Autumn is a time for reflection and reaping harvest. A time to look back with exuberance on our accomplishments throughout the past year. For the KY TB Program, autumn is when data is gathered and evaluated to assist towards “planting” new goals and activities in the spring.

In this edition, we reflect on the outcome measures from our national reporting indicators and pay tribute to past accomplishments from individuals that have made our program stronger. We continue to cultivate future TB endeavors by sharing updates to public health TB practice and emerging technologies in TB screening methods. We welcome new staff and honor those “in the field” who continue to inspire and advocate for our mission towards TB prevention and control.

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Find the Super “T” winner!
Congratulations to Susan Rice, RN from the Barren River District Health Department for finding the Super “T” bug in the Winter 2017/Spring 2018 newsletter. For those that missed him-he was hanging out on page 6 behind Shaka Brown. We had 3 participants guess correctly!

“Autumn...the year's last, loveliest smile.”
–John Howard Bryan
WELCOME NEW STAFF

Charles H. Rhea, MPH
Epidemiologist I

Charlie Rhea began working as the Kentucky TB Program’s Epidemiologist in July of 2018. Charlie’s academic career has focused heavily on public health - receiving his Bachelors of Science in Public Health from Western Kentucky University in 2015 and his Masters of Public Health in Epidemiology from the University of Kentucky in 2018. Professionally, he has experience working in public health as an Epidemiology Technical Assistant with Kentucky Department for Public Health’s Reportable Disease Section and as an Epidemiology Teaching Assistant with the University of Kentucky’s College of Public Health. As the TB Program’s Epidemiologist, his responsibilities include all-things related to surveillance and data analysis, including: completing and submitting all RVCT variables to CDC, reconciling confirmed and ‘suspect’ TB cases, assessing genotyping results, preparing data reports, and serving as a website editor. Charlie is excited to be working with the Kentucky TB Program and looking forward to helping build the program’s epidemiological capacity during his time in this position.

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John M. Bennett, MD, MPH
Infectious Disease Branch Manager

Dr. John M. Bennett joined the Kentucky Department for Public Health as the Infectious Disease Branch Manager in September of 2018. Dr. Bennett is board certified in Family Medicine. He received his medical degree from the University of Arkansas for Medical Science and received a Master’s in Public Health from the University of Kentucky. Before joining the Kentucky Department for Public Health, he maintained an active role in state, local and regional public health for over two decades.

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Website Changes for CHFS

The official website for the Commonwealth of Kentucky inclusive of the Kentucky Cabinet for Health and Family Services was revamped and launched this summer (https://chfs.ky.gov/Pages/index.aspx). The Kentucky TB Prevention and Control Program (KTP) recommends that all policies and procedures be reviewed and updated with the newest links or web addresses. For your convenience, the link for the KTP program is https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tuberculosis.aspx

The KTP presented Core Clinical Service Guide and Administrative Reference revisions during the June 21, 2018 Public Health Nursing Webinar. The revised and newly created forms were a coordinated effort with representatives at both local and state levels. The updates can be found at the following links:
https://chfs.ky.gov/agencies/dph/dpqi/hcab/Pages/ccs-guide.aspx
https://chfs.ky.gov/agencies/dph/dafm/lhpb/Pages/admin-reference.aspx

https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tuberculosis.aspx
**TBits**

**News/Update: Tuberculosis Technical Instructions for Panel Physicians and Civil Surgeons**

Beginning **October 1st** the Department for Health and Human Services (HHS) implemented updated Tuberculosis Technical Instructions regarding the new 2018 “Tuberculosis Technical Instructions” for Division for Global Migration and Quarantine (DGMQ) Panel Physicians and Civil Surgeons performing immigrant and refugee medical screening.

