

# STAMPING OUT TB: A Community-based Outreach Worker Model for TB Prevention



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# Today's Discussion

- ◆ Trends in TB Control & Project Background
- ◆ Overview of the Refugee & Immigrant TB Prevention Project
- ◆ Project Results
- ◆ Lessons learned
- ◆ Work remaining
- ◆ Unanswered questions



# Have You Ever Wondered...

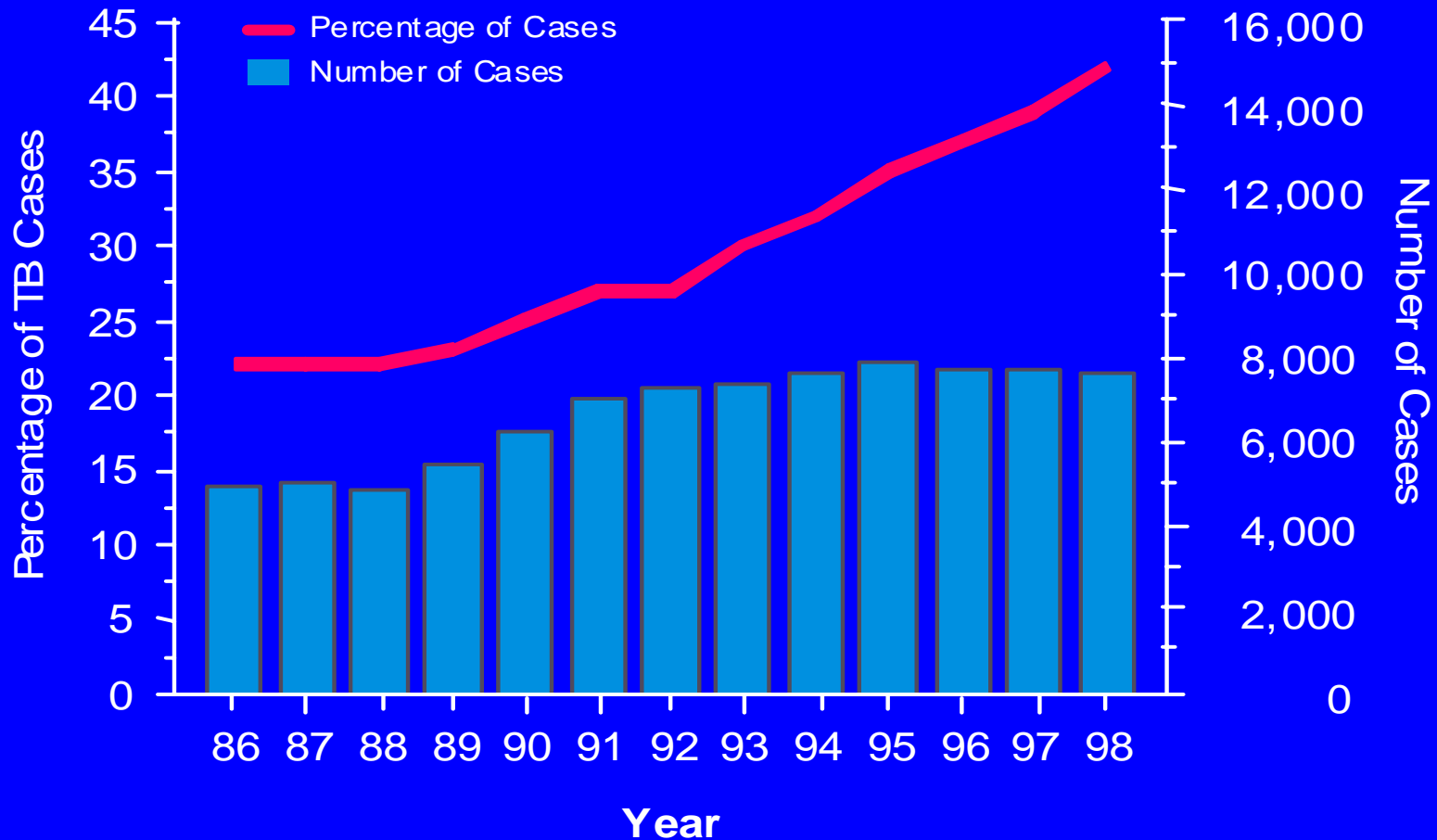
- ◆ ...why addressing TB among the foreign-born is so complex?
- ◆ ...why outcomes related to acceptance and completion of INH therapy are not always what is intended especially when working with refugees and immigrants?
- ◆ ...how to more clearly and effectively teach about INH TLTBI?



