

Tuberculosis in Colorado 2019

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COLORADO
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colorado.gov/cdphe/tb

Summary

In Colorado, 66 people were diagnosed with tuberculosis (TB) disease in 2019, an increase of 3% from the 64 reported in 2018 (Figure 1 and Table 1). The Colorado case rate remained steady at 1.1 per 100,000 people (the lowest rate on record) from 2018. The U.S. case rate was 2.7 per 100,000 people according to the [March 2020 TB report](#) from the Centers for Disease Control and Prevention (CDC), (Figure 2). Although the number of new TB patients in Colorado has fluctuated over the past 10 years, incidence of TB disease has declined approximately 54% from 2001, when 138 cases were found, the highest annual incidence in the past 25 years.

Fifteen (23%) of the state's 64 counties reported at least one person with TB disease in 2019. There were 19 new patients reported in Denver County, the most of any single Colorado county, followed by Arapahoe County with 18 and Adams County with nine (both the latter counties falling into Tri-County Public Health's jurisdiction). Eighty-three percent of all TB patients were reported in the Denver metro area (defined as Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson counties). Over half (55%) of Colorado's counties (35 of 64) have reported at least one new TB patient in the past 10 years (2010-2019) (Table 1).

In 2019, TB disease burden in Colorado remained highest among racial and ethnic minorities (Figure 4), which is consistent with national epidemiologic trends. Though comprising only 31% of the state's population, 88% of new TB patients identified as racial and ethnic minorities. The largest change among demographic groups was in the Black/African American population (13 patients in 2019, up from four in 2018). Having a diabetes diagnosis is the strongest medical risk factor for developing TB disease (12% of all patients in 2019). In addition, birth in one of the [30 countries with highest TB burden](#), as defined by the World Health Organization, remains a strong non-medical risk factor, comprising 38% of all patients in 2019 (Table 2 and Figure 11).

In 2019, TB disease was reported among people ranging in age from under-1 to 90 years, with an average age of 46 years (Figure 7). There was an equal number of cases reported in the 25-44, 45-64, and the 65 and older age groups with 17 cases (26%) each. There was an increase in cases diagnosed in the under-15-year age group (six patients in 2019, up from zero in 2018). TB disease in children is particularly concerning because it indicates ongoing transmission in the community as well as evidence of missed opportunities for prevention. Fifty-eight percent of new TB patients were female, and 42% were male (Figure 8).

Drug susceptibility testing is recommended for all culture-positive TB patients in the U.S. In 2019, 45 patients were culture-positive for TB and all 45 had drug susceptibility results. Nine (20%) of the 45 patients were resistant to one or more first-line TB drugs (isoniazid-INH, rifampin-RIF, pyrazinamide-PZA, ethambutol-EMB). There was no multi-drug resistant (MDR) TB (defined as being resistant to at least INH and RIF), or extensively drug resistant (XDR) TB (defined as being resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of three injectable second-line drugs [i.e., amikacin, kanamycin, or capreomycin]) identified in 2019 (Figure 13).

TB drug treatment is lengthy, so completion rates are pending for 2019. Of the 64 TB patients reported in 2018, the most recent year where final completion data are available, 63 initiated treatment (one patient was dead at diagnosis). Sixty one (97%) completed treatment; one moved out of the U.S. (completion data not available), and one died during treatment (Figure 15 and Figure 16). All new patients reported in 2019 initiated treatment.

Except for 2017, TB disease incidence remained steady over the past five years in Colorado. Colorado's TB elimination plan guides and informs programming to support people and populations at increased risk for developing TB disease as well as the providers who care for them. A key goal of the plan is to encourage people at risk to "know their TB status" while increasing public and private provider capacity to screen, test, and treat for TB infection. Untreated or incomplete TB infection treatment is the main driver of TB disease in Colorado.

The key path to TB elimination in Colorado will be to identify and treat people with TB infection who are at elevated risk of developing TB disease. Timely evaluation of people identified as contacts to an infectious TB patient and those who arrive in Colorado with a Class B TB designation (defined as being known to be non-infectious but in need of additional TB evaluation) will drive the identification and treatment of additional patients with TB disease and TB infection. The Colorado Department of Public Health and Environment acknowledges that generations-long social, economic, and environmental inequities have resulted in adverse health outcomes including TB infection and disease among racial and ethnic minorities and others experiencing deficits in key social determinants of health. These inequities affect communities differently and have a greater influence on health outcomes than either individual choices or a person's ability to access health care. Reducing the health disparities that can lead to TB infection and TB disease through policies, practices and organizational systems can help improve opportunities and health outcomes for all Coloradans. The TB elimination plan is available on the TB Program website <https://www.colorado.gov/pacific/cdphe/tb>.

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On the cover: A digitally colorized scanning electron microscopic image of a group of *Mycobacterium tuberculosis* bacteria, which cause tuberculosis (TB) in human beings. Photo from the Centers for Disease Control and Prevention.

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TB Cases and Rates

In 2019, 66 people were diagnosed and reported with tuberculosis disease (TB) in Colorado, an increase of 3% from 2018. Although the number of patients has declined between 2007 and 2019, the decline has leveled off since 2012. Further progress towards the CDC TB elimination goal of 1 case per million (~5-6 cases per year) in Colorado will require continued vigilance of the current public health TB control model in addition to investment in new interventions and expansion to and collaboration with private health care partners who serve at-risk patients. Overall, the number of patients and corresponding case rates are trending down in Colorado as the linear trend lines in Figures 1 and 2 illustrate.

Figure 1. Number of TB patients and trend line: Colorado 2000-2019

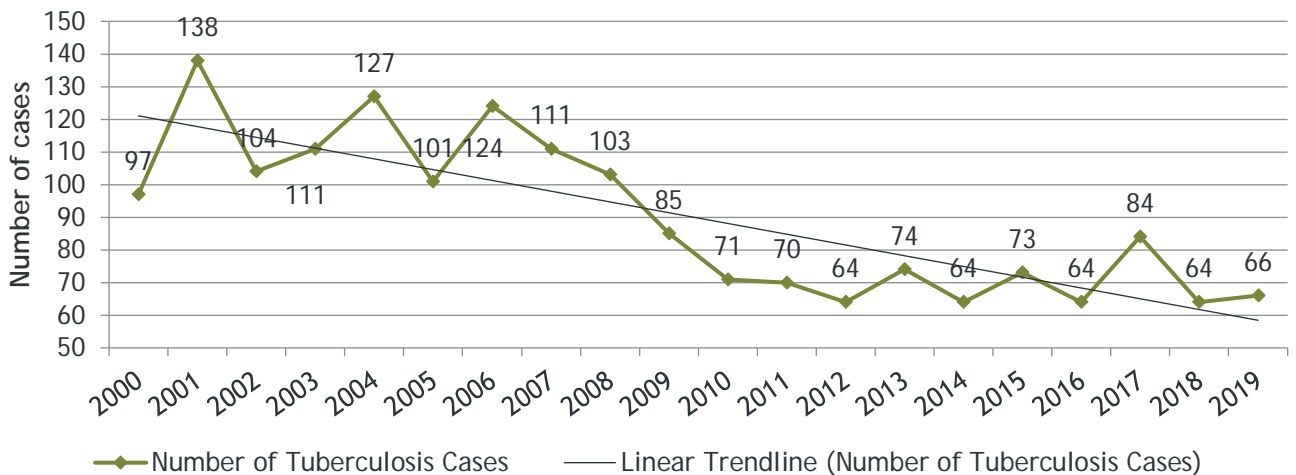
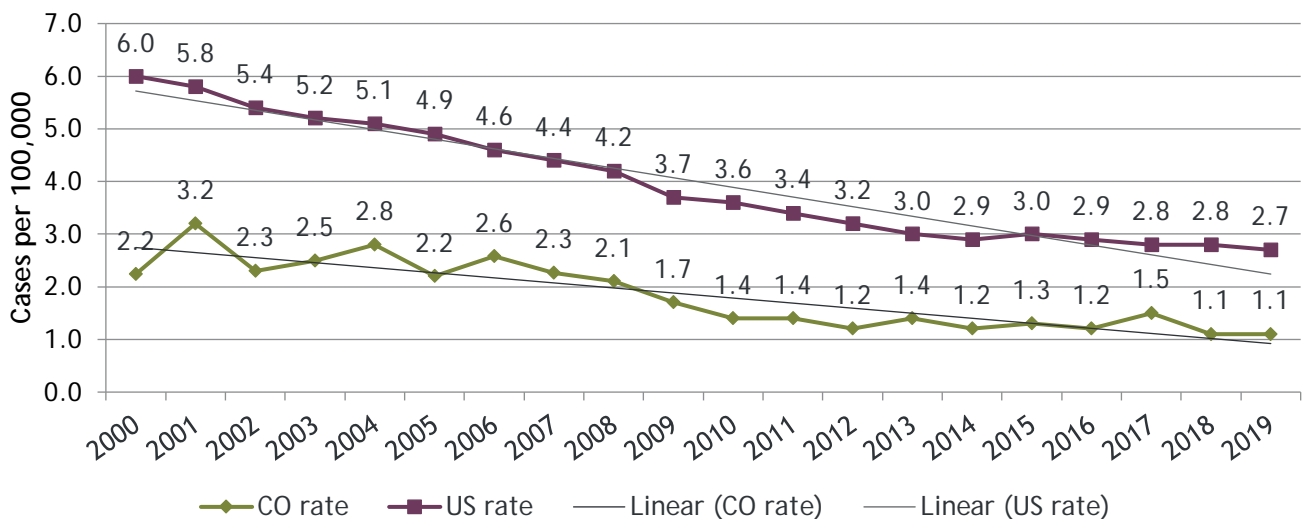


