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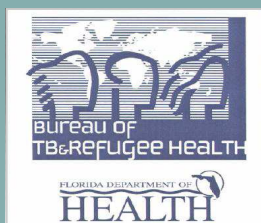
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TNN BETWEEN TB NURSES NETWORK

...AN E-UPDATE

JUNE 2010—ISSUE 4



Nurses' Week

Debbie Spike

Although Nurses' Week has passed (May 6th - May 12th) I can not miss an opportunity to pay tribute to our Florida TB nurses.

I searched and searched for just the right message, because a TB nurse is very different from any other nursing specialty. The TB nurse must create a relationship of mutual respect, trust and cooperation with their TB client, and then sustain that relationship for six months or longer, regardless of their attitude, level of education or social status in life. Plus, you must accomplish this without a magic wand, an increase in pay, or even that proverbial "pat on the back".

Why do you do it? You do it because you **are** a TB nurse and for that I salute you!

I hope you enjoyed Nurses' Week, and I hope that you were recognized in some way, by someone, for all that you do for our TB clients. I thank you!

*Being a **NURSE** means...*

*You will never be bored.
You will always be frustrated.*

*You will be surrounded by challenges.
So much to do and so little time.*

*You will carry immense responsibility
and very little authority.
You will step into people's lives
and you will make a difference.*

*Some will bless you.
Some will curse you.
You will see people at their worst...
and at their best.*

*You will never cease to be amazed
at people's capacity for love, courage, and endurance.*

You will see life begin...and end.

*You will experience resounding triumphs
And devastating failures.*

*You will cry a lot.
You will laugh a lot.
You will know what it is to be human
and to be humane.*

Written by:
Melodie Chenevert RN, MN,
MA

Debbie Spike

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Our revised TB Nurses Network (TNN) conference call schedule will be as follows:

August 11, 2010
October 13, 2010
December 8, 2010

Conference Dial-in
Number:
888-808-6959
Conference Code:
9781059

* **Note:** Calls are every other month on the 2nd Wednesday of the month. All calls are 9:30 - 10:30 AM (EST) with the **exception of the August 11th call which will be from 1:00-2:00 PM (EST)**. The TNN Between E-Update will be sent every other month opposite the calls.

Lagniappe

By the time you read this article, the Bureau of TB & Refugee Health (BTBRH) will have sent out the Schedule Cs to all 67 county health departments identifying how much funding is going to support TB Prevention & Control activities in their counties. Some counties will see an increase, others a decrease and some might not see hardly any changes at all. These changes are most commonly caused by the amount of TB cases being reported by each county averaged over a five-year period. If your cases continue to decrease, your allocation decreases. If you should see a continuous rise in the number of TB cases reported for your county, your funding increases. In addition, the BTBRH was forced to cut over \$266,000 of General Revenue from our TB budget. All of our GR goes out to the CHDs with the exception of the incentive/enabler funding. So, when cuts are made to our GR budget it directly impacts the CHDs. Finally, the legislature also reduced our line item budget for Incentive/Enablers by approximately \$13,000 this year. This translates to the difference of 12 fewer TB patients being placed in hotels until they are considered non-infectious to the community, or 2,400 fewer gift cards for Publix or McDonald's. I wish I could say that we are finally out of the woods but I hesitate to, simply because I am concerned that fiscal year 2010-2011 will be just as hard from a funding outlook as 2009-2010. I promise to try my best at protecting the money that leaves headquarters heading towards you and your valuable programs. I remain committed to being a diligent steward of the money Florida receives from our Federal partners and our state legislatively appropriated dollars.

Jim Cobb
Bureau Chief, BTBRH
jim_cobb@doh.state.fl.us



Bammin' Ham Ala Cobb

Serves: 12-14

Prep Time: 2 hours plus soaking

Ingredients:

1 smoked ham	3 apples, peeled, cored and quartered
3-6 oranges, quartered	3 pears, peeled, cored and quartered
1 large brown paper grocery bag	½ cup brown sugar
2 tablespoons yellow mustard	1 can pineapple rings, about 16 oz
1 jar of maraschino cherries	

Directions:

1. Soak ham for 8-24 hours to remove excess salt; change water several times as needed.
2. Cut apples, pears and oranges into quarters.
3. In large pot, place ham in fresh water, add fruit.
 - Boil for 45 minutes to 1 hour depending on size of ham; turn ham at least 4 times during boiling.

