

Iowa Tuberculosis Control Program 2017 Annual Report



CERTAMEN AD FINEM PERGIT
THE FIGHT CONTINUES
TO THE END



Frank Sinatra with (TB) Christmas Seals children, circa 1963. Celebrities were often featured by the American Lung Association to promote the purchase of Christmas Seals to raise funds in the fight against TB.

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Pine Knoll TB Sanatorium, Davenport, Iowa

FOREWORD

Tuberculosis (TB) remains a major health problem globally, in the U.S. and in Iowa, killing an estimated 1.3 million people annually. Despite this grim statistic, TB morbidity rates are declining in the U.S. and around the world. In Iowa, TB case rates remain relatively stable due to the influx of immigrants and refugees from areas of the world where TB is prevalent. Vigilance is required to properly treat and cure patients to prevent treatment relapse, treatment failure or the development of acquired drug resistant TB. Declines in funding, delayed diagnosis and challenging clinical case management still plague TB control efforts in the United States.

PURPOSE AND OVERVIEW

The purpose of this report is to provide a summary of TB in Iowa and the activities and achievements of the TB Control Program and our partners during the 2017 calendar year. This report provides Iowa-specific TB rates, funding sources and program-specific data, often in 10-year time lines to more accurately reflect trends.

The annual report serves as an informational resource for stakeholders, local partners, policy makers and others interested in Iowa's TB control efforts. The report is available for download on the TB Control Program webpage at <http://www.idph.state.ia.us/ImmTB/TB.aspx?prog=Tb&pg=TbHome>.

IOWA'S TB CONTROL PROGRAM

The TB Program is comprised of two full time employees: the Program Manager and the Nurse Consultant. The program provides direct oversight of cases afflicted with latent tuberculosis infection (LTBI) and TB disease from admission to discharge in the TB Control Program. This includes consultation with physicians, nurses, local public health agencies (LPHAs) and other healthcare providers regarding TB transmission, pathogenesis, treatment, signs and symptoms, infection control practices and contact investigations.

The purpose and scope of responsibilities is defined by the core functions of the TB Control Program which include:

- Disease consultation and education
- Investigation of active or suspect TB cases
- Case management of LTBI and active TB cases
- Administration of Iowa's TB Medication Program
- Data management and analysis
- Administration and finance

During the last decade, Iowa averaged > 1,200 LTBI and 46 TB disease cases each year. Figure 1 illustrates the average number of cases in Iowa each year by decade, dating back to 1930. Note that Iowa averaged 757 cases of TB disease each year during the decade of the 1940s. During this decade, scientists first discovered antibiotics that could treat TB, culminating with the discovery of other antibiotics in the 50s and 60s that led to doctors curing patients of TB. The discovery and use of these antibiotics ultimately led to the sharp decline of TB cases and subsequently, the number of persons with LTBI. Persons with untreated LTBI represent the reservoir of future TB cases.

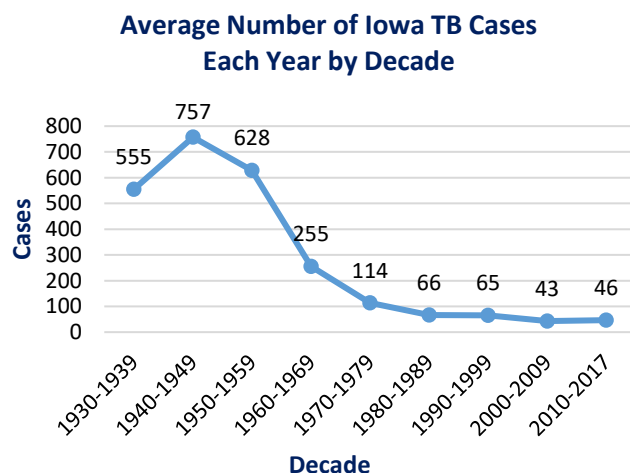


Figure 1: Average Number of TB Cases in Iowa Each Year - by Decade.

In 2017, Iowa reported 47 cases of active TB disease. Since 2007, Iowa has averaged 46 cases of TB each year. (Figure 2: Number of TB cases 2008 - 2017). Although case rates are declining, many cases have existing co-morbidities that make TB treatment considerably more complex and require extensive care, including the use of second line drugs.

Treatment with second line drugs is complicated and expensive, requiring expert consultation and extended treatment durations.