Figure 2. TB case rates per 100,000 people in the U.S. and Colorado 2000-2019



TB by County and Demographic Characteristics

Fifteen of Colorado’s 64 counties reported at least one new person with TB disease in 2019. Denver County reported 19; followed by Arapahoe (18), Adams (9), and Jefferson and El Paso counties (four each) (Figure 3). Thirty-five of Colorado’s 64 counties have reported at least one new TB patient in the past ten years (Table 1). Table 2 offers a comparison between the demographics of 2017 and 2018 TB patients.

Figure 3. Tuberculosis disease patients by county: Colorado 2019

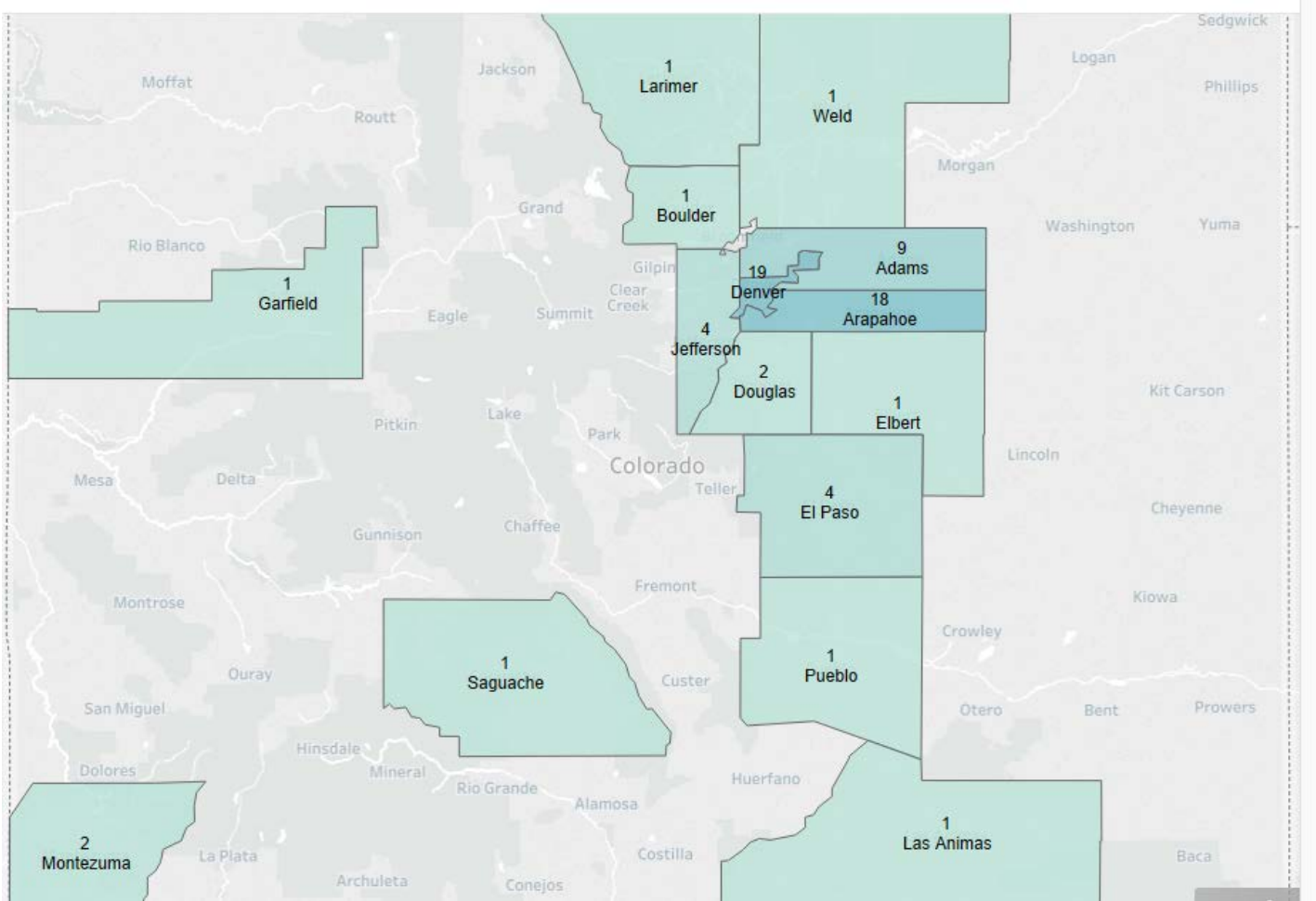


Table 1. TB in Colorado: Cases by County and Year of Report 2010-2019

County ^a	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 ^b	5-Year Case Rate 2015-2019 ^{cd}
Adams	7	12	7	7	7	7	4	6	12	9	1.5
Arapahoe	17	5	11	14	14	14	18	19	10	18	2.4
Archuleta	0	0	0	1	0	0	0	0	0	0	n/a
Baca	0	0	0	1	0	0	0	0	0	0	n/a
Boulder	0	5	9	6	3	5	0	5	5	1	1.0
Broomfield	1	0	0	1	0	1	0	0	0	0	0.3
Denver	23	21	10	21	23	17	22	25	14	19	2.8
Douglas	1	2	1	2	1	8	1	0	3	2	0.8
Eagle	0	0	1	0	1	1	0	0	0	0	0.4
Elbert	0	0	0	0	0	0	0	0	0	1	0.8
El Paso	8	7	5	8	1	3	3	10	5	4	0.7
Fremont	1	0	0	0	0	0	0	1	1	0	0.8
Garfield	0	0	0	0	1	2	2	1	0	1	2.0
Huerfano	1	0	0	0	0	0	0	0	0	0	n/a
Jefferson	0	8	3	2	4	3	3	3	2	4	0.5
Kit Carson	1	0	0	0	0	0	0	0	0	0	n/a
La Plata	0	0	1	0	0	0	0	0	1	0	0.4
Larimer	5	2	4	3	1	2	4	1	1	1	0.5
Las Animas	0	0	0	0	0	0	0	0	0	1	1.4
Logan	0	0	0	0	1	0	1	0	0	0	0.9
Mesa	0	1	1	2	0	1	1	0	4	0	0.8
Montezuma	0	0	0	0	0	0	0	0	0	2	1.5
Montrose	0	0	0	0	0	1	0	0	0	0	0.5
Morgan	0	2	1	0	1	0	1	2	0	0	2.1
Park	0	0	0	0	0	0	0	1	0	0	1.1
Pitkin	0	0	0	0	1	1	0	1	0	0	2.2
Prowers	0	0	0	2	0	0	0	0	0	0	n/a
Pueblo	2	1	1	2	2	3	2	3	2	1	1.3
Rio Grande	1	0	0	0	0	0	0	0	0	0	n/a
Saguache	0	0	0	1	0	2	0	0	0	1	9.2
San Miguel	0	0	0	0	0	0	1	0	0	0	2.5
Summit	1	0	1	0	0	0	0	1	1	0	1.3
Teller	0	0	1	0	0	1	0	0	0	0	0.8
Weld	2	4	7	0	3	1	1	4	3	1	0.7
Yuma	0	0	0	1	0	0	0	1	0	0	2.0
TOTAL	71	70	64	74	64	73	64	84	64	66	1.2

^aOnly counties reporting an active case of TB (2010-2019) are included.