Preheat oven to 350 degrees.

1. Place ham in brown paper bag on baking sheet on the center rack of a hot oven and bake for 45 minutes to 1 hour
 - Remove from oven and let cool.
 - Cut away the paper bag to hasten cooling of ham.
 - Trim away excess fat, or "cross-cut" diamond fashion, and leave until serving.
2. In a small mixing bowl, mix brown sugar and mustard until smooth.
3. Using toothpicks, decorate ham with pineapples and cherries.
 - Spread mustard mixture over fruit and ham.
4. Place pan in oven and glaze. Bake at 350 for 30 minutes.

Sevim's Perspective

The County Performance Snapshot and TB

As most of you are aware, the two TB measures on your County Performance Snapshot are the TB case rate per 100,000 population and the treatment completion proportion (for uncomplicated TB cases) within 12 months.

As a key epidemiological measure of morbidity, the TB case rate captures the distribution (in terms of person, place and time) of the disease in your county. It is a large impact measure synthesizing the four main strategized priorities of TB prevention and control and reflects your county's success and progress towards TB elimination. Florida's TB case rate was 4.4 per 100,000 in 2009, which was lower than the 5.0 per 100,000 case rate we had in 2008. By the way, elimination is epidemiologically defined as a reduction of incidence in a population of 1 per million. You can visit the Bureau's website (http://www.doh.state.fl.us/disease_ctrl/tb/Trends-Stats/Fact-Sheets/Florida/County%20Incidence/2009-TBCountyincidentrates.pdf) to see the incidence rate for your county in 2009 and compare that to the previous years as well as the state's overall case rate.

Finding all patients with active TB and ensuring completion of treatment (COT) remains the top priority of TB prevention and control in Florida. Delays in timely completion of therapy often reflect treatment lapses and

other undesirable outcomes such as default and loss to follow-up. TB cases infected with a drug-susceptible *M. tuberculosis* strain are expected to complete treatment within 6-9 months. For drug resistance other than rifampin, TB cases are expected to complete treatment within one year. Additionally, cases who were MDR; dead at diagnosis; or who died during treatment and were less than 15 years old with meningeal, bone, joint, or miliary disease are also excluded from the denominator when calculating the attainment of this objective. For example, if county X had 10 cases in 2008, 1 of whom died during treatment, 1 was RIF resistant, and 6 completed treatment in an year, its completion rate within 12 months would be 75% ($(10-2=8)$ cases should have completed within 12 months. Since only 6 did, $6/8=75\%$).

Defining "timely" completion of treatment as completion within 12 months provides a 3-6 month grace period for the majority of TB cases. This allows for extra time to make up any missed doses, so that programs can follow the practice of counting doses for a treatment regimen rather than relying on duration of time. Failure to reach the objective for this indicator should trigger in-depth data analysis to identify barriers to timely completion of therapy. Once barriers are identified, appropriate interventions can be designed to improve performance.

