMS BRANCH UPDATE

### TB in Indigenous Peoples

Among the 9.2 million new cases of TB and 1.7 million deaths due to TB globally each year,<sup>1</sup> the absolute magnitude of TB among the estimated 370 million indigenous people worldwide<sup>2</sup> is not known because few disaggregated surveillance data exist. However, evidence from nations where data are available, such as the United States, Canada, Australia, and New Zealand, suggests that the rates of TB are higher among indigenous than non-indigenous people.<sup>3,4,5,6,7</sup> In November 2008, indigenous leaders and TB experts from around the world met in Canada to develop a strategy for reducing the burden of TB among indigenous people globally.<sup>8</sup> Poverty and other social determinants of health were acknowledged as factors influencing indigenous

peoples' vulnerability to TB.<sup>9</sup> Furthermore, participants highlighted the need for documenting and monitoring the burden of TB in indigenous people and better understanding the social realities of these groups to design more effective TB interventions. To help address these needs and to inform public health approaches to address TB disparities, two projects were undertaken to measure and better understand TB in indigenous peoples in the United States.

#### *Tuberculosis in indigenous peoples in the United States, 2003–2008* \*

We examined TB trends and epidemiology of American Indians and Alaska Natives (AIAN) and Native Hawaiians and Pacific Islanders (NHPI) relative to other racial/ethnic groups during 2003–2008. We analyzed cases in the U.S. National Tuberculosis Surveillance System (NTSS) and calculated TB case rates among all racial/ethnic groups from 2003 to 2008. Socio-economic and health indicators for counties where TB cases were reported came from the Health Resources and Services Administration Area Resource File.

We found that, among the 82,836 TB cases, 914 (1.1%) were in AIAN and 362 (0.5%) were in NHPI. In 2008, TB case rates for AIAN and NHPI were more than five and 13 times greater than for non-Hispanic whites. From 2003 to 2008, AIAN had the largest percentage decline in TB case rates for any racial/ethnic group, but NHPI had the smallest percentage decline. AIAN were more likely than other racial/ethnic groups to be homeless, have excessive alcohol use, and come from counties with a greater proportion of persons living in poverty and without health insurance; they were also more likely to be prescribed totally directly observed therapy. A greater proportion of NHPI had extrapulmonary disease and came from counties with a higher proportion of persons with a high school diploma.

Determinants of health extend beyond individual-level traits and behaviors, and involve social and economic factors that operate at the community

or population level.<sup>10,11</sup> Disparities in health, including differences in TB risk and burden, between indigenous and non-indigenous peoples, may be the result of the complex interplay among the individual, the community, and the social determinants of health.<sup>12,13</sup> Results from this project showed that there is a need to develop flexible TB control strategies that address the social determinants of health, and are tailored to the specific needs of AIAN and NHPI in the U.S.

*Estimating the burden of TB among American Indians and Alaska Natives in the US, 2006-2009: a surveillance evaluation*

The second project aimed to evaluate the completeness and accuracy of the Indian Health Service (IHS) National Patient Information Reporting System (NPIRS) for identifying active TB cases among AIAN. Another aim of the project was to evaluate whether TB cases identified by IHS providers are reported to state public health authorities, and would therefore be captured in the National TB Surveillance System.

A multistage sampling approach was used to select IHS units and health facilities proportional to the population of AIAN using the IHS for health care. A total of 24 IHS units, each containing several health facilities, were included in the sample, located across 8 states. Line listings were generated from the IHS NPIRS for all patients recorded with a diagnosis of active TB at selected facilities between 2006 and 2009, based on the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9CM). Up to 30 patients were selected from each inpatient and outpatient listings in the NPIRS for each facility. For all selected patients, medical records were reviewed to identify and capture data on TB symptoms, screening, diagnosis, and treatment using standardized forms.

