RTMCC

Northeastern Spotlight

FALL 2009 VOLUME 4 · NUMBER 3

Dear Colleague,

I hope that you all had an enjoyable summer. We at GTBI, like many of you, spent part of our summer preparing our submission for the 2010 CDC Cooperative Agreements. This year's Cooperative Agreement had interesting new additions and requirements around Program Collaboration and Service Integration (PCSI), program evaluation, and cohort review. In 2010 we will continue to conduct cohort review training and will be working with the TB Program Evaluation Network (TB-PEN) on identifying training needs around program evaluation. We have also worked successfully on securing funding for some exciting PCSI training activities with other federally-funded training centers (FTCs) in the Northeast planned for 2010, and will share details of these in upcoming newsletters.

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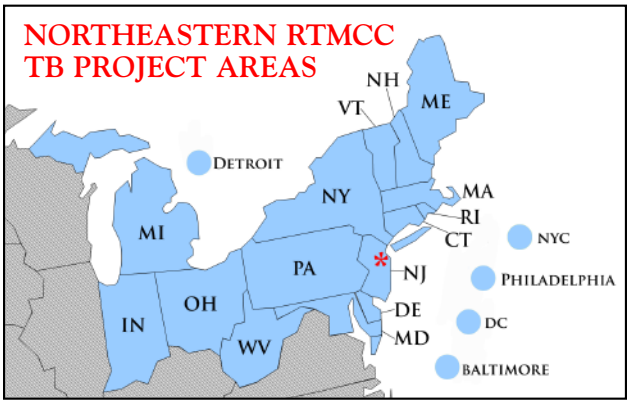

This newsletter includes a staff profile of Jeanette Rodman, the TB Program Manager from Delaware, as well as another article in our series on Behavioral Research in TB Control. We also highlight a newly posted audio-archive from our website and a training course for clinicians conducted this summer in Washington DC, the southern reaches of the Northeast region.

As always, thanks for all your efforts, and we look

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The Northeastern Regional Training and Medical Consultation Consortium is a collaborative effort of the Charles P. Felton National Tuberculosis Center at Harlem Hospital, the Massachusetts Department of Public Health, Division of Tuberculosis Prevention and Control, and the NJ Medical School Global Tuberculosis Institute and provides training, technical assistance, and medical consultation to health care professionals throughout the Northeastern United States.

RTMCC Communications Sub-Committee: Bill Bower, MPH • Nickolette Patrick, MPH
Newsletter design by Judith Rew

We would like your feedback…please let us know what you think of this newsletter, future newsletter ideas, and/or article contributions you wish to make. Send an email to Nickolette Patrick, MPH, Newsletter Editor at npatrick@hria.org. Thanks!

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INSIDE:

STAFF PROFILE

Jeanette Rodman's Long Trek to the TB World

Jeanette (Jeannie) Rodman, the Tuberculosis Nurse Consultant for the Delaware Division of Public Health, came to work in Tuberculosis through a very roundabout path. She grew up in bucolic Salem, New Jersey, "where they grow tomatoes and mosquitoes." After working as a printer and a salesman, she eventually went to nursing school at the age of 37 and then moved to Delaware to work in one of the state's big nursing homes as a woundostomy and continence nurse/supervisor.

Delaware doesn't have a lot of nurses with both an MSN and community health experience, so when a position opened up four years ago in the TB Program, someone from the communicable disease bureau called and asked if she'd like to interview for the position. Jeannie decided she had nothing to lose, and was interviewed by two nursing supervisors, the program administrative support person, and Dr. Jackson, the communicable disease bureau chief.

"Dr. Jackson looked a bit like an oversized Andy Warhol, but as soon as I saw him I knew he'd be an important person in my life," Jeannie recollected. "It was the most fun I'd ever had on a job interview, and I was so impressed with the people that I decided I'd take the job if offered."

"Sometimes it's easier to do things in a small state, because you know everyone and can personally keep track of all the cases."

Jeannie enjoys working in a field where there are always new challenges and the learning never stops. The Delaware TB Program consists of two people: Jeannie and Robin Saxton, the Administrative Assistant. "Sometimes it's easier to do things in a small state, because you know everyone and can personally keep track of all the cases," Jeannie says.

