

Introduction

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About the Idaho Tuberculosis Program Manual

Purpose

This manual is designed to present the key steps and crucial information needed to perform tuberculosis (TB) control tasks in states in which TB occurs with a low incidence—defined by the Centers for Disease Control and Prevention (CDC) as less than 3.5 cases/100,000 population/year.¹ Where additional or more detailed information is available, hyperlinks to CDC guidelines and other resources are provided.

The Idaho Tuberculosis Program Manual is based on a template created by an advisory group convened during CDC Task Order #6. The advisory group developed the template's format and created its content by reviewing other TB control manuals, current CDC guidelines, and needs in the four low-incidence states of Idaho, Montana, Utah, and Wyoming.

Audience

The audience for this manual includes local-level public health nurses, outreach workers, physicians and epidemiologists; Indian Health Services (IHS) staff; physician consultants; private sector physicians, infection control nurses in hospitals and other facilities; disease intervention specialists; state epidemiologists; and state TB program staff.

How to Use This Manual

Portable Document Format

This manual is available electronically as a portable document format (PDF) file. To view the PDF file, you will need the free Adobe Reader available at this hyperlink:
<http://www.adobe.com/products/acrobat/readstep2.html>.

Hyperlinks

When viewing this manual online with an Internet connection, you can go directly to underlined Web addresses by clicking on them.

Cross References

When viewing this manual electronically, you can go directly to other sections or topics in the manual by clicking on text next to this icon:



Forms

Required and recommended forms are available on the Idaho Tuberculosis website at
<http://healthandwelfare.idaho.gov/Health/DiseasesConditions/Tuberculosis/TuberculosisForms/tabid/854/Default.aspx>. This icon alerts you that forms are available:



Icons

Throughout the manual, these icons quickly cue you into important information and other resources:



This warns about high-consequence information you must understand when performing the task.



This signals when you should call to report or to consult on the task.



This highlights special considerations for pediatric patients.



This suggests another relevant area in the manual or another resource that you may want to review.



This alerts you that a form is available for the task.

Abbreviations

Refer to the list below for abbreviations used in the manual.

ACET	Advisory Council for the Elimination of Tuberculosis
ACH	air changes per hour
AFB	acid-fast bacilli
AIDS	acquired immunodeficiency syndrome
All	airborne infection isolation
ALT	alanine aminotransferase
ARPE	Aggregate Report for Program Evaluation
ART	antiretroviral therapy
AST	aspartate aminotransferase
ATS	American Thoracic Society
BAMT	blood assay for <i>Mycobacterium tuberculosis</i>
BCG	bacille Calmette-Guérin
CDC	Centers for Disease Control and Prevention
CT	computed tomography
CXR	chest radiograph
DNA	deoxyribonucleic acid
DOT	directly observed therapy
DTBE	Division of Tuberculosis Elimination
DTH	delayed-type hypersensitivity
ED	emergency department
EMB	ethambutol
EMS	emergency medical service
ESRD	end-stage renal disease
FDA	U.S. Food and Drug Administration

HAART	highly active antiretroviral therapy
HCW	healthcare worker
HEPA	high-efficiency particulate air
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
IBL	Idaho Bureau of Labs
IDSA	Infectious Diseases Society of America
IGRA	interferon gamma release assay
INH	isoniazid
LTBI	latent tuberculosis infection
<i>M. tuberculosis</i>	<i>Mycobacterium tuberculosis</i>
MDR-TB	multidrug-resistant tuberculosis
MIRU	mycobacterial interspersed repetitive units
MOTT	Mycobacterium other than tuberculosis
NAAYT	nucleic acid amplification test
NIOSH	National Institute for Occupational Safety and Health
NNRTI	nonnucleoside reverse transcriptase inhibitors
NTCA	National Tuberculosis Controllers Association
NTNC	National Tuberculosis Nurse Coalition
NTM	nontuberculous mycobacteria
NTNCC	National Tuberculosis Nurse Consultant Association
OSHA	Occupational Safety and Health Administration
PAPR	powered air-purifying respirator
PCR	polymerase chain reaction
PPD	purified protein derivative
PZA	pyrazinamide
QA	quality assurance



QFT-GIT	QuantiFERON®-TB Gold in-tube test
RFB	rifabutin
RFLP	restriction fragment length polymorphism
RIF	rifampin
RNA	ribonucleic acid
RPT	rifapentine
RVCT	Report of Verified Case of Tuberculosis
RZ	rifampin and pyrazinamide
TB	tuberculosis
TNF- α	tumor necrosis factor-alpha
T-Spot	T-SPOT®. <i>TB</i> test
TST	tuberculin skin test
TU	tuberculin units
USCIS	U.S. Citizenship and Immigration Services
UVGI	ultraviolet germicidal irradiation
XDR-TB	extremely drug-resistant tuberculosis