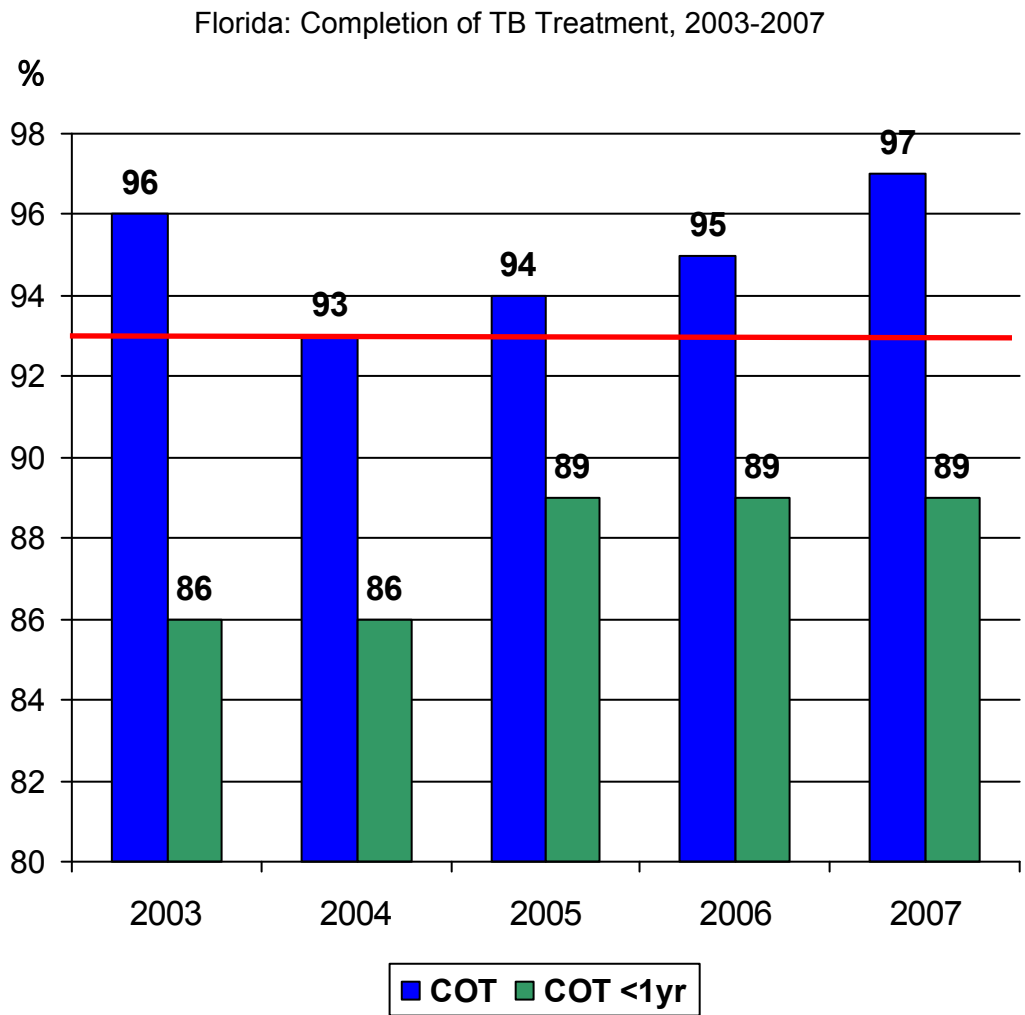
The completion of treatment objective is defined by the CDC as follows: For patients with newly diagnosed TB for whom 12 months or less of treatment is indicated, increase the proportion of patients who complete treatment within 12 months to 93%. So, how are doing in this respect?

As the graph on the next page indicates, Florida's overall completion of treatment has consistently been above 90% (the blue stacks). This is a tremendous achievement and reflection of your hard work and dedication. Thank you!

Florida has also achieved significant progress by increasing and maintaining a steady completion of treatment rate within 12 months over the last five years (the green stacks). While significant, the 89% COT falls short of the 93% target however. The red bar remains unconquered...

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**Sevim's
Perspective
(cont.)**



Source: Tuberculosis Information Management System (TIMS)

Nurse Spotlight

Take the time to learn about TB

Published in the March 24, 2010 issue of the St. Petersburg Times

World Tuberculosis Day is today. The Hernando County Health Department would like to use this opportunity to educate area residents on the disease, the effects it has on those infected and how it can be stopped.

Contrary to popular belief, tuberculosis is not a disease of the past. As a matter of fact, among infectious diseases, tuberculosis (TB) remains the second-leading killer of adults in the world, with more than 2 million related deaths each year. Although active cases are at an all-time low in the United States, there are between 9 million and 14 million persons in the United States infected with mycobacterium tuberculosis, the bacteria that causes TB.

The bacteria usually attack the lungs, but can attack any part of the body such as the kidney, spine and brain and if not treated properly, TB disease can be fatal. TB is spread through the air from one person to another when a person with active TB coughs, sneezes, speaks or sings and others breathe in the bacteria.

People with weakened immune systems are at greater risk for getting sick from TB. Weakened immune systems are often the result of chronic disease, low body weight, certain medical treatments or substance abuse. Symptoms of TB may include a bad cough that lasts three weeks or longer; pain in the chest; coughing up blood; weakness or fatigue; weight loss; chills, fever and/or night sweats.