"Our first case of 2009 started out with a panicked call from a local hospital on New Year's Eve. They had a suspect who was threatening to leave against medical advice, and they were wondering if they had a legal right to make him stay. In Delaware we can't legally restrict anyone unless they've been definitively diagnosed as having active TB disease and are a threat to the public health, or have been given several chances to comply with testing, treatment, etc. and failed. But I told the hospital to try and convince him to stay there for another 30 minutes, then got on the phone to one of the TB clinic nurses who immediately went running off to the hospital. Fortunately the patient was still there, and she drew his blood and ran a QuantiFERON test over the long weekend, which turned out positive. His skin test, read the following week, was negative, so he could have slipped through the cracks had we not caught him in time."

The poultry processing plants in the southern part of the state have been a particular challenge for the TB Program. "Because of OSHA guidelines, the workers rotate to different stations, so when a case pops up in a processing plant, there are a huge number of contacts," Jeannie explained. Delaware also collaborates with the plants on a targeted testing program for the workers, among whom are many immigrants. As a condition of employment, those who test positive must complete a course of treatment.

In her spare time, Jeannie likes to bird-watch, kayak, and garden. This summer she grew five different varieties of potatoes, rainbow chard, green beans, flowers, and the obligatory "pole limas" (the bush variety of lima beans are scorned in Delaware, despite being easier to grow).

Jeannie also recently acquired five Welsummers, a heritage breed of chicken that lays dark brown speckled eggs. "Soon after I got the chickens, a big craze for heritage breeds started and the hatcheries sold out. Little did I know I'd be so trendy!" Jeannie says.

She converted part of her backyard shed into a chicken coop, and the chickens run free in the backyard. "They're fun to watch, and I get fertilizer and breakfast from them." Her husband, Cliff, was initially reluctant to get chickens, but he has since warmed up to them.

Jeanette Rodman busy but smiling at work.

One day this summer, Jeannie looked out her window and saw Cliff sitting on a chair in the backyard with the chickens on the chair arms and his lap, sharing an ice cream cone with him. Unlike her husband, Jeannie's tomcat was extremely excited when the chickens arrived. He started stalking one of the chickens, but then the chicken whipped around and started chasing after the tomcat! The cat ran away, and hasn't tried to turn a chicken into lunch since.

Jeannie also loves to travel—she was inspired by a book she read to go to Scotland, and she has since been back five more times. After high school, Jeannie took an extended trip through Europe. She lived in a cave on the Canary Islands, fishing out of a lake and eating almonds. Then she took a boat to Morocco and hitchhiked across the Sahara desert, and finally ended up in Liberia, where she taught phonics at a Catholic school. On a related note, Jeannie says, tongue firmly in cheek, that she regularly wins awards for "Most Eccentric Employee."

—Submitted by Nickolette Patrick

SPOTLIGHT

Current Behavioral/Social Science Studies in Tuberculosis – Part 3: Providers Serving the Foreign Born

The last two installments of this column have focused on behavioral studies being conducted through the Tuberculosis Epidemiological Studies Consortium (TBESC) – specifically, Task Orders 13 and 9. The subject of this installment, Task Order 12, is motivated by the same concern as Task Order 9 – improving outreach and treatment to the foreign-born – but focuses instead on the providers who serve this group. As with other Task Orders (TOs), the co-principal investigators for TO 12 include experts from academia (Carey Jackson, University of Washington), public health (Jenny Pang, Seattle & King County), and CDC (Nickolas DeLuca). I served as an advisor for this project.

TASK ORDER 12 – PRIMARY CARE MANAGEMENT OF LATENT TUBERCULOSIS INFECTION (LTBI) AND TUBERCULOSIS DISEASE AMONG IMMIGRANT POPULATIONS: A STUDY OF BARRIERS AND FACILITATORS

As mentioned in the last installment, foreign-born people represent the majority of TB cases in the US (CDC 2008) and as indicated by several recent studies, a large majority of persons recommended for LTBI treatment (Horsburgh et al in press; Sterling et al 2006). TO 12 focused on primary care providers serving people from Mexico, the Philippines, and Vietnam, the three countries with the highest TB incidence among immigrants. The study was conceived in two phases: the first phase entailed formative research to determine TB knowledge, attitudes, and practices of primary care clinicians serving the target groups. Using information from the first phase, an intervention to change provider behavior was designed and tested in the second phase.

