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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Reported Tuberculosis Among African Americans, 2005

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Elvin Magee

Elvin Magee, MPH, MS, is a health scientist in the Surveillance, Epidemiology, and Outbreak Investigation Branch. As health scientist, he supports the Division of TB Elimination. He has focused his research efforts on TB in African Americans.

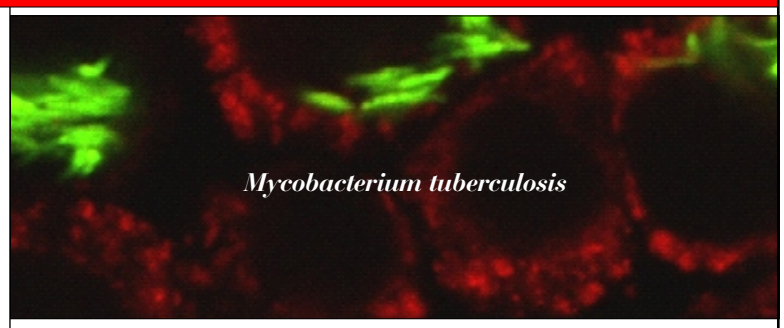
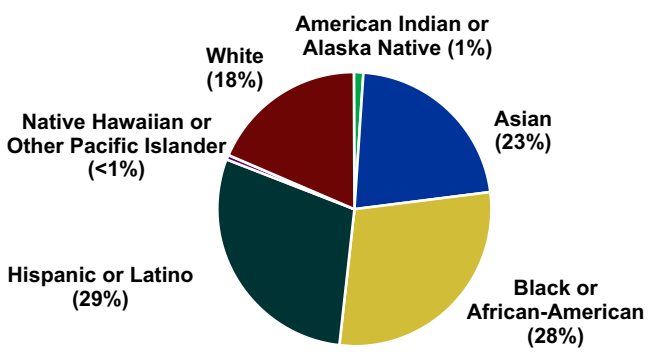


Figure 1. Reported TB Cases by Race/Ethnicity*, United States, 2005**



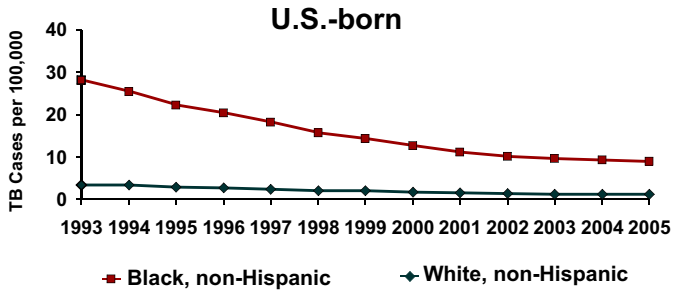
**All races are non-Hispanic. Persons reporting two or more races accounted for less than 1% of all cases and are not shown.*

***Updated as of March 29, 2006.*

Black or African American, non-Hispanic persons continue to have a disproportionate share of TB cases in the United States. As shown in Figure 1, this group represented 3,954 cases or 28% of all cases reported in 2005. Of this total, 2,442 were male and 1,512 were female.

U.S.-born blacks represented 2,887 or 45% of all reported U.S.-born TB cases in 2005.

Figure 2. TB Case Rates by Race/Ethnicity, United States, 1993–2005*

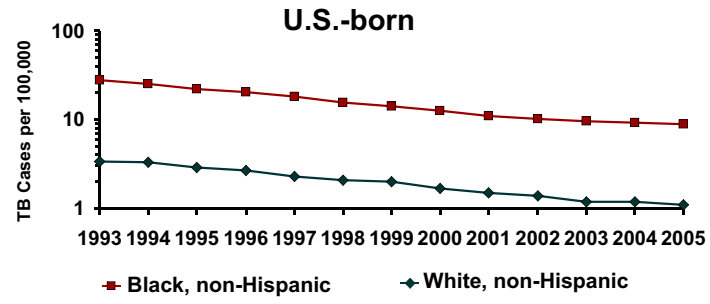


**Updated as of March 29, 2006.*

Although rates of TB in both U.S.-born blacks and whites have declined substantially over the past decade, Figure 2 illustrates that a disparity remains.

From 1993 through 2005, the rates in non-Hispanic blacks remained higher than those in non-Hispanic whites. Among U.S.-born TB cases, rates in blacks decreased from 28.0 per 100,000 to 8.9, whereas the rates in whites decreased from 3.4 to 1.1, for a risk ratio of 8.1.

