Members present:
Timothy Aksamit, M.D.  
Ed Ehlinger, M.D., M.S.P.H.  
Lori Groven, R.N., B.S.N., M.P.H.N.  
Neal Holtan, M.D., M.P.H.  
Sue Husby, R.N., B.S.N.  
Noreen Kleinfehr-Wald, P.H.N.  
Carol Klitz, B.S.N., P.H.N.  
Kevin McCoy, P.H.N.  
Tom Michaels, R.N.  
Christine Reisdorf  
Alberto Ricart, M.D.  
Chuck Sieber, R.N.  
Dean Tsukayama, M.D.

Organization:
Mayo Clinic, Pulmonary Disease and Critical Care  
Student Health Services – Boynton Health Service  
MN Association of Professionals in Infection Control  
St. Paul-Ramsey County Department of Public Health  
MN Association of Occupational Health Nurses  
Local Epidemiology Network of Minnesota  
Hennepin County Public Health Clinic  
Olmsted County Public Health TB Program  
Council of Health Plans – U Care Minnesota  
MN Department of Human Services  
Andover Park Clinic  
Department of Corrections  
Hennepin County Public Health Clinic


Guests: Ann Settgast, from the Center for International Health

Minnesota Department of Health (MDH) staff present:
Lenette Bauer  
Milayna Brueshaber  
Cynthia Hickman, M.P.H.  
Marge Higgins, L.S.W.  
Beth Kingdon, M.P.H.  
Nadya Sabuwala, R.N.  
Blen Shoakena, M.P.H.  
Ann Sittig, R.N., M.P.H.  
Deb Sodt, R.N., M.P.H.  
Sarah Solarz

TB Program Medication Coordinator  
TB Program Contact Investigations Coordinator  
Metro District Epidemiologist  
TB Program Refugee and Immigrant Coordinator  
TB Program Education Coordinator  
TB Nurse Case Manager  
TB Program Tracking Systems Coordinator  
TB Nurse Case Manager  
TB Program Manager  
TB Program Epidemiologist

Committee chair Tim Aksamit called the meeting to order at 6:07 P.M.

Welcome and introductions
Chair Aksamit welcomed all present, invited everyone to introduce him or herself, and announced new committee members:
- Lori Groven representing MN Association of Professionals in Infection Control (APIC) – HCMC – taking Cindy Larson’s place.
- Sue Husby – MN Association of Occupational Health Nurses (MAOHN) and working at Allina - taking Karen Ferrara’s place.
- Joanne Larson – School Nurses of Minnesota (SNOM) – Colombia Heights/district 916 – taking Marjorie Sandborne’s place.
Chair Aksamit and Deb Sodt acknowledged Committee member Chris Reisdorf who has served on the committee as a representative from DHS since 2001. She served as co-chair of the Committee for four of those years and provided valuable information at about changes in benefits, policy, and legislation that affects TB patients and providers. She has been a great asset and resource to our TB program and was responsible for formalizing a process to access state funds for uninsured TB patients to cover the cost of their diagnostic work-up and treatment. We are grateful for her input and leadership on this Committee.

**Updates and announcements**

- From the MDH TB Program, Deb Sodt shared that Beth Kingdon was voted “TB Educator of the Year” by the National TB Education and Training Network. This is a well-deserved acknowledgement of Beth’s leadership on the committee and her role in the development of TB education initiatives and materials both nationally and internationally.

- Deb gave a brief presentation (slides attached) about the “Affordable Health Care Act”, also known as “National Health Reform” from information presented at a one-day forum in Atlanta, GA, on October 7, 2010. The goal of this forum was to start the discussion of TB control within the context of the changing national health care system. The event drew a wide range of attendees from state and national stakeholders in TB prevention and control. Deb shared highlights from a presentation summarizing Massachusetts’ experience from the last 3-4 years:
  - The Massachusetts system incorporates similar measures to those in the national reform package. The few people that remain uninsured belong to the demographic groups most likely at risk for having TB: foreign-born, low income, unemployed, urban, and young males.
  - An important distinction is that access to health insurance does not equal access to health care. Dropping out of plans due to cost, changing health plans in search of cheaper rates, increasing co-pays, and long waiting times for appointments are all barriers to health care even in those states striving to achieve universal coverage.
  - Because of some of these barriers to care, over 50% of the TB cases in MA were sought TB care via an emergency department. Deb will investigate this further to find out the reasons for this. Committee members speculated that it might be due to a collapse in part of their health care system or inaccessible primary care.
  - Deb asked committee members to comment on any effects of health care reform they are experiencing here, a few comments were made:
    - General Assistance Medical Coverage (GAMC) has become inadequate in almost every situation. (Depending on the outcome of some proposed legislation, people on GAMC may be able to switch to Medical Assistance.)
    - Co-pays and deductibles have increased.
    - There is funding available for federally qualified health clinics (community clinics) and school-based clinics.
    - There is some funding in the bill for Community Health Workers.
    - The details are still unclear and need to be clarified.
  - Deb will continue to stay informed about these issues and will update Committee members as information becomes available.

- Sara Solarz gave a brief update on the Minnesota Electronic Disease Surveillance System (MEDSS). TB is the first program area at MDH to use MEDSS and Hennepin, Ramsey, and Dakota county public health staff now have access to the system as they are participating in a LPH “pilot” phase of the system. This is a big step forward and feedback from these counties will be helpful as MDH prepares to use the system statewide.
Sara Solarz also gave an update regarding “TB GIMS” (Genotyping Information Management System) in which MN culture positive TB cases are part of a national database that searches for genotype matches in other states. This system is developing workload management and investigation tools including “predictor models” for participants to use. Hennepin County is also part of this system, which currently has limited but growing usage.

