The TB Challenge

"Partnering to Eliminate TB in African Americans"

A Newsletter from the Division of Tuberculosis Elimination, Field Services and Evaluation Branch

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IN THIS ISSUE:

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Strategies for TB Elimination in African-American Communities

Dr. David Satcher, Director, National Center for Primary Care, Morehouse School of Medicine, Atlanta

Division of Tuberculosis Elimination (DTBE): As Surgeon General and Assistant Secretary for Health, you led the Department's effort to eliminate racial and ethnic disparities in health. What can we do as private, public, and government partners to narrow the disparities in TB in the African-American community?

Dr. Satcher: In order to narrow the disparities in TB in the African-American community, we must first understand the nature, magnitude, and distribution of the problem: what segments of the African-American community are most at risk for TB, and why that segment is at risk. For example, if we identify that the major segments include persons with HIV/AIDS, persons who are homeless, and persons who are victims of substance abuse, then our efforts must be geared to those areas. As private citizens, of course, we can work within our communities to reduce the risk of the spread of HIV/AIDS; we can work to ensure not only that there are services available for the homeless that will minimize infection with both HIV and TB, but also that people who are affected have access to care, including directly observed therapy. And of course, we can work with the government to make sure that programs are in place to respond to these community needs. So it begins with understanding the problem; secondly, with understanding the risks or causes for the problem; then intervening in various health settings, whether it's private, public, or government, making sure we evaluate what we do to ensure that we are being effective.

DTBE: Does your current role as the Director of the new National Center for Primary Care at Morehouse School of Medicine keep you on the forefront of public health issues? If so, how?

Dr. Satcher: I have been very fortunate to be able to acquire a position at the Morehouse School of Medicine as the Director of the National Center for Primary Care (NCPC), which allows me to continue to work on and with the major public health issues that I was able to deal with as Surgeon General. For example, the mission of the NCPC is to promote excellence in primary care as well as community-oriented primary care programs, as we have a special emphasis on the underserved and the underrepresented and a special focus on eliminating disparities in health. Those are issues that I dealt with as Surgeon General and as Assistant Secretary for Health. It was as Assistant Secretary for Health that I was able to lead the development and implementation of Healthy People 2010. By the same token, I was able to point out the critical role that primary care can and needs to play in dealing with issues such as asthma, hypertension, diabetes, and especially mental health, which had not received much attention before. We are in a position now to deal with all those issues within the context of the Southeastern Clinician Network and improve the quality of primary care providers there. Also, through our Center of Excellence on Health Disparities, we are able to target issues in cardiovascular disease, cancer, diabetes, mental health, maternal and child health, and HIV/AIDS.

DTBE: Can you relate any of your personal experiences with TB?

Dr. Satcher: Well, I must say that I grew up in an environment of poverty and poor access to health care, so there were people in that environment who suffered from TB. I remember meeting them and hearing about them as I was growing up, thus the people who were at highest risk for this disease were known to me as a child. But in medicine of course, especially when working in public hospitals, whether in Cleveland, Rochester, or Los Angeles at the King Drew Medical Center, I've also come to appreciate the people who are at greatest risk for TB and the fact that those persons are generally people who are either homeless, people who are victims of substance abuse, or people who are infected with other diseases like HIV/AIDS. Of course in a place like Los Angeles, a lot of people who come from other countries are at greater risk of having TB and actually contribute over half the new cases of TB in the country today. Finally, as Director of CDC, I facilitated emphasis on the directly observed therapy approach to tuberculosis control. We were seeing an increase in the incidence of TB in this country each year. However, after CDC assigned significant congressionally appropriated funding to New York City, we were able to develop this directly observed therapy model and show that it can be effective. For example, it's one thing to try to give medications to people who are homeless, but they have nowhere to store them, so among other things we provided funding for nurses or others (outreach staff) who would make sure that people got their medicine each day. They observed that they (TB clients) received their medications, and this is an important component of the worldwide strategy for dealing with TB--and it certainly has been an effective one.