^b Highlighted counties reported at least one case of active TB in 2019.

^cTB cases per 100,000 persons

^d Population data for determining the case rates throughout this report are from the Colorado Division of Local Government, State Demography Office.



Table 2. Demographic Comparison of 2018 and 2019 Active TB Cases

	2018		2019	
	n	%	n	%
Age Group (years)				
<15	0	0	6	9.0
15-24	5	7.8	9	13.6
25-44	23	35.9	17	25.8
45-64	19	29.7	17	25.8
65+	17	26.6	17	25.8
TOTAL	64	100	66	100
Gender				
Male	28	43.8	28	42.4
Female	36	56.3	38	57.6
TOTAL	64	100	66	100
Race/Ethnicity				
White	7	10.9	8	12.1
Black or African American	4	6.3	13	19.7
Hispanic	22	34.4	19	28.8
American Indian or Alaska Native	1	1.6	1	1.5
Asian	30	46.9	24	36.4
Native Hawaiian or Other Pacific Islander	0	0	1	1.5
Multiple race/Unknown	0	0	0	0
TOTAL	64	100	66	100
Region				
Denver-metro ^a	46	71.9	53	80.3
Outside Denver-metro	18	28.1	13	19.7
TOTAL	64	100	66	100
HIV Status				
HIV Negative	62	96.9	61	92.4
HIV Positive	0	0	3	4.6
Testing done, results unknown	0	0	0	0
Refused testing	0	0	0	0
Not offered	2	3.1	2	3.0
TOTAL	64	100	66	100
Risk factors^b				
Birth in one of the 30 highest TB-burden countries ^c	24	37.5	25	37.9
Homeless within past year	4	6.3	1	1.5
Diabetes	8	12.5	8	12.1
Resident of correctional facility at diagnosis	2	3.1	1	1.5
Resident of long-term care facility	0	0	1	1.5
Injected drug use within past year	0	0	0	0
Non-injected drug use within past year	1	1.6	1	1.5
Excess alcohol use within past year	6	9.4	2	3.0
Health care worker within past year	0	0	0	0

Note: percentages may not equal 100 due to rounding.

a. Denver metro includes: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson counties.

b. A case may have more than one risk factor indicated.

c. According to the World Health Organization's definition of 30 highest-burden countries http://www.who.int/tb/publications/global_report/en/ Annex 2. Country profiles

TB by Race/Ethnicity

The number of people reported with TB in Colorado for the last decade has been highest among racial and ethnic minorities. Though comprising only 34% of the state's population, 88% of new TB disease occurred in racial and ethnic minority populations (Figure 4). At 3.0 cases per 100,000 people in Colorado, the case rate in racial and ethnic minorities is 15 times that of the majority white population (Figure 5).

Figure 4. TB patients by race/ethnicity: Colorado 2019

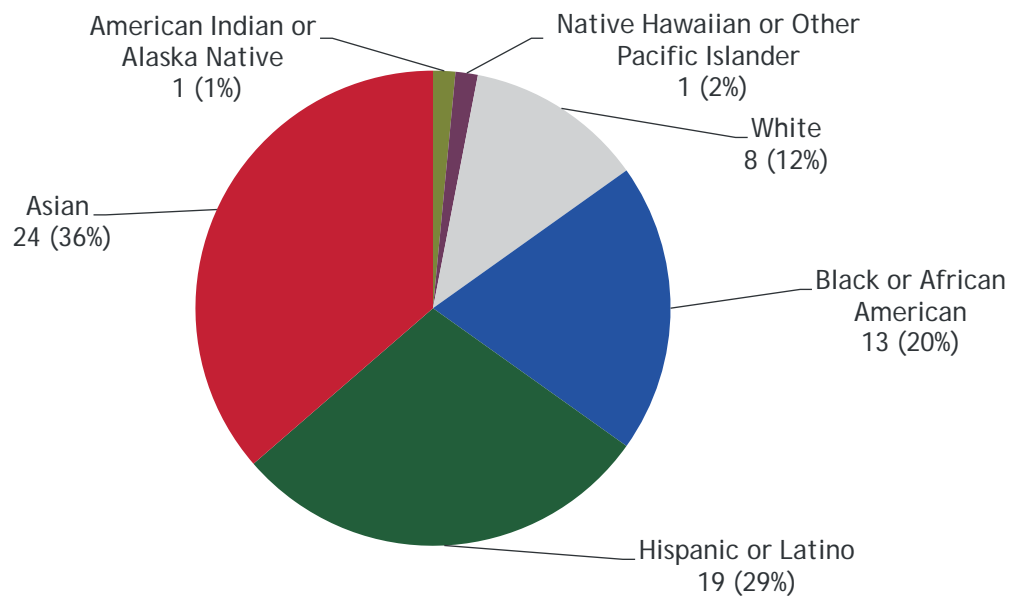
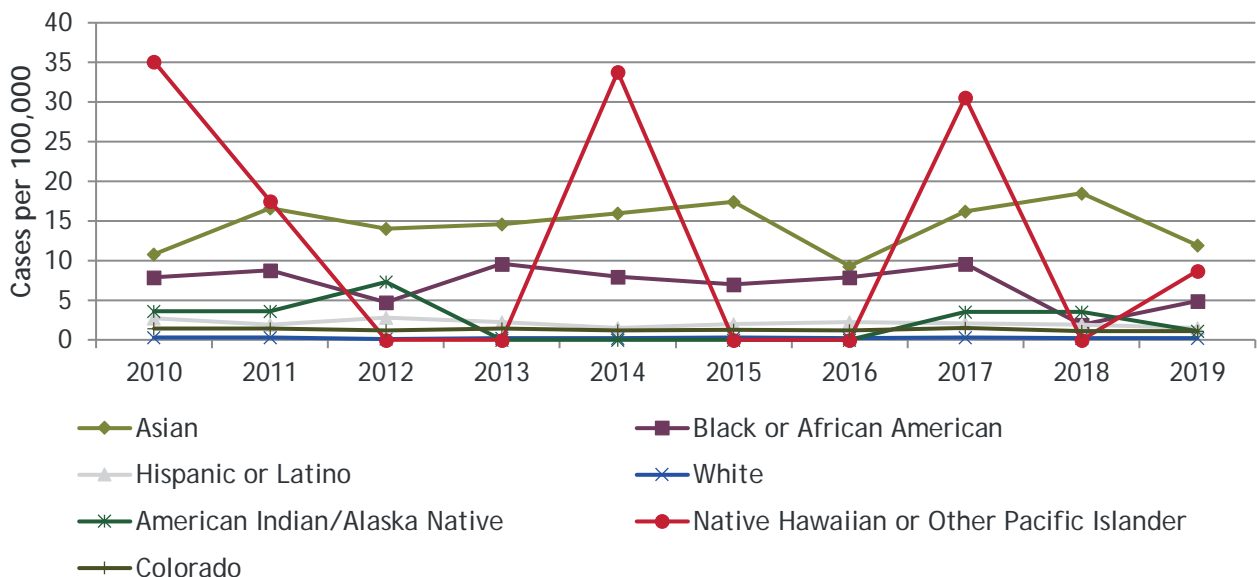