For your convenience, the KY TB Program has provided this summary of new TB-Technical Instructions for Panel Physicians (performing screenings for applicants overseas prior to arriving in the United States):

1.) **Interferon Gamma Release Assay (IGRA) replaces Tuberculin skin testing (TST) for all applicants ages 2 through 14 years old who are living in countries with WHO-estimated tuberculosis disease incidence rate of >20 cases per 100,000 population.**  
   *Impact on KY local health departments: NONE*

2.) **Applicants diagnosed with TB and who have completed directly observed treatment (DOT) prior to immigration and previously identified as B1, Pulmonary, will now receive in the Electronic Disease Notification (EDN) system, a TB classification of B0 TB, Pulmonary.**  
   *Impact on KY local health departments: NO CHANGE*
   
   *Civil Surgeons are required to complete the I-693 form. This form is not to be confused with the U.S. Department of State documents required for completion in EDN (See 2018/CCSG/TB Section/Evaluation of Immigrants and Refugees for Tuberculosis).*
   
   o Local TB Coordinators with EDN access will continue to complete EDN follow-up data reporting requirements.
   
   o Local TB Coordinators who do not have EDN access will continue to submit follow-up reporting requirements to the state TB Program.

Summary of new TB-Technical Instructions for Civil Surgeons (performing screenings for applicants for status adjustment to lawful permanent residence in the United States):

1.) **All applicants 2 years of age or older must have an IGRA performed. A chest x-ray is required for all positive IGRA results to be done by the Civil Surgeon.**  
   *Impact on KY local health departments:*
   
   - Civil Surgeons must not refer applicants to a health department for IGRA testing or chest x-ray. All IGRA and chest x-rays ordered by a civil surgeon must be performed independently of a health department.
   - Civil Surgeons must communicate all test results to the applicant.
   - Civil Surgeons **must report to the local health department of applicant’s jurisdiction** the applicant’s name, contact information, IGRA results, and chest x-ray results.
   
   o Civil Surgeons must proactively communicate with the health department of jurisdiction to coordinate reporting.
   
   *It is at the discretion of the local health department of jurisdiction how to maintain receipt of the I-693 forms.*
   
   - The new TB-Technical Instruction’s do not require the local health departments to contact these applicants or provide treatment for LTBI.

However, as a reminder, current KY TB Program requirements (See CCSG 2018/TB Section/pg 39) indicate that members diagnosed with LTBI and considered HIGH-RISK for being adherent to taking their LTBI medications must be placed on directly observed preventive therapy (DOPT).
Those HIGH-RISK members include:
- Children and adolescents
- Contacts to a case with active TB disease
- Homeless individuals
- Persons who abuse substances
- Persons with a history of treatment non-adherence
- Immunocompromised patients, especially HIV infected

The CDC/Division of TB Elimination and the National TB Controllers Association are communicating with states to evaluate the impact these instructions will have for state and local health departments. The KY TB Program will share with local health departments any additional changes to current requirements as issued by HHS and/or CDC.

More information can be found at this link:
https://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/tuberculosis-civil-technical-instructions.html

Please contact Tammy Hall at the KY TB Program for any questions/concerns regarding B1 or B2 notifications arriving to your jurisdictions.

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Articles of Interest

Rapid Communication: Key changes to treatment of multidrug- and rifampicin-resistant tuberculosis (MDR/RR-TB)

*World Health Organization, August 2018*

Major improvement in treatment outcomes and quality of life of patients with multidrug-resistant tuberculosis (MDR-TB) are expected, following key changes in MDR-TB treatment announced by WHO in the Rapid Communication.

The first important change is a new priority ranking of the available medicines for MDR-TB treatment, based on a careful balance between expected benefits and harms. Treatment success for MDR-TB is currently low in many countries. This could be increased by improving access to the highest-ranked medicines for all patients with MDR-TB.

The WHO rapid communication aims to encourage and prepare countries to implement the upcoming new consolidated, updated and more detailed WHO policy guidelines on MDR-TB treatment which will be released later this year. WHO is also establishing a multi-stakeholder Task Force to coordinate support to national TB programmes in their rapid transition to the key changes envisaged.

https://www.who.int/tb/publications/2018/WHO_RapidCommunicationMDRTB.pdf?ua=1
Long-term outcome and safety of prolonged bedaquiline treatment for multidrug-resistant tuberculosis.