# NATIONAL TRENDS: Reported TB Cases United States, 1978-1998



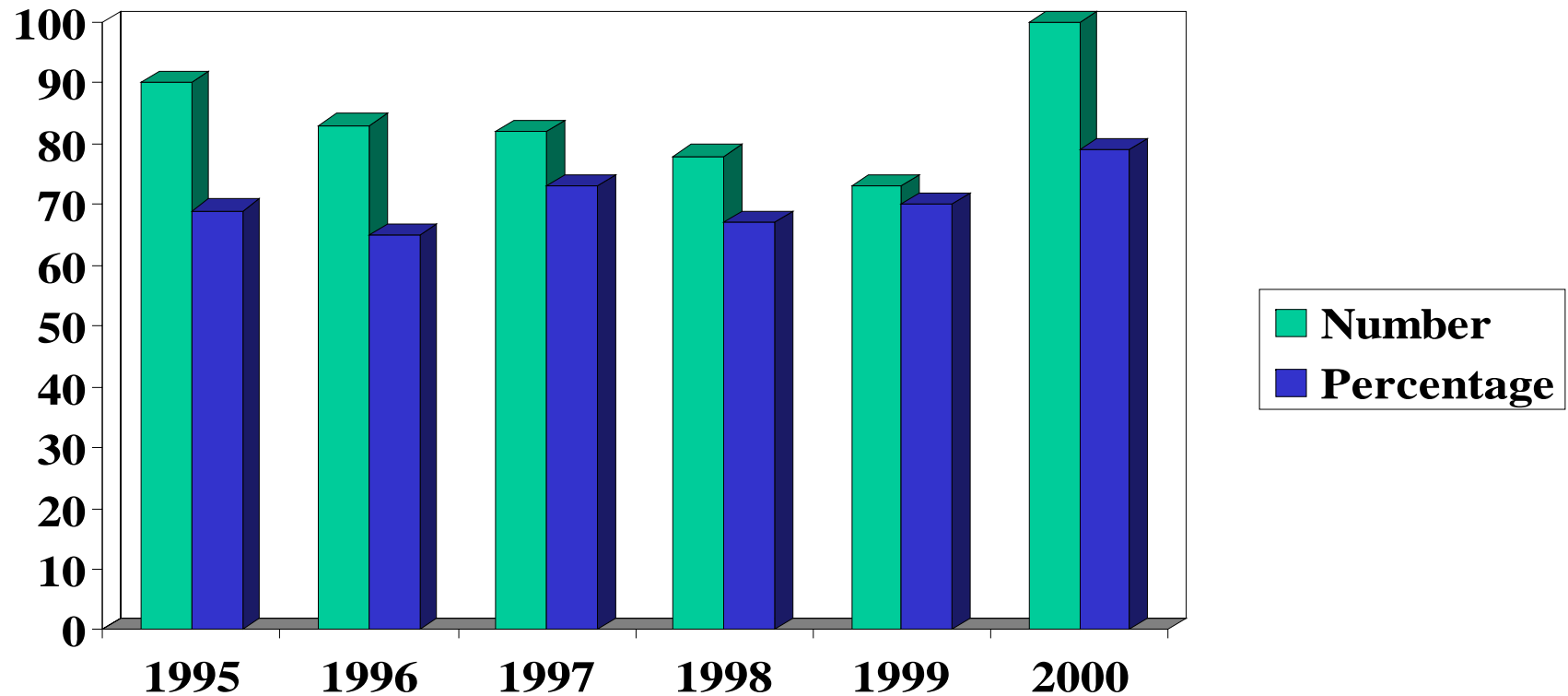
# Trends in TB Cases in Foreign-born Persons, United States\*, 1986-1998