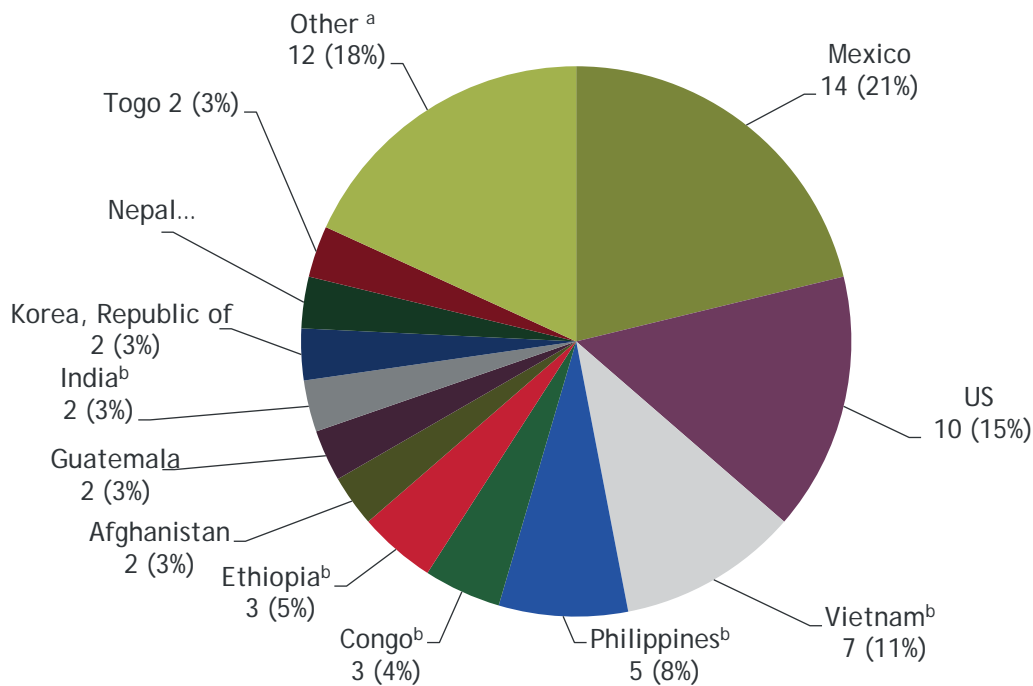
Figure 5. TB case rates by race/ethnicity: Colorado 2010-2019



TB by Country of Birth

TB disease was diagnosed in people originating from 24 different countries in 2019. The largest cohort came from Mexico with 14 people followed by the United States with 10. Of people born outside of the United States, 24 (36% of all patients) came from one of the [top 30 highest-burdened countries](#), which comprise 85-89% of all global TB disease according to the World Health Organization (WHO) (Figure 6).

Figure 6. TB patients by country of birth: Colorado 2019



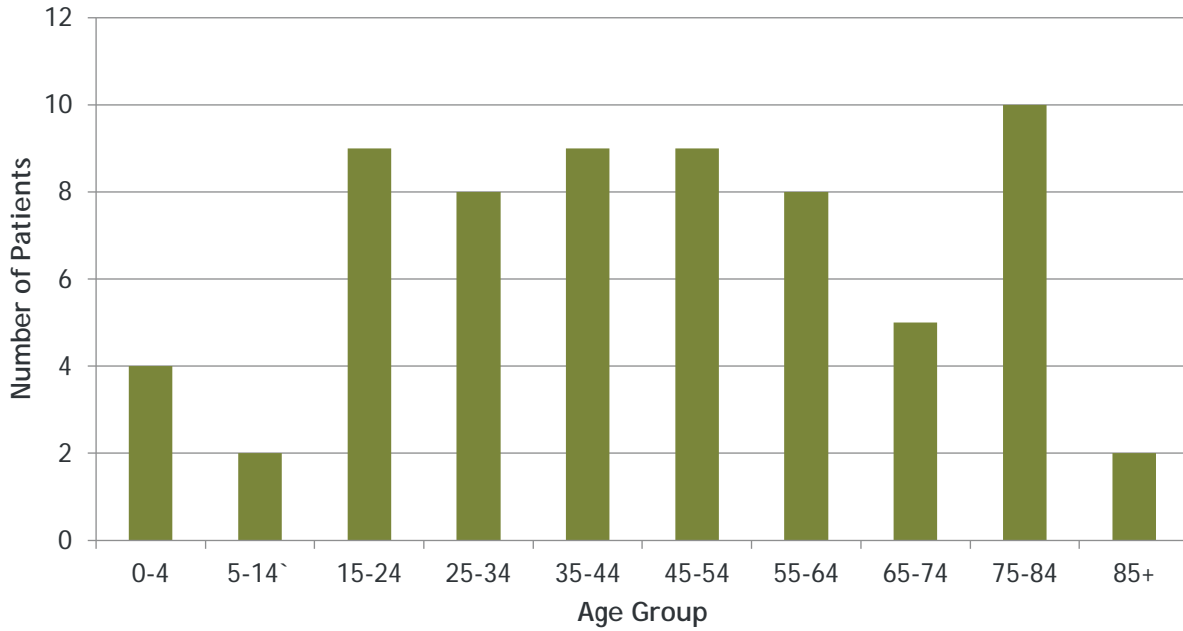
^aOther countries: Bhutan-1, China^b-1, Ecuador-1, France-1, Indonesia^b-1, Myanmar^b-1, North Korea^b-1, Pakistan^b-1, Somalia-1, Sudan-1, Ukraine-1, Venezuela-1

^bDenotes one of the 30 highest TB burdened countries according to the World Health Organization (http://www.who.int/tb/publications/global_report/en/Annex 2. Country profiles)

Tuberculosis by Age Group

In 2019, TB was reported among people ranging in age from newborn to 90 years. Twenty-six percent of TB occurred in three different age categories: among people 25-44 years old, 45-64 years old, and in those 65+ years. There were 6 children defined as <15 years of age (9%) diagnosed with TB disease in 2019. This is concerning because TB in children is an indication of recent transmission and missed opportunities for TB prevention (Figure 7).

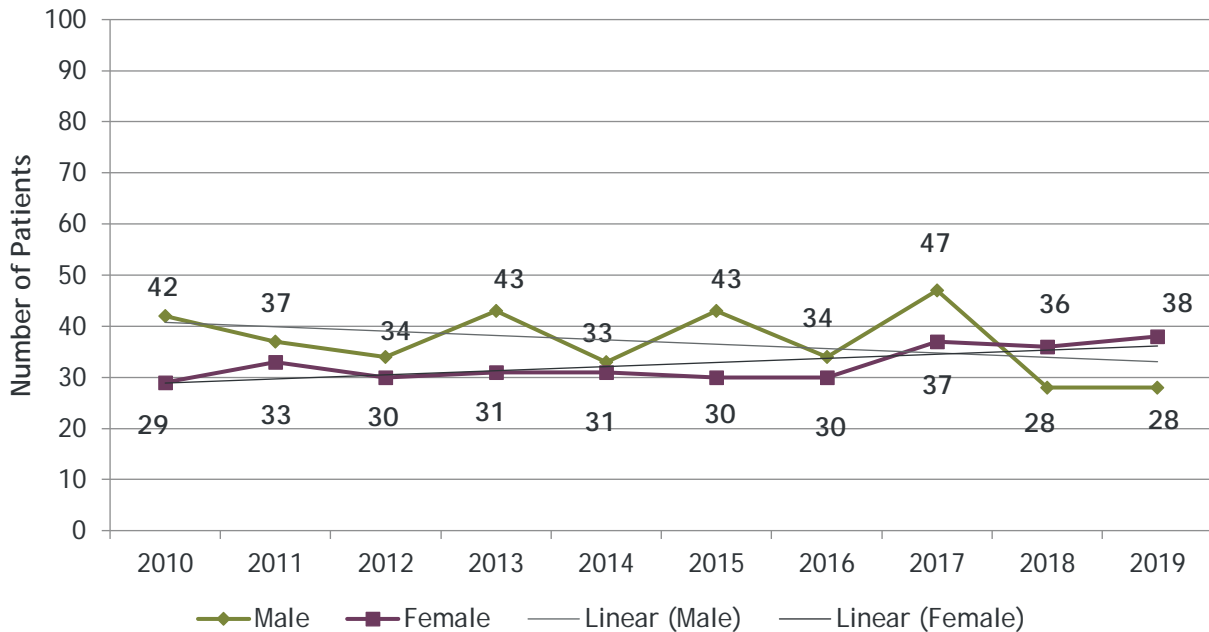
Figure 7. TB patients by age group: Colorado 2019



Tuberculosis by Gender

In most years, TB disease is diagnosed in males in greater numbers than females in Colorado; however, in 2019 58% of TB patients were females (Figure 8).