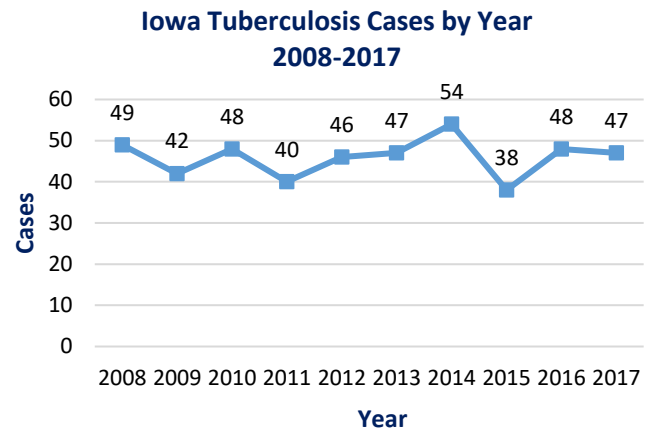


Figure 2: Number of Iowa TB Cases per Year 2008 - 2017

Counties with larger population centers such as Polk, Black Hawk and Johnson, report the majority of TB cases. However, as Figure 3 illustrates, 53 of 99 Iowa counties reported TB cases during calendar years 2008 - 2017.

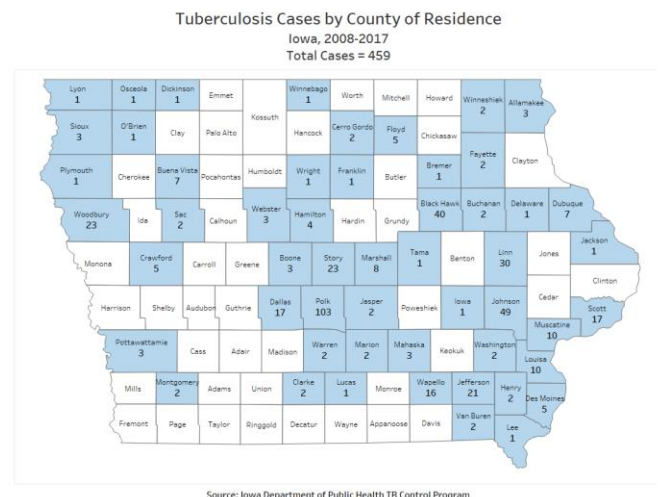


Figure 3: Iowa Counties with TB Cases 2008 - 2017

LTBI AND TB DISEASE TREATMENT

The program prioritizes the detection and treatment of persons with LTBI to prevent future cases of TB disease. Figure 4 illustrates the program issues greater than 1,100 LTBI prescriptions on average each year to lowans diagnosed with LTBI. Left untreated, 5-10 percent of persons with LTBI will develop TB disease. The only way to eliminate TB disease is to treat and cure all persons diagnosed with LTBI.

Iowa Latent Tuberculosis Infections by Year 2008-2017

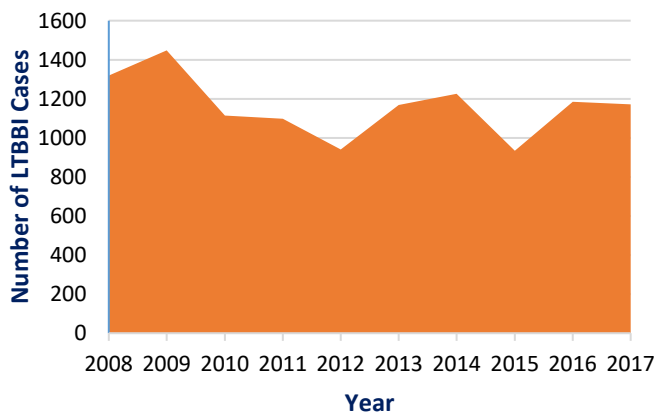


Figure 4: Number of LTBI cases each year from 2008 – 2017

The length of LTBI treatment (up to nine months) coupled with a lack of public health resources, results in patients having to complete LTBI treatment on their own accord, just like with other illnesses. Significantly shorter treatment regimens paired with public health monitoring is the only method that will achieve TB elimination.

Figure 5 represents the percentage of patients who completed treatment from 2007 - 2016. During this period, all patients with infectious TB completed treatment. Patients not completing treatment had extrapulmonary TB, were not infectious and did not represent a public health risk.