Bedaquiline, a recently approved drug for the treatment of multidrug-resistant tuberculosis (MDR-TB), is recommended for a duration of 24 weeks. There are scarce data on patients treated with this drug outside clinical trials. All MDR-TB patients who started treatment from January 1, 2011 to December 31, 2013 and received ≥30 days of bedaquiline were included in a multicentre observational cohort. Among 45 MDR-TB patients, 53% harboured isolates resistant to both fluoroquinolones and second-line injectables, and 38% harboured isolates resistant to one of these drug classes. Median bedaquiline treatment duration was 361 days and 33 patients (73%) received prolonged (>190 days) bedaquiline treatment. Overall, 36 patients (80%) had favourable outcome, five were lost to follow-up, three died, and one failed and acquired bedaquiline resistance. No cases of recurrence were reported. Severe and serious adverse events were recorded in 60% and 18% of patients, respectively. Values of Fridericia-corrected QT interval (QTcF) >500 ms were recorded in 11% of patients, but neither arrhythmias nor symptomatic cardiac side-effects occurred. Bedaquiline was discontinued in three patients following QTcF prolongation. No significant differences in outcomes or adverse events rates were observed between patients receiving standard and prolonged bedaquiline treatment. Bedaquiline-containing regimens achieved favourable outcomes in a large proportion of patients. Prolonged bedaquiline treatment was overall well tolerated in this cohort.

https://doi.org/10.1183/13993003.01799-2016

Clinical significance of QT-prolonging drug use in patients with MDR-TB or NTM disease.


SETTING:
Many drugs with potential QT prolongation effects (QT drugs) have already been used for decades in patients with multidrug-resistant TB (MDR-TB) or non-tuberculous mycobacterial (NTM) disease, but without a common consensus.

OBJECTIVE:
To investigate the effects of QT drugs on cardiac events in patients with MDR-TB or NTM disease.

METHODS:
We retrospectively reviewed 373 patients (mean age: 56.4 years) with MDR-TB or NTM disease treated for >1 month with clofazimine (CFZ), moxifloxacin (MFX), bedaquiline (BDQ), delamanid (DLM) or macrolides (clarithromycin or azithromycin). Adverse cardiac events, death and QTcF changes were evaluated.

RESULTS:
Forty-four per cent had MDR-TB; 165 (44%), 315 (85%), 10 (3%), 229 (61%) and 1 patient received CFZ, MFX, BDQ, macrolides and DLM, respectively. Except for three patients (0.8%) lost to follow-up with unknown cause of death, 3 (0.8%, 95%CI 0.2-2.4) adverse cardiac events were documented: atrial fibrillation, cardiac tamponade due to TB pericarditis and cardiac arrest, which was determined to not have been caused by QT drugs. Clinically significant QTcF changes (QTcF > 500 msec or an increase > 60 msec) were observed in 10/60 patients (17%, 95%CI 8.0-30.7) without clinical events.

CONCLUSION:
The use of QT drugs, alone or in combination, in the treatment of MDR-TB or NTM disease is relatively safe.

https://doi.org/10.5588/ijtld.17.0174
Immediate-type hypersensitivity reactions due to antituberculosis drugs: a successful readministration protocol.


BACKGROUND:
Little is known about drug hypersensitivity reactions from antituberculosis drugs.

OBJECTIVE:
To determine the frequency, risk factors, and characteristics of immediate-type hypersensitivity reactions from first-line antituberculosis drugs and to evaluate the usefulness of a readministration protocol for culprit drugs in this group of patients.

METHODS:
The study population consisted of patients with tuberculosis who were hospitalized and treated in the authors' hospital in 2011. Demographics and disease and treatment characteristics of patients with immediate-type hypersensitivity from antituberculosis drugs were compared with the other patients. Culprit drugs were readministered gradually according to a defined protocol to patients with immediate-type hypersensitivity.