Data have been collected from all facilities in 22 of the 24 selected IHS service units. Data collection from the remaining health facilities and linkage of the TB cases verified by chart review

at the IHS facilities to the state database is projected to be completed by August 2011. Preliminary analysis suggests that the IHS system using ICD-9CM codes for identification of patients with active TB disease greatly overestimates the burden of TB in the AIAN population. Approximately 10%-30% of patients with an ICD-9CM code for active TB disease in the NPIRS could be validated as having active TB based on information recorded in the medical record. Furthermore, there is no direct mechanism for IHS health facilities or units to report cases of TB disease directly to the National TB Surveillance System, and the extent to which IHS facilities and providers interrelate and report to the local and state public health authorities is variable in different regions. Information from this evaluation will help guide policies and activities for the IHS and CDC to promote the accuracy and completeness of federal reporting and recording of nationally-notifiable diseases, including TB, to CDC. Collectively, findings from these studies will help to improve our understanding and highlight the importance of accurately measuring the burden of TB and of TB programs and initiatives to address both individual-level and community-level social determinants of TB, especially among indigenous groups in the United States.

—By *Emily Bloss, PhD, Laura Podewils, MS, PhD, John Jereb, MD, and Eugene McCray, MD, Div of TB Elimination; Timothy Holtz, MD, MPH, Div of HIV/AIDS Prevention; John Redd, MD, MPH, and James Cheek, MD, MPH, Indian Health Service*

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## LABORATORY BRANCH UPDATES

### Highlights from the APHL 7th National Conference on Laboratory Aspects of Tuberculosis

More than 140 participants attended the 7th National Conference on Laboratory Aspects of Tuberculosis which was held in Atlanta, Georgia, June 13–15, 2011. The 2.5 day event featured speakers who addressed a variety of topics. Conference attendees included clinicians, TB controllers, and representatives from clinical, academic, and public health laboratories.

The conference began with a keynote address given by Dr. William Burman, University of Colorado. Dr. Burman spoke about insights into drug resistance and drug-susceptibility testing from a clinician's viewpoint, as an example, reviewing in detail the inter-related clinical and laboratory challenges with the use of ethambutol. Additional topics of discussion during the conference included practical considerations for implementation of new technologies such as assays for the molecular detection of mutations associated with drug resistance and interferon gamma release assays in the laboratory; updated recommendations for mycobacteriology drug-susceptibility testing; approaches for assuring quality; and strategies for validating non-FDA approved assays. New basic research discoveries and TB as a global disease were also featured.

Ken Jost, right, receives Laboratorian Award from Ed Desmond. Photo by Wanda Walton.



The 2-day conference was colocated with the National TB Conference for the second year in a row. A Laboratory Late Breaker

Session was included as part of the conference. This session included short oral presentations selected from abstracts submitted for the laboratory conference, and other late breaking topics. Participants had an opportunity to learn about significant findings and model practices impacting laboratory testing for TB. Another breakout session, moderated by Dr. Beverly Metchock, DTBE, Dr. Ed Desmond, CA Department of Public Health, and Dr. Susan Ray, Emory University, covered drug-resistant TB and featured audience-interactive case studies involving collaboration between the laboratory and control program.

On June 15<sup>th</sup>, NTCA presented awards for Exemplary Performance and Service in TB Prevention and Control. A highlight of the event was the presentation of the Ed Desmond Laboratorian of the Year Award to Ken Jost of the Texas Public Health Laboratory. Ken was nominated by Dr. Barbara Seaworth, Dr. Charles Wallace, Denise Dunbar, and others. Among the many accolades given to Ken, the nominators stated "... (Ken) works diligently to ensure that as providers we have the most rapid access to laboratory services possible. He takes a sincere interest in patients and their outcomes. He has a tremendous understanding of the importance of each laboratory test used in management of those at risk for tuberculosis. He is able to educate providers on the value and biases of particular tests, as well as to explain test results and to provide references to those interested." Ken is known both nationally and internationally as a recognized expert consultant, educator, and

technical advisor for CDC, the International Union Against Tuberculosis and Lung Disease (IUATLD), and the Association of Public Health Laboratories (APHL). He has shown leadership through his participation on numerous APHL workgroups. CDC/DTBE/LB wishes to congratulate Mr. Ken Jost on this well-deserved honor.