Completed TB Treatment Iowa: 2007 - 2016

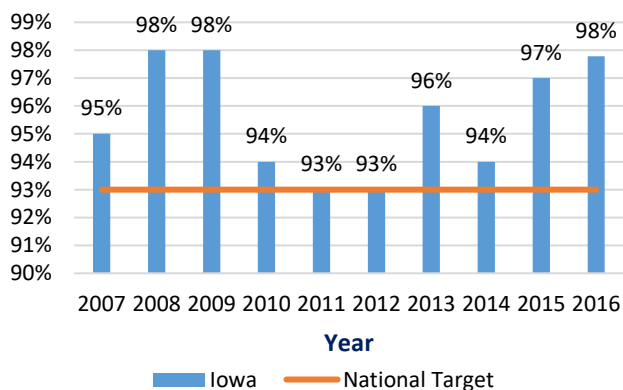


Figure 5: Percentage of Iowa TB Cases Who Complete Therapy 2007 - 2016

It is very important that people who have TB disease finish the medicine, taking the drugs exactly as prescribed. If patients stop taking the drugs too soon, they can become sick again; if they do not take the drugs correctly, the TB bacteria that are still alive may become resistant to those drugs. Drug resistant TB is harder and more expensive to treat.

DIRECTLY OBSERVED THERAPY (DOT)

DOT is a strategy used by public health officials to assure patients with TB disease are correctly treated and cured. DOT is the standard of care for all patients afflicted with TB disease. The Centers for Disease Control and Prevention (CDC), Infectious Diseases Society of America (IDSA), World Health Organization (WHO), and the American Thoracic Society (ATS) recommend healthcare providers implement DOT on each case of TB disease. With DOT, a designated healthcare worker watches a patient swallow each dose of TB medication. Without DOT, many patients do not take their medication properly, resulting in disease relapse, treatment failure and development of drug resistance, including multidrug-resistant TB (MDR-TB).

In 2001, the Iowa TB Control Program began providing DOT incentive funds to increase the proportion of TB patients who receive DOT. Since implementation of incentive funding, DOT rates have risen 40 percent in Iowa. During this time period, virtually all pulmonary (infectious) cases of TB have had the benefit of DOT. Clinical benefits of DOT include significant reduction in disease relapse, treatment failure and development of multidrug-resistant TB (MDR-TB).

COUNTRY OF ORIGIN DATA

The proportion of reported TB cases in non-U.S. born persons has increased significantly in the past two decades. In 1995 for example, non-U.S. born persons accounted for 38 percent of reported TB cases in Iowa. From 2008 - 2017, non-U.S. born persons accounted for 75 percent of reported TB cases in Iowa. Non-U.S. born persons account for only 4 percent of the Iowa population, highlighting the disparity. The decreasing numbers of U.S.-born cases are due in part to effective TB control practices in this country.

TB Cases By U.S. vs. Non-U.S. Born Iowa: 2008 - 2017

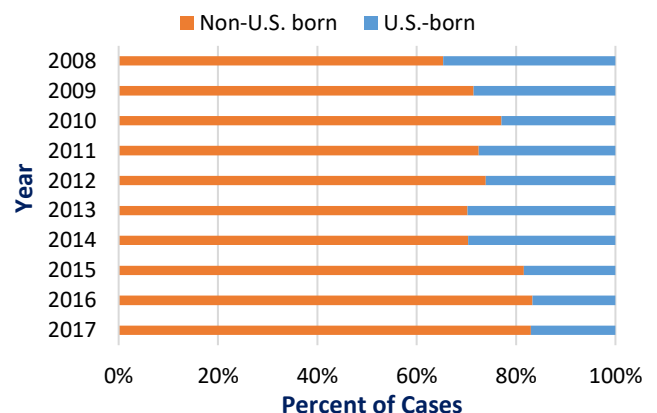


Figure 6: Percent of U.S. born Versus Non-U.S. born TB cases in Iowa 2008 - 2017

In many parts of the developing world, TB is still widespread and remains a leading cause of death. Immigration of people from these countries to the United States illustrates what happens in one part of the world, directly impacts other parts of the world. Effective targeted testing programs for newly arriving refugees, immigrants and students play a major role to identify and treat these populations.

Figure 7 represents Iowa’s TB cases by immigration status from 2009 – 2017 (data collected on this variable starting in 2009). The Centers for Disease Control and Prevention requires permanent bound immigrants (refugees and immigrant visa holders) to the U.S. have a medical examination prior to entry, which includes screening for communicable diseases of public health significance. This ensures persons are not arriving with communicable diseases such as TB. However, these persons can develop TB disease after arrival. Temporary visitors to the U.S., including greater than 130 million tourists each year, receive no TB screening or testing.

