Enforcement and Removal Operations
ICE Health Service Corps
U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536

U.S. Immigration and Customs Enforcement

May 16, 2018

Memorandum To: Community Healthcare Partners

From: Edith Lederman, MD, MPH, FACP, FIDSA
National Infectious Disease Consultant ICE Health Service Corps

Subject: Identification and Treatment of Pulmonary Tuberculosis

As the Infectious Disease Consultant for U.S. Immigration and Customs Enforcement (ICE), ICE Health Service Corps (IHSC), I am writing to inform you about the burden of pulmonary tuberculosis disease (PTB) that exists among individuals held in ICE custody and our approach to PTB management. **ICE relies on you as our community healthcare partners to ensure an optimal continuum of medical care for our patients**.

Since all individuals held in ICE custody are foreign born, PTB incidence is much higher than the general U.S. population. Surveillance conducted from January 2014-February 2015 determined the PTB incidence case rate to be 96/100,000 among persons detained in IHSC facilities.[1] This is in stark contrast to U.S. case rate of approximately 3/100,000 persons.[2] Furthermore, approximately 75% of our PTB cases were in asymptomatic individuals; over 50% of those with smear-positive disease were asymptomatic as well.

In accordance with Centers for Disease Control and Prevention tuberculosis (TB) guidance for correctional and detention facilities,[3] IHSC utilizes chest radiographs as the primary screening method for PTB. This is to ensure rapid identification of possible PTB, leading to timely isolation and further evaluation and management, including empiric treatment. Performing chest radiographs for individuals entering custody results in the identification of findings that can be consistent with early, asymptomatic PTB. These subtle, seemingly benign and/or "chronic" radiographic findings may be discounted by medical providers practicing in the general U.S. healthcare setting who do not frequently encounter PTB.

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[1] Boardman et al. Chest radiograph screening for pulmonary tuberculosis disease among US Immigration and Customs Enforcement detainees: early detection, rapid intervention. IDWeek 2016, October, New Orleans, abstract #68
[2] https://www.cdc.gov/tb/publications/factsheets/statistics/tbtrends.htm
[3] https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm

Most IHSC facilities have some capacity to house and manage patients with suspected PTB; however, when our respiratory isolation rooms are at full capacity, we rely on community-based healthcare systems to conduct the initial management of these patients.

We cannot place a patient suspected of having PTB in congregate housing ("general population") until:

1) Three (3) consecutive sputum smears are confirmed to be acid-fast bacillus (AFB) negative on initial evaluation; *and*
2) The patient has taken at least five (5) consecutive days of standard four-drug therapy.

Individuals with AFB smear positive PTB cannot be placed in congregate housing until:

1) Three (3) consecutive smears are AFB-negative; *and*
2) The patient has been on a minimum of 14 consecutive days of standard four-drug therapy (***See enclosed check list***).

IHSC appreciates your help with isolation of patients with suspected PTB, initiation of the evaluation and treatment, and consideration of the congregate setting to which these high-risk patients will return. Despite the absence of respiratory or constitutional symptoms, a negative tuberculin skin test or interferon gamma release assay result, and sputum specimens or bronchoscopy washings that are AFB smear-negative and nucleic acid amplification test (NAAT) negative, chest radiograph findings consistent with PTB that cannot be otherwise explained should be considered PTB and treated accordingly until proven otherwise. When a hospital admission is sought for such an evaluation, since it is at the request of IHSC, **the receiving hospital will receive remuneration at the prevailing Medicare rate.**

Thank you for your kind consideration of our need to ensure the safety of all persons in congregate housing and your continued partnership in controlling the spread of tuberculosis. We appreciate that the care of these patients is not always a simple matter and therefore have partnered with the TB Centers of Excellence (CoEs) in our efforts to promote optimal care. We encourage consultation and collaboration with your referring correctional facility and your local health department first but please know that you can contact us at any time to discuss a patient under your care.

For ICE specific questions, please contact:

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For TB programmatic and public health queries specific to your state/jurisdiction, please reference the National Tuberculosis Controllers Association's website listing of key contacts by state, big city, and US territory at the following website:
https://tinyurl.com/US-TBprograms

For TB medical management queries, please reference the TB Center of Excellence which corresponds to your geographic area:

TB Centers of Excellence, 2018-2022:

West:	Curry International Tuberculosis Center, http://www.currytbcenter.ucsf.edu/
Central:	Heartland National Tuberculosis Center, http://www.heartlandntbc.org/
Northeast:	The Global Tuberculosis Institute, https://njms-web.njms.rutgers.edu/gtbi/
Southeast:	Southeastern National Tuberculosis Center, http://sntc.medicine.ufl.edu/