RESULTS:
Three hundred seventy-nine patients were included in the study. Eighteen immediate-type hypersensitivity reactions were detected in 13 patients (3.43%). The only identified risk factor was female sex (odds ratio 4.085). Isoniazid, rifampicin, pyrazinamide, and ethambutol were readministered in 11 patients and rifampicin was readministered in 2 patients, with 6- to 8-step protocols for each drug. Only in 2 patients did allergic reactions with rifampicin develop during the procedure. In these patients, after treatment and complete remission of allergic symptoms, the last tolerated dose was administered and the protocol was completed with the same adjustments.

CONCLUSION:
Immediate-type allergic reactions from antituberculosis drugs are not rare and not related to disease or treatment characteristics. The protocols used in this study provide a useful and safe method for readministration of culprit drugs to patients with antituberculosis drug hypersensitivity.

https://doi.org/10.1016/j.anai.2015.04.015

Voices from the frontline: barriers and strategies to improve tuberculosis infection control in primary health care facilities in South Africa

Zinatsa, F., et. al. BMC Health Services Research 18:269. April 2018

BACKGROUND:
Tuberculosis (TB) infection control at primary healthcare (PHC) level remains problematic, especially in South Africa. Improvements are significantly dependent on healthcare workers’ (HCWs) behaviours, underwriting an urgent need for behaviour change. This study sought to 1) identify factors influencing TB infection control behaviour at PHC level within a high TB burden district and 2) in a participatory manner elicit recommendations from HCWs for improved TB infection control.

METHOD:
A qualitative case study was employed. TB nurses and facility managers in the Mangaung Metropolitan District, South Africa, participated in five focus group and nominal group discussions. Data was thematically analysed.
RESULTS:
Utilising the Information Motivation and Behaviour (IMB) Model, major barriers to TB infection control information included poor training and conflicting policy guidelines. Low levels of motivation were observed among participants, linked to feelings of powerlessness, negative attitudes of HCWs, poor district health support, and general health system challenges. With a few exceptions, most behaviours necessary to achieve TB risk-reduction, were generally regarded as easy to accomplish.

CONCLUSIONS:
Strategies for improved TB infection control included: training for comprehensive TB infection control for all HCWs; clarity on TB infection control policy guidelines; improved patient education and awareness of TB infection control measures; emphasis on the active role HCWs can play in infection control as change agents; improved social support; practical, hands-on training or role playing to improve behavioural skills; and the destigmatisation of TB/HIV among HCWs and patients.

https://doi.org/10.1186/s12913-018-3083-0

Discovery, research, and development of new antibiotics: the WHO priority list of antibiotic-resistant bacteria and tuberculosis

BACKGROUND:
The spread of antibiotic-resistant bacteria poses a substantial threat to morbidity and mortality worldwide. Due to its large public health and societal implications, multidrug-resistant tuberculosis has been long regarded by WHO as a global priority for investment in new drugs. In 2016, WHO was requested by member states to create a priority list of other antibiotic-resistant bacteria to support research and development of effective drugs.

METHODS:
We used a multicriteria decision analysis method to prioritise antibiotic-resistant bacteria; this method involved the identification of relevant criteria to assess priority against which each antibiotic-resistant bacterium was rated. The final priority ranking of the antibiotic-resistant bacteria was established after a preference-based survey was used to obtain expert weighting of criteria.

FINDINGS:
We selected 20 bacterial species with 25 patterns of acquired resistance and ten criteria to assess priority: mortality, health-care burden, community burden, and prevalence of resistance, 10-year trend of resistance, transmissibility, and preventability in the community setting, preventability in the health-care setting, treatability, and pipeline. We stratified the priority list into three tiers (critical, high, and medium priority), using the 33rd percentile of the bacterium's total scores as the cutoff. Critical-priority bacteria included carbapenem-resistant Acinetobacter baumannii and Pseudomonas aeruginosa, and carbapenem-resistant and third-generation cephalosporin-resistant Enterobacteriaceae. The highest ranked Gram-positive bacteria (high priority) were vancomycin-resistant Enterococcus faecium and meticillin-resistant Staphylococcus aureus. Of the bacteria typically responsible for community-acquired infections, clarithromycin-resistant Helicobacter pylori, and fluoroquinolone-resistant Campylobacter spp, Neisseria gonorrhoeae, and Salmonella typhi were included in the high-priority tier. CONCLUSIONS:
Future development strategies should focus on antibiotics that are active against multidrug-resistant tuberculosis and Gram-negative bacteria. The global strategy should include antibiotic-resistant bacteria responsible for community-acquired infections such as Salmonella spp, Campylobacter spp, N gonorrhoeae, and H pylori.