Through sponsorship from APHL and CDC, representatives from public health laboratories that are partially funded through CDC cooperative agreements attended the conference this year. The authorized PowerPoint presentations from the 7th National Conference on Laboratory Aspects of Tuberculosis are now posted online at:

<http://www.aphl.org/conferences/proceedings/Pages/2011TBConference.aspx>

—By Frances Tyrrell, MPH, MT (ASCP), SM  
Div of TB Elimination

### Tuberculosis Laboratory Aggregate Report Released

The Tuberculosis Laboratory Aggregate Report was distributed to attendees of the 7<sup>th</sup> National Conference on Laboratory Aspects of TB on June 13, 2011, in Atlanta. It was developed by the Laboratory Capacity Team (LCT) within the Laboratory Branch (LB) and contains data provided by 58 U.S. Public Health Laboratories (PHL) that receive cooperative agreement funds from CDC's Division of Tuberculosis Elimination. This is the second report of its kind; the first was



released in 2010 and contained PHL workload and turnaround time (TAT) data from 2008. In this latest edition, LCT reports similar data for calendar year 2009 and provides a comparison to 2008 indicators to identify changes in testing volumes and TAT. The analyses presented, which in many cases are stratified by volume, are meant to serve as a guide for PHL to develop benchmarks and make peer comparisons. The data can be used as an educational tool to aid in the exploration of successful testing practices, as well as those that may need examination. This report is to be used only as a guide and is not intended for other purposes that may be disciplinary in nature.

Some of the principal changes in PHL workload shown in this year's aggregate report include a significant decrease in the number of clinical specimens received for TB testing, as well as a decrease in the number of patients with culture-positive results for *Mycobacterium tuberculosis* complex between 2008 and 2009. However, there was a significant increase in the number of nucleic acid amplification tests (NAAT) performed by PHL in 2009 as compared to 2008. Additionally, TAT indicators for 2009 were analyzed and compared to 2008. With the exception of time to specimen receipt in the laboratory, TATs increased for all indicators (i.e., smear result, identification of *Mycobacterium tuberculosis* complex, and drug susceptibility testing). The reasons for the slower TATs are unknown, but might be due to reductions in staff and batching of tests resulting from changes in resources.

In addition to the workload and TAT data, the report provides information on testing methods and algorithms. The current report graphically depicts the criteria for NAAT used by the PHL to determine which specimens will receive testing. The most used criterion observed was testing a diagnostic specimen from all patients with a smear-positive result and on request, from patients with a smear-negative result. Also, first-line and second-line drug susceptibility testing

(DST) methodologies and the specific anti-tuberculosis drugs tested are presented. Currently, 37 PHL perform first-line DST using the MGIT 960 system and 10 of the 18 PHL that perform second-line DST in-house reported using the indirect agar proportion method. The document concludes with relevant references and resources. Future reports will monitor and identify potential trends in workload, TAT, and methodologies.

Members of LCT have learned a great deal through collaboration and communication with our PHL partners. We would like to thank them for taking the time to provide the data utilized in the Tuberculosis Laboratory Aggregate Report as well as for their participation in LCT site visits.

To review the report online, please visit [www.cdc.gov/tb/publications/reportsarticles/labreports.htm](http://www.cdc.gov/tb/publications/reportsarticles/labreports.htm)

—Submitted by Tracy Dalton, PhD  
Div of TB Elimination

## NEW CDC PUBLICATIONS

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## PERSONNEL NOTES

Regina Bess, Training Specialist in the Communications, Education, and Behavioral Studies Branch (CEBSB), has left the division for another position with CDC. Regina has been offered and accepted the position of Health Communication Specialist in the Scientific Education and Professional Development Program Office, Office of Surveillance, Epidemiology and Laboratory Science (OSEL/SEPDPDPO), effective August 15. As much as we do not want to lose Regina as a valuable member of DTBE, we support the opportunity for her to take on this new challenge.

Regina first came to DTBE in 1992 as a Visual Information Specialist (VIS). She left DTBE in 1996 after accepting a position in ATSDR, but returned in 2000. In 2003, Regina applied and interviewed for and was hired as a Health Education Specialist / Training Specialist in CEBSB, taking on a new role and further developing her knowledge and skills in TB education, training, and communication. Most recently, Regina has been pursuing a Master of Public Administration degree, with expected completion in December 2011. We will miss Regina very much – besides the formidable talents she has shared with us, she brightens every room she enters with her wonderful smile and her never-met-a-stranger attitude. Good luck, Regina!