DTBE: CDC has not received large increases in funding for TB prevention and control for over a decade; since we cannot advocate directly to Congress for increased funding, what strategies and approaches would you suggest for leveling the playing field to ultimately eliminate this disease?

Dr. Satcher: It is true that persons working in government cannot lobby Congress or advocate for increased funding for their own programs. I think what we can do, however, is empower those who are able to advocate by providing up-to-date information and providing it in a form that is efficient and easy to use. We have to educate, motivate, and mobilize communities against problems like tuberculosis. And when we do that, those communities themselves will get the message to their representatives in the local, state, or federal government that these programs deserve more funding. We must do a better job of empowering advocates with this information and with motivation.

DTBE: How can CDC, working with traditional and nontraditional partners, better engage African-American communities?

Dr. Satcher: Well, CDC needs to better engage African Americans and other underserved communities in all of its programs. And I think that there are at least two or three approaches to that. The first is that CDC must have more people on its team from those communities, people who understand the culture and patterns of those communities and are able to help develop programs that are relevant. By the same token, we must develop partnerships with those communities. Institutions within the African-American community, whether they are schools, churches, or fraternities and sororities, must become partners with CDC just as they did in the campaign to increase immunizations in the early to mid 90s. So, I think that we must make sure that we have a diverse workforce, partner with institutions in the communities, and by the same token, learn more about those communities and educate everybody about the needs of those communities.

A Successful Intervention to Improve TB Treatment Outcomes in Georgia's Homeless: An Interview with Pamela Collins, American Lung Association of Georgia

Michael Fraser, DTBE/ FSEB

Pamela Collins, M.S.A.
Vice-President
Adult Lung Disease Programs,
American Lung
Association of Georgia

Michael Fraser: How and when did the homeless TB patient program get started?

Pam Collins: It started after the closing of the TB inpatient unit—a wing at the Northwest Georgia Regional Hospital in Rome — in June 1996. This wing could house up to 10 in a semi-secured area for TB patients and had done so for some 50 years. With the closing of the unit, the alternative housing project, which is a collaboration between the American Lung Association of Georgia (ALA GA) and the Georgia Department of Human Resources (DHR) Division of Public Health, Prevention Services, Tuberculosis Program, was begun to provide housing for homeless TB clients in the state of Georgia. Today, we can provide housing for homeless or inadequately housed TB clients within their locale; we work closely with DHR to locate motels, trailers, or apartments that will house infectious TB patients in the various health districts. Funds allocated for this project pay for rent, meals, and personal supplies, and even provide transportation to medical appointments that are unrelated to TB. We also offer social service referrals and make various accommodations for patient families; some of these include shared housing for spouses and children. Project funds are used to ensure that clients with little or no income, and those who cannot work because of their infectiousness, maintain their basic necessities. There is no assistance, however, for such amenities as phone or cable services.

MF: How did you come up with this intervention and get support for it?

PC: The GA DHR TB control program manager, Beverly DeVoe-Payton, had been in communication with the ALA of North Carolina and learned that they had a project that provided housing for TB clients. However, we decided to take a different approach in the design and implementation of our project. For example, in North Carolina, funds were provided directly to the health districts for overall management of their housing program. Here in Georgia, we wanted to have staff directly oversee project activities and funding. We worked closely with the state's TB control program to remove obstacles that may present barriers to completing treatment; also, our monitoring/case management efforts have ensured that clients receiving our services are not lost to medical follow-up in the process.

MF: What are the criteria for TB clients to enter into this program and who makes the decision about who is eligible?

PC: First of all, the patient must be infectious, or if the infectious status is unknown, a determination is made through medical consultation at the local health department referring the client for housing. The TB client must also demonstrate that he/she has an unstable home environment. If they are in the hospital and they're saying that they can't go back home because they do not have a home to go to, then an assessment is made by the health department and hospital social service staff to confirm this. Clients may have been residing, prior to admission, in a homeless shelter and quite frankly we would want to pull them out of that setting. If a client is indicating that he/she does not wish to return to a housing environment that is with family, but unstable, then we work with the client to provide housing.

