

# Consensus Statement of the TB Medical Advisory Board

## Local Health Department TB Control Programs

The Local Health Department is legally accountable for tuberculosis (TB) control within the jurisdiction.

The *first priority of tuberculosis (TB) control* is to assure early identification and complete treatment of infectious patients. In this regard, as soon as a TB patient is identified within the jurisdiction, the local health department should designate a trained 'Case Manager' as responsible for that patient. Under supervision and guidance from the Local Health Officer, the Case Manager should be responsible and held accountable for the following:

- Assisting the primary care provider in obtaining a laboratory diagnosis of TB. If indicated, the Case Manager should be prepared to obtain three sputum specimens for analysis in the ISDH laboratory.
- Assuring that TB patients are isolated (in hospital or home) until meeting the criteria to be considered as non-infectious. Isolation is particularly important to protect individuals at high risk for development of TB (children 0-4, elderly  $\geq 65$ , and immunocompromised individuals). High-risk individuals, who must stay in the household with an infectious TB patient, should be on directly observed preventive therapy (DOPT).
- Assuring that the correct antituberculosis drugs are started at the right dose, according to CDC/ATS recommendations.
- Assuring that complete and appropriate information is transmitted to the ISDH TB Program in a timely fashion.
- Communicating effectively with the primary care provider, including:
  - ✓ Keeping the physician informed of the patient's condition
  - ✓ Offering up-to-date information and guidelines on diagnosis and management of TB, and
  - ✓ Referring the physician to ISDH or Medical Advisory Board members for consultation, when needed.
- Assuring that all doses of medication are taken as prescribed. Directly Observed Therapy (DOT) is the standard of care for achieving this goal, and does not require a physician's order.
- Monitoring the patient for side effects, adherence to medication, clinical progress and conversion of sputum to smear and culture negative.
- Assuring that a complete contact investigation is performed in a timely fashion.
- Educating the patient about TB, medication side effects, the risk factors for spread, the rationale for isolation, and the expected results from treatment.
- At least monthly:
  - ✓ Clinical follow-up of the patient, including evaluation of symptoms, collection of follow-up sputum specimens, and review of results of X-ray and other diagnostic procedures;
  - ✓ Communication with the physician; and
  - ✓ Reporting to ISDH TB Program.

The *second priority of tuberculosis control* is to identify untreated individuals infected with latent tuberculosis, and to assure that they complete preventive therapy so they will not become infectious. Tuberculosis skin testing programs identifying persons with latent tuberculosis should be undertaken only if the diagnostic evaluation and course of preventive treatment are likely to be completed.

- Screening and preventive treatment should be directed first and foremost to the highest-risk individuals. Those at highest risk include contacts of known cases, individuals known to be HIV (+), and individuals with chest X-ray changes suggestive of old, healed TB.
- Persons who are Tuberculosis Skin Test (TST) or Interferon Gamma Release Assay IGRA (+) should be fully evaluated with a chest X-ray; sputum smear and culture should be done if indicated by radiology results.
- Persons who are TST or IGRA (+) with a normal chest X-ray should be offered preventive therapy with a CDC/ATS recommended regimen. Efforts should be made to assure that treatment is completed.
- Highest risk household contacts should receive DOPT when the active TB disease case is receiving DOT. Highest risk contacts include children 0-4, individuals 65 and older, and immunocompromised individuals.

Local Health Departments should *specifically avoid allocation of financial and personnel resources to low-priority TB control activities* at the expense of activities related to the two major priorities for TB control.

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The Indiana State Department of Health Tuberculosis Program adopted this consensus statement in June of 2009. This statement updates the previous TB Medical Advisory Board statement on local health departments adopted in January 1999.