Scott Cope, BS, has joined the Surveillance, Epidemiology, and Outbreak Investigations Branch (SEOIB) as a first-year graduate student from Emory University. Scott graduated from Samford University in Birmingham, AL, this past May with a BS degree in Biology and a minor in Bioinformatics. Seeking an MSPH degree in Epidemiology from the Rollins School of Public Health, Scott is a part of RSPH's Practical Experience program that allows students to work part-time each semester with various public health venues across the Atlanta area. His interests in the public health field include infectious diseases, food and waterborne illnesses, Geographical Information Systems (GIS), and global health. As a former member of the Samford Cross-Country and Track team, his interests outside of public health include competing in road races and triathlons. Welcome, Scott!

Tracie Gardner, MS, PhD, recently joined the Molecular Epidemiology Activity in SEOIB. Tracie completed her master's and PhD degrees at the University of Texas Health Science Center – School of Public Health; her PhD dissertation focused on pulmonary *Mycobacterium avium*. She then joined the faculty at the Baylor College of Medicine in the Department of Psychiatry and

Behavioral Sciences. Tracie came to CDC as an EIS Officer in 2008 and was assigned to the Alaska Department of Health. While in Alaska, Tracie assisted DTBE with a multi-state TB outbreak investigation and worked on various public health projects involving pandemic H1N1 influenza, campylobacter, gonorrhea, and occupational injury surveillance. After EIS, Tracie moved to Atlanta to work with the Global Immunizations Division and the Division of Global Migration and Quarantine. Tracie is an avid cyclist, swimmer, and runner, and joined three other DTBE staff on two triathlons this summer!

Kristin Hake, RN, joined the Surveillance, Epidemiology, and Outbreak Investigations Branch as a Rollins Opportunity Student on September 9, 2011. She will be working with TBESC project coordinators to prepare study databases for the consortium's database repository. Kristin received her bachelor of science in nursing degree from Georgia State University in December 2003 and went to work at Emory University Hospital Midtown, caring for cardiovascular and thoracic surgery patients in the surgical ICU and surgery step-down unit. Last year, she cut back her hours to one shift a week and enrolled in the MPH program at Emory to fulfill a long-held goal to become an epidemiologist. She expects to graduate in May with a concentration in global epidemiology.

Christine Ho, MD, MPH, has joined DTBE headquarters as an FSEB medical officer. She transferred from the San Francisco TB control program, where she had been a field medical officer since 2007. In San Francisco, she was responsible for the supervision and restructuring of contact investigation activities and for introducing and propagating blood-based interferon-gamma release assays for TB testing into the targeted community health clinics and testing sites. Her clinically related activities included supervising medical trainees, consulting for community providers, and seeing TB patients. Her background includes bachelor degrees with honors in biophysics and art at UC Berkeley, and

a medical degree from UC San Francisco. She was board certified in internal medicine in 1996 and was recently recertified in 2006. After completing her internship and residency in primary care internal medicine at UC San Francisco, Christine stayed on as faculty in the Division of General Internal Medicine. There she started the nascent primary care residency program at the Mount Zion site, developing the outpatient curriculum and clinical rotations, as well as developing a faculty-resident partnership model at the new practice site. She then worked for 5 years as a primary care physician at Asian Health Services, a nationally renowned community health clinic that serves Asian primarily non-English speaking patients. She instituted the first community-based case conference series there, which has been published and replicated in the SF area. She also worked as a TB clinician at the San Francisco TB clinic during that time. In 2004, Christine obtained an MPH degree in epidemiology from UC Berkeley, and then went on to work with Dr. Art Reingold at the California Emerging Infections Program. She served as the project clinician for multiple projects including the Unexplained Pneumonia Project, Unexplained Deaths Project, and the California Variant Creutzfeldt-Jakob Disease (vCJD) Surveillance Project. She also conducted an investigation of deaths secondary to *C. sordellii* in young women through retrospective death certificate review and molecular assays.

