RTMCC

Northeastern Spotlight

SPRING 2009 VOLUME 4 · NUMBER 1

Dear Colleague:

On March 20th, the New Jersey Medical School hosted its second annual *Reynard J. McDonald World TB Day Lecture*. Dr. Kenneth Castro, Director of CDC's Division of Tuberculosis Elimination, gave an inspiring presentation on *The Global Challenges to Eliminating TB in the US* which generated a good deal of interest and lively discussion. Later in the day, Dr. Castro was a discussant during GTBI's bimonthly web-based grand rounds for TB program medical consultants in the Northeastern Region. It was gratifying to see that many of you also carried out educational and awareness activities in association with World TB Day.

In this issue of the Northeastern Spotlight, we are pleased to highlight three new products that we feel will be useful to TB program staff: a *Patient Education Flipbook*, a consolidated and revised *Diagnosis and Treatment of LTBI Pocket Card*, and a web-based resource on *TB Education and the Congregate Setting Contact Investigation*. This issue also includes the next Behavioral/Social Science installment which highlights some early and practical findings from the TB Epidemiologic Studies Consortium Task Order 13 on *Factors Associated with Acceptance of, Adherence to, and Toxicity from Treatment for LTBI*. In

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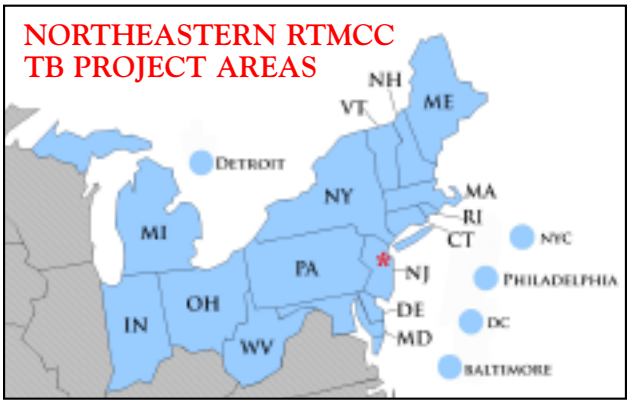

On-Line Survey:
WE VALUE YOUR FEEDBACK!
CLICK HERE AND TELL US WHAT YOU THINK OF OUR NEWSLETTER

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 • Chris Hayden
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 Chris Hayden, Newsletter Editor at haydench@umdnj.edu. Thanks!

NEW JERSEY MEDICAL SCHOOL
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INSIDE:

EDUCATION PRODUCTS

Three New/Revised GTBI Products

The end of 2008 and beginning of 2009 has been a busy time for GTBI health educators and trainers. We finalized development or revision of three TB educational products highlighted below, and several more are still in the works, so look for other new products in upcoming issues of this newsletter!

PATIENT EDUCATION FLIPBOOK

We are very pleased to announce the release of our new Patient Education Flipbook: *What You Need to Know About Tuberculosis*. This colorful, 30-panel flipbook, designed using the principles of low literacy health communication, was developed for health care providers to use while providing TB education to TB patients, suspects, and contacts. The flipbook includes simple, easy to understand messages with full color pictures and drawings on the panel seen by the patient, with talking points for the provider on the side viewed by the health care professional.

Though we feel that the completed flipbook was worth the wait, it was a long time coming! In 2002, CDC, in collaboration with NJMS GTBI, conducted needs-assessment activities around developing culturally appropriate TB patient education materials. Several formats were tested, including a patient education flipbook. Although brochures were identified as the preferred educational material, the flipbook also tested well with patients. A plan was made to develop a patient education flipbook based on the culturally appropriate TB patient education brochures once the brochures were completed. Development of the flipbook began in 2007 when NJMS GTBI staff went to three locations to interview TB clinic providers about the perceived utility of a patient education flipbook and to interview patients about the preferred graphic image style within a flipbook.

Key messages and photos (already field-tested) were then selected from the series of culturally appropriate TB patient education materials. Original drawings were developed to illustrate behaviors not easily depicted with photos. A draft flipbook incorporating information on TB diagnosis, infection, disease, and treatment was completed in early 2008. Volunteers for national field-testing were identified based on ability to test the flipbook with English-speaking TB patients and to represent a diverse group of incidence areas, professions, and geographic settings.

