



Interprofessional Collaboration in TB Care

Jason Jones

Director, KDHE Bureau of Disease Control & Prevention

Topeka, KS

Accreditation Statement



Accreditation Statement

In support of improving patient care, Mayo Clinic College of Medicine and Science is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team.

Credit Statement(s):

AMA

Mayo Clinic College of Medicine and Science designates this live activity for a maximum of 18.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.



ACPE

Mayo Clinic College of Medicine and Science designates this educational activity for a maximum of 18.25 ACPE Knowledge-based contact hours. Participants should claim only the credit commensurate with the extent of their participation in the activity.

UAN Number: UAN JA0000238-0000-26-089-L99-P.

ANCC

Mayo Clinic College of Medicine and Science designates this activity for a maximum of 18.25 ANCC contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.



IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive 18.25 Interprofessional Continuing Education (IPCE) credit for learning and change.

Other Healthcare Professionals:

A record of attendance will be provided to all registrants for requesting credits in accordance with state nursing boards, specialty societies or other professional associations.

For disclosure information regarding Mayo Clinic School of Continuous Professional Development accreditation review committee member(s) and staff, please go here to the course accreditation page.

Available Credit

- 18.25 ACPE,
- 18.25 *AMA PRA Category 1 Credit™*
- 18.25 ANCC
- 18.25 Attendance
- 18.25 IPCE

Disclosure:

No relevant financial disclosures to report and no mention of off-label use of any medications or products.

Learning Objectives

1. Recognize the silos

Identify clinical, public-health, and programmatic silos that were stressed.

2. Analyze a real outbreak

Examine how collaboration contained the Kansas City Metro TB outbreak (2024–2025).

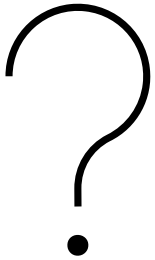
3. Apply national best practices

Use guidance from CDC, the National TB Coalition and Mayo Clinic Center for Tuberculosis.

4. Leave with team actions

Identify concrete steps to strengthen collaboration in your own setting.

Polling Question



When a hospital diagnoses infectious pulmonary TB, who remains accountable for completing the contact investigation?

- A. The clinical team caring for the individual patient
- B. The jurisdictional TB program / health department
- C. Hospital infection prevention, because the exposure was identified on site
- D. CDC DTBE, once genotyping confirms a cluster

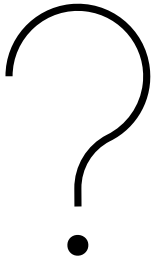
The Three Silos; KC Outbreak

- **Clinical**
 - Individual diagnosis and treatment, side-effect management, hospital/clinic focus
- **Public health**
 - Surveillance, contact investigation, outbreak response, DOT/vDOT, free treatment access
- **Programmatic**
 - Funding, staffing, data systems, interjurisdictional coordination, policy

Why Silos Matter

- **Fragmentation creates predictable failures across the TB continuum.**
- Delayed diagnosis — reporting lags; public health lacks clinical context.
- Incomplete contact tracing — missing information between clinic and health department.
- Treatment non-adherence — DOT and clinical monitoring are not coordinated.
- Eroded trust — stigma and mixed messages undermine community engagement.
- Secondary transmission and resource waste follow.

Polling Question



Which problem is most characteristic of unbridged silos in TB care?

- A. Therapy is started in the hospital before the health department interviews the patient
- B. Contact names and exposure windows not reaching the health department after discharge
- C. Requesting a TB Center of Excellence consult on a complex case
- D. Offering video DOT instead of in-person DOT for a stable patient

Case Study: Kansas City Metro TB Outbreak

- One of the largest U.S. TB outbreaks in recent decades
- **68 active TB cases**
- **103 latent infections treated preventively**
- **650+ people evaluated or monitored**
- 2 associated deaths • no drug-resistant strains identified
- Detected early 2024 in Wyandotte and Johnson counties
- Last new active case April 2025. Declared over Nov. 14, 2025
- Partners: KDHE, CDC, University of Kansas Medical Center, local health departments.

Collaboration in Action — and Under Strain

• **What worked**

- KDHE, CDC, KU Medical Center and local health departments aligned
- Widespread free testing and contact investigation
- Directly observed therapy supporting adherence
- Education campaigns to reduce stigma
- Community engagement increased trust and participation

• **Challenges encountered**

- Local systems still strained after COVID-era demands
- Coordination friction among local, state and federal partners
- KDHE at points assumed greater operational control
- Rapid, culturally responsive trust-building was required
- Data systems and surge staffing needed fast adaptation

National Best Practices — Three Key Sources

- **CDC**
 - Public-health responsibility, contact investigation guidelines, video DOT, TB Centers of Excellence
- **National TB Coalition of America**
 - Nurse, clinician and epidemiology sections; LTBI guide; interjurisdictional forms; outbreak lessons
- **Mayo Clinic Center for Tuberculosis**
 - Multidisciplinary consultation; CDC-designated COE serving Kansas; education that models team-based care.

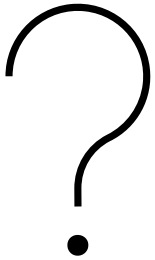
Cross-Cutting Principles

- **Clear role definition and shared goals**
 - Everyone knows their scope and the outcome they are protecting.
- **Reliable communication channels**
 - Standing case conferences, shared dashboards, designated liaisons
- **Patient and community centered care**
 - Address stigma, social determinants, and adherence barriers together.
- **Continuous evaluation and joint training**
 - Train clinicians and public-health staff side by side.

Actionable Framework: Bridging the Silos

1. Map the local team — who owns diagnosis, contacts, DOT, data, outreach and funding?
2. Establish communication routines — operation syncs, dashboards and shared products, liaisons vs “the program.”
3. Standardize handoffs — interjurisdictional forms and joint LTBI vs. disease protocols.
4. Invest in joint training and community partners.
5. Measure across silos — completion, investigation completeness, time to treatment, trust.
6. Pre-plan surge capacity — a direct lesson from Kansas City.

Polling Question



Which action best prepares a jurisdiction before the next outbreak?

- A. Stand up a dedicated outbreak clinic as soon as the first epi-linked case is confirmed
- B. Pre-assign surge roles, communication routines, and triggers before the next cluster appears
- C. Move all TB treatment from local health departments to hospital-based specialists
- D. Write a protocol in advance that CDC on-site help will be requested only after genotyping confirms a large cluster

Key Takeaways

- **Silos are real — and costly.**
 - They delay diagnosis, weaken contact tracing and erode trust.
- **The KC Metro outbreak proved collaboration works.**
 - Aligned partners contained one of the largest recent U.S. outbreaks despite real friction.
- **Best practices already exist.**
 - CDC, NTCA and Mayo Clinic Center for Tuberculosis provide ready frameworks.
- **Make bridging routine, not crisis-driven.**
 - Map teams, standardize handoffs, train together, measure across silos and pre-plan surge capacity.

Questions and Answers





Thank you