Rickenya Hodge joined DTBE/OD as a Resource Management Specialist on August 29, 2011. She will be working with the Resource Team (in the position previously held by Pat Farah), and will be responsible for managing various key aspects of DTBE's intramural and extramural budget. Rickenya began her CDC career in 1997 with the Procurement and Grants Office (PGO), Office of the Director. While in PGO, she held positions that allowed her to gain experience in simplified acquisition and Federal assistance.

In 2002 she joined the Public Health Practice Program Office (PHPPHO), Extramural Service Activity, where she served as the Program Manager for the Association of American Medical Colleges (AAMC). In 2005, Rickenya began working in the National Center for Health Marketing, and continued serving as the AAMC Program Manager for 8 years. In addition, she became a Center Extramural Liaison and was responsible for the overall management of several CDC-wide cross-cutting and complex umbrella cooperative agreements, including administrative and procedural direction, policy oversight, and planning, coordination, and program development phases of extramural programs. A few of the cooperative agreements she supported included the CDC Public Health Partners, Academic Partners, Entertainment Education, and National Business Organizations.

In 2010, she joined the Office for State, Tribal, Local and Territorial Support (OSTLTS), Technical Assistance Branch (TAB), where she served as the Extramural Liaison for the National Public Health Improvement Initiative (NPHII). She provided support in the areas of pre- and post-award administration, including financial administration and regulatory guidance for extramural activities.

Rickenya graduated with a Bachelor of Science degree in Paralegal Studies from Sullivan University in Louisville, Kentucky. Key government experiences prior to her arrival at CDC included serving as a cooperative educational student for the US Army Corps of Engineers and an intern with US Small Business Administration. She is approaching 19 years of Federal service.

Emma Johns has joined SEOIB as a CDC Experience Fellow. She will be working with the Molecular Epidemiology Activity and the Outbreak Investigations Team until the summer of 2012. Emma is between her 3<sup>rd</sup> and 4<sup>th</sup> years of medical school at Emory. She completed her undergraduate studies at Rice University, where

she majored in International Health. She has also worked at the Aga Khan Foundation in Washington, DC, where she worked on grants management, research, and project development for projects related to international public health, microfinance, and education. Welcome, Emma!

Joan Mangan, BSMT, ASCP, MST, PhD, has been hired as a behavioral scientist on CEBSB's Education, Training, and Behavioral Studies Team. She comes to the division with more than 10 years' experience in designing, conducting, monitoring, and evaluating research projects focused on epidemiology, behavioral change, and treatment adherence in relation to TB, asthma, and congestive heart failure. Dr. Mangan received her doctorate at the University of Alabama at Birmingham in Health Education and Health Promotion. She most recently worked at the Southeastern National TB Center, where she was the principal investigator of an American Lung Association social and behavioral research grant designed to develop culturally salient messages to facilitate TB treatment adherence among foreign-born patients. Additionally, Dr. Mangan led the study coordination for the Florida site of the CDC TB Epidemiologic Studies Consortium Task Order 25, Examining Tuberculosis Mortality in the United States. Dr. Mangan also has over 9 years of experience working in and managing clinical and research laboratories. Welcome, Joan!

Suzanne Marks, MPH, MA, of DTBE's Clinical Research Branch, is the worthy recipient of the DTBE Director's Recognition Award for the fourth quarter of 2011. Suzanne was selected to receive this honor because of the exceptional quality of her work and productivity over the past year. During this time Suzanne has served as the principal investigator and project officer for:

- TBESC Task Order 27: Determining the Programmatic Costs and Benefits of Using a Nucleic Acid Amplification (NAA) Assay for TB Diagnosis Within the United States

- TBESC Task Order 28: Treatment Practices, Outcomes and Cost of Multidrug-Resistant (MDR TB) and Extensively Drug Resistant Tuberculosis (XDR TB) in the United States
- TBESC Task Order 29: Improving Testing for Tuberculosis (TB) and Latent TB Infection (LTBI) for Persons with HIV Infection at HRSA Part C-funded HIV Clinics; and
- The California HIV Testing Project.