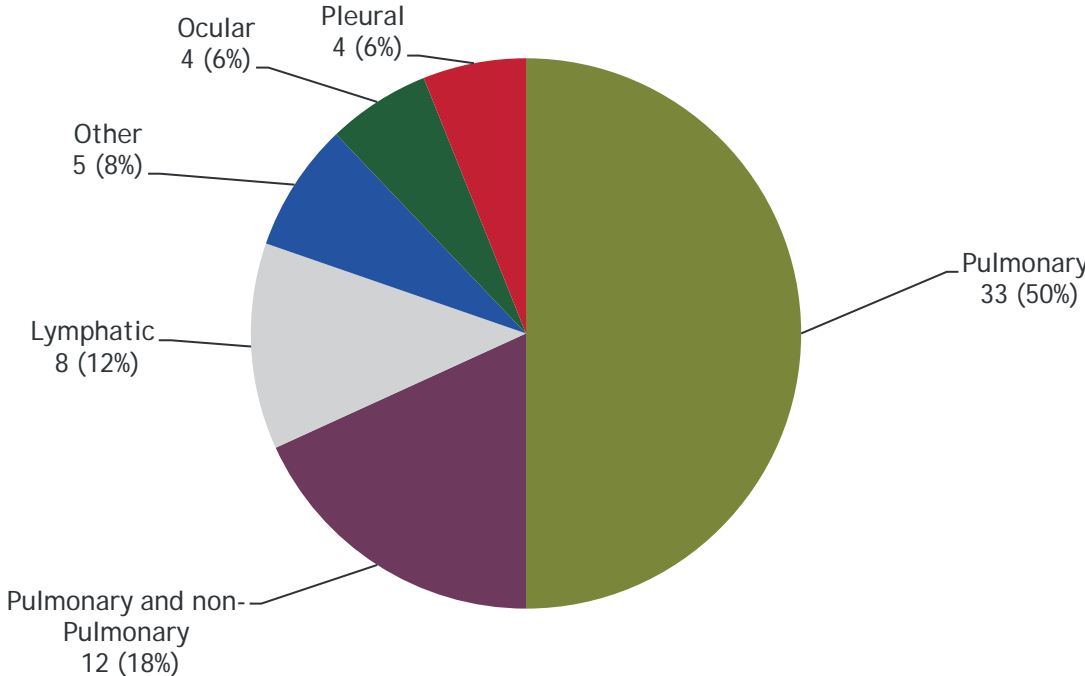
Figure 8. TB patients by gender: Colorado 2010-2019



Tuberculosis Patients by Major Site of Disease

Tuberculosis most often attacks the lungs (pulmonary TB) but may also affect any part of the body (extra-pulmonary TB). In 2019, 45 of the 66 (68%) patients were found to have a pulmonary or both a pulmonary and extra-pulmonary site of disease. The next most common site of infection in 2019 was lymphatic TB 8 incidences (12%). Sites classified as “other” included bone and joint-1, genitourinary- 1, peritoneal- 1, meningeal-1 and one was not stated (Figure 9).

Figure 9. TB patients by major site of disease: Colorado 2019

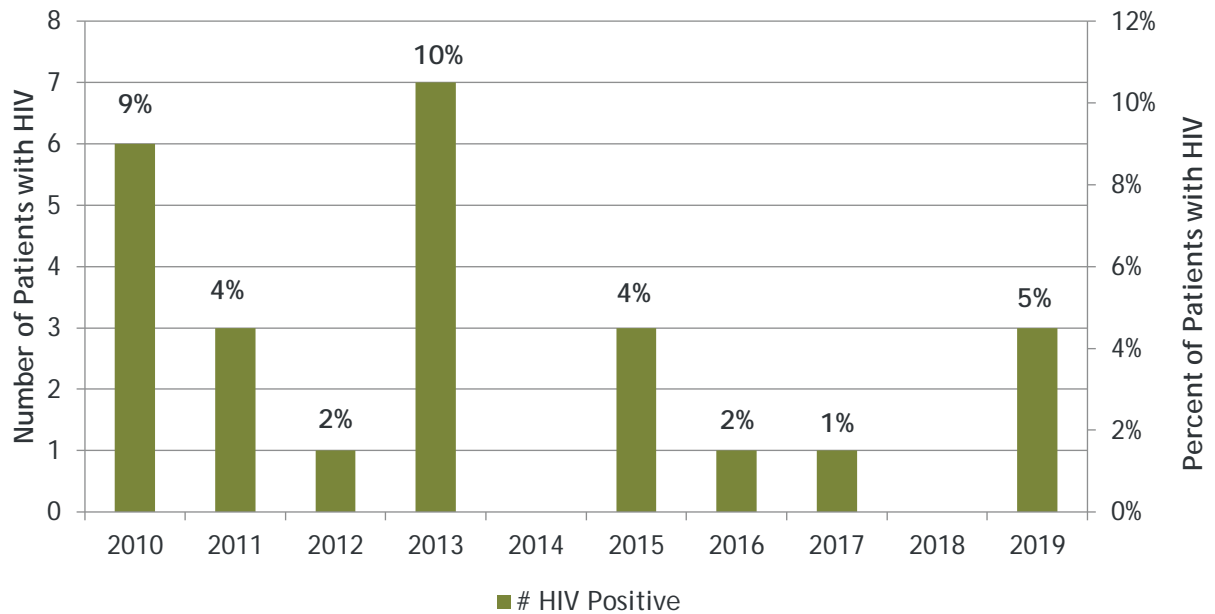


HIV Co-infection

Worldwide, one in four people with HIV who die of AIDS-defining conditions do so as a result of TB disease. HIV-infected people with TB infection are at higher risk of progression to TB disease because HIV weakens the immune system. Of the 66 people with TB in 2019, recent HIV test results were available for 64 (97% of total). Three people were found to be co-infected with HIV in the 2019 cohort. Two people were not offered HIV tests as they were less than 1 year old (Figure 10). Over the past 10 years, HIV/TB co-infection has fluctuated between seven patients in 2013 (10% of total) to zero patients in 2014 and 2018. When analyzing small numbers, the annual percentages can fluctuate widely and incidence rates, being unstable and imprecise, are likely to lack statistical significance (Figure 10).



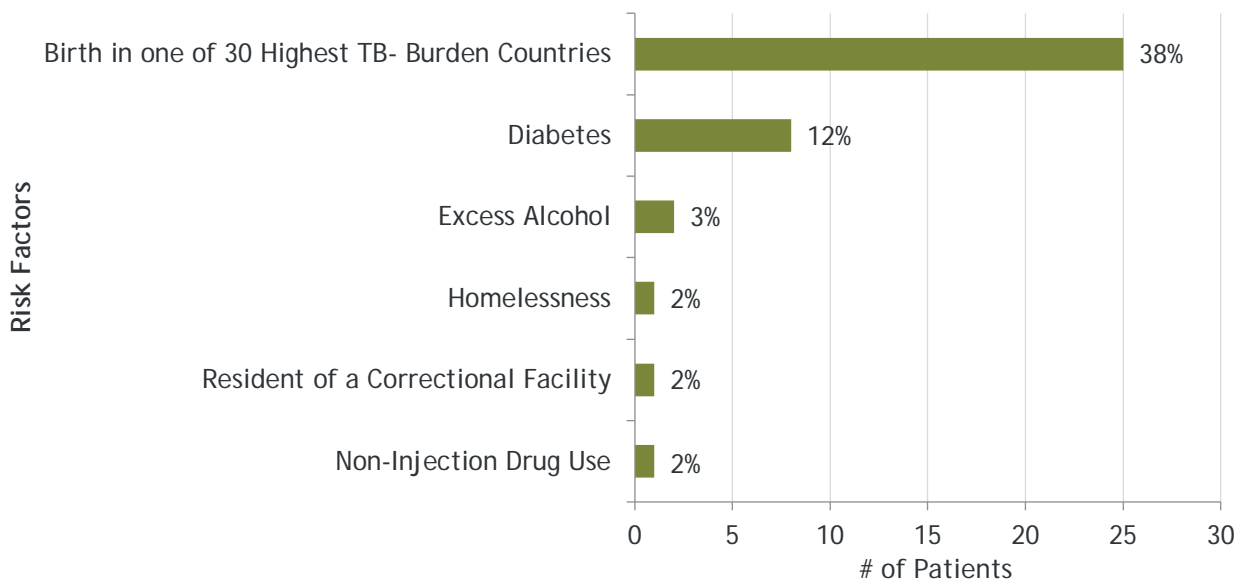
Figure 10. HIV-positive TB patients and percentage of annual total: Colorado 2010-2019



