NJ Annual TB Update

Looking Back on How Far We Have Come

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A Bit of Personal History -1

• *Dramatis personae*
  – Allen Gibbs
    First Deputy Commissioner of Health, New York City Health Department,
    Later Deputy Commissioner Department of Institutions and Agencies
    (Human Services) NJ State Department of Health
  – Lee B. Reichman
    Director, Bureau of TB, New York City Health Department (later,
    Director Pulmonary Division, College of Medicine & Dentistry of NJ
  – Time Frame: 1974
A Bit of Personal History -2

- After his transition to New Jersey, Gibbs approached Reichman
  - Gibbs: “You once told me TB could be treated almost entirely on an outpatient basis”
  - Reichman: “That is true, why?”
  - Gibbs: “We have a TB Sanatorium, Glen Gardner, that costs the state $3.3 million annually to run, can you help me close it”
  - Reichman: “Sounds like a great challenge, thanks for asking. Let’s do it!”

Tuberculosis Hospitals in the US -1

- Tuberculosis hospitals (sanatoria) proliferated in the 20th century
- 1904: 115 TB hospitals with 8000 beds
- 1923: 656 TB hospitals with 66,000 beds (half under state, county, or municipal auspices; half private)
- Institutions and beds continued to increase steadily, despite declining TB mortality
- 1953: 839 TB hospitals with 130,322 beds
Tuberculosis Hospitals in the US -2

- The structured, sheltered environment represented a haven from the stigma and realities of their diagnosis, providing a structure for education and psychological support
- But, the hospitals also represented a time of imprisonment, isolation, and diversion from patient responsibilities and achievement of their ambitions

Tuberculosis Hospitals in the US -3

- Initial enthusiasm was supplanted by reality as statistics were examined around 1914-1920
- 51% of discharged patients were dead at 5 years
- Among those discharged as “cured” death rate was still triple the general population
By 1973 in New Jersey

- New TB drugs and improvements of social conditions had decreased TB and its complications
- Ranked 19th in its new active TB cases rate and 9th in total TB incidence among all 50 US states
- Newark (largest city) ranked first among 58 US cities of 250,000 or more population in new active case rates
- High TB rates were thought to be due to: poor reporting, variability of tuberculosis clinics, lack of patient follow-up, uncoordinated services, varying organizational structures of TB control programs, and out-dated laws

In 1974 New Jersey addresses the TB Problem

- Four major recommendations were issued:
  - All outdated tuberculosis control laws should be revised or repealed
  - The State Health Commissioner be given supervisory powers over all aspects of all local tuberculosis control programs
  - General hospitals should be required to provide in-patient care of tuberculosis patients with financial aid adopted for all hospitals
  - Bacteriological examinations shall only be performed by laboratories approved by the State
In 1974 New Jersey addresses the TB Problem

- Because of the new rules, it was decided to assess the New Jersey Hospital for Chest Diseases, a free standing TB Sanatorium, built and owned by the state and used since 1907
- The State Commissioner of Institutions and Agencies appointed a 9 member task force, made up of local and national authorities, to assess the hospital, it’s future and the future of tuberculosis control in New Jersey
- All the patients at The New Jersey Hospital for Chest Diseases we personally seen and evaluated by this task force on November 15, 1974

History of New Jersey TB Hospital

- In 1907, New Jersey opened its only state owned and operated TB Hospital in Glen Gardner, NJ: New Jersey Sanatorium for Tuberculosis Disease
- The NJ State TB Hospital’s premier location high up on a mountaintop with 600 acres of land provided inpatient, comprehensive TB treatment for adult patients
- It was a model institution, providing individual and public health benefits to an expected 500 cases annually
- It treated more than 10,000 patients between 1907 and 1929
- In 1975, after the task force report, it was closed as a dedicated TB hospital
- In 1977 it became a state nursing home and a 288-bed psychiatric hospital
- In 2011, New Jersey decided to close the hospital, saving $9 million annually
TB Therapy in 1974