https://doi.org/10.1016/S1473-3099(17)30753-3
Kentucky’s 2017-2018 National Tuberculosis Indicator Project Objectives

The National Tuberculosis Indicator Project (NTIP) was developed by the Centers for Disease Control and Prevention’s Division of Tuberculosis Elimination. The purpose of NTIP is to help TB program officials utilize surveillance data to monitor progress toward achieving the national TB program objectives. This information can be used to inform decisions on program planning, evaluation, and resource allocation.

For each national objective, a standardized indicator was developed to set program goals and monitor their progress over time. Additionally, the Kentucky TB program developed state-specific indicators, which allows us to monitor our TB program’s progress more accurately.

This report is an indicator summary of Kentucky TB cases for 2017, however it also includes 2016 “Final” ARPE data and preliminary data on 2018 cases counted within the first half of the year. In 2017, Kentucky met the national indicators for 13 out of the 25 objectives (52%). Among the 12 objectives where the national indicator was not met, 6 (or 50%) did meet the Kentucky-specific indicators. Kentucky did not meet 5 (or 20%) objectives according to national or state indicators.

These objectives provide information on the performance of our state and local TB programs within areas essential to achieving TB elimination. While this report does show areas where Kentucky is struggling, it also highlights the many things we are doing well. Moving forward, these objectives and indictors will help steer our program’s evaluation efforts as we seek to meet the national indicator for each of these objectives with the ultimate goal of TB elimination.
Earlier this year, the Centers for Disease Control and Prevention (CDC) released provisional 2017 surveillance data on reported tuberculosis (TB) cases in the United States. The full report, entitled Reported Tuberculosis in the United States, 2017, is now available online.

Key findings:
• There were 9,105 TB cases reported in the United States in 2017, which represents a 1.6% decrease from 2016.
• The overall annual TB incidence decreased to 2.8 cases per 100,000.
• People born outside of the United States continue to bear the burden of TB, largely because of reactivation of latent TB infection that occurred in their country of origin.
• About 13% of U.S. TB cases with genotype data are attributed to recent transmission.

CDC has developed a slide set, fact sheet, infographic, and web graphics with highlights from the surveillance report to support TB education and outreach to clinicians, health care agencies, and community organizations. TB control programs can also use a customizable infographic template to highlight state and local surveillance data.


Dear TB Nurse Consultant

Question: What is the difference between the new QFT-(Gold) Plus and the QFT-Gold in Tube?

Answer: QuantiFERON-TB Gold Plus (QFT-Plus) is blood-based laboratory test that measures responses to TB-specific peptide antigens in whole blood. Like the tuberculin skin test (TST), it is an indirect test for M. tuberculosis infection, but is more specific than TST and is unaffected by prior Bacille Calmette-Guerin (BCG) vaccination and most environmental mycobacterial infections.

The principal differences from the previous QFT-Gold In-Tube (QFT) version are in the new, proprietary formulation, adding CD8 stimulating antigens and new options for blood collection and processing. Compared to QFT, which contains antigens that are designed to primarily stimulate CD4 T cells, QFT Plus adds an additional antigen tube containing a proprietary formulation designed for optimal CD4 and CD8 T cell stimulation and thereby provides a broader picture of the immune response. Due to certain regulatory requirements, QFT-Plus will replace QFT, with a transition period of approximately one year.