Risk Factors

In 2019, the most common risk factor for TB disease was birth in one of the [30 highest TB-burden countries](#), followed by a diabetes diagnosis (Figure 11).

Figure 11. Risk factors for TB: Colorado 2019

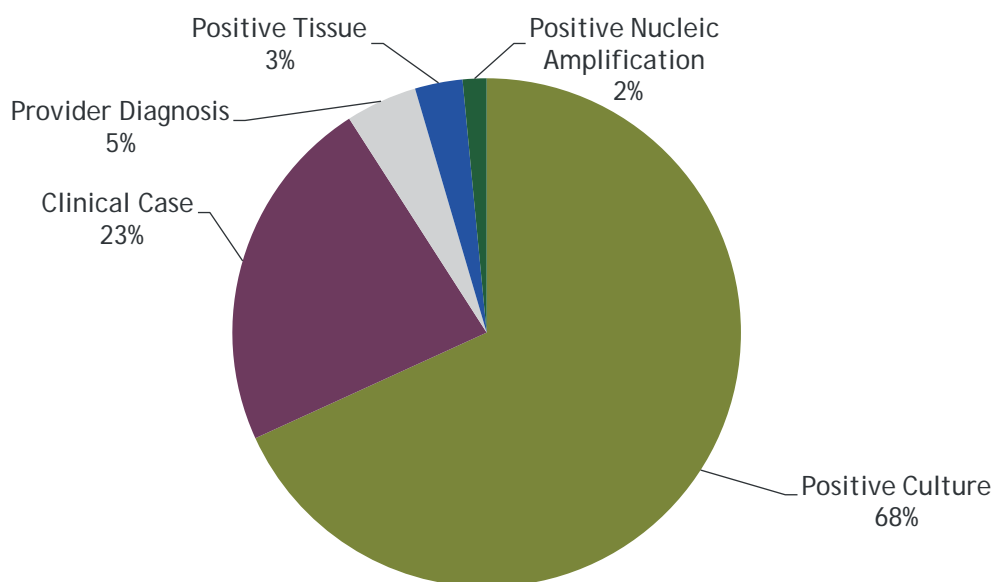


Note: A TB patient may have more than one risk factor indicated/Percentages may not equal 100%

Tuberculosis Case Verification

Mycobacterium tuberculosis complex was culture-positive in 68% of the TB patients in 2019. Another 23% met the clinical case definition (positive tuberculin skin test or interferon gamma release assay [IGRA] with an abnormal chest radiograph), and 5% were verified by provider diagnosis (Figure 12). For more information on verification criteria visit CDC's [website](#).

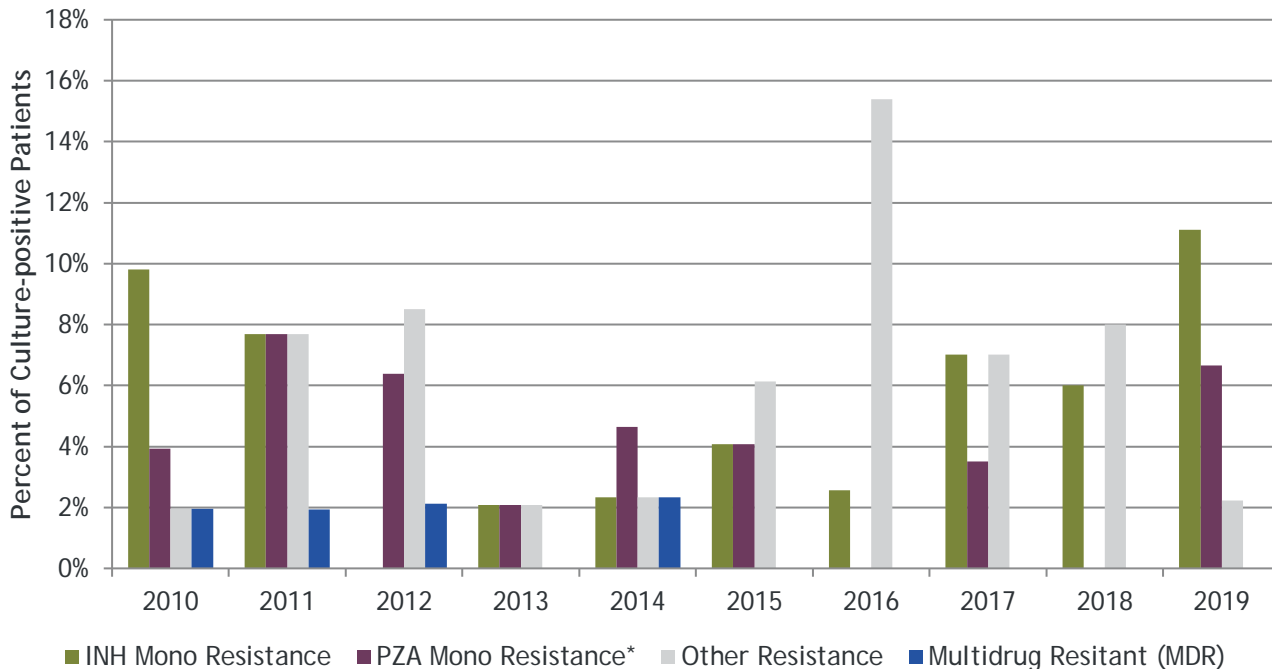
Figure 12. TB patients by verification criteria: Colorado 2019



Drug Resistance and Tuberculosis

Of the 66 TB patients reported in 2019, 45 (68%) had a positive culture and of those, nine (20% of culture positive patients) were found to be resistant to one or more TB drugs. Nine were resistant to one or more of the four first-line TB drugs: isoniazid (INH), rifampin (RIF), pyrazinamide (PZA) and ethambutol (EMB) and one was resistant to Streptomycin which is not currently used to treat TB. Of those nine resistant to first-line drugs, five had INH mono-resistance, one was resistant to INH and streptomycin, and three were resistant to PZA. There was no multi-drug resistant (MDR: defined as being resistant to at least INH and RIF), or extensively-drug resistant TB (XDR: defined as being resistant to isoniazid and rifampin, plus any fluoroquinolone and at least one of three injectable second-line drugs [i.e., amikacin, kanamycin, or capreomycin]) identified in 2019 (Figure 13).