Purpose of Tuberculosis Control

Tuberculosis (TB) is caused by the bacterial organism *Mycobacterium tuberculosis*. *M. tuberculosis* is one of several mycobacteria that belong to the Mycobacterium tuberculosis complex. Other tuberculous mycobacteria that are part of the “MTB complex” and are human pathogens include *M. bovis* and *M. africanum*. Other mycobacteria are called nontuberculous mycobacteria (NTM) because they do not cause TB. One common type of nontuberculous mycobacteria that causes human disease is *Mycobacterium avium*. Tuberculous mycobacteria readily spread from person to person; nontuberculous mycobacteria do not usually spread from person to person.

The goal of TB control in the U.S. is to reduce TB morbidity and mortality by:

- Preventing transmission of *M. tuberculosis* from persons with contagious forms of the disease to uninfected persons, and
- Preventing progression from latent TB infection (LTBI) to active TB disease among persons who have contracted *M. tuberculosis* infection.²



For information on the transmission of *M. tuberculosis* and on how LTBI progresses to TB disease, see the Centers for Disease Control and Prevention’s (CDC’s) online course, *Interactive Core Curriculum on Tuberculosis* at this hyperlink:

https://www.cdc.gov/tb/webcourses/Course/main_menu/index.html.

The four fundamental strategies to reduce TB morbidity and mortality are:

1. Early and accurate detection, diagnosis, and reporting of TB cases, leading to initiation and completion of treatment;
2. Identification of contacts of patients with infectious TB and treatment of those at risk with an effective drug regimen;
3. Identification of other persons with latent TB infection at risk for progression to TB disease, and treatment of those persons with an effective drug regimen; and
4. Identification of settings in which a high risk exists for transmission of *M. tuberculosis* and application of effective infection control measures.³



For more information on these strategies and the thinking behind them, see “Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America” (MMWR 2005;54No. RR-12: 1-84) at this hyperlink:

<http://www.cdc.gov/MMWR/PDF/rr/rr5412.pdf>.

Idaho and National Objectives

Current Idaho Tuberculosis Program Objectives

The Idaho TB Control Program has TB prevention and control objectives and human resource development objectives. Below are the prevention and control objectives. Each objective is currently targeted by the Idaho TB Program based on Idaho’s epidemiology and recent program performance but is also structured to assist the Program in meeting national Healthy People 2020 TB objectives. Please contact the TB Control Program for the human resource development objectives.

TABLE 1: IDAHO TUBERCULOSIS PREVENTION AND CONTROL OBJECTIVES

Case Rates
<p>Idaho objective 1: In Idaho, maintain the TB case rate in U.S.-born persons below the national target of 0.7 TB cases per 100,000 persons in this cohort through the end of 2018.</p>
<p>Idaho objective 2: In Idaho, maintain the TB case rate in foreign-born persons below the national target of 14.0 TB cases per 100,000 persons in this cohort through the end of 2018.</p>
<p>Idaho objective 3: In Idaho, maintain the TB case rate in U.S.-born non-Hispanic blacks below 1.3 TB cases per 100,000 persons in this cohort through the end of 2018.</p>
<p>Idaho objective 4: In Idaho, maintain TB case rate in children under 5 years of age less than or equal to 0.4 TB cases per 100,000 persons in this cohort through the end of 2018.</p>
Treatment and Case Management
<p>Idaho objective 5: In Idaho, increase the percentage of patients completing treatment for newly diagnosed with TB for whom 12 months or less of treatment is indicated to 95% by the end of 2017 for patients counted in 2018.</p>
<p>Idaho objective 6: In Idaho, increase the proportion of culture-positive or nucleic acid amplification (NAA) test-positive TB cases with a pleural or respiratory site of disease that have the identification of <i>M. tuberculosis</i> complex reported by a laboratory within 25 days from the date of the initial diagnostic pleural or respiratory specimen was collected to 85% by the end of 2018.</p>
<p>Idaho objective 7: In Idaho, maintain the proportion of culture-positive TB cases with drug-susceptibility testing at 100% through the end of 2018.</p>
<p>Idaho objective 8: In Idaho, for AFB smear positive counted TB cases, increase the proportion of cases who start treatment within 7 days of the collection date of their first AFB positive smear to 85% through 2018.</p>
<p>Idaho objective 9: In Idaho, maintain the proportion of TB patients with positive sputum culture results who have documented culture conversion within 60 days of initiating treatment at or above 61.5% through the end of 2018.</p>
<p>Idaho objective 10: In Idaho, maintain the percentage of patients with TB disease started on the recommended initial 4-drug regimen at or above 93.4% through the end of 2018.</p>
<p>Idaho objective 11: In Idaho, maintain the percentage of culture-confirmed TB cases that have a genotyping result at or above 94% through 2018.</p>
<p>Idaho objective 12: In Idaho, maintain the percentage of counted TB cases with an HIV status noted at or above 88.7% through 2018.</p>