MF: Can you indicate how successful this project has been?

PC: Sure. From July 1, 1996, through June 30, 2004, we have had 538 clients utilize our services. We have been successful in that there was a 97% compliance rate with directly observed therapy and a 91% completion of therapy rate in this cohort of TB clients.

MF: What is the racial and demographic profile of clients served?

PC: For the cohort mentioned earlier, 77% were reported as black or African American; 12%, Caucasian; 8% percent, Hispanic; and 2%, Asian. In addition, 82% were male and 18% were female.

MF: What is the length of stay for TB clients in alternative housing?

PC: It just depends. Even if a TB client becomes sputum-smear negative, the health department may feel strongly that a TB client may become noncompliant with TB treatment; then all efforts for that client to remain are made, up to completion of therapy. Ordinarily, TB clients in the metro Atlanta area will stay in the program until they have three negative smears and one negative culture. Usually that takes up to 90 days from the time residency begins. Ninety days is our target; however, discharge from alternative housing in the state could occur before 90 days are up. There are other sources in the community that the ALA works with for continued housing of TB clients, when necessary. Some of these include the Antioch Urban Ministries, along with many others. We have 159 counties in Georgia that we provide services for. If a patient is in Blakely County, we're there, and if they are in Catoosa County, we're there too.

MF: What are some of the rules that TB clients must adhere to in order to remain in the program?

PC: TB clients are expected to keep their rooms clean and undamaged. As a matter of fact, we don't want them to damage any property. At the end of their stay, we want them to make sure that their room is left clean. After a new client is placed in alternative housing, there is follow-up from the ALA and DHR. Of course, directly observed therapy for the client's TB is a requirement for housing. There is accountability for TB clients receiving alternative housing during their treatment for TB; patients who are recipients of alternative housing are periodically reviewed by the state TB control program during regularly scheduled case reviews, although there is co-management with ALA.

MF: Finally, are there any plans to house persons diagnosed with HIV who are infected with TB? As you know, these are persons who are at high-risk for developing TB disease.

PC: Yes. We are always looking for new projects and the opportunities to work collaboratively across disease programs.

Upcoming Events

World TB Day
March 24, 2005

Title: Blacks in Government 27th Annual National Training Conference
City: Orlando, Florida
Location: Orange County Convention Center
Date: August 1-5, 2005
Phone: (202) 667-3280
Website: www.bignet.org

Title: National TB Controllers Workshop
City: Atlanta, Georgia
Location: J.W. Marriott Lenox
Date: June 28-30, 2005
Contact: Sherry Brown
Phone: (404) 639-8135
Email: sbrown@cdc.gov

Title: 2005 African American and Hispanic Leadership Conference on HIV/AIDS
City: Louisville, Kentucky
Location: Executive Inn, 978 Phillips Lane Louisville, KY
Date: September 23-24, 2005
Contact: Ramonda Yocum
Phone: (800) 420-7431
Email: Ramonda.Yocum@ky.gov
Website: www.kyaalc.com

Michael Fraser and Gail Burns-Grant, DTBE, FSEB, provided information on the national rate of TB among non-Hispanic blacks at the 19th National Conference on Chronic Disease Prevention and Control, March 1-3, 2005.

Minority Health Resources:

Visit the CDC web page at www.cdc.gov, click on Health Topics and select conferences and meetings to view the CDC calendar of major events.

CONTACT US ...

If you have story ideas or articles to share, or would like to provide comments, please e-mail Gail Burns-Grant at gab2@cdc.gov or call (404) 639-8126.

To add/delete someone to/from our mailing list, please contact Vivian Siler, Management & Program Analyst, DTBE/FSEB, by e-mail at vas6@cdc.gov or (404) 639-5319.

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