- Up until TB drugs started to be introduced in the 1950's, treatment was long term bed rest and fresh air which led to the Sanitorium (TB Hospital) movement in the late 19th century and early 20th century
- Short course therapy with Rifampin containing regimens had not yet been introduced
- Usual duration of these regimens were 18-24 months
- DOT and case management made outpatient follow up very feasible and adherence was vastly improved

TB Clinical Care in 1974

- Widely accepted that TB patients should be hospitalized only on the basis of clinical conditions requiring acute in-hospital care and not because of their diagnosis
- Comprehensive *out-patient care* for tuberculosis patients with DOT and case management was more successful and far less costly than long term hospitalization and kept the patient in his own community, with his/her family and other support system
TB Hospital Survey

- To prepare for the Task Force visit and evaluation, the hospital administrative staff had completed survey forms on each of the 173 in-patients indicating demographic information, payment sources, source of referral, current diagnosis, bacteriology examination and current drug therapy.
- The survey forms were reviewed by the task force and the patients placed in one of five categories.

Survey Categories in 173 Inpatients in 1974

1. Negative cultures, under 65 years of age – 31 (17.9%)
2. Negative cultures, over 65 years of age – 12 (6.9%)
3. Special medical problems – 28 (16.2%)
4. Newly admitted, culture status pending – 36 (20.8%)
5. Positive bacteriology – 66 (38.2%)
Task Force Re-evaluations -1

- All patients were personally visited by Task Force members to objectively evaluate their ambulatory condition, ability to care for personal needs, symptoms, other concurrent diagnosis: alcoholism, addiction, chronic obstructive pulmonary disease, other chronic disease, behavioral problems, psychiatric problems
- Survey forms re-reviewed after the patient visits; each patient was further categorized according to the level of care needed for his/her present tuberculosis condition

Task Force Re-evaluations -2

- Out-Patient Care – 133 (76.9%) –taking TB treatment fully ambulatory; did not require in-patient care by current standards, but required continued supervision in adequate out-patient facilities until adequate anti-tuberculosis drug therapy completed (18 to 24 months)
Task Force Re-evaluations -3

- Nursing Home Care – 28 (16.3%) – taking tuberculosis treatment, not fully ambulatory, and could not care for themselves. They did not require in-patient care in this hospital, but required care in nursing homes or other long-term care facilities.

Task Force Re-evaluations -4

- Acute Hospital Care - 2 (1.1%) – acutely ill with newly diagnosed or reactivated tuberculosis. Acute care could be provided in a general hospital that treats acutely ill patients of all kinds.

- Support services such as medical intensive care unit, coronary care unit, arterial blood gases, cardiac arrest team, and operating room facilities available in a general hospital setting, were not available in this TB hospital.
Task Force Re-evaluations -5

- **Chronic Hospital Care** – 2 (1.1%) – TB treatment plus primarily chronic pulmonary disease. Require specialized support facilities such as respiratory care unit with frequent blood gases; constant use of respirator or oxygen which should be available in long-term facilities

- **Psychiatric Hospital Care** – 8 (4.6%) – TB treatment plus psychiatric or behavioral problems which belong in specialized psychiatric hospitals

Alcoholism

- Question of feasibility of treating tuberculosis alcoholic patients as out-patients in lieu of hospitalization as a means of ensuring drug ingestion

- It has been amply proven that a comprehensive clinic arrangement with field visit follow-up or directly observed treatment at the clinic or patient's home, daily or intermittently, is extremely successful and far more economical and humane than hospitalizing these patients
Conclusions of the Task Force -1

• Tuberculosis is still a serious public health problem in New Jersey. The development of general hospital treatment facilities and adequate out-patient facilities is needed to update the quality of care and control and has actually been *impeded* by the ready availability of the New Jersey Hospital for Chest Diseases for long-term care at state expense.

