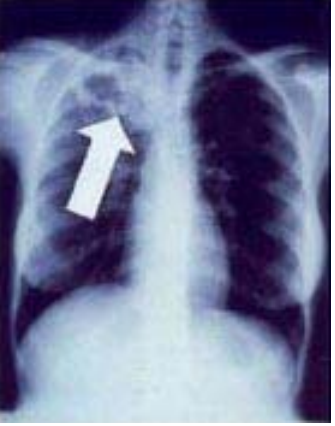

PDA is OK…..

Public/Private **D**octor **A**greement in Managing TB Cases

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Region 8 Medical Director

TEXAS Department of State Health Services

Overview

- Various TB Management Relationships in Texas
  - Benefits, Drawbacks of each
- How to start a “PDA” in your community
- Effect on TB rates with a PDA, local example
- Impact on disease reporting with a PDA
- Next steps

Management of TB in Texas

- Primary Care Provider Managed
  - Benefits:
    - trusted by patient,
    - full spectrum care,
    - locally available,
    - affordable for insured or sliding scale,
    - complications managed locally and quickly
  - Drawbacks:
    - difficult to locate in rural areas,
    - uninsured difficult to access,
    - Follow medical care model (not public health),
    - doctors see TB rarely and not comfortable managing, don’t follow standard of care.

Management of TB in Texas

- Public Health Managed
  - Benefits
    - Know Standard of Care of TB management
    - Know public health law/quarantine regulations
    - Know TB resources in community, statewide and national
    - Staff knowledgeable to do full investigation and DOT
    - Resources available to all regardless of nationality or financial situation
  - Drawbacks
    - “super sub-specialty” care, not full scope health care
    - Patients not overly trusting of “government” health care
    - Limited number of physicians in public health (shrinking area)

Management of TB in Texas

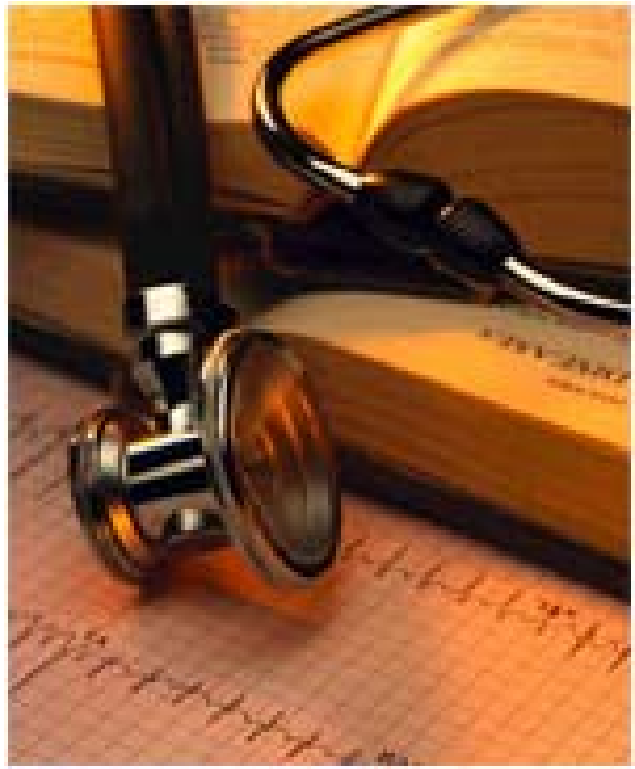
- Private/Public Doctor Agreement (PDA)
  - Benefits:
    - Private MD sees public health as a referral area (not only a consultant). System in place for referrals in most practices.
    - Reduces private MD liability concerns
    - Encourages private MD to interact with public health more regularly.
    - Reporting increases
    - Public health establishes a place for referral for other patients in community.
    - Educates private docs on TB (and other public health issues).
  - Drawbacks:
    - Private medical community does not learn to manage cases.
    - Requires MD in public health to be certain management able to be done with local system.