Not everyone infected with TB bacteria becomes sick. As a result, two TB related conditions have been identified: latent TB infection (not contagious) and active TB disease (contagious). In some cases, latent TB can result in active TB disease. Therefore, treatment is recommended for both conditions. Both latent TB infection and active TB disease can usually be treated and cured with medicine if taken as directed.

The number of cases of TB has been declining in the United States for the past 16 years, but the rate of decline has slowed. Public health professionals continue to take steps to eliminate TB by strengthening current TB control, treatment and prevention systems, educating communities and monitoring progress. TB elimination is an achievable goal.

For more information on tuberculosis, visit www.cdc.gov/tb or call the Hernando County Health Department at (352) 540-6800, ext. 82179.



Aliene Weisenburg
Senior Community Health Nurse
Hernando County Health Department

From our Partners:

HMS

"If you are not lighting any candles, don't complain about the dark"

You have had a busy day and it's not over yet; you still have to enter the recently reported TB case into the Health Management System (HMS). You cringe, you cry, you even curse under your breath. "Why does the system have to be so cumbersome? Why do I have to click this mouse so many times to enter in data that would only take me a few minutes to write in a paper chart? Who made this system and why am I being made to use it? When they created this system, they should have asked me for my opinion. I would make this thing run like a dream." If this is you, the TB HMS SIG (Special Interest Group) wants YOU! Don't complain about the "dark" of HMS anymore, start "lighting the candles" with your brilliant ideas. The SIG is looking for two illuminated souls to become voting members and two bright souls for alternate members. Of course, if you question the luminosity of your soul or simply want to check us out before making a commitment, please plan on joining the TB HMS SIG for our two calls in June:

General Discussion Call on June 11, 2010, at 2:00p.m.; (888) 808-6959; conference code – 7538520; Webex link: <https://suncom.webex.com/suncom/j.php?ED=132511482&UID=0&RT=MiMxMQ%3D%3D>

Business Call on June 24, 2010, at 2:00p.m.; (888) 808-6959; conference code – 9781059; Webex link: <https://suncom.webex.com/suncom/j.php?ED=132515467&UID=0&RT=MiMxMQ%3D%3D>

Laboratory

Comprehensive TB Laboratory Services in 2010 and Beyond

TB status. Eliminating TB, defined as 1 case per 1 million, would mean that the US would have reported just 305 new TB cases last year – instead, CDC reported 11,540 new TB cases, a figure almost 40 times larger than our goal of eliminating TB in US. The increasing threat of multi-drug resistant (MDR) and extensively drug-resistant (XDR) TB does not only have a human price (more patients are dying of drug-resistant tuberculosis versus patients with drug-susceptible TB), but also an economic impact on healthcare. It is estimated that preventing a single case of MDR TB would save the US healthcare system more than \$250,000 and the average estimated hospitalization cost for treating a patient with XDR TB is \$600,000, not including costs of outpatient care and related health interventions.

Role of the laboratory. The diagnosis and management of TB disease rely on accurate laboratory tests both for the benefit of individual patients and for control of TB in the community through public health services. Therefore, laboratory services are an essential component of effective TB control at the local, state, national and global levels.

In the United States, up to 80% of all initial TB-related laboratory work (e.g., acid fast bacilli smear and culture) is performed in hospitals, clinics, and independent laboratories outside the public health system, whereas more than 50% of mycobacterial species identification and drug susceptibility testing is performed in public health laboratories. Thus, effective TB control requires a network of public and private laboratories to optimize laboratory testing and the flow of information. Public health laboratory scientists, as a component of the public health sector with a mandate for TB control, should take a leadership role in developing laboratory networks and in facilitating communication among laboratory scientists, clinicians, and TB Controllers.

Elements. Seven types of tests for the diagnosis of TB disease and detection of drug

Laboratory (cont.)

resistance performed within the tuberculosis laboratory system are recommended for optimal TB control services. These laboratory tests (listed below with their ideal turn-around times) should be available to every clinician involved in TB diagnosis and management and to jurisdictional public health agencies charged with TB control:

- I) Nucleic acid amplification test, detection of TB (1 day);
- II) Nucleic acid amplification test, TB drug resistance markers (1 to 2 days);
- III) AFB microscopy (1 day); IV) Growth detection - average 10-14 days (up to 6-8 weeks);
- V) Identification of *Mycobacterium tuberculosis* complex (1 day* [* after detection of growth]);
- VI) First-line drug susceptibility testing - liquid medium (1 to 2 weeks*);
- VII) Second-line and novel compound drug susceptibility testing – liquid medium (1 to 2 weeks*) or agar/egg-based medium (3 to 4 weeks*).