\* Comprises the 50 states, the District of Columbia, and New York City

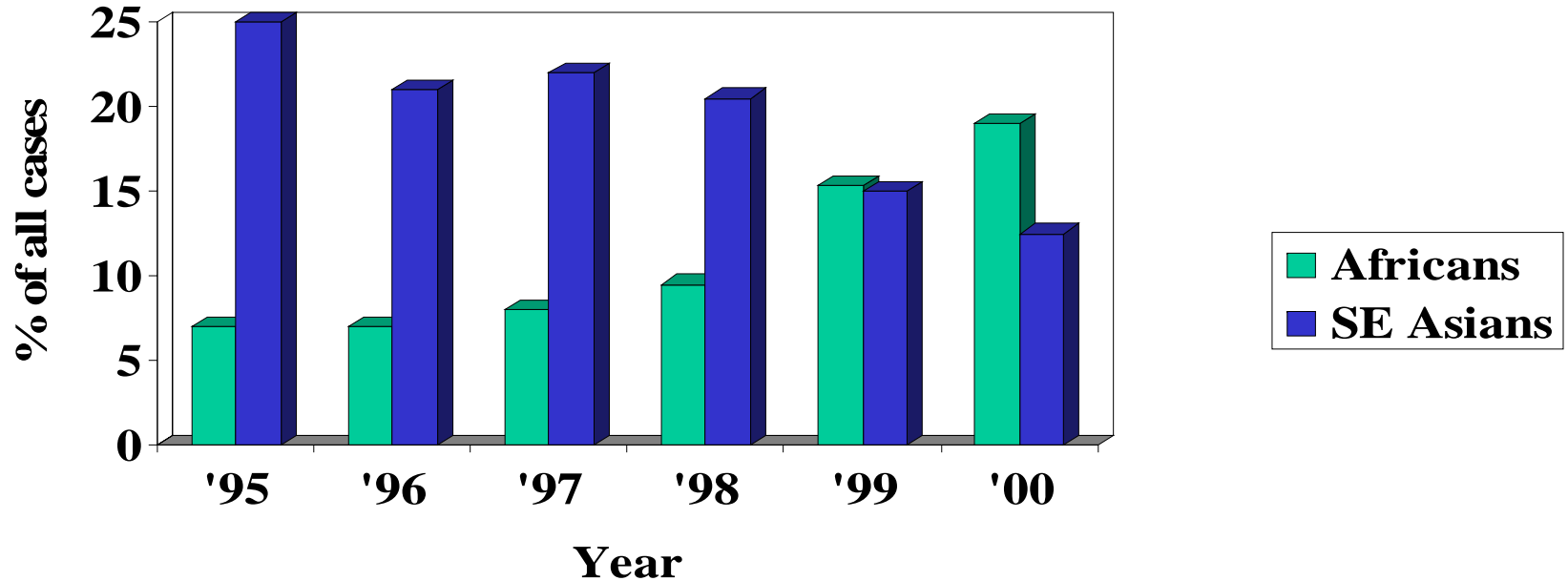
# Figure 1

## Tuberculosis in Foreign-born Persons, Seattle-King County 1995-2000



# Figure 3

## Tuberculosis morbidity in two immigrant/refugee groups, Seattle-King County 1995-2000



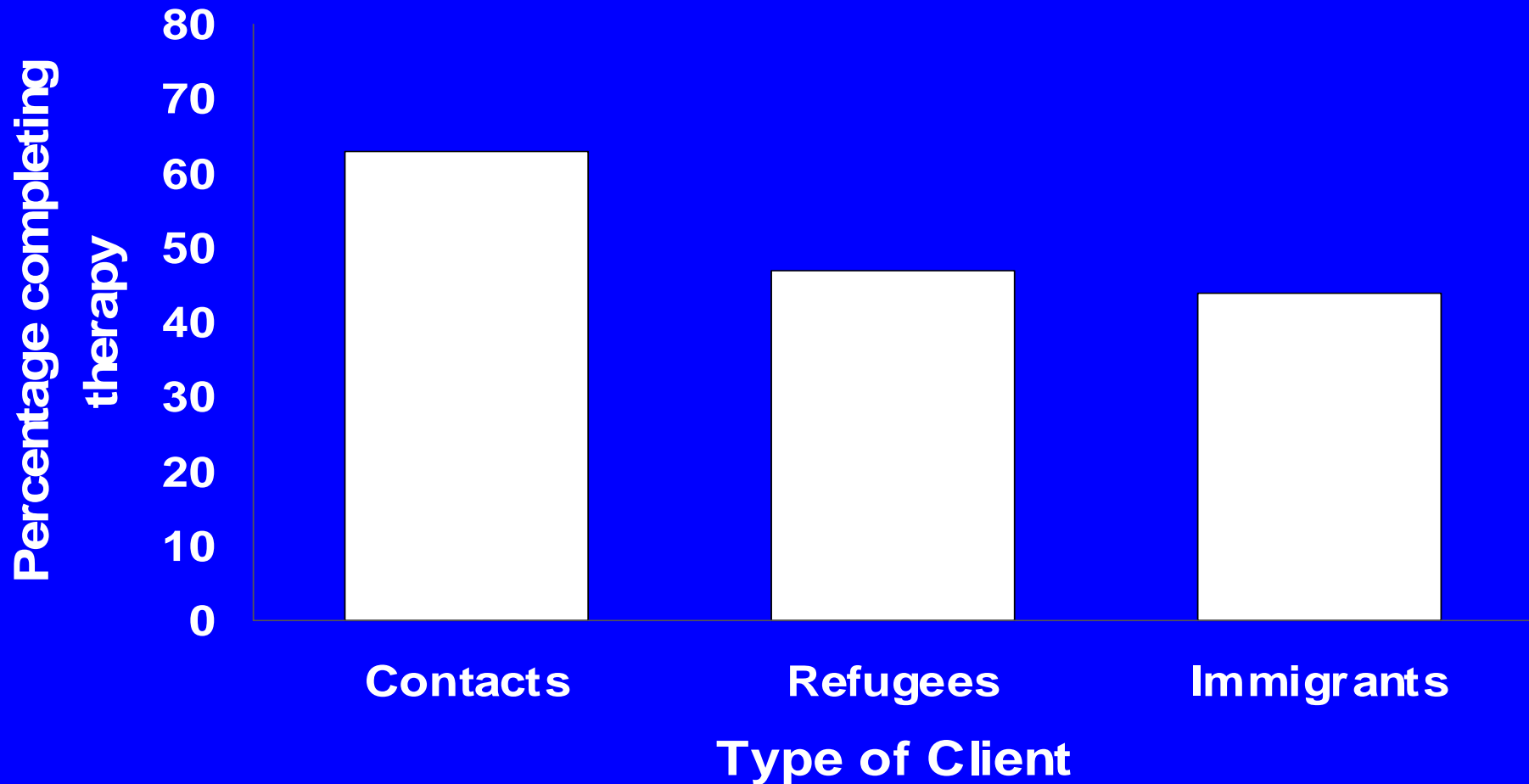


# Screening Foreign-born Populations

- ◆ Screening high risk populations for latent TB infection (LTBI) is a national priority in TB control
- ◆ Treatment of LTBI with anti-microbials active against TB significantly reduces the risk of developing active disease



# Completion rate for preventive therapy Seattle-King County TB Clinic, 1996





# Refugee & Immigrant TB Prevention Project

- ◆ Began in early 1999
- ◆ Collaboration between the Seattle-King County Health Department TB Control Program & Harborview Medical Center
- ◆ Modeled after HMC's Community Housecalls Program which embraces a bilingual, bicultural outreach worker model



# More about the Project

- ◆ 3 main target refugee groups
  - Bosnian
  - Somali
  - Former Soviet Union
- ◆ Funding from a combination of sources:
  - Annie E. Casey, Firland, & Nesholm Foundations
  - Federal Refugee Resettlement Dollars
  - DSHS matching funds



# Project Goals

- ◆ Increase the rates of acceptance and completion of INH therapy among new immigrants to King County
- ◆ Pilot the use of bilingual, bicultural outreach workers in this therapy
- ◆ Develop culturally informed materials for community outreach and provider education
- ◆ Monitor the cost and delivery of outreach services