Field testing revealed that both patients and providers were very happy with the flipbook. Patients indicated they were comfortable with the use of the flipbook for receiving TB education: all patients reported that they understood the information presented and that they found the flipbook visually appealing. Overall, providers reported feeling comfortable using the flipbook and stated they would use the flipbook with future patients. Some minor changes were made to the flipbook based on feedback received during field testing, and the flipbook was finalized and printed in early 2009. Copies of the flipbook will be sent to TB programs this Spring and will be available on the GTBI website.

Submitted by Lauren Moschetta
Training and Consultation Specialist
NJMS Global Tuberculosis Institute

MERGER AND FACELIFT FOR POPULAR LTBI POCKET CARDS

In 2000, when new guidelines for tuberculin skin testing and treatment of LTBI were developed, the Charles P. Felton National TB Center at Harlem Hospital (a partner of the Northeastern RTMCC), launched a series of pocket reminder cards. These cards were targeted at providers serving the general patient population, pregnant/postpartum women, and adolescents/children. Step-by-step information was provided to guide decisions on whom to test, how to interpret the TST result, who should be treated, which regimens to use, and how patients should be monitored. Over 200,000 of the cards have been distributed nationwide, making it the most widely circulated clinical support tool for managing LTBI.

But a lot has changed since then. RIF-PZA as an alternative regimen has been discredited because of hepatotoxicity, a regimen of RIF alone is increasingly accepted, and new, more specific tests for detecting LTBI (IGRAs) have been approved. Hence, a renovation was long overdue!

Education and training staff, Bill Bower (Charles P. Felton National TB Center) and Rajita Bhavaraju (NJMS Global Tuberculosis Institute), developed a series of questions and

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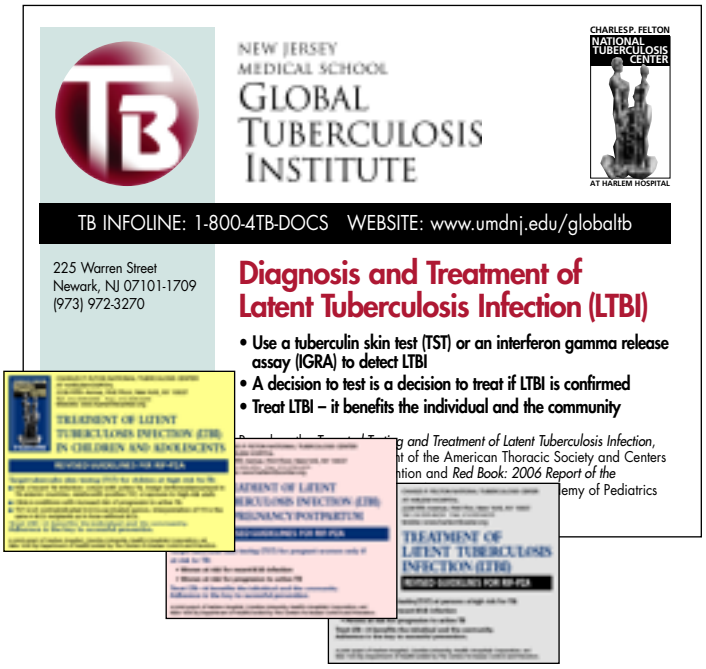