Figure 13. TB drug resistance: Colorado 2010-2019

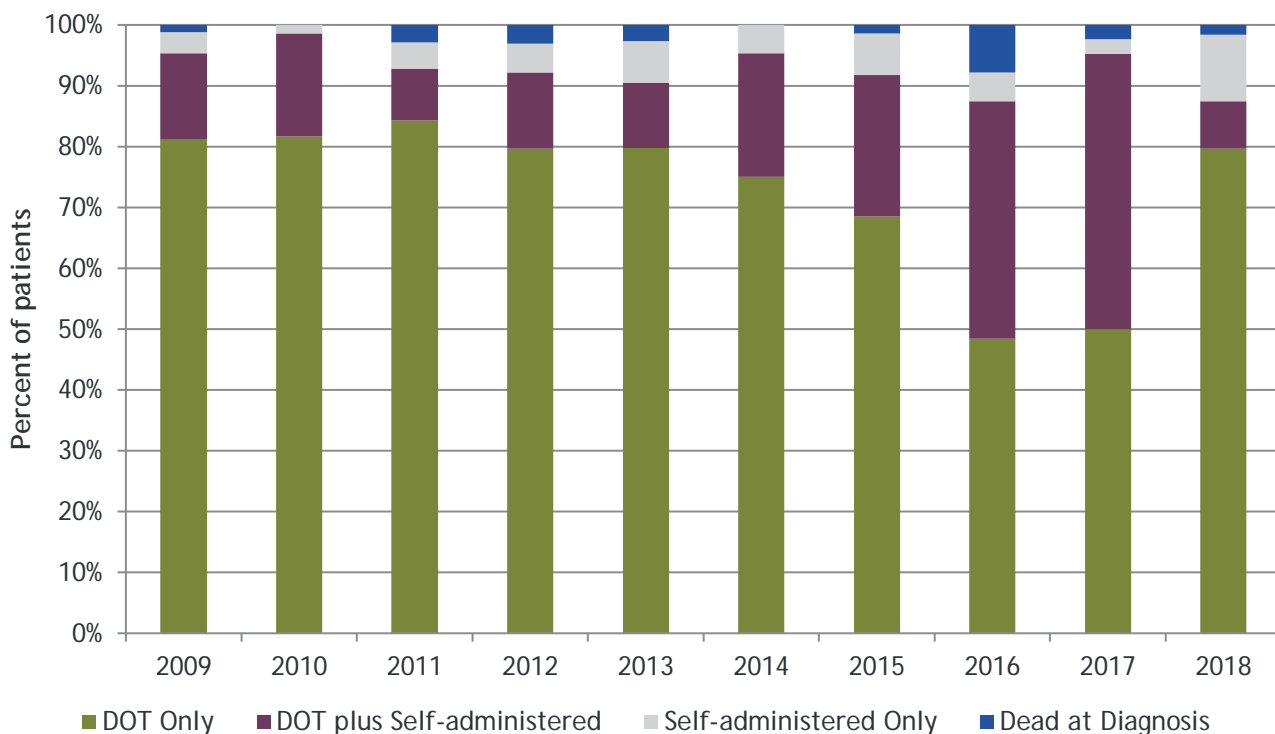


*Isolates with PZA resistance may indicate *Mycobacterium Bovis*, a form of tuberculosis, which causes tuberculosis in humans, cattle, and mammals. It is characteristically resistant to PZA.

Directly Observed Therapy

Directly observed therapy (DOT) is required for all patients with pulmonary TB in Colorado. DOT means health care workers observe the patient taking every dose of his/her TB medications. During 2018 (the most recent year with complete data), of the 63 patients who initiated treatment, 81% received medications via DOT, 11% self-administered medications (non-infectious extra-pulmonary patients) and 8% received a combination of DOT and self-administered therapy (Figure 14).

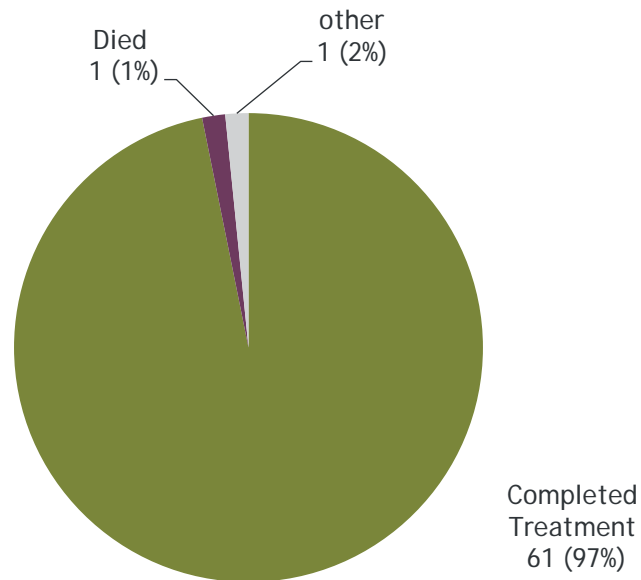
Figure 14. Mode of TB therapy: Colorado 2009-2018



Tuberculosis Treatment Outcomes

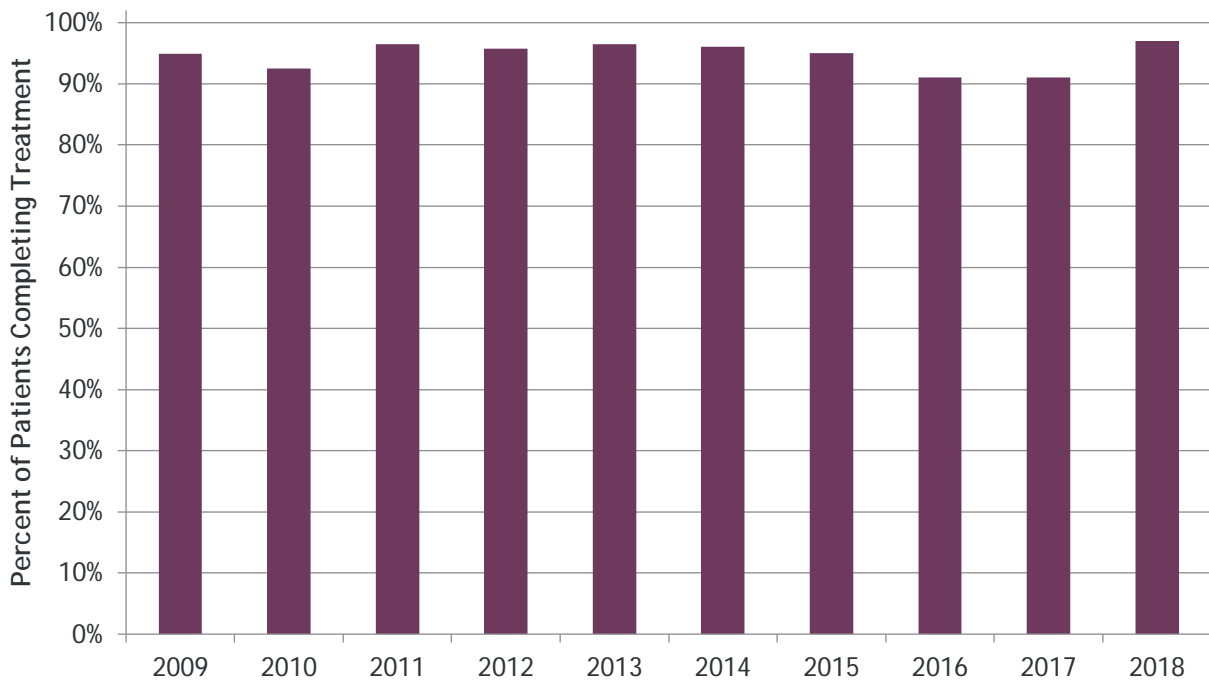
The standard treatment for TB disease is six months using isoniazid, rifampin, ethambutol and pyrazinamide. Of the 64 patients in 2018 (the most recent year with complete data), 63 TB patients (98%) initiated treatment (1 patient was dead at diagnosis). For those who initiated treatment, 61 completed; one moved outside of the U.S. before treatment completion (completion data unavailable); and one died during treatment (Figure 15). All 2019 patients have initiated treatment.

Figure 15. TB treatment outcomes: Colorado 2018



In 2018, there were 58 patients who were expected to complete TB treatment within one year of diagnosis and of those, 56 (91%) completed within that expected timeframe. Two others completed treatment in greater than one year. (Figure 16).

Figure 16. Completion of TB treatment within one year: Colorado 2009-2018



Note: Excludes patients with rifampin-resistant disease, patients with meningeal, bone and/or joint, or central nervous system disease, patients less than 15 years of age with disseminated tuberculosis disease, and patients that died less than one year after treatment initiation or moved out of the country.