# Central Outcomes of Interest

- ◆ Compliance with INH preventive therapy
  - Start & Completion Rates
- ◆ Case management process outcomes
- ◆ Cultural profiles of TB for 3 target communities
- ◆ Cost/efficacy of intervention



# Project Assumptions

- ◆ Bilingual, bicultural outreach workers can effectively mediate between their clients and the medical system in order to improve health outcomes of members of their community
- ◆ Cultural and linguistic information specific to immigrant populations must be understood more completely by health care workers in the USA in order to improve the delivery of health services to these high-risk populations



# General Methods

- ◆ Screen new refugees and immigrants for latent TB infection (LTBI)
  - New refugees entering King County receive screening and evaluation for TB by Health Department
  - Refugees and immigrants seeking primary care at HMC ambulatory care clinics receive screening and evaluation for TB



# Methods Continued

- ◆ Case management provided for refugees and immigrants from Somalia, Bosnia, and the former Soviet Union
- ◆ Limited case management provided by House Calls CCMs
- ◆ Collection and analysis of data on the provision and outcome of TB services including case management
- ◆ Conduct focus group discussions and analyze results





# Outreach Workers

- ◆ Respected members of the target communities
- ◆ By nature of ‘being Bosnian, Somali, or Russian/Ukrainian’ outreach workers embody the cultural knowledge and understanding of their community
- ◆ Must effectively straddle the divide between the medical system and the beliefs and values of their community- advocating for both sides



# Case Management Involves

- ◆ INH refill deliveries to the home and regular telephone contact throughout course of therapy
- ◆ TB related health education initially and reinforced over time
  - Infectious disease information specific to TB
  - Isoniazid and its side effects
  - Cultural implications of TB and related symptoms
- ◆ Informational assistance related to housing, school, employment, etc.
- ◆ Health care referral assistance
- ◆ Social support



# Tracking Systems

- ◆ Database #1: process outcomes for all case-managed clients documented after each encounter by project outreach workers



# Case management Process Outcomes

## ◆ Encounter Topics

- 93% of encounters involved discussion of INH
- 34% of the time TB was discussed outside of context of INH and compliance
- 92% of encounters involved discussion of socio-cultural issues
  - housing
  - school
  - employment
  - referral for primary care