**IGRA Guidelines**

Deb Sodt presented highlights from the “Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection” published in June by CDC (slides attached). She noted that:

- IGRAs are approved for use in all situations that a TST would be recommended.
- As with the TST, it is important to target “at risk” groups for TB screening with IGRAs.
- There are certain situations when an IGRA test is preferred:
  - BCG vaccinated persons, and
  - populations where TST reading return rates are poor.
- The TST is preferred for children less than 5 years of age.
- Routine testing with both TST and IGRA is not recommended.

More details about these recommendations are available on the CDC website at: [http://www.cdc.gov/tb](http://www.cdc.gov/tb)

Several current and former TB Advisory Committee members volunteered to work with Deb to develop MN specific IGRA guidelines. They are Tim Aksamit, Ed Ehlinger, Karen Ferrara, Cynthia Hickman, Billie Juni, Kevin McCoy, Alberto Ricart, Patty Seflow, Sharon Traen, and Dean Tsukayama. Ann Settgast volunteered to join this group. Committee members suggested inviting a pediatric ID physician to join the group as well as Dr. Neilson from St. Cloud State University (where all incoming foreign-born students are being screened with an IGRA), and Dr. Paulson from the Department of Corrections.

Ann Sittig attended a symposium in Chicago on October 6, 2010 sponsored by Cellestis (QFT manufacturer) titled: *Screening for TB Infection: Putting IGRAs Into Practice*. Some of the points made at the symposium included:

- It’s time to “cut the cord” with TSTs. In screening health care workers at the University of Illinois at Chicago, 70% of persons with a positive TST had a negative QFT. Treating only those with positive QFT for LTBI represents a huge cost savings.
- The IL Department of Health has published a statement incorporating IGRAs into the statutes that previously listed only the TST for use in TB screening.
- As labs gain experience with IGRA testing, they have less “indeterminate” results.
- Patients are more willing to believe IGRA results.
- IGRA use in children is still controversial.
- There have been no studies showing that a TST is superior to an IGRA.
- While the specificity of an IGRA is better that the TST, the sensitivity is the same. It is hard to get people and systems to move toward another “imperfect” test.

Committee members furthered the discussion on IGRAs and the following points were raised:

- A European document draft on IGRAs states that while a positive TST represents a 10% lifetime risk of developing TB disease, a positive IGRA doubles or triples that risk.
Health Partners has used QFT for employee screening for two years and that data is now available for surveillance.

Some of the larger employee screening sites in MN are using IGRAs for initial hiring, and the TST for subsequent testing of employees.

IGRA Guidelines from the State will help clarify Minnesota specific populations and situations. They would also gain the attention of the large organizations in the state that screen for TB.

**Trends in TB – nationally and statewide**

Marge Higgins presented information about the changes in refugee arrivals to MN in recent years followed by a presentation by Deb Sodt showing the changes in our TB cases. (Slides attached.) Some significant changes in refugee demographics noted are:

- There has been an overall decline in numbers in recent years, although we already have several hundred more arrivals in 2010 than we received in 2009.
- There has been a shift in that the largest number of refugees this year are from the Near east/South Asia region instead of Africa.
- Refugee resettlement from specific countries are concentrated in specific counties in MN (Burma = Ramsey, Somalia = Hennepin or Stearns, Iraq = Olmsted, Former Soviet Union = Anoka).
- Almost half of our refugees in 2010 are “Free cases”, whereas historically almost all of our arrivals were “Family reunification”. This affects every aspect of resettlement.
- We are seeing an increase in secondary migration, both into and out of Minnesota, often shortly after arrival in the U.S.
- TB Class Immigrant arrival number is now greater than Refugees with TB Class conditions.

Deb Sodt focused on the following changes in TB cases:

- Nationally and statewide there is a decrease in TB Cases, and the decrease is real (not due to a change in the case definition, underreporting or other factors).
- The decrease has several possible explanations, including:
  - Revisions and improvements to the overseas screening, resulting in finding and treating TB cases prior to entering the U.S.
  - Fewer foreign-born people coming to the U.S. due to the economic decline.

Following this presentation Deb raised the question, “Do we need to change strategies?” Committee members shared the following insights:

- Past performance may not guide us in this unique situation.
- It would be foolish to scale back our program or resources prematurely.
- TB is still a huge issue globally. We still will have to see how MDR TB evolves and how this affects overseas screening.
- MN is still quite unique in our high percentage of foreign-born TB cases even as our numbers decline.

**Wrap-up – Final thoughts or comments from Committee members and future agenda items**

Chair Aksamit invited each member to share final comments about the issues raised in the meeting. These included:

- Staff exposure work-ups in some health care settings have increased this year – TB is still an important issue in high-risk settings.
- Concern about the impact of declining numbers of TB cases along with budget shortages on the MDH TB Program.
● TB screening of international students involves a lot of resources with very little payback. This needs to be further evaluated.
● Cost, availability, and currier issues need to be addressed before IGRAs can be widely used in many of the smaller counties and health care settings.
● This may be the time to shift our focus toward prevention and successful treatment of LTBI. Follow the data for targeting resources.
● As TB numbers decline, fewer providers will be seeing TB. Educational efforts will be needed in order to maintain vigilance.
● Linking new arrivals to public programs will be even more important with more “free” refugee arrivals, or “arrivals without ties”.
● If we move toward more LTBI tracking and focus, we may want to consider the pros and cons of an LTBI registry.
● The immigrant arrivals with TB Class are a high-risk group we can track. We need to look closely at this population and work to increase successful evaluation and follow-up.

**Next Meeting Date**
*February or March 2011*

Chair Aksamit thanked everyone for participating and adjourned the meeting at 8:05 p.m.