All persons at increased risk for exposure to TB should have baseline TB screening and testing upon arrival to the U.S. Clinicians should offer those diagnosed with LTBI treatment so they never develop TB disease in the future.

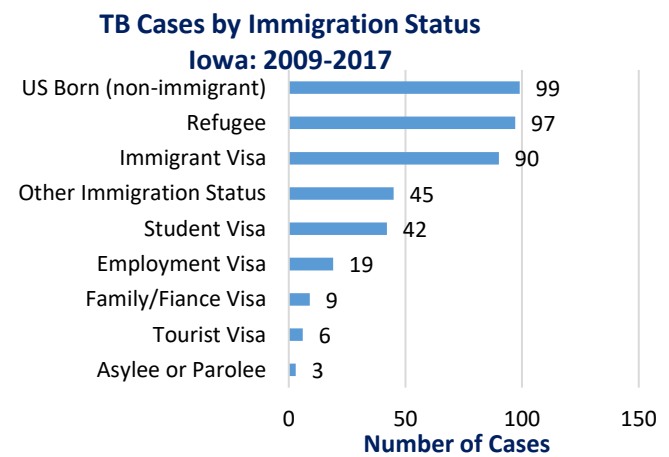


Figure 7: Iowa TB Cases by Immigration Status, 2009-2017

From 2008 - 2017, 343 individuals, emigrating from 46 countries (excludes U.S.) developed TB disease after their arrival to Iowa (Figure 8). India and Mexico account for 25 percent of the TB morbidity in Iowa during this time period. As the map illustrates (Figure 9), TB anywhere is TB everywhere. Approximately 95 percent of all patients with active TB disease live in the developing world, where 99 percent of all TB deaths occur. TB is a good example of the global nature of public health.

It is important to implement consistent and aggressive public health measures to halt TB disease, which left untreated, kills half of its victims.

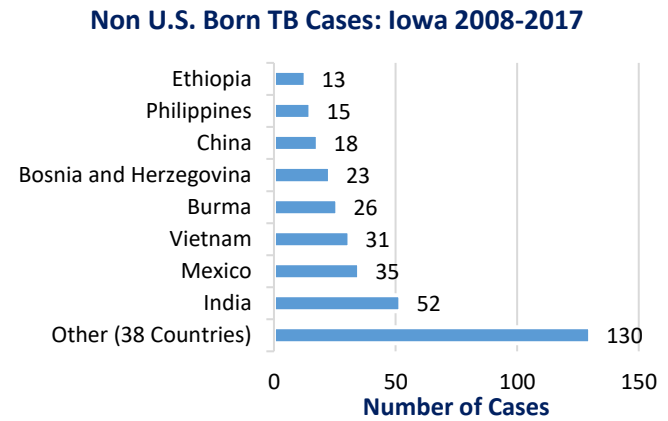


Figure 8: Iowa TB Cases by Country of Origin 2008-2017

In Iowa, eight countries, led by India and Mexico, account for 213/343 (62 percent) of non-U.S. born TB cases from 2008 - 2017 (Figure 9). Thirty-eight other countries complete the TB morbidity, further illustrating the global burden of TB.

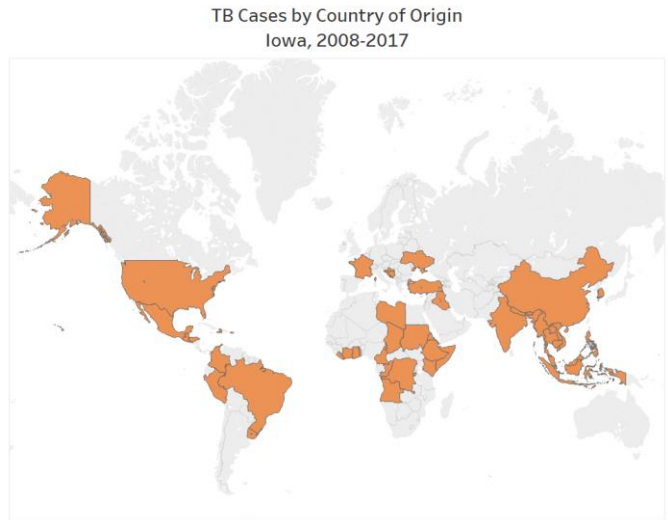


Figure 9: Country of Origin by Global Representation: Iowa 2008-2017

SITE OF DISEASE

The lungs are the most common site for TB disease, but any organ or body site may be involved. TB of the pleura (lining of the lungs) and lymph nodes is the most commonly occurring form of extrapulmonary tuberculosis. In Iowa, pulmonary cases accounted for 70 percent (includes pulmonary and both) of the total cases during the last 10 years (Figure 10). Patients with either pulmonary (lungs) or laryngeal (throat) TB are usually infectious.