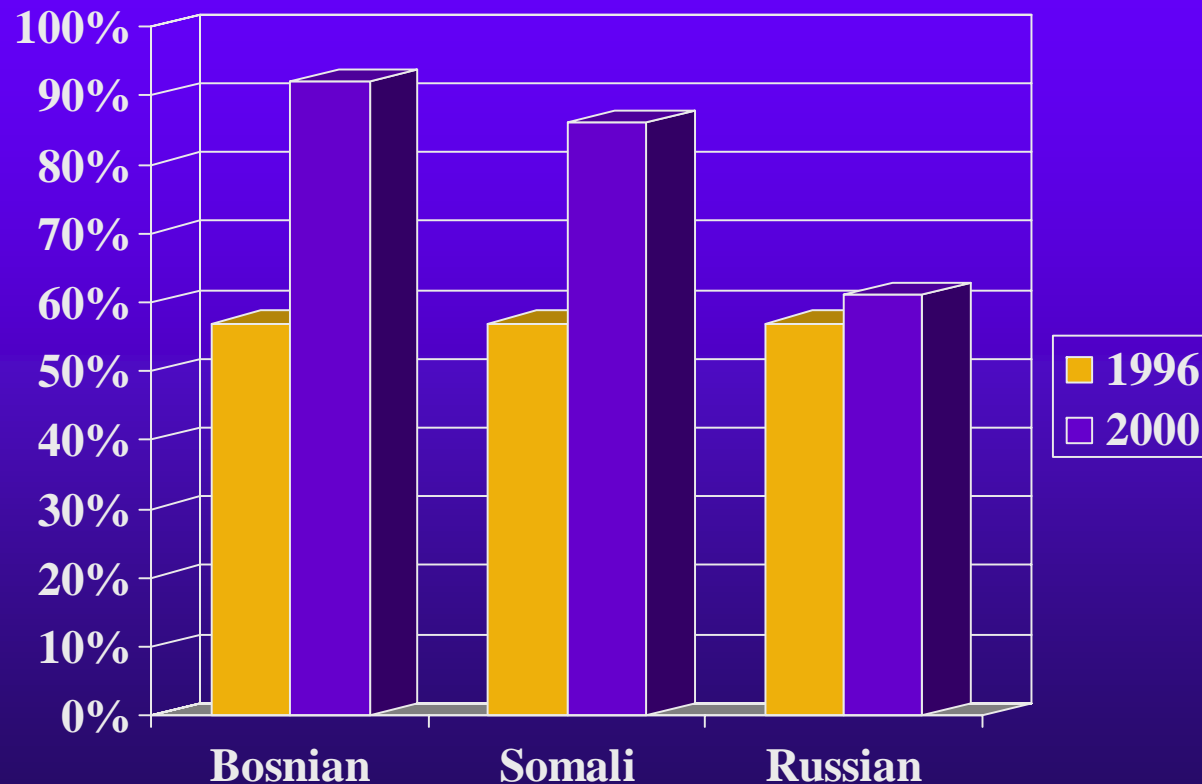


# Tracking Systems

- ◆ Database #2: demographic and clinical information for all clients screened including PPD & CXR results and INH start & completion dates

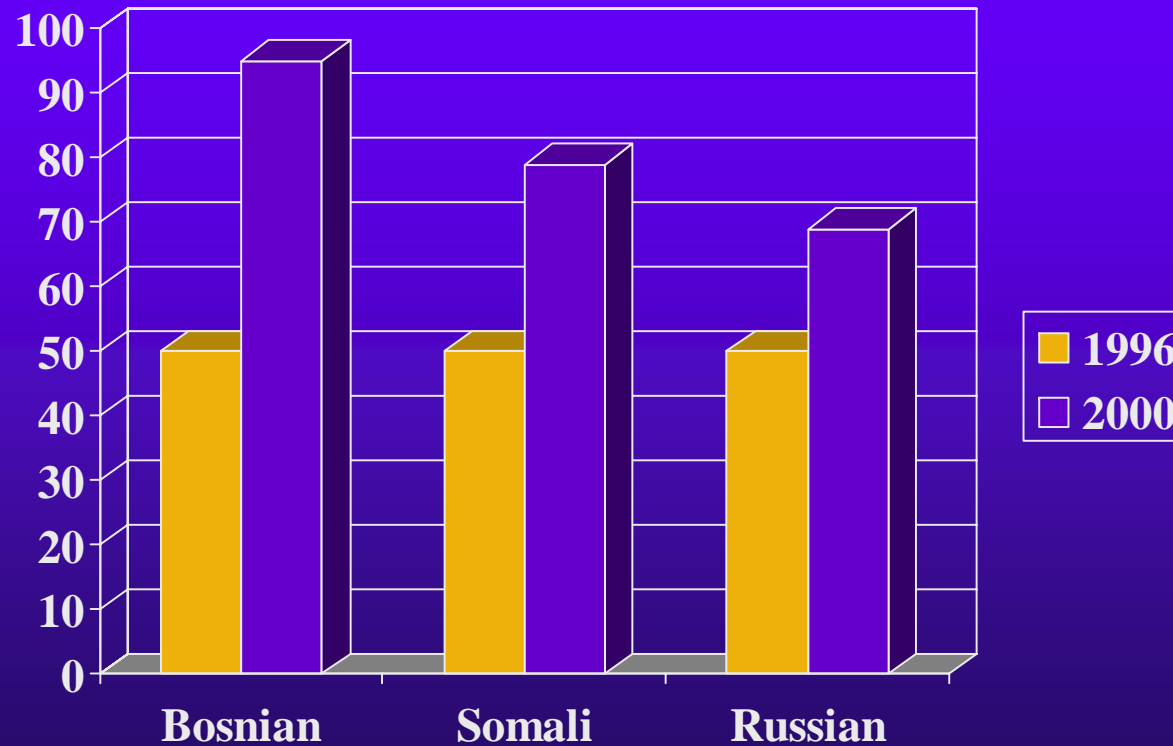
# Acceptance of INH

Initiation of therapy rates (1996 Vs. 2000)