Figure 3. TB Case Rates by Race/Ethnicity, United States*, 1993–2005**

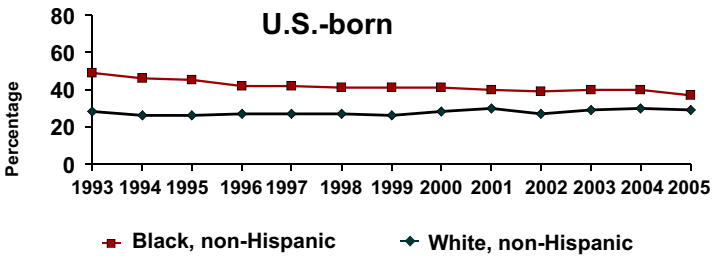


**Includes the same data as Figure 2, but rates are presented on a logarithmic scale.*

***Updated as of March 29, 2006.*

Figure 3 above is the same as Figure 2, but the rates are presented on a logarithmic scale to better illustrate the trend in TB rates among U.S.-born blacks and whites. The lines show a steady rate of decline among both groups; however, the disparity remains the same over time.

Figure 4. TB Among persons with Risk Factors*, 1993–2005**



**Injecting drug use, non-injecting drug use, excess alcohol use, homeless, or diagnosed with TB while incarcerated.*

***Updated as of March 29, 2006.*

To close the gap, increased efforts must be made to eliminate TB in blacks in the United States. Recent surveillance data indicate blacks are more likely than whites to be homeless, incarcerated, or have a recent history of substance abuse. Figure 4 graphically illustrates the difference in disease burden among these persons with risk behaviors. Although the percentages of cases of TB among blacks who have these risk factors may be declining slightly over time, TB among these persons, both blacks and whites, remains a problem. These surveillance data suggest greater need for targeted testing and evaluation among all persons with risk factors associated with TB.

Setting the Course for Action: A Chief Perspective

Michael Fraser, Public Health Advisor, Field Services and Evaluation Branch

Dr. Stephanie Bailey

Stephanie B.C. Bailey, M.D., MSHSA, is Chief of Public Health Practice at the Centers for Disease Control and Prevention (CDC). As Chief of Public Health Practice, Dr. Bailey is responsible for assuring the U.S. public health system is strengthened and that CDC provide leadership in building and supporting public health infrastructure to improve overall public health system performance. The Office of the Chief of Public Health Practice serves as an advocate, guardian, promoter and conscience of public health practice throughout CDC and in the larger public health community.

Michael Fraser (MF): Dr. Bailey, you have had an impressive career in public health. In your last position as the Director of the Metropolitan Health Department in Nashville, Tennessee, you accomplished so much over your 11-year tenure. What inspired you to join CDC in October of last year?

Dr. Bailey: Two things. Given my professional journey, joining CDC was an "inescapable summons." And, from my interview with Dr. Gerberding, I really buy into and see the vision that she has set forth.

MF: You have joined CDC in the Office of the Chief of Public Health Practice (OCPHP). Can you explain the responsibility of this office and what you and your team are charged to do?

Dr. Bailey: For many, internally and externally, OCPHP is the "connection to the practice." The mission of the office is to *advance achievement of CDC's health protection goals through science-based, practice-oriented standards, policies, and legal tools.* In working terms, this means that this office serves as an advocate, guardian, promoter, and conscience of public health practice throughout CDC and in the larger public health community. A key OCPHP strategy is to ensure coordination and synergy between CDC's scientific and practice activities and their support for practitioners, policy makers, and partners throughout the public health system. Key foci include performance standards, accreditation, workforce, infrastructure, community engagement, public health, law, policy development, best practices and the science of that practice, public health systems research, and public health practice improvement strategies. The venue to facilitate the discussion of practice issues will be the newly established Public Health Practice Council.

MF: Dr. Bailey, in the state of Tennessee you spearheaded an initiative, Bridges to Care (BTC), that linked thousands of uninsured Tennesseans to health care through a public/private consortium. Can you tell us how you did it, the challenges you faced, and what led to the successful outcomes from these initiatives?