QFT-Plus has a four-tube format with an additional antigen tube (TB2) containing both CD4 and CD8 stimulating antigens. The Nil and Mitogen tubes remain the same, while the TB Antigen Tube 1 (TB1) contains CD4 T cell stimulating ESAT-6 and CFP-10 antigens as before, without TB7.7. The second TB Antigen Tube 2 (TB2) contains the same CD4 antigens of TB1 and proprietary CD8 antigens.

QFT-Plus procedure

Blood collection workflow options- There is no specific order for blood collection, however a commonly used fill order is Nil, TB1, TB2 and then Mitogen.

Option 1: Direct draw into QFT-Plus Blood Collection Tubes

- Draw a 1 ml sample of blood from a patient directly into each of the four blood collection tubes, following the manufacturer’s instructions.
- Ensure delivery to the laboratory for incubation as soon as possible (and within 16 hours) after blood draw. Keep at room temperature (22±5ºC) before incubation.
- Alternatively, at the collection site, incubate the tubes standing upright for 16 to 24 hours at

https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/tuberculosis.aspx
37°C before shipping them to the laboratory at room temperature (or refrigerated) within 3 days.

Option 2: Blood collection into a single lithium-heparin tube and then transfer to QFT-Blood Collection Tubes

- Draw a 6 ml blood sample into a lithium-heparin tube. Proceed with next steps according to arrangements made with your designated laboratory. These may include:
  - Workflow 1 – room temperature storage and handling: Ensure delivery of the lithium heparin tube to the laboratory as soon as possible for aliquoting to QFT-Plus tubes and immediate incubation within 12 hours.
  - Workflow 2 – refrigerated storage and handling: After blood draw, leave at room temperature for between 15 minutes and 3 hours. Then, refrigerate at 4°C for up to 48 hours. Aliquoting to QFT-Plus tubes should be completed within 2 hours at room temperature prior to incubation.


Got a TB Question? Email your questions to Maria.Lasley@ky.gov

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TB on the move

WORLD TB DAY 2018

Each year, we recognize World TB Day on March 24. This annual event commemorates the date in 1882 when Dr. Robert Koch announced his discovery of Mycobacterium tuberculosis, the bacillus that causes tuberculosis (TB). The theme for World TB Day 2018 is “Wanted: Leaders for a TB Free United States. We can make history. End TB.” In recognition of World TB Day 2018, the KTP distributed red, black and gold lapel ribbons representing those that have perished from TB, those that are courageously fighting the battle of TB, and finally those that are cured from TB. A press release was issued and a proclamation signed by Governor Bevin recognizing March as TB Awareness Month in Kentucky. Additionally, the history of TB in Kentucky was displayed at the CHFS.
2018 KY TB Update for Physicians and Clinicians

On March 29th the KY TB Program and SNTC presented the 2018 KY TB Update for Physicians and Clinicians at the Sloan Center in Bowling Green, KY. Agenda topics of TB and LTBI diagnosis and treatment were presented through case presentations by Dr. Connie Haley (SNTC), Dr. Malkanthie McCormick (UKHC), Dr. Robert Brawley (KTP), and Dr. Lori Caloia (LMPHW). Physicians and clinicians attended from across the state.

Pictured to the right-Dr. Sandy Breeding, Dr. Robert Brawley, Dr. Connie Haley, Dr. Lori Caloia

2018 Super “T” Award

The KY TB Program announced the 2018 Super “T” Award at the KY TB Update for Physicians and Clinicians on March 29, 2018. The award recognized an individual or group who made significant contributions to improve public health through their work in TB Prevention and Control. This year’s recipient was Kathy Gifford from the Graves County Health Department for her Superior Understanding, Performance Excellence and outstanding Representation of Kentucky’s efforts to combat TB.

CONGRATULATIONS KATHY!!!!!

TST TRAIN-THE-TRAINER ACROSS THE STATE!