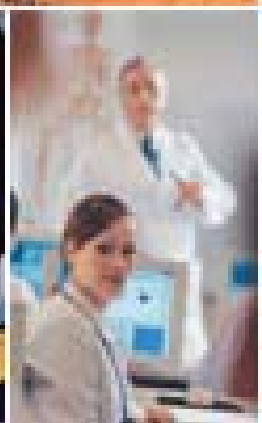
How to Start a “PDA”

- Health authority makes “co-management” of TB cases and suspects by public health standard of care for the community.
  - Support includes: morbity numbers, investigation needs, DOT orders by physician on staff (liability), standard of care, reporting requirement completed
- Distribute the information to the physicians most commonly treating TB in the community.

How to Start a “PDA” (con’t.)

- Train at least 2 public health physicians in tuberculosis management fully (large LHD)
- Instruct TB staff to accept orders only from a public health physician,
  - outside physician orders to be co-signed or re-written by public health physician.





How to Start a "PDA" (con't.)

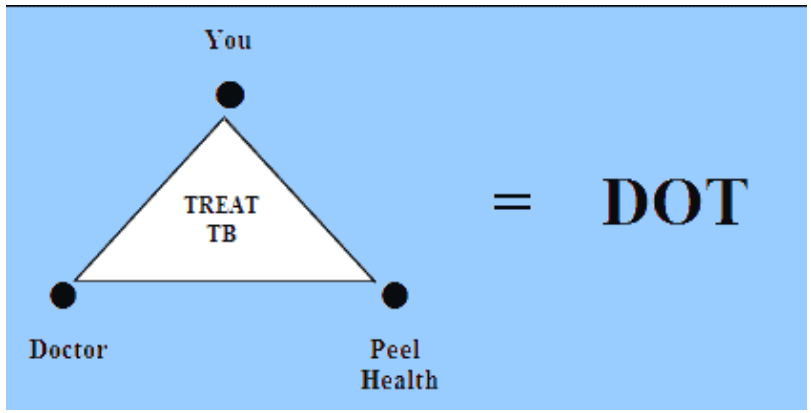
- Write community specific guidelines to include:
  - when to skin test,
  - when to order CXR's,
  - when to order LTBI,
  - when to "clear" people to go to school/work/shelter (how to document it)
  - what to do with a TB suspect/case, including mask isolation and referral to public health (regardless of insurance or funding status)
- Public health to be the "expert" with regard to TB assessments
  - Know own limitations and when to request consult from others (TB Heartland Center)

How to Start a "PDA" (con't.)

- Develop system to keep primary care physician "in the loop"
  - Written notes, phone calls, follow up appointments, etc.
- Patient should be informed overall health care has not "transferred" to public health, only TB.
  - If no, PCP, refer to one based on need and availability.
- Public health physician should feel supported in his/her effort to manage all TB cases through out completion of therapy by public health system.

Example of Implementation of PDA at a LHD

- LHD TB program filling DOT and other orders from PCP's and ID docs in community without regard to standard of care or consult. (PH not the "experts")
- Patients were often over-treated or under-treated if symptoms/CXR resolved quickly (routine medical model)
- TB skin tests were required to be positive to be a TB suspect
- Often, suspects not placed in isolation or started on meds unless cultures positive.