Take home message. Clinicians, public health officials and laboratory scientists (clinical and public health) must work together to develop an integrated system that ensures optimal selection of assays, timely laboratory testing and seamless flow of information among clinicians, TB Controllers and laboratory scientists.

References. STOP TB USA: A call for action on the tuberculosis elimination plan for the United States. March 2010; CDC: Report of expert consultations on rapid molecular testing to detect drug-resistant tuberculosis in the United States; ATS-CDC-IDSA: Diagnostic Standards and Classification of Tuberculosis in Adults and Children. April 2010 Draft; Association of Public Health Laboratories (APHL): Core TB laboratory services for public health laboratories, December 2009.

Nurse Consultant's Corner

Having completed the TB Nurse Case Management Course in Volusia County last week, it occurred to me that even though we cannot offer the course as often as we would like, or in locations convenient to all, I could use this medium to highlight the objectives of the course, thus bringing a portion of the course to you each issue.

So, until we arrive at a county near you, let's review the *Fundamental Elements of TB Case Management*.

Listed below are the ten fundamental elements:

1. Case Finding
2. Assessment
3. Problem Identification
4. Plan Development
5. Implementation of Treatment Plan
6. Legalities and Nurse Case Management
7. Monitoring/Discharge Planning for TB Cases/Suspects in Corrections
8. Variance Analysis
9. Evaluation including QI
10. Documentation

Nurse Consultant's Corner (cont.)

We will start at the beginning with case finding.

Case finding is the **number one priority** in TB control and is defined as the early identification of the client with TB symptoms to ensure that TB control activities are initiated as soon as possible.

Activities of case finding include the following:

Communicate with healthcare providers. Communication, education, and networking with hospital infection-control practitioners and physicians are important because these activities help ensure early notification of those suspected or diagnosed with TB. The nurse case manager often acts as a resource for nurses and physicians as they identify TB suspects and active cases of TB.

Develop a system to track patients with TB who are hospitalized during outpatient treatment. Their status should be monitored to prevent interruption in services after discharge.

Ensure that all public health reporting regulations have been met and that essential TB control activities are initiated. Essential TB control activities include the TB interview and contact investigation. If the TB case is not reported in a timely manner, there may be missed opportunities for prevention of transmission and treatment of infection and disease.

Ensure that a contact investigation is completed in accordance with state and local policy. Every attempt is made to identify the source case in cases of infectious or potentially infectious TB.

There must be a sense of urgency when very young children (less than 4 years of age) are household or close contacts of an infectious case, because these children are at particular risk of developing TB disease once exposed and infected.

Provide education about TB infection and disease to healthcare providers in the community to increase the awareness of TB, especially in areas of high prevalence. A high level of suspicion on the part of healthcare providers will prevent delayed diagnosis and treatment as well as misdiagnosis.

This is especially important in diagnosing children who do not present with the usual symptoms of TB, such as cough and night sweats.

In the next issue we will discuss assessment as it relates to TB nurse case management.

Debbie Spike

Reference

Tuberculosis Case Management for Nurses Self-Study Modules
New Jersey Medical School National Tuberculosis Center

TB Tidbits

Weekend TB medication

Does it count?

Do we need to provide weekend medication?

Should we allow self-administration on weekends?

Treatment completion is defined by number of doses ingested, as well as the duration of treatment administration. A full course of therapy (completion of treatment) is determined more accurately by the total number of doses taken, not solely by the duration of therapy. For example, the "6-month" daily regimen given 7 days/week should consist of at least 182 doses of INH and RIF, and 56 doses of PZA. Clinical experience suggests that patients being managed by DOT administered 5 days/week have a rate of successful therapy equivalent to those being given drugs 7 days/week. Thus, "daily therapy" may be interpreted to mean DOT given 5 days/week and the required number of doses adjusted accordingly. For example, for the 6-month "daily" regimen given 5 days/week the planned total number of doses is 130. As an option, patients might be given the medications to take without DOT on weekends.