PHASE 1 – FORMATIVE RESEARCH

In the qualitative assessment phase conducted in 2005 – 2006, a total of 80 health care providers were interviewed in groups or individually in six regions – Honolulu, Seattle, San Francisco, Orange County CA, Dallas-Fort Worth, and Boston. To participate, providers had to work in primary care settings (family practice, internal medicine, pediatrics, women's health), have at least 25% of patients be foreign-born, have at least 3 years of clinical practice with at least one year at their current sites, and *not* be employed by a public health department.

Providers reported a number of factors they felt facilitated effective LTBI screening and treatment:

- having a designated staff person to manage TB screening and treatment adherence
- maintaining a good relationship with the local TB clinic
- making disease prevention and health promotion part of the clinic's culture of care

Factors and attitudes working against effective LTBI care included:

- believing that patients' positive TST results were solely due to past BCG infection
- not taking TB seriously because it was so rarely seen
- financial disincentives for screening and treating LTBI
- lack of staff to ensure or encourage LTBI treatment adherence
- LTBI treatment viewed as "too long" (considering BCG vaccination, HIV, and recent contact), and guidelines suggesting that age should no longer be considered a factor in prescribing LTBI treatment.

PHASE 2 – INTERVENTION TO ALTER KNOWLEDGE AND ATTITUDES

Phase 1 results were used to design an educational intervention to modify knowledge and attitudes among providers serving the foreign-born. An educational intervention was chosen because the Phase 1 primary care providers were not clear on the definition of risk groups for TB (including HIV, diabetes, and other co-morbid conditions), TST interpretation

Participants showed increased knowledge regarding TST interpretation, risk groups, and the effectiveness of isoniazid therapy for all age groups unless contraindicated.

A pre-test survey was administered to 92 primary care providers (who were selected using the same criteria as Phase 1 but with different individuals), followed by a 1-hour didactic session delivered by a local TB expert and then a post-test survey. Responses to knowledge items generally improved from pre- to post-test, becoming more consistent with CDC/ATS guidelines. Participants showed increased knowledge regarding TST interpretation, risk groups, and the effectiveness of isoniazid therapy for all age groups unless contraindicated.

However, some items revealed on-going issues consistent with those identified in Phase 1. Private physicians continued to be concerned about reimbursement for LTBI care and the financial incentives for ensuring LTBI treatment completion. Providers who worked in federally qualified health

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Medical Consultation

MEDICAL CONSULTATION SERVICES:

GTBI faculty and staff respond to requests from providers seeking medical consultation through:

- Our toll-free TB Infoline: 1-800-4TB-DOCS and
- Email

During each consultation, the GTBI consultants will advise providers of TB Program resources for consultation in their jurisdiction. In addition, TB programs will be informed of TB cases with public health implications such as MDR/XDR-TB, pediatric TB in children <5, or potential outbreak situations.

More information about our consultation service, including downloadable Core TB Resources, can be accessed at http://www.umdnj.edu/globaltb/consultation.htm

MEDICAL CONSULTANT WEB-BASED GRAND ROUNDS:

Periodically, designated TB program medical consultants are invited to participate in a web-based TB case conference (or grand rounds). Consultants are encouraged to present challenging TB cases on which they would like feedback from their colleagues throughout the Region. The next grand rounds will be held this Fall and we will notify TB programs when a date and time have been established. TB program medical consultants who would like to present a case should contact Dr. Alfred Lardizabal at 973-972-8452 or lardizaa@umdnj.edu.

Current Behavioral

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centers and public hospitals, in contrast, were more likely to encourage patients to initiate LTBI treatment and to access resources for billing and nursing support. Providers also pointed out the difficulty in explaining the need for LTBI treatment, suggesting that more attention be given to patient education materials.

CONCLUSION

Findings from Task Order 12 demonstrate the effectiveness of an educational intervention to modify basic TB knowledge among primary care providers serving foreign-born patients. It also underscores the limitations of an educational approach in addressing issues such as financial and logistical limitations in screening and treating LTBI in private practice settings, and overcoming attitudes about the need for LTBI treatment among individuals who received BCG vaccination.

This column's next installment will focus on Task Order 11.

Submitted by Paul Colson, PhD, Program Director, and Julie Franks, PhD, Health Educator and Evaluator
Charles P. Felton National TB Center at Harlem Hospital

CITATIONS:

Centers for Disease Control and Prevention. Trends in Tuberculosis — United States, 2007. MMWR 2008; 57:281-285.

Horsburgh CR, Goldberg S, Bethel J, Chen S, Colson P, Hirsch-Moverman Y, Hughes S, Shrestha-Kuwahara R, Sterling TR, Wall K, Weinfurter P, TBESC. In Press. Latent tuberculosis infection treatment acceptance and completion in the United States and Canada. Chest.