Example Continued

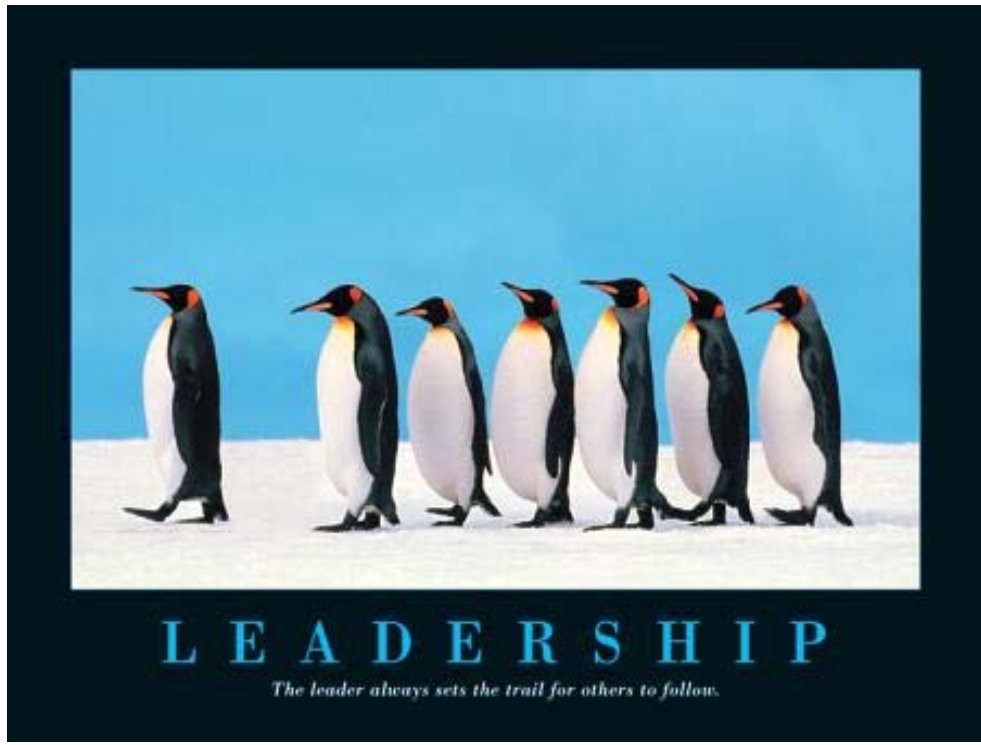
- Not all patients were DOT (up to PCP and his/her determination of patient's ability to be reliable)
- Not all TB patients had contact investigations.
- Public health good at caring for indigent, not for insured.
- Private docs did not do LTBI.
- Pregnant patient care was deferred to OB (LTBI case found active during c-section delivery)

Implementation of PDA Benefits

- PDA implemented (3-4 months) and the following improved:
  - Private MD's appreciative of involvement/assistance
  - Patients got consistent care regardless of funding.
  - Increased numbers of reports
  - TB staff received consistent orders, able to readily report adverse reactions, problems, etc.
  - Increased number of court ordered quarantine cases
  - LHD interaction with state improved due to consistent reporting, completion and submission of TB 400's
  - Improved tracking of cases, epidemiological investigations, statistics (important for funding formula)

Sustaining of PDA Difficult

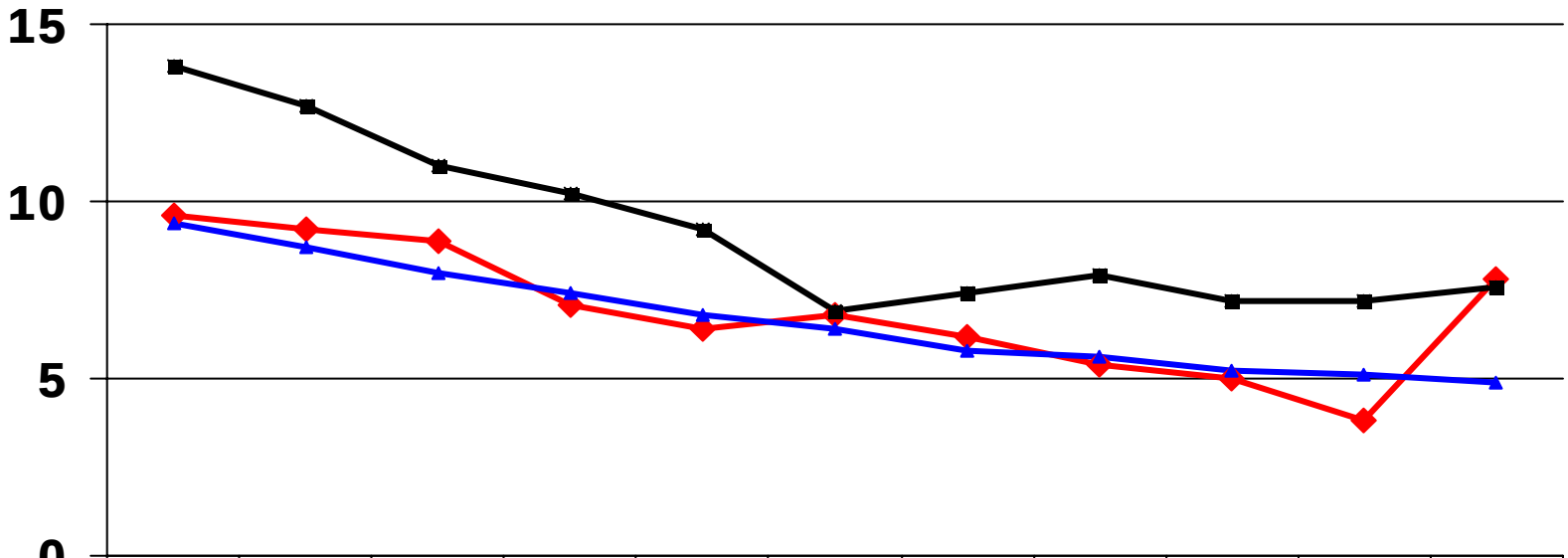
- Difficult to sustain without local physician leadership in the area of TB
  - (contractors, consultants, etc cannot carry role for public health).
- TB practitioners returning to TB after implementation of PDA resistant to change.
- Increased reporting leads to increased case loads which difficult to manage fully.