For further information regarding medication regimens refer to TB TAG 6 - *Treatment of Tuberculosis (TB) Disease*, [Treatment of Tuberculosis Disease](#).

Interrupted TB treatment

What is the number of "missed" doses allowed before a TB client has to "start over"?

Interruptions in therapy are common in

the treatment of tuberculosis. When interruptions occur, the person responsible for supervision must decide whether to restart a complete course of treatment or simply to continue as intended originally. Consultation with an expert (the TB Physicians' Network) is recommended to assist in managing treatment interruptions.

This decision depends in part on whether the interruption occurred during the initial or the continuation phase of therapy. In general, the earlier the break in therapy and the longer its duration, the more serious the effect and the greater the need to restart the treatment from the beginning. Continuous treatment is more important in the initial phase of therapy, when there is the highest bacillary population and the chance of developing drug resistance is greatest. During the continuation phase, the number of bacilli is much smaller and the goal of therapy is to kill the persisting organisms. The duration of the interruption and the bacteriological status of the patient before and after the interruption are also important considerations.

Because there is no evidence on which to base detailed recommendations for managing interruptions in treatment, and no recommendations will cover all of the situations that may arise, consultation with your TB Physicians' Network is critical to ensure that completion of treatment is achieved.

Referenced from: CDC MMWR June 20, 2003/Vol. 52/No. RR-11 *Treatment of Tuberculosis*; <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm#top>.

Did you Know?

TO EAT, OR NOT TO EAT?

One of the most commonly asked questions is, "Can this medication be taken with food?" When it comes to medications for TB the answer is nearly always "NO."

Food contains many minerals that can combine with medications to form large complexes that cannot be absorbed into the system. The most common minerals that cause problems are iron, magnesium, calcium, and zinc.

The TB drugs that are most effected are isoniaizid (INH), ethambutol (EMB), rifampin (RIF), and the quinolones such as ciprofloxacin, ofloxacin, levofloxacin and moxifloxacin. Rifampin taken with food can decrease its absorption by 30%.

All of these drugs should be taken either 2 hours before or after food. Remember that dairy products and juices fortified with calcium as well as nutritional supplements such as Ensure and Boost should also be avoided.

When patients are on tube feedings, the feedings should be stopped from 2 hours before to 2 hours after the medications are administered.

Multivitamin preparations and antacids should also be avoided within 2 hours of these TB medications.

Rifabutin, rifapentine, cycloserine , PAS and ethionamide can be taken without regard to meals.

Having said all that, patients often tolerate TB medications better if their stomach is not entirely empty. An "empty stomach" 2 hours after a meal is not the same as after an overnight fast. If the patient is having GI distress after taking TB medications, ask if they have eaten that day, A breakfast or lunch 2 hours before the medication may make them better tolerated. If the patient is still having GI problems, you can try giving metoclopramide (Reglan) 30 minutes before the medications. In more severe cases, a low dose of lorazepam (0.5 – 1 mg) given 30 minutes before the TB medications can be helpful.

Jerry Stambaugh, PharmD
Director of Pharmacy
A.G. Holley TB Hospital

Education & Training

Can a provider incorporate their client's cultural norms and behaviors to increase the length of treatment for Latent Tuberculosis Infection?

A study published in 2010 in *Public Health Nursing* by Rita Ailinger, Ph.D.; Diona Martyn, M.S.N.; Howard Lasus, Ph.D.; and Natalie Lima Garcia, B.S.N.; documents the effectiveness of a cultural intervention on adherence to latent tuberculosis infection (LTBI) therapy.

In addition to standard LTBI care, the study placed a group of 53 Latino immigrant LTBI clients into a cultural intervention. Dr. Ailinger, an anthropologist and a public health nurse, designed the cultural intervention. She and another nurse who trained in the intervention were the only interventionists to provide the LTBI services and the cultural intervention throughout the study.

The cultural intervention consisted of five core components. First, each client was provided their LTBI services from the same nurse for every visit to the clinic. This standard is aligned with the Latino value of *personalismo*, or personal attention. It respects the establishment of rapport and an enduring relationship with the client.

Second, before starting care at each monthly visit, the nurse would seek information regarding the welfare of the client's family members. They were able to do this because of information they gathered during the client's first clinical visit. Then, the nurse recorded the information into the medical chart to serve as a reminder of specific names and roles in the family structure. This part was based on the Latino value *familism*, or family ties.