EDUCATION PRODUCTS

GTBI Products

continued from page 2

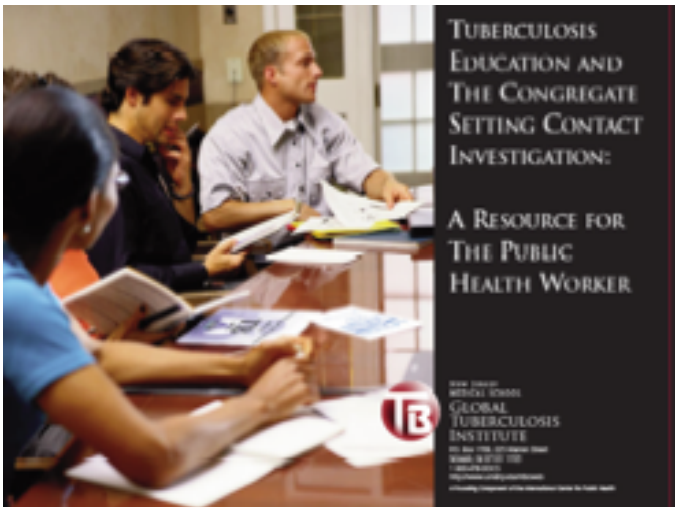
fanned out to interview clinicians in their respective settings. They asked respondents to systematically review the old card(s) for issues related to usability, accuracy, and relevance. The result is a single, improved pocket reference card that will be suitable for all health care settings and patient/population risk groups. It will reflect current published LTBI guidelines and refer users to a website where all current guidelines can be accessed and new guidelines will be posted. The new pocket card can be ordered from GTBI or accessed and downloaded at http://umdnj.edu/ntbcweb/products/ltbidrugcard.html.

Submitted by Bill L. Bower, MPH
Charles P. Felton National Tuberculosis Center
at Harlem Hospital

TUBERCULOSIS EDUCATION AND THE CONGREGATE SETTING CONTACT INVESTIGATION: A RESOURCE FOR THE PUBLIC HEALTH WORKER

This web-based resource is a revised version of a GTBI product originally created in 2004. As TB program staff know, contact investigations are an essential component of TB prevention and control in the United States, and congregate settings such as workplaces, schools, and social settings are often identified during the course of contact investigations. The success of these contact investigations rely to some extent on the quality and effectiveness of the TB education session provided in the congregate setting. If TB program staff can effectively communicate information about risk of TB transmission and the TB control efforts that are being undertaken, it can set the stage for a successful collaboration and outcome. Having written policies and procedures for investigations can improve the efficiency and uniformity of investigations, including the way in which TB education sessions are provided. This resource was designed to ensure that health care workers utilize standard content and format in conducting the education session.

In 2008 GTBI staff began revisions of the on-line resource based on an assessment of TB education sessions in New Jersey from April 2006-April 2007 that identified areas for improvement. The revised resource can assist public health workers who plan and conduct TB education sessions in congregate settings. It includes general guidance and the following templates: a modifiable PowerPoint® presentation on the fundamentals of TB, frequently asked questions about TB (specific to congregate setting contact investigations), TB vocabulary for lay audiences, a pull-out TB fact sheet, and an education session evaluation form. We hope this revised resource will be useful to TB program staff conducting education sessions in congregate settings!



This resource is available for downloading at: http://www.umdnj.edu/globaltb/products/congregatesetting.htm

Submitted by Anita Khilall, MPH
Training and Consultation Specialist
NJMS Global Tuberculosis Institute

Current Behavioral/Social Science Studies in Tuberculosis

The first two installments of this column highlighted the limitations of behavioral and social science research in the TB literature. I also expressed the commonly-held view that, increasingly, public health problems will be solved less by new technological developments (e.g., drugs, vaccines) and more by attention to human-level factors such as resistance to adopting new behaviors, poor adherence to existing regimens, and non-acceptance of beneficial regimens or actions.

Partly in response to a charge issued in the 2000 IOM report, "Ending Neglect," the CDC formed the Tuberculosis Epidemiological Studies Consortium (TBESC), whose mission it is to "conduct epidemiological, behavioral, economic, and programmatic research" on TB and LTBI. Starting with this issue's column, I will discuss TBESC studies (called "Task Orders") having a strong behavioral/social science component, starting with Task Order 13. (For the record, I serve on the Task Order 13's protocol team and also as a Co-Investigator of Phase 3.)