TB Cases by Site of Disease Iowa: 2008-2017

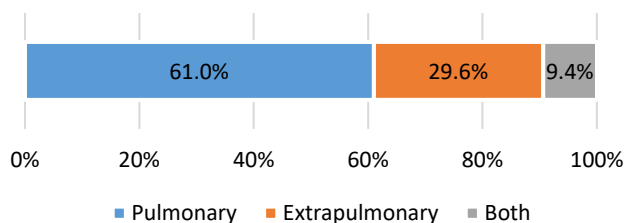


Figure 10: Iowa TB Cases by Site of Disease 2008-2017

CONTACT INVESTIGATIONS

All infectious cases require a contact investigation by a local public health agency (LPHA) to identify contacts who:

- Have LTBI so treatment for LTBI can be given and active disease can be prevented.
- Have TB disease so they may be treated and further transmission can be stopped.

TB Contact Investigations, Iowa 2007-2016

Cases for investigation: 253
Number of contacts identified: 4,146
Number of contacts who completed evaluation: 3,601 (87%)
Number of LTBI identified: 723 (20%)
Number of TB cases identified: 22 (<1%)

Figure 10: Contact Investigation Data

Each infectious TB case in the United States has 10 contacts identified on average, per CDC. Approximately, 20 to 30 percent of all contacts have LTBI, and 1 percent has TB disease. Of those contacts that ultimately will have TB disease, approximately half acquire disease in the first year after exposure. For this reason, contact investigations constitute a crucial prevention strategy.

LPHAs in Iowa are responsible for conducting investigations of infectious TB. Local Public Health agencies work closely with other agencies (e.g., Community Health Centers, private providers, labs, etc.) to ensure the prompt reporting of suspected TB cases. A major challenge for LPHAs is the time involved to complete contact investigations. In order to be considered “evaluated,” contacts to infectious TB cases must complete all TB testing, often requiring two TB tests. Persons with positive tests require a medical evaluation to include a chest x-ray to rule out active TB. LPHAs spend considerable

amounts of resources in their efforts to complete the evaluation of contacts exposed to infectious TB.

The TB Control Program Manager and TB Nurse Consultant provide consultation to LPHAs on each infectious case of TB. Consultation consists of:

- When to initiate a contact investigation
- Assigning priorities to contacts
- Diagnostic and public health evaluation of contacts
- When to expand a contact investigation, and
- Data management of contact investigations

Contact investigations are timely, costly and consume limited resources from local, state and federal assets. “Contact investigations typically require hundreds of interdependent decisions, the majority of which are made on the basis of incomplete data, and dozens of time consuming interventions.”¹ For these reasons, consultation and collaboration among LPHAs and the TB Program is vital to the diagnostic and public health evaluation of contacts.

TB CONTROL PROGRAM FUNDING

In 2017, the TB Control Program received funds from the federal TB Cooperative Grant and state funds totaling \$539,039. Federal funds comprise 72 percent of the total budget, while state funds comprise 28 percent of the program finances. (Figure 11)

Funding Source 2016	
Federal TB Cooperative Grant	\$388,235
State Prescription Services	\$150,804
Total	\$539,039

Figure 11: 2017 total program funds

Program expenditures are divided into three main categories: **program infrastructure** (staff salary and operating expenses), **contracts** (including incentive funding for LPHAs to conduct directly observed therapy, pharmacy for prescription services and the State Hygienic Lab), and **TB medications**. The funding distributions for these three categories are illustrated in Figure 12.

¹ Guidelines for the Investigation of Contacts of Persons with Infectious TB – Recommendations from the National TB Controllers Association and CDC.