Treatment and Case Management (continued)

Idaho objective 13: In Idaho, maintain the percentage of TB cases with a pleural or respiratory site of disease in patients ages 12 years or older that have a reported sputum-culture result reported to 95.7% in 2018.

Contact Investigation

Idaho objective 14: In Idaho, maintain the percentage of AFB smear positive TB cases who have had contacts elicited at 100% through the end of 2018.

Idaho objective 15: In Idaho, increase the proportion of contacts to AFB smear positive TB cases evaluated to or above 94% through the end of 2018.

Idaho objective 16: In Idaho, increase the proportion of contacts to AFB smear positive TB cases diagnosed with LTBI who start treatment for LTBI at or above 85% through the end of 2018.

Idaho objective 17: In Idaho, increase the proportion of contacts to AFB smear positive TB cases diagnosed with LTBI who complete LTBI treatment to or above 75% through 2018.

Evaluation of Immigrants and Refugees

Idaho objective 18: In Idaho, increase the percentage of refugees and immigrants with abnormal chest x-rays read overseas as consistent with TB (refugees and immigrants assigned A, B1, or B2 TB notifications) who initiate medical evaluation within 30 days of arrival to 50% through the end of 2018.

Idaho objective 19: In Idaho, increase the percentage of refugees and immigrants with abnormal chest x-rays read overseas as consistent with TB (refugees and immigrants assigned A, B1, or B2 TB notifications) who complete medical evaluation within 90 days of arrival to or above 50% through 2018.

Idaho objective 20: In Idaho, increase the percentage of refugees and immigrants with abnormal chest x-rays read overseas as consistent with TB (refugees and immigrants assigned A, B1, or B2 TB notifications) diagnosed with LTBI who start treatment for LTBI to or above 75% through 2017 (for those arriving in 2018).

Idaho objective 21: In Idaho, increase the percentage of refugees and immigrants with abnormal chest x-rays read overseas as consistent with TB (refugees and immigrants assigned A, B1, or B2 TB notifications) diagnosed with LTBI who complete treatment for LTBI to or above 50% through 2017 (for 2017 arrivals).

National Program Objectives

Below are the CDC National TB Program Objectives and Performance Targets for 2020, updated August 2015 and found at:

https://www.cdc.gov/tb/programs/evaluation/pdf/national_tb_objectives_2020_targets_20160307.pdf .

TABLE 2: NATIONAL PROGRAM OBJECTIVES AND PERFORMANCE TARGETS

National TB Program Objectives & Performance Targets for 2020

Mission: To promote health and quality of life by preventing, controlling, and eventually eliminating tuberculosis (TB) from the United States, and by collaborating with other countries and international partners in controlling global tuberculosis.

Goals for Reducing TB Incidence ^{1, 2, 5}		Targets
TB Incidence Rate	Reduce the incidence of TB disease.	1.4 cases per 100,000
U.S.-Born Persons	Decrease the incidence of TB disease among U.S.-born persons.	0.4 cases per 100,000
Foreign-Born Persons ⁶	Decrease the incidence of TB disease among foreign-born persons.	11.1 cases per 100,000
U.S.-Born Non-Hispanic Blacks or African Americans ⁶	Decrease the incidence of TB disease among U.S.-born non-Hispanic blacks or African Americans.	1.5 cases per 100,000
Children Younger than 5 Years of Age	Decrease the incidence of TB disease among children younger than 5 years of age.	0.3 cases per 100,000