In addition, Suzanne was lead author on two peer-reviewed articles published in 2011 (IJTLD 2011; 15: 9822-4 and IJTLD 2011; 15: 465-70), and she made four presentations (to a national conference on the homeless, to CSTE, to an NCHHSTP consultation, and to the Health Economics Workgroup). She reviewed submissions for three journals, and reviewed abstracts submitted to four national or international conferences. She served on the Publications and Presentations Committee of TB Epidemiologic Studies Consortium, and served as a member on at least six different divisional, center, or departmental work groups. In addition, Suzanne has been relied upon to respond to short-fuse deadline economic analysis requests received through the Division's policy office. Her willingness to serve, remarkable productivity, and accomplishments reflect outstanding commitment to the core mission of DTBE, NCHHSTP, and CDC. Congratulations to Suzanne for this well-deserved honor!

Sharon McAleer has left the DTBE Web team to take on a new challenge as a Usability Analyst in the Electronic Media Branch, Division of News and Electronic Media, Office of the Associate Director for Communications (OADC), effective August 29. Sharon joined the DTBE Web team in October 2005 as the Internet webmaster. She has been instrumental in ensuring the usability of the DTBE website. She had the lead for migrating the DTBE website into the new template, conducting usability studies, and formatting the DTBE website using Web best practices. While we are saddened to see Sharon leave the DTBE Web team, we are pleased that

she will have the opportunity to share her wealth of knowledge with others at CDC. In her new position she will be part of the usability community of practice which assists CDC offices and divisions with their usability needs. She will be responsible for ensuring the usability of the CDC mobile website, mobile applications, and the CDC website. She will also conduct usability testing on the new CDC Web content management system. It has been a pleasure working with Sharon, and we'll miss her Irish humor and "can do" attitude.

Brittany Moore, MPH, has completed a fellowship in the International Research and Programs Branch (IRPB) and accepted a position as a Health Scientist with the TB/HIV Team. Brittany joined DTBE/IRPB in September 2009 as an Association of Schools of Public Health Global Health Fellow. During her 2-year fellowship, she proved to be an invaluable member of IRPB's TB/HIV Team. In her new role she will continue to lead and work on projects with the TB/HIV Team while also assisting the OD with international policy and programmatic inquiries. Brittany earned her MPH from the Global Health Department of the Emory University Rollins School of Public Health and dual degrees in Journalism and Political Science from the University of Georgia. Congratulations, Brittany!

Lee Ann Ramsey, SEOIB Deputy Branch Chief, has been selected as the recipient of the DTBE Director's Recognition Award for the third quarter of 2011. Lee Ann was selected to receive this honor because of her exemplary efforts in providing leadership to SEOIB and DTBE activities, and maximizing performance and increasing morale in SEOIB. Lee Ann has developed multiple activities that resulted in improved communications and morale within the Branch, including publishing a popular monthly Branch newsletter, maintaining a Branch bulletin board, arranging for weekly "office hours" with the Branch Chief, and systematically sharing information from senior staff meetings. She has also implemented a monthly "Blue Ribbon

Award" to provide information and recognition of notable contributions by staff, contractors, and students. These initiatives were at the time unique in the Division, but have since led to other branches pursuing similar activities.

Lee Ann is a trained and certified mediator. She has used these skills to help Branch members communicate effectively. These mediation activities have been above and beyond what is normally expected of a deputy branch chief and have led to improved working relationships within the Branch. Additionally, she routinely takes a leadership role within the Division on administrative and management issues, such as use of ILA funds and development of travel policies. She also serves as an administrative and management subject matter expert for Branch and Division personnel, and mentors new team leads in developing leadership and management skills.