Sterling TR, Bethel J, Goldberg S, Weinfurter P, Yun L, Horsburgh CR, Tuberculosis Epidemiologic Studies Consortium. The scope and impact of treatment of latent tuberculosis infection in the United States and Canada. Am J Res Crit Care Med 173(8):927-31, 2006.

Dear Colleague

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forward to working with you in 2010 as we all implement the plans submitted in next year's Cooperative Agreements.

Lee B. Reichman, MD, MPH
Executive Director
NJMS Global Tuberculosis Institute, the Northeastern RTMCC

Pushing it Up a Notch: Advanced TB Training for Clinicians

As TB cases are declining but getting more complex and expertise is waning, we have heard from our stakeholders that a different kind of TB training is needed. Many TB programs have done the traditional "intensive" or "comprehensive" courses geared to immersing clinicians in all topics related to TB, but not exclusively focusing on one or two areas. What do you do when there are experienced clinicians who seem to know all there is to know about the basics? You create a tailor-made course for the experienced clinician! This idea lead to the Advanced TB Training for Clinicians, a one-day course which took place in Washington, DC on July 10, 2009.

The Advanced TB Training for Clinicians course was a joint venture, conceived by the District of Columbia Department of Health – TB Control Program, Maryland Department of Health and Mental Hygiene, the Baltimore City Department of Health - TB Program, and the NJMS Global Tuberculosis Institute,. The three TB control programs in the group, along with the Virginia TB program, co-manage many cases along their common borders. Their existing relationship made for a very effective planning process.

This course was designed for experienced TB physicians and nurses with at least one background course in TB fundamentals, and attendance was by invitation of the participating TB programs. Advanced topics in TB were addressed using a lecture and interactive, case-based approach. Topics included an overview of recent TB guidelines as well as management of adverse reactions, drug intolerance, and co-morbidities. In addition, there was also a breakout session for medical management issues (drug resistant TB and radiography) and nurse case management issues.

We were fortunate to have faculty who brought expertise from the four project areas represented. Not only did faculty teach, but they sat around the table with the participants and engaged in discussion and questions, also learning from the experience of the whole group. There were twenty invited participants (nine physicians and eleven nurses).

Not only did faculty teach, but they sat around the table with the participants and engaged in discussion and questions, also learning from the experience of the whole group.

Participants enjoyed the course and particularly valued the case-based approach. There are plans in the works to extend this model to other parts of the RTMCC region using the same customized approach, as well as offering another training in the Maryland, Baltimore, DC, and VA area.

—Submitted by Rajita Bhavaraju and DJ McCabe

New Archived Webinar: Working Effectively with Diverse Populations

We are pleased to announce that a new web-based seminar has been added to the GTBI audio archive. The well-attended Best Practices in TB Control: Working Effectively with Diverse Populations web-based seminar, originally broadcast on March 26, 2009, is now available. The web-based seminar (webinar) explores topics around understanding cultural differences in health attitudes, beliefs, behaviors, and language. A better awareness of these differences helps health care providers and other TB program staff work more effectively with patients from other cultures.

The webinar began with a presentation by Bill Bower, Director of Education & Training at the Charles P. Felton National TB Center. Bill presented an overview of TB epidemiology in the Unites States, including TB in non-US born individuals, and an introduction to cultural competency and why it is important in providing TB care.

Sapna Pandya, Director of Programs for the South Asian Health Initiative at New York University School of Medicine's Center for Immigrant Health, followed with a lively and interactive presentation covering differences in naming systems, generalizations versus stereotypes, a discussion of barriers to care faced by immigrants, and individual- and programmatic-level suggestions for addressing these barriers.

Finally, Jane Moore, the Assistant Director/Nurse Consultant for the TB Control and Prevention Program, Division of Disease Prevention in the Virginia Department of Health, shared the experiences of the Virginia TB Program with using technology to improve communication. Jane described the need to develop materials that could be used to work with TB patients from other cultures and gave a live demonstration of the online patient education tools in a number of different languages that were developed in conjunction with Healthy Roads Media.