TASK ORDER 13 - STUDY OF FACTORS ASSOCIATED WITH ACCEPTANCE OF, ADHERENCE TO, AND TOXICITY FROM TREATMENT FOR LATENT TUBERCULOSIS INFECTION

While getting less attention than treatment for active TB, LTBI treatment is a far more common form of TB treatment in the U.S., with 291,000 - 433,000 patients on LTBI treatment per year (Sterling et al 06) compared to 14,000 on treatment for TB disease. Unfortunately, treatment completion rates are persistently low with at best 65% of patients completing treatment in general clinical practice (Hirsch-Moverman 08). Strategies to improve LTBI completion rates are weakened by an imperfect understanding of what motivates people to accept LTBI treatment and what motivates them to complete treatment once started. Task Order 13 was designed to learn more about the incentives and disincentives to LTBI treatment, in a variety of ways.

Phase 1 In Phase 1 of Task Order 13, estimates were gathered from the 21 TBESC sites of the number of individuals receiving LTBI treatment and their risk factors (e.g., foreign birth, substance use, homelessness, contact to a case of TB). These characteristics were examined in relation to the type of clinic at which the patient was seen (e.g., public health, HIV specific, pediatric). The results were reported by Sterling and colleagues (2006).

Phase 2 A second phase was designed to gather more detailed information through retrospective chart review. The same sites were asked to conduct chart reviews of randomly-selected LTBI patients, collecting information on demographic characteristics and a more detailed list of TB risk factors. In an oral presentation at the 2007 American Thoracic Society conference, Robert Horsburgh presented preliminary results which showed that 90.3% of those offered treatment accepted it, while just 46.4% of LTBI patients starting treatment completed therapy. There was an inverse relation between completion and length of prescribed treatment, with those taking four months of Rifampin significantly more likely to complete.

In a paper currently under review, two separate analyses are presented. The first examines characteristics leading to treatment completion in 1,674 LTBI patients who began treatment in any of the 68 study clinics. Information on clinic characteristics was also collected for this analysis.

The second analysis highlights one of Task Order 13's unique features – attention to treatment decliners. Most LTBI treatment studies examine factors predicting completion among patients who begin treatment. Both Phase 2 and Phase 3 collect information on people who are offered LTBI treatment, including those who decline. In Phase 2, characteristics associated with the decision to accept treatment are examined in 720 persons offered LTBI treatment in a subset of 32 study clinics that did not accept outside referrals for treatment. Use of this subset allows the calculation of an acceptance rate for LTBI treatment.

Phase 3 As a prospective study of individuals offered and accepting LTBI treatment, Phase 3 is able to fully consider behavioral/social factors. Enrollment of approximately 1,800 individuals has been completed and follow-up data collection will end in Summer 2009. Eligibility criteria included a diagnosis of LTBI (through a TST) and a provider recommendation to treat with INH.

As a prospective study, Phase 3 will give us new insight into patient behavior and the impact of clinic characteristics – we interviewed people who were offered LTBI treatment, whether they accepted or declined treatment.

In designing Phase 3, the Co-Investigators (Robin Shrestha-Kuwahara, Yael Hirsch-Moverman, and I) took an ecological approach to viewing LTBI treatment. That is, we felt it necessary to gather data on three levels: 1) personal characteristics such as knowledge and attitudes about TB and LTBI, and health-seeking behaviors, 2) life circumstances (barriers to accessing care and life stressors such as substance abuse and homelessness), and 3) characteristics of the healthcare setting (clinic services and accessibility, patient education, experiences with providers and other staff). These data were

continued on page 5

Behavioral

continued from page 4

collected through face-to-face interviews with individuals offered LTBI treatment and through questionnaires filled out by clinic managers.

As a prospective study, Phase 3 will give us new insight into patient behavior and the impact of clinic characteristics – we interviewed people who were offered LTBI treatment, whether they accepted or declined treatment. And we are interviewing all patients who started treatment, regardless of when and why they discontinued treatment. The results should enable us to address a variety of questions, including:

- Does greater knowledge about TB and LTBI led to increased treatment acceptance and treatment completion?
- Are BCG-vaccinated foreign-born people less likely to accept or complete LTBI treatment because they don't trust the diagnosis?
- Are people who worry about the stigma surrounding TB more or less likely to complete LTBI treatment?
- Are people who are considered fatalistic less likely to complete treatment?
- Does having social support facilitate LTBI treatment completion, or do supportive relationships hinder it when patients don't want others to know that they're on treatment?
- What modifiable factors or interventions might prevent patients on treatment from dropping out?
- What impact do negative experiences with healthcare providers have on treatment completion?
- Does having an interpreter in the clinic improve treatment completion for those who don't speak English?
- What forms of patient education materials are effective?
- What impact do limited clinic hours or lack of child care have on treatment completion?
- Do incentives impact treatment acceptance and completion? Which ones?
- What is the impact of long clinic waits on treatment completion?
- Does "one-stop-shopping" really help patients, compared to having to go to different places for prescriptions, X-rays, etc.?