In support of the 2010 HHS "Contract to FTE" initiative requiring reduction of contracted positions by 20% by 2012, Lee Ann worked closely with the Atlanta Human Resources Center (AHRC) in early 2011 to convert six branch contract positions into FTEs within 4 months. She proactively analyzed 3 years of contract cost data, identifying positions that, if converted to FTEs, would generate substantial cost savings. After prioritizing these positions based on long-term program needs, and to maximize benefits of the conversion process, she established a new position description merging the work of a vacant FTE with the deliverables of a contract. She explored over 20 different position descriptions and hiring mechanisms, developed numerous personnel packages, and worked tirelessly with management, SBU, and AHRC until the positions were filled, achieving for CDC an annual cost savings of >\$200,000. The long hours and expertise she dedicated to the process resulted in the conversion of six highly qualified and capable former contractors who in April 2011 began their tenure as civil servants with the agency. Lee Ann has displayed

exemplary leadership in team building, in cost savings, and in maximizing branch performance and morale. Her expertise, attention to detail, and passion for her job are key factors in the success of SEOIB. Congratulations to Lee Ann for this well-deserved honor!

Neha Shah, MD, MPH, DTBE Field Medical Officer, joined the California TB Control Branch as of August 1, 2011. Neha has extensive experience in TB and communicable disease control. She most recently served as the DTBE Field Medical Officer assigned to the Chicago TB program. Prior to her work in DTBE, Dr. Shah was an Epidemic Intelligence Service (EIS) Officer with the CDC Global AIDS Program (GAP) during 2007-2009. As an EIS Officer, she conducted epidemiologic research, monitoring and evaluation, and public health surveillance to inform policy and strengthen HIV and TB-HIV control efforts. Neha has worked in a variety of international settings including Thailand, Vietnam, El Salvador, and China, and domestically with the Washington, DC, and Cleveland, Ohio, health departments on HIV and STD-related projects. She has also worked with the Guatemala Ministry of Health to help initiate and strengthen their TB-HIV surveillance. Before joining CDC, Dr. Shah worked with the American Lung Association domestically in Chicago, as well as internationally in Nigeria conducting malaria research, and in Guatemala and India providing clinical care to underserved populations. Neha received her MPH from Johns Hopkins University in international health and her MD from New York Medical College. She completed her internal medicine residency at Boston University with the primary care program.

### **In Memoriam**

Marilyn Hansen, who served as executive director of the American Thoracic Society (ATS) from 1988 until her retirement in 1997, died on March 6 at the age of 79 following a prolonged illness. She was an important contributor to U.S. TB prevention and control. Marilyn led an

ATS/CDC effort in collaboration with a number of national medical organizations forming the National Tuberculosis Training Consortia which then developed the original TB Core Curriculum. CDC regularly updates and makes the Core Curriculum available to TB control students across the nation (the most recent version will be available soon). Marilyn also helped the National TB Nurses Coalition and the National Tuberculosis Controllers Association develop the Nurses TB Manual. In an article announcing her retirement that appeared in the ATS News in the summer of 1997, Ms. Hansen said that two of the most gratifying aspects of her tenure with the Society were working closely with members and being a part of the organization's international growth. As founder of the ATS Assembly on Nursing, she was particularly pleased to see the role of nurses within the Society grow.

Daniel "Dan" Reyna, Director of the U.S.-Mexico Border Health Commission, died on July 29 of an apparent heart attack; he was 59. Dan was a champion for improving the health and quality of life of the people of the U.S.-Mexico border region, and worked tirelessly to achieve his goals. Those who had the opportunity to work with Reyna on a regular basis recognized his unique ability to convene federal, state, and local partners from both sides of the border to address critical infectious disease and emergency preparedness issues impacting the region. In June 2011, Dan coordinated and oversaw the implementation of both the 2011 U.S.-Mexico Border Binational Infectious Disease Conference in El Paso, as well as the 2011 Tuberculosis Consortium in San Diego. He also attended the 2<sup>nd</sup> annual U.S./Mexico TB Summit held in conjunction with the National TB Conference in Atlanta. Dan is also remembered for his presentations at ACET where he represented the special needs and challenges of the border region.