The webinar was very well evaluated and participants were very enthusiastic about using the online tools. The archived audio, presentations, and supporting materials can be accessed at: http://www.umdnj.edu/globaltb/audioarchives/diverse.html

Bacteria with Fangs: The Story of the New England Vampires

Coughing up blood, weight loss, lethargy, night sweats—today we urge anyone with these symptoms to "think TB." But 18th and 19th century Americans had an alternate diagnosis for these symptoms: vampire attack.

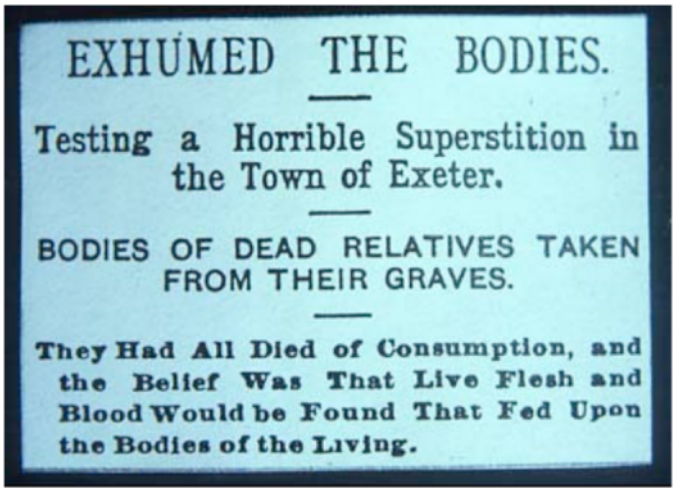
Vampires were thought to be dead people who slept in their graves during the day and were transformed into blood-sucking monsters at dusk. They preyed on the living, particularly any of their friends or family members, slowly draining their victims of blood until they died. The symptoms of TB closely mirrored the folkloric traits of vampires, a belief that immigrants from Europe brought with them to America.

The idea quickly took root among settlers in the New England countryside as a rationalization for the TB epidemic spreading through their communities. Crowded living conditions, poor nutrition, and a long-held belief that drafts and fresh air were unhealthy meant that TB spread easily and frequently turned into active disease.

Desperate to stop more people from wasting away and dying, New Englanders conducted contact investigations. To be considered a suspect, you had to be in close contact with the person who was ill, just like contact investigations today. But their list was narrowed down rather quickly, since in order to be a suspected vampire you also had to be dead.

Fortunately this meant the suspects were easy to locate, as most sat nicely labeled in the local graveyard. The suspected vampires were then exhumed and their remains examined for signs of vampirism. Diagnostic criteria included well-preserved remains, blood in the heart, bloating, and hair and fingernail growth after death. However, these were not hard-and-fast rules. If the level of suspicion was high enough, even the most desiccated, bloodless corpse could be declared a vampire.

Once you had a vampire, the next order of business was to kill it. This was rather challenging: How do you kill something that already appears dead? The plucky New Englanders came up with a variety of methods they determined effective, including burning the heart, severing the head and leg bones, and decapitating the head and creating a "skull and crossbones" arrangement. If the New Englanders were feeling particularly industrious, they went ahead and burned the body entirely.



EXHUMED THE BODIES.

Testing a Horrible Superstition in the Town of Exeter.

BODIES OF DEAD RELATIVES TAKEN FROM THEIR GRAVES.

They Had All Died of Consumption, and the Belief Was That Live Flesh and Blood Would be Found That Fed Upon the Bodies of the Living.

Providence Journal headline of March 19, 1892.

After the vampire was proclaimed dead, the next task was to cure anyone the vampire had preyed upon. A frequent remedy was burning the heart of the vampire and feeding the ashes to those afflicted. Presumably they had poor treatment outcomes, but the tradition continued for a couple centuries for lack of any better ideas.

One of the last documented cases of vampirism in the United States occurred in 1892 in Rhode Island (at one point known as "the Transylvania of America"). George Brown watched as his wife and two daughters slowly wasted away and died. When his son Edwin fell ill, a group of friends and neighbors approached George and offered to help dig up his dead family members to determine which one was the vampire preying on Edwin. George didn't believe in the theory of vampire attacks, which by this time had just about died out. But when Edwin's condition worsened and the doctors couldn't do anything to help him, George decided he had nothing to lose and might as well give the vampire killing thing a try.

Accompanying George and his well-meaning friends and neighbors at the exhumation was Dr. Harold Metcalf, a medical examiner who remained unconvinced that vampires were behind Edwin's illness. George's wife and one daughter were exhumed first, and both bodies were well-decomposed. But when the second daughter, Mercy, was unearthed, the crowd was astonished to see the corpse in very good condition.