Effects on TB Rates

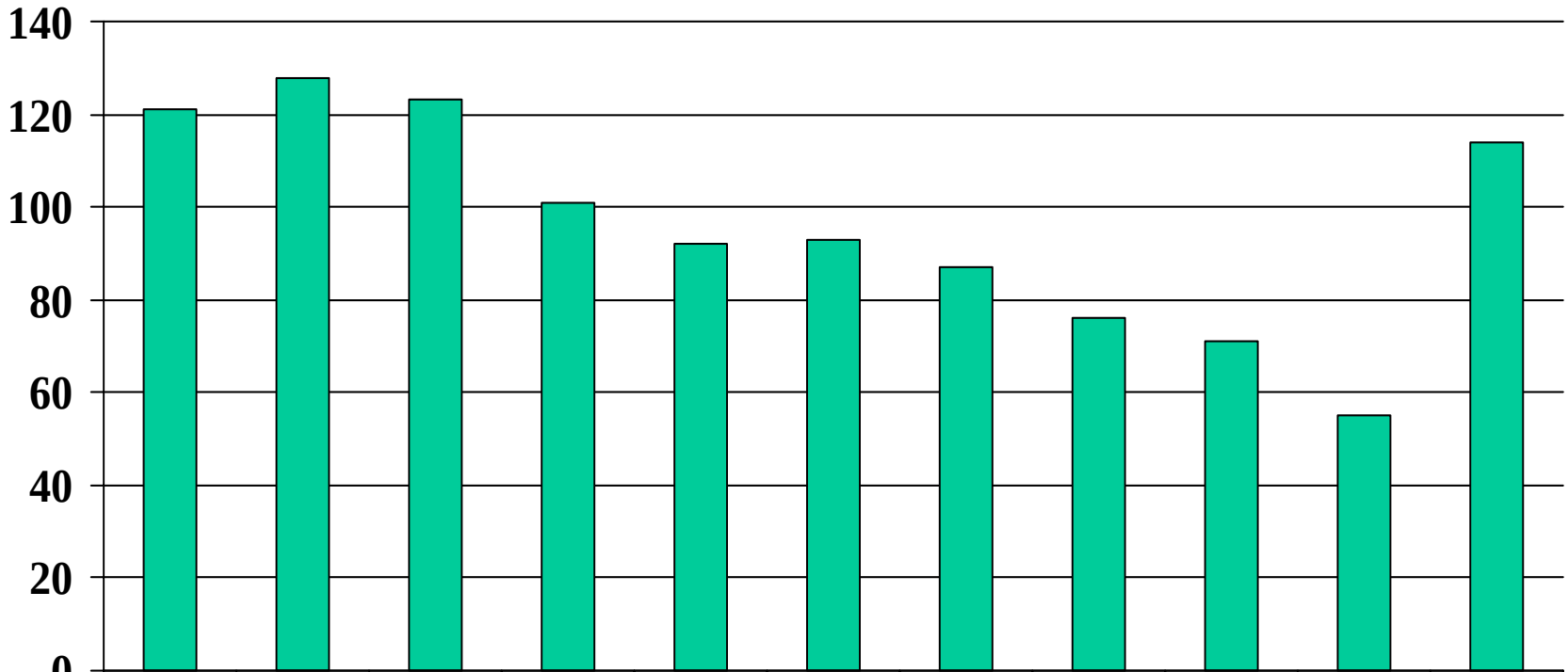
- After implementation of PDA, TB rates locally increased
  - Able to track cases better
  - Case definitions improved
  - More clinical cases
  - More HIV testing (requirement)
  - More pediatric cases found
  - More non-pulmonary cases identified
  - Able to provide public information on TB rates, risks, etc