Objectives on Case Management and Treatment ^{1, 2, 5}		Targets
Known HIV Status	Increase the proportion of TB patients who have a positive or negative HIV test result reported.	98%
Treatment Initiation	For TB patients with positive acid-fast bacillus (AFB) sputum-smear results, increase the proportion who initiated treatment within 7 days of specimen collection.	97%
Recommended Initial Therapy	For patients whose diagnosis is likely to be TB disease, increase the proportion who are started on the recommended initial 4-drug regimen.	97%
Sputum Culture Result Reported	For TB patients ages 12 years or older with a pleural or respiratory site of disease, increase the proportion who have a sputum culture result reported.	98%
Sputum Culture Conversion	For TB patients with positive sputum culture results, increase the proportion who have documented conversion to negative results within 60 days of treatment initiation.	73%
Completion of Treatment	For patients with newly diagnosed TB disease for whom 12 months or less of treatment is indicated, increase the proportion who complete treatment within 12 months.	95%

August 2015

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of Tuberculosis Elimination



CS258755A



Objectives on Laboratory Reporting ^{1, 2, 5}		Targets
Turnaround Time — Culture	For TB patients with cultures of respiratory specimens identified with <i>M. tuberculosis</i> complex (MTBC), increase the proportion reported by the laboratory within 25 days from the date the specimen was collected. NOTE: 25 days includes 21 days for culture to grow and 4 days for specimen collection and delivery to lab.	78%
Turnaround Time — Nucleic Acid Amplification (NAA)	For TB patients with respiratory specimens positive for MTBC by nucleic acid amplification (NAA), increase the proportion reported by the laboratory within 6 days from the date the specimen was collected. NOTE: 6 days includes 2 days for detection and 4 days for specimen collection and delivery to lab.	92%
Drug-Susceptibility Result	For TB patients with positive culture results, increase the proportion who have initial drug-susceptibility results reported.	100%
Universal Genotyping	For TB patients with a positive culture result, increase the proportion who have a MTBC genotyping result reported.	100%
Objectives on Contact Investigations ^{1, 3, 5}		Targets
Contact Elicitation	For TB patients with positive AFB sputum-smear results, increase the proportion who have contacts elicited.	100%
Examination	For contacts to sputum AFB smear-positive TB cases, increase the proportion who are examined for infection and disease.	93%
Treatment Initiation	For contacts to sputum AFB smear-positive TB cases diagnosed with latent TB infection, increase the proportion who start treatment.	91%
Treatment Completion	For contacts to sputum AFB smear-positive TB cases who have started treatment for latent TB infection, increase the proportion who complete treatment.	81%
Objectives on Examination of Immigrants and Refugees ^{1, 4, 5}		Targets
Examination Initiation	For immigrants and refugees with abnormal chest radiographs (X-rays) read overseas as consistent with TB, increase the proportion who initiate a medical examination within 30 days of notification.	84%
Examination Completion	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB, increase the proportion who complete a medical examination within 90 days of notification.	76%
Treatment Initiation	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB who are diagnosed with latent TB infection or have radiographic findings consistent with prior pulmonary TB (ATS/CDC Class 4) on the basis of examination in the U.S., for whom treatment was recommended, increase the proportion who start treatment.	93%
Treatment Completion	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB who are diagnosed with latent TB infection or have radiographic findings consistent with prior pulmonary TB (ATS/CDC Class 4) on the basis of examination in the U.S., and who have started on treatment, increase the proportion who complete treatment.	83%



Objectives on Data Reporting		Targets
• RVCT ⁷	Ensure the completeness of each core Report of Verified Case of Tuberculosis (RVCT) data item reported to CDC, as described in the TB cooperative agreement announcement.	100%
• ARPE ⁸	Ensure the completeness of each core Aggregate Reports for Tuberculosis Program Evaluation (ARPE) data items reported to CDC, as described in the TB cooperative agreement announcement.	100%
• EDN	Ensure the completeness of each core Electronic Disease Notification (EDN) system data item reported to CDC, as described in the TB cooperative agreement announcement.	93%

Objectives on Program Evaluation	
• Evaluation Activities	Increase program evaluation activities by monitoring program progress and tracking evaluation status of TB cooperative agreement recipients.
• Evaluation Focal Point	Increase the percent of TB cooperative agreement recipients that have an evaluation focal point.

Objectives on Human Resource Development	
• Development Plan	Increase the percent of TB cooperative agreement recipients who submit a program-specific human resource development plan (HRD) and a yearly update of progress, as outlined in the TB cooperative agreement announcement.
• Training Focal Point	Increase the percent of TB cooperative agreement recipients that have a TB training focal point.