# Completion of INH

Completion of therapy rates (1996 Vs. 2000)





# Focus Group Discussions

- ◆ 6 per target community
- ◆ Unstructured discussions by design
- ◆ Examples of discussion topics
  - Symptoms of TB and respiratory diseases
  - Social significance of TB
  - Implications of medication therapy
  - Medication in the absence of illness
- ◆ Attempting to Identify
  - Culture-specific concepts that impact TB control
  - Areas of conflict within medical culture





# Emerging Themes from FG Data

## ◆ Bosnian

- “Polluting the body” phenomenon:
  - ‘man-made medicines do more harm than good’
  - ‘man-made medicines are too strong’
- “Health goes through the mouth”
- MDs in Bosnia will prescribe natural remedies in tandem with ‘man-made medicines’:
  - the 2 ‘systems’ are by no means in conflict

# More Emerging Themes

## ◆ Russian/ Ukrainian

- Positive skin test results are indicative of successful prior BCG immunization
  - + PPD is understood to = protection from TB
- Distrust of approach and techniques among MDs in USA “higher technology, but less skilled practice”
- Refusal to start INH TLTBI in part related to the ‘way’ in which the recommendation for treatment is made by the provider and the lack of confidence on the part of the client that follows



# More Emerging Themes

## ◆ Somali

- TB diagnosis = an unavoidable and life-altering stigma
- Active TB well understood, however frequently no reference point exists for understanding latent TB infection
- When providers use the word ‘try’ as in “try this medicine” there is a belief that the medicine is given for experimentation not for health promotion purposes
- Families can be ‘TB Families’...TB reoccurring throughout generations
- TB as a test by God
- TB as ultimately related to ‘God’s Will’ but one is obligated to try to treat the disease- “can’t give up”





# Some Lessons Learned

- ◆ Acknowledgement of health screening overseas during clinic encounter is important and impacts understanding, trust, and outcome of TB evaluation

“why is TB screening needed again when I passed my screening in Kenya?”

- Overseas: Screening for Active TB
- USA: Screening for Active & Latent TB



# More Lessons Learned

- ◆ TB 'INFECTION' VS. TB 'DISEASE'
  - Medicine for TB overseas = Medicine for active TB
  - INH TLTBI is not widely used/ available in overseas settings
  - TB is well understood to involve a cough, fever, weight loss, etc. but TB in the absence of symptoms (LTBI) is not commonly understood
  - Emphasis in TB education is more successful when focussed on 'preventing this horrible stigmatizing disease' rather than on 'treating an infection'



## More Lessons Learned

- ◆ Culturally-based model for TB Prevention is in conflict with ‘business as usual’ in TB control
  - community-centered not clinic-centered model of care
  - acknowledgement and acceptance that a trained outreach worker is not only capable of, but **BETTER** positioned to, provide TB related education in a culturally congruent and thus, meaningful manner
  - time spent with case managed clients addressing non-TB related issues needs to be viewed as just as important as it impacts the trust relationship, which ultimately impacts compliance with INH



## More to Come. . .

- ◆ Partnerships with community clinics
- ◆ Cost/efficacy of intervention
- ◆ Complete ethnographic analysis
- ◆ Education
  - Providers
  - Communities
- ◆ Project replication in communities elsewhere in the country



# UNANSWERED QUESTIONS

- ◆ Self-reported INH compliance Vs. actual consumption?
- ◆ Use of cultural knowledge by outreach workers- how does it play out?
- ◆ Importance and value of cultural knowledge for providers in clinic settings?
- ◆ Adaptability/flexibility of clinic system - supervisors/policies/etiquette/funding constraints?
- ◆ Can this model for TB prevention be replicated with similar results elsewhere in the country?
- ◆ Cost per course of therapy completed? Value of cost results in respect to all benefits of program?





# Further Resources

TB Clinic:

<http://www.metrokc.gov/health/stssvs/tuberculosis.htm>

Ethnomed:

<http://healthlinks.washington.edu/clinical/ethnomed/>