Tuberculosis Control Program
TB Cases Rates per 100,000 Population



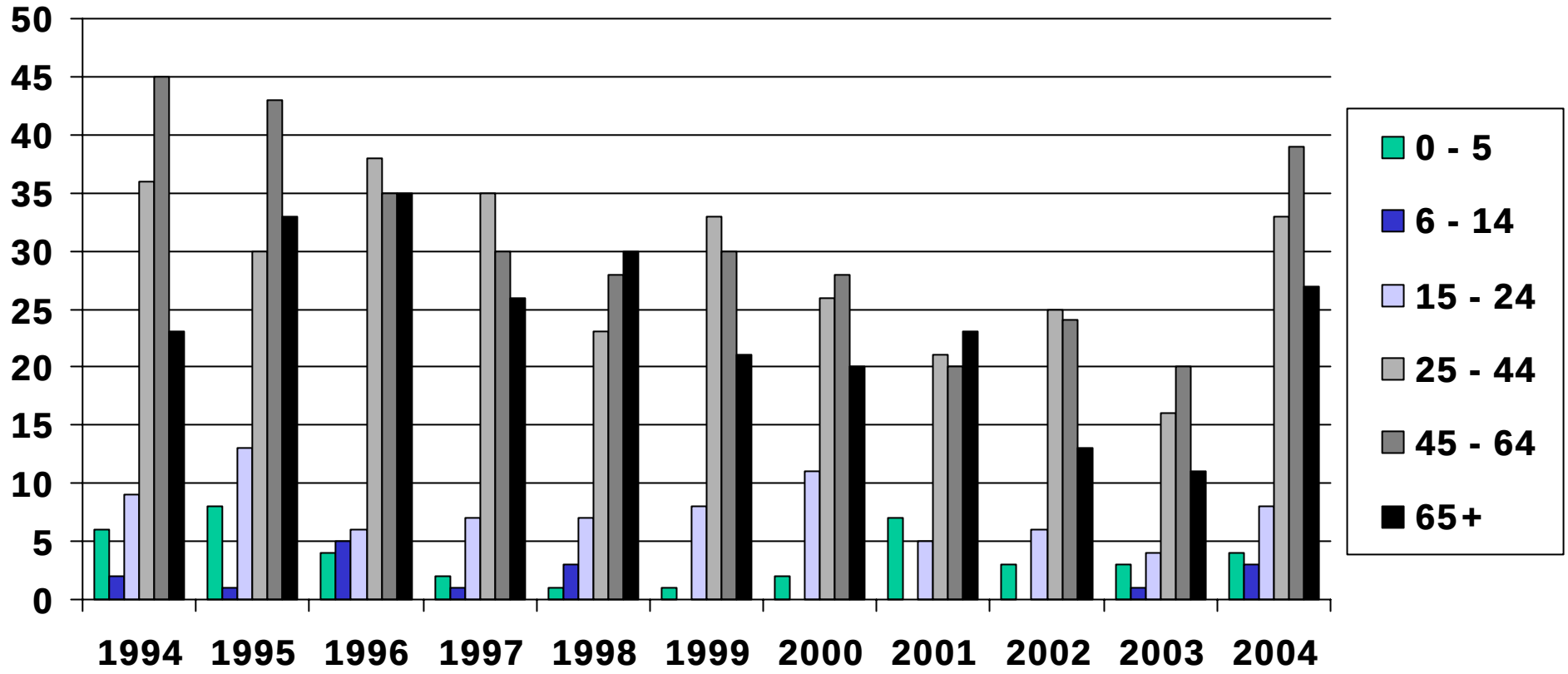
	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Bexar County	9.6	9.2	8.9	7.1	6.4	6.8	6.2	5.4	5	3.8	7.8
Texas	13.8	12.7	11	10.2	9.2	6.9	7.4	7.9	7.2	7.2	7.6
United States	9.4	8.7	8	7.4	6.8	6.4	5.8	5.6	5.2	5.1	4.9