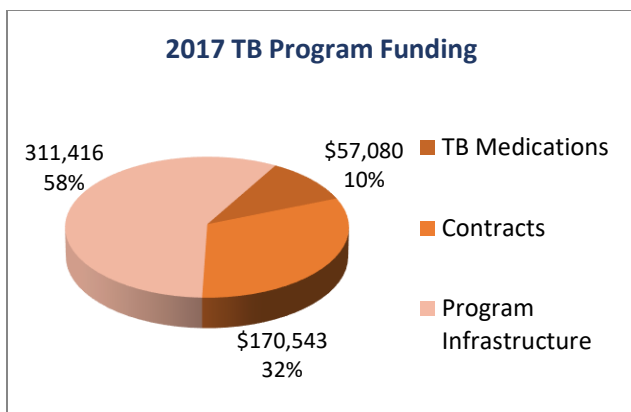


Figure 12: 2017 total program funds by funding source

Figure 13 illustrates how the TB Program disperses available contractual funds. LPHAs receive incentive funding for DOT and medical evaluation services. The funds for the pharmacy service support providing free antibiotics for all Iowans with LTBI or TB disease. Funds for the State Hygienic Lab support rapid identification of TB, smear, culture and drug sensitivity testing.

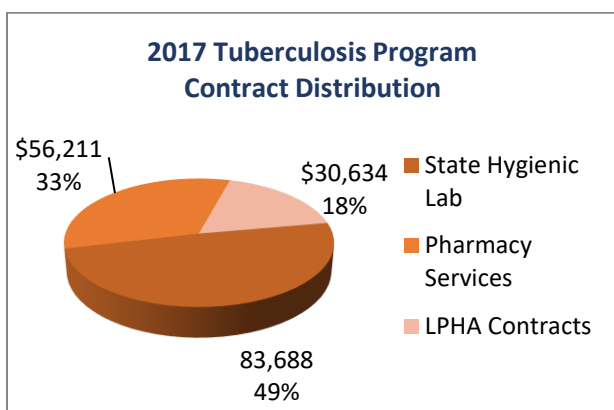


Figure 13: 2017 total funds distribution

CONTRACT SERVICES

STATE HYGIENIC LAB

The TB Control Program contracts with the State Hygienic Lab (SHL) through the *Tuberculosis Elimination Cooperative Agreement*. In 2017, the TB Control Program contract amount with SHL was \$83,688 as demonstrated in Figure 13. This agreement allows SHL to be the primary source for public health submission of suspect TB patient specimens (typically sputum) for evaluation. The goal of SHL is to provide objective information within 24 - 48 hours of specimen receipt for smear and TB NAAT (rapid detection of MTB complex as well as rifampin drug resistance). SHL works with CDC to transfer clinical specimens of patients for whom second line drug testing is necessary. Additionally, SHL

coordinates genetic testing of all culture positive MTB specimens with CDC to allow genetic linking of cases nationwide. The ability to rapidly and accurately detect drug resistance in *Mycobacterium tuberculosis* Complex (MTBC) clinical isolates is critical for the appropriate treatment of patients suffering from TB and the effectiveness of the TB Control program.

SHL also is one of the few labs in the state that performs Interferon-Gamma Release Assays (IGRAs). IGRAs are whole-blood tests that can aid in diagnosing TB infection. SHL offers two IGRAs that have been approved by the U.S. Food and Drug Administration (FDA) and are commercially available in the U.S: QuantiFERON TB Gold In-Tube test (QFT-GIT); and T-SPOT® TB test (T-Spot). IGRAs are of particular use to LPHAs in the course of a contact investigation to an infectious TB patient. In a contact investigation, IGRAs are offered to Iowa citizens free of charge through the SHL.

PHARMACY SERVICES

The TB Program contracts with NJL Pharmacy of Pleasant Hill, Iowa to dispense TB medications for both LTBI and active TB disease patients. In 2017, the TB Control program spent \$57,080 on TB medications for Iowa citizens (Figure 12). The contract for pharmacy services is \$56,211 as demonstrated in Figure 13.

LOCAL PUBLIC HEALTH AGENCIES

Iowa is unique in its ability and desire to provide incentive funding for LPHAs who provide directly observed therapy (DOT) to active pulmonary patients in their county. DOT is a standard of care for TB in which patients are observed to ingest each dose of anti-tuberculosis medications, to maximize the likelihood of completion of therapy. Programs utilizing DOT as the central element in a comprehensive, patient-centered approach to case management (enhanced DOT) have higher rates of treatment completion than less intensive strategies.

The CDC, American Thoracic Society and Infectious Disease Society of America (IDSA) all recommend healthcare providers implement DOT on each active case of TB. Eligibility of LPHAs for DOT incentive funding may vary by funding cycle due to funding availability and the number of TB cases; but generally, all infectious (pulmonary and laryngeal), pleural, HIV positive, and childhood cases of TB disease are eligible. In 2017, the Iowa TB Control Program spent \$30,634 on contracts with LPHAs for DOT services as shown in Figure 13.