Footnotes:

1. Indicator calculations for measuring progress are established by the National TB Indicators Project (NTIP).
2. Targets for incidence rates and objectives on case management and laboratory reporting are established on the basis of performance reported in NTIP using 2000-2013 data from the National TB surveillance system.
3. Targets for objectives on contact investigation are established on the basis of performance reported in NTIP using 2000–2011 data from the Aggregate Reports for Tuberculosis Program Evaluation (ARPE) for contacts.
4. Targets for objectives on the examination of immigrants and refugees are established on the basis of performance reported in NTIP using 2008–2012 data from the Electronic Disease Notification (EDN) system. The latest year with data available for treatment outcome of immigrants and refugees diagnosed with TB infection is 2011.
5. Targets are based on a statistical model that uses data to find trends from 2000 through 2013 (or the latest year with data available). TB programs with fewer than 150 cases from 2011–2013 were excluded. For each objective, we used a quantile regression model to estimate the 90th percentile for each year, and extrapolated the fitted model to predict the estimated 90th percentile in the year 2020, which served as the target for 2020. The “90th percentile” values reflect the projected performance of the top 10% of TB programs in the United States in 2020. The quantile regression serves to establish a smooth trend over time, which is useful since the actual percentiles in any given year (e.g. the final year of available data) may not be representative of the overall trend.
6. Jurisdictions with a foreign-born population or U.S.-born non-Hispanic black or African American population less than an average of 100,000 persons per year in 2011-2013 are also excluded in the statistical model for TB incidence rates for foreign-born persons and U.S.-born non-Hispanic blacks or African Americans.
7. Report of Verified Case of Tuberculosis (RVCT) is the standard surveillance data collection form for reporting tuberculosis cases.
8. Aggregate Reports for Tuberculosis Program Evaluation (ARPE) is the standard form for reporting contact investigation activities.

Standards

Program standards are what the stakeholders of the TB program would consider to be "reasonable expectations" for the program. For TB, standards have been established by nationally accepted authorities, such as ATS, IDSA and CDC, and generally recognized TB control experts, such as the National Tuberculosis Nurse Coalition (NTNC) and National Tuberculosis Controllers Association (NTCA). Many state programs, and some local TB control programs, have established their own standards and objectives for case management.

The standards of care for the medical treatment and control of TB are published jointly by the American Thoracic Society (ATS), the Infectious Diseases Society of America (IDSA), and the CDC. These standards should be available for reference by each TB staff member.

The standards are included in the following guidelines:

- ATS, CDC, IDSA. "Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America" (*MMWR* 2005;54[No. RR-12]). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5412.pdf>
- ATS, CDC, IDSA. "Diagnosis of Tuberculosis in Adults and Children" (*Clinical Infectious Diseases* 2016; 64[2]). Available at: <https://academic.oup.com/cid/article/64/2/e1/2629583/Official-American-Thoracic-Society-Infectious>
- ATS, CDC, IDSA. "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" (*Am J Respir Crit Care Med* 2000;161[4 Pt 1]). Available at: <http://www.cdc.gov/tb/publications/PDF/1376.pdf>
- ATS, CDC, IDSA. "Treatment of Drug-Susceptible Tuberculosis" (*Clinical Infectious Diseases* 2016: 63[7]). Available at: <http://cid.oxfordjournals.org/content/63/7/e147.full>
- CDC, NTCA. "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC" (*MMWR* 2005;54 [No. RR-15]). Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf>
- CDC. "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-care Settings, 2005" (*MMWR* 2005;54[No. RR-17]). Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf>
- CDC. "Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection" (*MMWR* 2000;49[No. RR-6]). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf>

For additional guidelines, see the CDC Division of Tuberculosis Elimination "Guidelines" page at : <http://www.cdc.gov/tb/publications/guidelines/default.htm> (accessed October 31, 2017).