Cascade of Care for Individuals at High Risk for TB Infection

The key strategy for eliminating TB in Colorado is to identify and treat people with TB infection (also known as latent TB infection or LTBI) who are at high risk of developing TB disease. Timely evaluation of people identified as contacts to an infectious TB patient and of those who arrive in Colorado with a Class B TB designation is vital to the success of this strategy. Class B TB is designated in immigrants and refugees who are traveling to the United States. They are evaluated for TB prior to arrival as required by U.S. immigration law and are assigned a classification according to the status of their disease. CDC’s Division of Global Migration and Quarantine notifies CDPHE’s TB Program of all individuals traveling to Colorado who are known to be non-infectious but are in need of additional TB evaluation (referred to as Class B TB). By evaluating those at high risk, specifically contacts to pulmonary TB patients and Class Bs, and treating those diagnosed with TB disease and infection (Figure 17 and Table 3), further cases of TB disease can be prevented.

Figure 17. Cascade of care for high risk individuals (contacts and class B TB): Colorado 2018

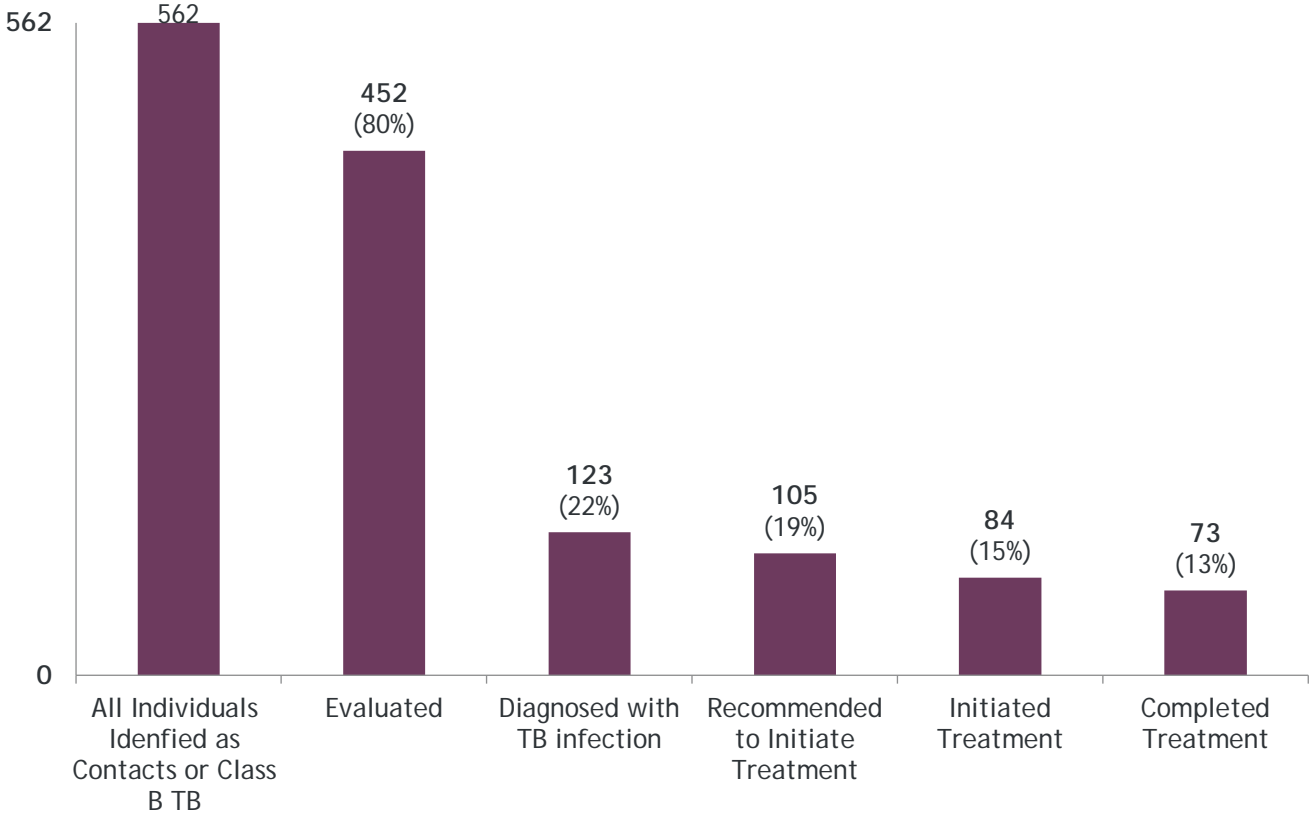


Table 3. Treatment outcomes for high risk individuals (contacts and class B TB) recommended to initiate TB infection treatment: Colorado 2018

Outcomes	No.	(%)
Total Diagnosed with TB Infection	123	(100%)
Recommended to Initiate Treatment	105	(85%)
Initiated Treatment	84	(80%)
Completed Treatment	73	(87%)
Did Not Complete Treatment (Reasons below)		
Died	0	(0%)
Moved	2	(2%)
Developed TB disease	0	(0%)
Adverse Effect/s	2	(3%)
Patient Chose to Stop	3	(4%)
Lost to Follow-up	1	(1%)
Provider Decision to Stop	2	(2%)
Pending Outcome Documentation	1	(1%)

Conclusions and Next Steps

The number of TB disease patients in Colorado increased slightly from 2018 to 2019 (3%). The case rate in Colorado remained consistent at 1.1 per 100,000 persons over those two years. To ensure a continued downward trend, private providers and local public health agencies must continue to identify and screen those most at-risk for TB infection and initiate treatment where appropriate in order to reduce the chance that patients develop TB disease. As the demographic breakdowns in this report attest, the key risk factors and the most at-risk groups for developing TB disease have been identified (see [Figures 5 and 11](#)). TB elimination plan activities initiated in 2019 include the expansion of limited English proficiency (ELP) patient-education materials; continued promotion of over-the-phone interpretation for non-English speaking TB patients as well as those presumptive for TB; the continued expansion of and advocacy for video directly-observed treatment services (V-DOT); and expanded access to reliable, no cost (to patient or local public health agency) TB and HIV blood testing services. Next steps for 2020-2021 remain in development due to the comprehensive COVID-19 response. The goal is to tailor traditional in-person TB training curricula to a remote online platform. Other ongoing strategies include promoting and facilitating a regional collaboration model toward improving case management and community engagement activities in under-resourced jurisdictions; the continued provision of no-cost V-DOT services to local public health agencies statewide; and the pursuit and promotion of opportunities to replicate the ongoing TB infection screening, testing and treatment pilot underway by a private healthcare provider network. Monthly enhanced TB case management (ECM) sessions will continue designed to educate providers and increase capacity among those caring for TB patients will continue. These ECM sessions allow non-Denver-metro LPHAs and

providers that care for TB patients the opportunity to review current patients with subject matter experts from CDPHE and the Denver Metro TB Clinic via a web-based, HIPAA-compliant online/remote platform. Other plans include developing a nurse case management tool kit to guide LPHA case managers through the chronological steps necessary to guide a TB patient through completion of treatment. Efforts will continue to support non-LPHA agencies and other healthcare providers by developing site-specific algorithms to screen, test and treat their patients at-risk for TB infection. This strategy is crucial, as private providers will need to care for their TB-infected patients in order to avoid over-burdening local public health agencies with referrals, as past practice dictated.

It will be both a challenge and an exciting opportunity to engage affected communities and populations in TB elimination activities. CDPHE's TB Training and Education Coordinator will spearhead the planning, collaboration, and implementation of these activities in coordination with TB Program colleagues and community partners. Community participation is essential to developing meaningful messaging that will resonate with individuals at-risk for both TB infection and progression to TB disease. Colorado's public health TB community looks forward to working with new partners with a shared vision of reduced TB morbidity and mortality among Coloradans. Reducing health disparities through improved policies, practices and organizational systems will benefit the entire state and help in the improved TB-specific health outcomes for all Coloradans impacted by the leading infectious disease killer in the world.

Colorado's TB elimination plan is available on the TB Program website

<https://www.colorado.gov/pacific/cdphe/tb>.