Conclusions of the Task Force -2

• Any change will affect the entire State of New Jersey.
• No consideration of the TB hospital’s future can be made without considering the entire State’s tuberculosis control program for both inpatients and outpatients.
• Recommendations are presented together as a unit. *It would be disastrous to implement any of these recommendations separately.*
Conclusions of the Task Force -3

- Tuberculosis should be fully integrated into modern medical practice. “The perpetuation of specialized tuberculosis hospitals is an anachronism”
- A review of all the patients at the New Jersey Hospital for Chest Diseases revealed that *most did not require in-hospital care and could be discharged*
- Adequate out-patient facilities offering DOT and case management are not available to many patients in the state. *Such facilities must be established and widely distributed*

Conclusions of the Task Force -4

- Patients who do not require in-hospital care could receive it in TB clinics near their homes
- Remaining patients have problems other than or in addition to tuberculosis which could be adequately and more economically cared for in long-term care facilities
- Tuberculosis in alcoholics is usually difficult to treat but can be successfully managed in properly designed and administered ambulatory care programs
Task Force Recommendations -1

- The New Jersey Hospital for Chest Diseases should be closed as a state chest disease hospital no later than June 30, 1975
- The tuberculosis control program of the State Department of Health should be revised and upgraded as pertains to in-patient and out-patient care and control
- All outdated tuberculosis laws should be revised or repealed and the Commissioner of the State Department of Health be given, proper supervisory powers over all local tuberculosis control programs

Task Force Recommendations -2

- General hospital and long-term care facilities, including state institutions, should be required to provide in-patient care for tuberculosis patients as needed
- Since modern tuberculosis treatment and control depend upon ambulatory services, these services must be initiated, expanded and improved, augmented, and upgraded
Task Force Recommendations -3

• An equitable and up-to-date program of state financial aid should be adopted for all in- and out-patient facilities which supply adequate care for TB patients *contingent upon* prompt reporting and adherence to standards of performance
• The estimated additional costs to the State Department of Health will be $1.3 million for fiscal year 1976

Task Force Recommendations -4

• These monies would be provided by the transfer of $1.3 million of the annual $3.3 million budget of the New Jersey Hospital for Chest Diseases to the State Department of Health
• An evaluation committee appointed by the State should periodically review the performance of the State Health Department in its Tuberculosis Control Program
• A concerted educational effort on the part of the official and voluntary agencies, with the help of the media, to prepare the providers and consumers to accept and participate in general hospital and community based diagnosis and treatment of tuberculosis
Task Force Recommendations -5

• Commissioner Ann Klein of the Department of Institutions and Agencies and her staff were concerned about the appropriateness of the fact that New Jersey still had a dedicated tuberculosis facility
• Questioned the utility of such a program in an era when tuberculosis was widely being brought back into the mainstream of medicine and medical care
• Concerned about the annual use of $3.3 million dollars that perhaps might be better spent elsewhere
• Concerned that existence of state TB hospital as a convenient dumping ground for undesirable patients, actually kept the state from facing its responsibility to develop a meaningful program for outpatient tuberculosis management

Task Force Recommendations -6

• The time had come for general hospitals to accept their rightful responsibility to hospitalize tuberculosis patients when needed, some of whom are alcoholic or unkempt
• The medical profession, in its hospitals, clinics, and private offices, must respond to the local needs of the community
• There is no valid medical or non-medical reason why tuberculosis should be separated from the rest of medical care with segregated hospitals and clinics
• If a need for care for tuberculosis patients exists, than the local community must fulfill that need
• With the existence of state TB hospital, there has been no motivation to do this
Final Thoughts

- An assessment of the process and result caused one to ask “Why did it take so long?”
- The answer wasn’t too obscure
  - The hospital was the biggest employer in the area
  - The hospital director was a well loved older gentlemen with a long standing chronic debilitating disease, and his colleagues and patients feared he wouldn’t be able to find new employment elsewhere
Acknowledgements

- Bernie Rodriguez

Reference

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