Dr. Metcalf pointed out that Mercy's condition was

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Mercy Brown's grave today

Upcoming NE RTMCC Training Courses Planned for 2009

Courses are open to participants in the 20 project areas (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, NJ, New York State, New York City, Pennsylvania, Michigan, Indiana, Ohio, West Virginia, Delaware, Maryland, Washington DC, Detroit, Baltimore, and Philadelphia) which are served by the Northeastern Regional Training and Medical Consultation Consortium.

Individuals outside of this region who wish to attend our training courses should first contact their Regional Training and Medical Consultation Center to check whether the same or a similar course is being offered. If this is not the case, the out-of-region participant may then register for this course.

NAME OF COURSE	DATES	LOCATION
Substance Abuse and Tuberculosis: New Policy for Tuberculosis Control in Substance Abuse Treatment Centers	10/7, 10/14, 10/28, 11/5	Tewksbury, MA; Boston, MA; South Hadley, MA; Fall River, MA
TB Nurse Case Management: Strategies and Practical Applications	10/15	Albany, NY
TB Intensive Workshop (with IN, OH, MI, and Detroit)	10/21-10/22	Fort Wayne, IN
Cultural Awareness in TB Control	11/5	Newark, NJ
Medical Update in TB Control: Management of Tuberculosis in Emergency Department Settings	11/19	Web-Based Seminar
Tuberculosis Case Management and Contact Investigation for Nurses	12/9-12/10	Newark, NJ
Program Manager's Workshop for Regional and Local Staff	12/1, 12/8, 12/15	Web-Based Seminar

Bacteria with Fangs

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completely normal—the other two women died about ten years ago, while Mercy had only been dead for nine weeks. Also, it was the middle of winter, and you don't need any fancy degrees to know that not a lot of decomposing takes place when it's freezing. But it seems logic and reason don't hold much sway when you're debating with a crowd of enthusiastic vampire hunters, and despite Dr. Metcalf's hesitation, Mercy's heart and liver were removed and examined.

When blood started dripping from Mercy's organs, George finally became convinced his dead daughter was feasting on his living son. He took Mercy's organs to a nearby rock and burned them, then fed the ashes to poor dying Edwin, who promptly died a few weeks later.

Mercy Brown's grave can still be seen in Chestnut Hill Cemetery in Exeter, Rhode Island. The headstone is bolted to the ground, in case anyone is tempted to run off with a souvenir from one of America's many TB victims and one of its last suspected vampires.

For more information, check out the book Food for the Dead: On the Trail of New England's Vampires *by Michael E. Bell* (http://www.foodforthedead.com).

—Submitted by Nickolette Patrick

TB TRAINING COURSES

Upcoming TB Program Training Courses - 2009

TB PROGRAM SPONSOR	NAME OF COURSE	TARGET AUDIENCE	TARGET AREA	DATES	LOCATION	CONTACT PERSON
NH	5th Annual TB Conference	Public health Nurses, Other HCWs	NH	10/23	Catholic Medical Center, Manchester, NH	Lisa Roy 603-271-4492 lisa.b.roy@dhhs.state.nh.us
IN	TB Symposium	Public Health, Medical & ICP staff	IN	October	Indianapolis	Indiana State Department of Health & ALA 317-233-7434 sburkholder@isdh.in.gov
Ohio	4 Client - Centered HIV Counseling Courses will be offered. (This is a collaboration between HIV and TB programs)	Public Health Nurses	Ohio	TBA TBA TBA TBA	Regional areas in Ohio	Frank Romano CDC Public Health Advisor 614-466-6563 Frank.romano@odh.ohio.gov
Ohio	2 HIV Testing Courses	Public Health Nurses working with TB	Ohio	TBA TBA	TBA	Frank Romano CDC Public Health Advisor 614-466-6563 Frank.romano@odh.ohio.gov
MI	Tuberculin Skin Testing Workshops	Pubic Health TB Staff who regularly perform TST	MI	10/15, 10/22, 11/10, 12/9, 1/14, 2/11, 3/15	Regional areas in Michigan	ALA of Michigan 800-678-LUNG www.michigantb.org/hcp/trainings.asp
NYC	Tuberculin Skin Test Administration (2 additional courses planned)	Non-HD health care staff	NYC & Vicinity	TBA	TBA	Elvy Barroso 212-676-2914 ebarroso@health.nyc.gov