Roles, Responsibilities, and Contact Information

Idaho Division of Public Health Tuberculosis Control Staff

TABLE 3: IDAHO STATE TUBERCULOSIS PROGRAM STAFF ROLES, RESPONSIBILITIES, AND CONTACT INFORMATION

Roles and Responsibilities	Contact Information
<p>Roles and Responsibilities of Idaho Division of Public Health Tuberculosis Control Staff</p> <p>The TB Controller provides medical consultation to the public health districts and providers in Idaho; directs the overall goals of the program; ensures funding for TB medications; ensures program goals are met. In addition, the controller provides consultation on other aspects of TB prevention and control, including case management, contact investigation, and outbreak investigation.</p> <p>The Program Manager administers the TB program and subgrants with the public health districts, acts as the state-level TB epidemiologist, assists with consultation on routine questions around the practice of diagnosis of TB, assures compliance with applicable public health laws and regulations related to tuberculosis (TB) reporting and control, coordinates statewide TB surveillance, data evaluation, and development of policies and guidelines for the control and/or elimination of TB in the state, and also assists the TB Controller in directing the overall goals of the program; ensuring funding for TB medications; and ensuring program goals are met. The TB Epidemiologist/Program Manager also provides coordination between local and other state jurisdictions.</p>	<p>Christine Hahn, MD (TB controller)</p> <p>Scott Hutton, MPH (TB Epidemiologist and Program Manager)</p> <p>Address and contact information: Bureau of Communicable Disease Prevention, Epidemiology Program 450 W. State St., 4th floor Boise, ID 83720-0036 Tel: 208-334-5939 Fax: 208-332-7307</p> <p>Email: Dr. Chris Hahn: Christine.Hahn@dhw.idaho.gov Scott Hutton: Scott.Hutton@dhw.idaho.gov</p>

Public Health Districts and Community HealthCare Providers

TABLE 4: LOCAL PUBLIC HEALTH DISTRICTS AND COMMUNITY HEALTHCARE PROVIDERS' ROLES AND RESPONSIBILITIES

Public Health Districts	Private Medical Providers
<p>Roles and Responsibilities of Idaho Public Health Districts</p> <p>Idaho public health districts are responsible for receiving reports of suspected or confirmed cases of tuberculosis (TB) within their jurisdictions and reporting these to the Idaho Division of Public Health. District public health departments ensure that TB cases within their jurisdictions are appropriately isolated (if necessary) and treated until cured. In addition, district public health departments perform contact investigations surrounding infectious/potentially infectious TB cases. Regular reporting of Directly Observed Therapy and contact investigation results are submitted to the Idaho Division of Public Health.</p> <p>For a list of district public health agency contacts, see http://www.healthandwelfare.idaho.gov/Health/HealthDistricts/tabid/97/Default.aspx</p>	<p>Roles and Responsibilities of Private Medical Providers</p> <p>Medical providers in Idaho are required to report suspected or confirmed TB cases to their district public health departments. In addition, providers are urged to coordinate care and treatment of patients with the district health department jurisdictions, which ensure that TB cases are appropriately managed for public health reasons.</p>



State Laboratory

TABLE 5: ROLES, RESPONSIBILITIES, AND CONTACT INFORMATION OF THE STATE LABORATORY

Roles and Responsibilities	Contact Information
<p>State Laboratory</p> <p>The Idaho Bureau of Laboratories (IBL) provides tuberculosis diagnostic services that are a vital part of tuberculosis control. The IBL is the only facility in the state providing full diagnostic tuberculosis services, including AFB smear; culture isolation, identification, and full drug susceptibility testing; and isolates are sent to a reference public health laboratory for genotyping. In addition, the IBL provides consultation, training, and referral services to other laboratories performing TB diagnostic services within the state.</p>	<p>Idaho Bureau of Laboratories 2220 Old Penitentiary Road Boise, ID 83712</p> <p>Tel: 208-334-2235</p>



Resources & References

Resources

- CDC. "Framework for Program Evaluation in Public Health" (*MMWR* 1999;48[No. RR-11]). Available at: <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf>
- CDC Division of Tuberculosis Elimination. *A Guide to Developing a TB Program Evaluation Plan*. Available at: https://www.cdc.gov/tb/programs/Evaluation/Guide/PDF/Complete_guide_Developing_eval_plan.pdf
- CDC Division of Tuberculosis Elimination. *Understanding the TB Cohort Review Process: Instruction Guide*. Available at this hyperlink: <http://www.cdc.gov/tb/education/cohort.htm>
- New Jersey Medical School National Tuberculosis Center. *Planning & Implementing the TB Case Management Conference: A Unique Opportunity for Networking, Peer Support and Ongoing Training* (Newark, NJ; 2004). Available at: <http://globaltb.njms.rutgers.edu/downloads/planning&implementing/TBCaseMGT.pdf>
<http://www.umdnj.edu/globaltb/products/planning&implementing.htm>

References

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- ¹ CDC. Progressing toward tuberculosis elimination in low-incidence areas of the United States: Recommendations of the Advisory Council for the Elimination of Tuberculosis. *MMWR* 2005;51(No. RR-5):1.
- ² ATS, CDC, IDSA. Controlling tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):14.
- ³ ATS, CDC, IDSA. Controlling tuberculosis in the United States: recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America. *MMWR* 2005;54(No. RR-12):15.