Dr. Bailey: This effort was accomplished because everyone involved recognized the reality of the impact of having 42,000 uninsured persons in Davidson County and committed to the broader vision to address this. The true engagement of stakeholders led to a mission and a deliberate strategy for the city. As partners committed to this effort, we all committed resources, time, and effort. This led to continuous successful outcomes. Our target was to enroll 4,000 uninsured in the first year; by the end of the first quarter of the first year, we had enrolled 8,000. Our target for BTC Plus, the system of specialty services, was 3,000 slots within the first year, and at the end of that year we had 4,200 slots. Some of the challenges presented themselves mostly upfront: fear of taking this on; the perception of already being at capacity; and, what would be the cost? Also, there were issues around protection of turf, constraints of procedures, and convincing others who needed to be persuaded. Everyone at high levels stayed committed. Today, the system has enrolled about 33,000 persons of the original 42,000; has committed funding from the city government, all the hospitals, the local foundations, and still is receiving some Healthy Communities Access Program funds; the return on investment has been shown; and two new clinics have been established to meet the demand. It is governed by a 501C3 (the term "tax exempt," when used in reference to nonprofit organizations) and is used as a platform to address disparity issues of medical and preventive practice; and is a model for the state to address access issues secondary to TennCare's disenrollment policy in June '05. Partnerships with significant partners in the city have enhanced the effectiveness of this system (e.g., the local food chain, mental health community providers, and Nashville's Medical Society). Michael, thank you for allowing me to talk about this wonderful initiative that really changed the way things were done in Nashville.

MF: While serving as Director of the Metropolitan Health Department in Nashville, you served on CDC's Advisory Council for the Elimination of Tuberculosis (ACET) from 1999 until 2003. During this time, ACET called to attention the historically high rates of TB in U.S.-born blacks that resulted in CDC funding three demonstration projects in 2002 to target and intensify TB elimination activities in the African-American community. Dr. Bailey, what fueled the fire in 2002 to address historically high TB rates in this community?

Dr. Bailey: It was, and is really, a disgrace to still haveTB, home grown, and concentrated in specific areas (the Southeast and a few cities outside of the Southeast) and among blacks, particularly when TB is still relatively responsive to drugs. TB was decreasing everywhere, and more and more counties were reporting no TB, but in the Southeast, it was not. It seemed that with a little bit of extra "oomph" we could do something about this trend and even reach the definition for elimination.

MF: Considering the significant decreases in federal funding for TB control and prevention, and for that matter decreases at the state and local level, how do our programs maximize public health efforts for desired health outcomes during these times of crisis?

Dr. Bailey: There will never be enough money. You posed the question correctly as to how does the program maximize public health efforts for desired health outcomes during these times of crisis? Clearly, by maximizing the assets of a community, as evidenced above in an earlier answer. While there are a lot of priorities for a local community, the low- hanging fruit could be found in addressing the TB incidence. The approach benefits other issues if true community engagement happens and the messages are clear. Those communities that have come together for efforts such as eliminating syphilis, Racial and Ethnic Approaches to Community Health (REACH) relative to the articulated health disparities, Step Up to Better Health, Mobilizing for Action through Planning and Partnerships (MAPP), are assuring access to care are coalesced in a sustainable way that will allow them to take on and eliminate the impact of home-grown TB.

MF: Dr. Bailey, CDC and RTI International sponsored a summit, "Stop TB in the African-American Community," in May of last year, where some 100 participants from the African-American community came together to learn about TB; participants later participated in breakout groups to develop strategies and action steps to take back to their respective areas to raise awareness about TB. In addition, three of the TB project areas that were funded by CDC to reduce TB in African-American communities launched social marketing campaigns. Other TB project areas use World TB Day to promote community awareness through health fairs and other forums to raise awareness about TB. What else can be done to mobilize around this disease so that TB gets the attention and the provision for resources that will be needed for elimination?

Dr. Bailey: Again, I think the processes and structures are in place and tapping into them to cause impact may be a strategy. For example, we still need to tap the National Association of Local Boards of Health who govern the local health departments. We also need to ask what mayors would want to have TB increasing in their city? They like to compare with other cities and like to rank higher than their colleagues, but not on some things like tuberculosis. So, the U.S. Conference of Mayors may need to adopt the agenda. How do you tie livability reports to living without TB? I think the strategic engagement of the black community as you have done in the past requires deliberate and ongoing follow-up to monitor the strategic planning and results that come from it. TB is a tremendously social and local phenomenon. Supporting the broader vision and message to eliminate disparities will get to addressing TB.

MF: Dr. Bailey, over the course of your career, you have served as a faculty member at some of the nation's finest historically black colleges and universities, one of which is Meharry Medical College. From your experience, is the medical school curriculum addressing the social and cultural factors that can influence health outcomes, and are these schools and other schools like the University of North Carolina at Chapel Hill, where you have served, including TB in their medical school curriculum?

Dr. Bailey: To this question, let me just say that there is a lot of room for improvement.

MF: Thank you Dr. Bailey. We wish you all the best in your position here at CDC.

Minority Health Resources:

Visit http://www.cdc.gov/omh/ to view announcements, upcoming conferences, meetings, trainings, reports, publications, and other minority health-related resources.

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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 at (404) 639-5319.

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