Third, at every clinic visit, a common Latino proverb was stated: "*Es mejor prevenir que lamentar*," or "It is better to prevent than to lament." They also printed this proverb on stickers and a keyring

flashlight that were distributed to the clients as gifts.

Fourth, educational materials were written at a sixth-grade level and included pictures of Latino families. These materials also included the proverb, "*Es mejor prevenir que lamentar*."

Fifth, both nurses were fluent in Spanish. Also, culturally appropriate nonverbal communication was utilized, such as touching the arm of Latino women or the back of the shoulder of men. This was done at the end of each clinic visit.

In the end, the cultural intervention proved effective. Adherence to LTBI therapy was measured by the number of pills reported by the clients (which also represents one of the study's limitations). The investigators compared these data to a comparison group of randomly selected medical records of Latino immigrants who had been treated for LTBI the previous year at the same clinic. The intervention group took a greater number of pills, and the difference was statistically significant.

Clay Weiss

Health Educator, BTBRH

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Reference Cited:

Ailinger, R., Martyn, D., Lasus, H., & Garcia, N. (2010). The effect of a cultural intervention on adherence to latent tuberculosis infection therapy in Latino immigrants. *Public Health Nursing, 27*(2), 115-120.

Comings & Goings

Welcome

Vicki Carswell, RN and **Tara Gunter, RN** - Hillsborough County

Kena Foster, RN - Putnam County

Kristen Jackson, RN - Gilchrist County

Stacy Hendrix, RN - Bradford County

Sandra Crawford, RN - Union County

Rhoda Pate, RN - Lafayette County

Yulett Christie, RN - Marion County

Jenevieve Ferreira, MA - Flagler County

Melanie Key, ARNP - Madison County

Farewell

Barbara Cunningham, RN - Hillsborough County

Guy Carosa, RN - formerly with Hillsborough County, is now an RN Consultant within the Office of Public Health Nursing

Sherrie Arnwine-McGowan, RN - formerly with Hillsborough, is now an RN Consultant with the Office of Health Services in the Department of Juvenile Justice

Happy Retirement to **Carole Foxworth!** Carole will retire on July 30th after 27 years of service with Florida Department of Health. Twelve of those years were in the TB program. Carole, thank you for your service. You will be greatly missed. Good luck and Best Wishes!

We also want to wish a Happy Retirement to **Mary Beth Downs** who will retire on July 30th after 29 years with the Gadsden County Health Department. Your service and dedication to your work has been greatly appreciated. Your clients and co-workers will miss you!

SCRAPBOOK

Nurse Case Management Course in Volusia County May 2010

Special note of appreciation to Dr. Sorensen, Volusia CHD Director and her wonderful staff: Solinka Murillo-McIntosh, Lynda Lignelle, Nira Durden, Michael Warshawsky, Bonita Stevenson for their outstanding hospitality during the nurse case management training.



Dr. Bonita Sorenson welcoming the participants.



Sevim Ahmedov, Dr. Sorenson & Lynda Lignelle



Susan and Jen from Flagler CHD



Lynda Lignelle, Sevim Ahmedov, Diana Picolo and Debbie Spike



Group activities...



Dr. Michael Lauzardo and TB 101

Refugee Health

The Central Florida Refugee Task Force (approx 20 multi-agency org) is planning a World Refugee Day event for June 19th at the Fashion Square mall in Orlando. The event will include: testimonials, student art contest, musicians, folk dancers, children's activity area, recognition/awards for outstanding refugees.

Carol Jonda, RN, BSN
Seminole CHD

**Florida Department of Health
Bureau of TB & Refugee Health**

www.doh.state.fl.us/Disease_ctrl/tb/

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DOH's Mission

**'Promote, Protect, & Improve
the health of all people in
Florida.'**

**TB Physician's Network
1-800-4TB-INFO**

VISION: The Bureau of Tuberculosis and Refugee Health will be a model TB Control and elimination and refugee screening program for the nation.

MISSION: The mission of the Bureau of Tuberculosis and Refugee Health is to eliminate tuberculosis as a public health threat in Florida; and to provide culturally sensitive health services for refugees to enhance personal health status and protect Florida's public health.