Tuberculosis Control Program
Active TB Cases
Bexar County



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
TB Cases	121	128	123	101	92	93	87	76	71	55	114

Tuberculosis Control Program
Active TB Cases by Age Group
Bexar County

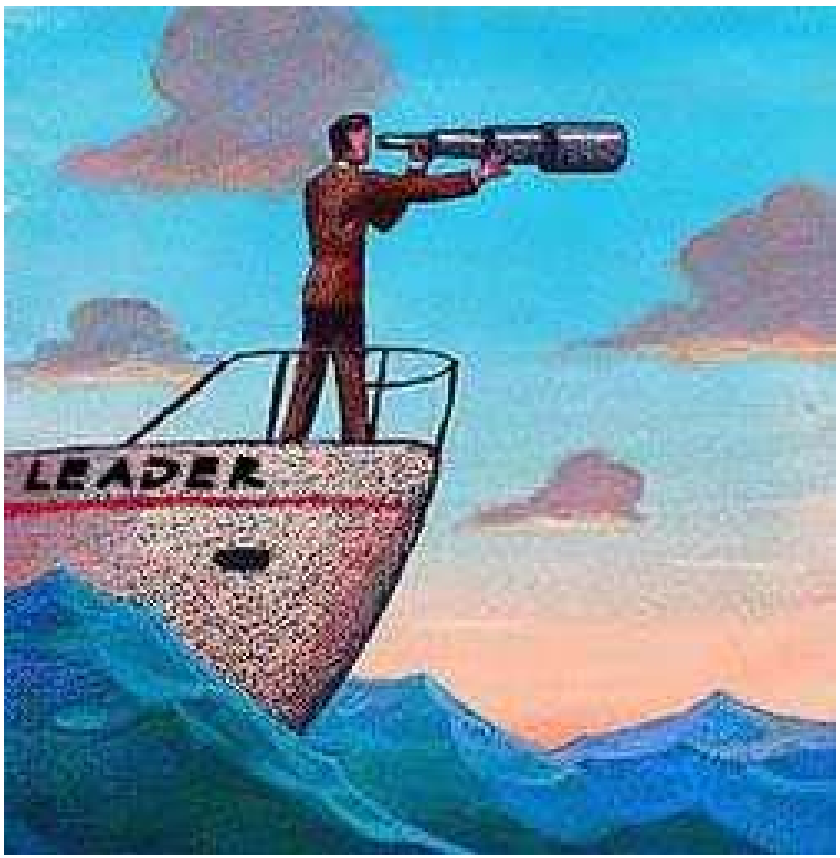


* The majority of patients with TB disease are greater than 25 years of age.

Effect on Disease Reporting

- "Spill over" effect.
  - More TB cases, more HIV testing, more STD testing, more issues with regard to special populations…impacted public health overall
- Increased public awareness of TB due to "high profile" cases in school, workplace, etc.
  - More awareness leads to more reporting

Next Steps



- Support LHD and Regional HD to become “TB expert” role
- Get all specialties to recognize the role
  - Radiology
- PDA ensures a small subset of persons are fully aware of TB management standards and ensures essential PH function

Conclusions

- Various TB Management Relationships in Texas
  - Benefits, Drawbacks of each
  - Primary Care/Medical Model
  - Public Health Model
  - Public/Private Doctor Agreement (co-management) Model
- How to start a "PDA" in your community
  - Support of Health Authority
  - Informing medical and public health community
  - Informing patient
  - Setting community guidelines
- PDA can increase TB rates and overall disease reporting
- Next steps include supporting LHD leadership role, increase reporting of suspects from groups, more training of PH docs.

Questions?

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