The KY TB Program in coordination with Dr. Ellen Murray, SNTC, provided the TST Train-the-Training Course to over 75 nurses across Kentucky. This one-day skill-building course provides the knowledge needed to plan, teach, and evaluate a Mantoux Tuberculin Skin Test (TST) course. The course content includes skills for planning and conducting a TST training, including adult learning principles and teaching strategies. The trainings took place at the Green River District Health Department, the Franklin County Health Department and the Laurel County Health Department during the first week of June 2018. In a show of continued appreciation and support of our local health departments, the KY TB Program gifted the local health departments that had staff attending, a set of Tuberculin Skin Test (TST) training arms to assist with ongoing in-house and local community TST educational trainings. This valuable training tool also assists the staff in meeting the completion of practicum qualifications set forth by the Southeastern National TB Center TST Train-the-Trainer Course.
Breaking Through Barriers to Achieve TB Elimination

TB Education and Training Network (ETN)  
TB Program Evaluation Network (PEN) Conference

The KY TB Program nurse educator, Ruth Willard, DNP, MBA, RN-BC was a speaker at the 2018 CDC’s ETN/PEN conference, Breaking Through Barriers to Achieve TB Elimination. The conference was held September 18-20, 2018, at the Marriot Courtyard Decatur in Georgia. Dr. Willard gave a presentation highlighting the KY TB Program’s TB 101 Orientation, Contact Investigations. Contact Investigations (CI) are an essential component in TB prevention and control. The training session focused on contact investigation training of TB program staff and provided CI resources for TB programs.

Charlie Rhea, KY TB Program Epidemiologist, attended and provided a poster presentation on “Confirmed and “Suspected” Cases of Tuberculosis in Kentucky: A Five-Year Trend”. This poster denotes the enhanced TB surveillance conducted across the state on suspected TB cases and the burden of care to medical and public health services.

2018 Viral Hepatitis Conference

The KY TB Program participated with a Tuberculosis Awareness exhibit table at Kentucky’s 5th Annual Hepatitis Conference--Kentucky’s Hepatitis Epidemic: The Role of Professionals in Hepatitis Elimination on July 31st at the Griffin Gate Marriott Resort & Spa in Lexington, KY. Information and resources on current diagnosis and treatment of TB Disease and Latent TB Infection (LTBI) was available to the over 300 participants of the conference.
2018 Red Snapper Award

Dr. Robert L. Brawley was recognized by the KY TB Program for his outstanding service and achievements toward the prevention and control of Tuberculosis throughout the Commonwealth of Kentucky at the 36th Annual Southeastern TB Controllers Meeting on October 4, 2018 in Lexington, KY.

Dr. Brawley served as the Infectious Disease Branch Manager and the TB Controller for the KY TB Prevention and Control Program from 2005 to 2018. He is best known for his antibiotic stewardship and creating the motto “Get the bugs before you give the drugs!”

Congratulations Dr. Brawley!

2018 Tuberculosis Champion

Dr. Connie White, Kentucky Department for Public Health, Senior Deputy Commissioner, was recognized by the KY TB Program for her devotion, dedication and personal commitment to the program and the individuals served in the Commonwealth of Kentucky at the 36th Annual Southeastern TB Controllers Meeting on October 4, 2018 in Lexington, KY. Dr. White’s presentation to the group gave tribute to her family’s plight with TB disease and the lasting impact on her life. She further discussed how health in KY is shaped by Adverse Childhood Experiences (ACES) and the efforts in KY to address them.

Congratulations Dr. White!
2018 Training and Events

November 5-10, 2018
8:00 AM - 5:30 PM EST
SNTC Comprehensive TB Course, Gainesville, FL
SNTC presents a five-day intensive course for the clinician and healthcare worker with all aspects of tuberculosis infection, disease and clinical care. Please contact the KY TB Program for more information.

November 7-8, 2018
8:00 AM - 4:30 PM EST
TB 101 Orientation, CHFS, Frankfort, KY
2-day course for new LHD personnel. Prerequisites.
https://ky.train.org/ Course ID: 1080083

Coming soon-2019 Training Opportunities!
For education and training questions please contact Ruth Willard.

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