Finally, we are following a randomly-selected sample of study participants who accept LTBI treatment and interviewing them at several monthly intervals. This will give us information about adherence patterns, and address questions such as:

- Do patients who drop out mostly do so in the first month (as is commonly believed)?
- Do patients drop out when confronted by life stressors?
- What distinguishes those who refuse treatment from those who accept but quickly drop out?

As pointed out in the 2000 Institute of Medicine report on TB, Ending Neglect, effective treatment of LTBI is a vital step in the process of eliminating TB in the US. Unfortunately, this form of treatment has itself been the victim of neglect. Task Order 13 has the potential to uncover a wealth of information about the decisions people make to accept LTBI treatment and to continue through to completion. This information will provide TB controllers with useful information to better understand patients and to improve clinic services.

This column's subsequent installments will focus on Task Orders 9, 11, and 12. A summary of the purpose and scope of each Task Order can be at the following website: http://www.cdc.gov/tb/TBESC/research_projects.htm

Submitted By Paul Colson, PhD, and Julie Franks, PhD
Charles P. Felton National Tuberculosis Center at Harlem Hospital

CITATIONS:

Hirsch-Moverman Y, Daftary A, Franks J, Colson PW. Adherence to treatment for latent tuberculosis infection: systematic review of studies in the US and Canada. Int J Tuberc Lung Dis 12(11):1-20, 2008.

Horsburgh CR, Goldberg S, Bethel J, Colson P, Hirsch-Moverman Y, Hughes S, Shrestha-Kuwahara R, Sterling T, Wall K, Weinfurter P, TBESC. Low latent tuberculosis infection treatment completion with 9-month INH regimen. Am J Respir Crit Care Med 2007;175:A24.

Institute of Medicine. Ending Neglect: the Elimination of Tuberculosis in the United States. Washington, DC: National Academy Press 2000.

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.

STAFF PROFILE

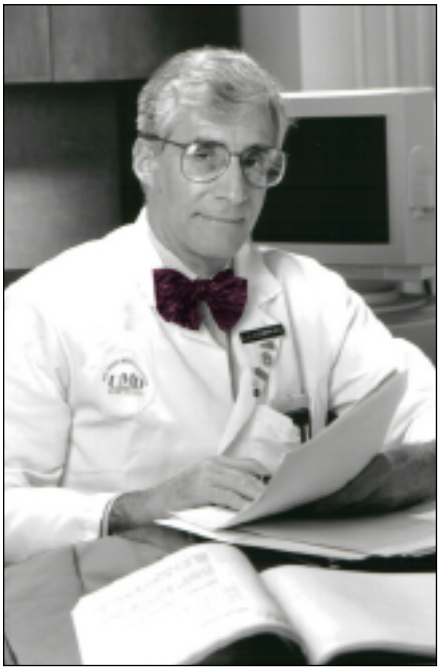
Staff Profile: Lee B. Reichman, MD, MPH

It's no easy task scheduling some quiet interview time with one of the most mobile TB experts on the planet. As we spoke on February 25th, his carry on suit case stood poised at the door ready to be whisked off to Vancouver later that afternoon where Dr. Reichman would be participating in the North American Region IUATLD meeting. On his way back, he would represent the American College of Chest Physicians at the Advisory Committee on the Elimination of TB (ACET) in Atlanta. After 2 days back at the GTBI, he'd be off to New Delhi for a week to serve as a key resource person for a media tour with the Lilly MDRTB Partnership. On March 17th, he would host a World TB Day lecture by Dr. Kenneth Castro in the morning and chair the Northeastern RTMCC web-based grand rounds in the afternoon before flying off to Portugal and Brazil. He was particularly honored to be asked by President George Sampaio (former president of Portugal) and now the UN Secretary General's Global Envoy for Tuberculosis, to give the keynote address at President Sampaio's World TB Day Symposium in Lisbon. He then flies on to Rio de Janeiro to participate in the third STOP TB Partnership Forum where he'll serve on the new Advocacy Advisory Committee and chair a plenary symposium. When a colleague suggested it was "too much" he said, "probably, but you don't turn down a former president of a country, especially one who is such a good guy!"