In May 2006, he joined the U.S.-Mexico Border Health Commission as general manager of the U.S. Section, Office of Global Affairs, Office of

the Secretary, U.S. Department of Health and Human Services. He also served as director of the New Mexico Office of Border Health, New Mexico Department of Health in Las Cruces from 1993 to 2006. Reyna was a retired colonel from the U.S. Army Reserve, and had served in Afghanistan as the Senior Health Action Officer and Coalition Forces Liaison to multiple national ministries, including the Ministry of Health in 2003 and 2004. Dan will be missed by all, especially by those in the TB community who worked alongside him to advocate for healthy outcomes of binational TB patients.

John Sbarbaro, MD, MPH, passed away on August 30 after several months of declining health. He was a mentor to many in TB control and his influence was felt globally. His obituary states that he obtained his BS degree from St. Mary's College, his MD degree from Johns Hopkins School of Medicine, and his MPH degree from Harvard School of Public Health. Between 1965 and 1986, Dr. Sbarbaro served in several capacities with the Denver Department of Health and Hospitals, but primarily as the Director of Public Health and Preventive Medicine. Starting in 1969, he also held several positions at the University of Colorado Health Sciences Center, School of Medicine, where he was a professor in the departments of medicine and of preventive medicine. He finished his career there as the Medical Director of University Physicians, Inc. In addition, he retired in 2000 as a colonel in the U.S. Army Reserves Medical Corps.

Dr. Sbarbaro was a world-renowned expert in the field of tuberculosis. During his career, he worked with CDC, the World Health Organization, the Institute of Medicine, the Department of Health and Human Services, and other institutes and agencies. He authored over 160 journal articles and 18 book chapters. Dr. Sbarbaro will be greatly missed by the global TB community, where he was deemed not only a leading expert in TB control but a positive force who influenced many in TB control.

Maybelle (Tina) Schein, RN, former DTBE nurse, died on July 2. Tina was highly regarded for her expertise and experience as a TB research nurse, and was DTBE's resident expert on the tuberculin skin test (TST). Tina had developed and honed the skills for applying and reading the TST and often served as CDC's spokesperson when it came to training others on the proper administration and reading of the TST. She was very affable and generous with her talents and knowledge – a consummate public health nurse! After her retirement from CDC, Tina moved to Sioux Falls, SD, to be close to family. According to her obituary, she attended nursing training at Methodist Hospital in Mitchell, SD, and graduated from Dakota Wesleyan University with a BS in Nursing in 1961. Early in her career, she taught nursing at Methodist Hospital and at Sioux Valley Hospital in Sioux Falls. After leaving Sioux Falls, Schein spent 33 years working for CDC, where her assignments included national and international travel. She worked for 23 years in New York City doing clinical research trials with TB and later HIV. She was proud to be a part of the many advances in clinical management brought about because of that research. She then spent 10 years in the CDC home office in Atlanta where she represented the TB division in therapy trials and national meetings, and was co-founder of the National TB Nursing Network. She retired from CDC in 1995 and returned to SD, and was an RN at the Dougherty Hospice House. In 2008, she received an alumni award from Dakota Wesleyan University for Outstanding Professional Achievement. Memorials may be directed to the Dougherty Hospice House or the United Methodist Church in Hartford. Her obituary may be read at [www.heritagesfsd.com](http://www.heritagesfsd.com) Tina will no doubt be missed by all of us who had the pleasure of knowing her and the privilege to work with her.

## CALENDAR OF EVENTS

October 12–15, 2011  
The Denver TB Course  
Denver, CO  
National Jewish Health

October 26–30, 2011  
[42nd Union World Conference on Lung Health](#)



Lille, France

IUATLD

[Call for abstracts -The Union/CDC late-breaker session](#)

Abstract submission deadline: July 30, 2011

November 7–9, 2011  
Implementing the Stop TB Strategy: skills for  
managers and consultants  
Sondalo, North Italy

[WHO](#)

E-mail: <mailto:lia.dambrosio@fsm.it>

November 28–December 10, 2011  
Human Resources Development and  
Management  
Bangkok, Thailand

[IUATLD](#)

E-mail: [imdp@theunion.org](mailto:imdp@theunion.org)

January 12–15, 2012  
3rd Global Symposium on IGRAs  
Waikoloa, Hawaii  
[UC San Diego School of Medicine](#)

[Call for abstracts](#)

Abstract submission deadline: September 1,  
2011