Lee B. Reichman, M. D., M.P.H., is the Founding Executive Director of the New Jersey Medical School Global Tuberculosis Institute, and Professor of Medicine, Preventive Medicine and Community Health at the New Jersey Medical School, in Newark, New Jersey. From 1971-1974 he served as Director, Bureau of Tuberculosis Control and Assistant Commissioner of Health at the New York City Health Department. In 1974 he came to the then College of Medicine and Dentistry of New Jersey, New Jersey Medical School as Director of the Pulmonary Division in the Department of Medicine and as Associate Professor of Medicine. He was promoted to Professor in 1977 and continued to serve as Director of the Pulmonary Division until 1993 when he founded the New Jersey Medical School National Tuberculosis Center, which has changed its name to Global Tuberculosis Institute reflecting its wider scope of activities. Since he joined the faculty at the New Jersey Medical School, he has been principal investigator on federal (NIH, CDC) grants and contracts totaling almost $37 million.

He serves on several national and international committees, advisory boards, professional organizations and societies including the National Coalition to Eliminate Tuberculosis (past chair)(now the Stop TB USA); U.S. Advisory Council for the Elimination of Tuberculosis; International Union Against Tuberculosis and Lung Disease (past vice-chair of the Executive Committee); American Lung Association (past president and recipient of the 1999 Will Ross Medal, their highest volunteer award); American Thoracic Society (honorary life member); American College of Chest Physicians (past Governor for New Jersey), and the World Health Organization Stop TB Partnership (Charter Member of The Advocacy Advisory Committee). He is immediate past President of the Stakeholders Association and current member of the Board of Directors of the Global Alliance for TB Drug Development.

As a child, Dr. Reichman recalls, he fantasized at various times becoming a bus driver, a baseball player, or a train engineer. It seems, perhaps, that he was destined to be in the driver's seat and achieve some degree of notoriety. As an undergraduate, he first got the notion to pursue a career in medicine, but majored in psychology as a back up in case he didn't get accepted in medical school. As it turned out, this was not a problem. After receiving a Bachelor of Arts degree in 1960 from Oberlin College in Ohio, Dr. Reichman earned his medical degree in 1964 from New York



University where in April 2003 he received their highest award, The Solomon A. Berson Award for lifetime achievement in Health Sciences. He completed his internship and the first year of his residency at Bellevue Hospital in New York and then served as a Peace Corps physician in Bolivia as a commissioned officer of the U.S. Public Health Service. He finished his training at Harlem Hospital Center in New York as senior medical resident and pulmonary fellow. He then earned a Masters in Public Health degree from Johns Hopkins University School of Hygiene and Public Health in Baltimore.

While a pulmonary resident at Harlem Hospital, Dr. Reichman met his mentor, Dr. Julia Jones, to whom he dedicated the book *Timebomb*: "she passed on to me a small bit of her dedication, commitment, and passion related to fighting tuberculosis." Besides mastering the clinical aspects of this disease, he gained an appreciation of how public policy, science, and research might be harnessed and coordinated to combat TB. He was also impressed that Dr. Jones was a "total TB doc," not a general pulmonologist who occasionally dabbled in TB. At a time when TB was

continued on page 7

Staff Profile

continued from page 6

anything but "sexy" and when most of his fellow residents had their sights on hanging their shingles on Park Avenue and becoming wealthy, Dr. Reichman became the Director of NY City's Bureau of TB Control in 1971 with a whopping salary of $25,800. "I decided that to be successful, I either had to be smarter than everyone else or I had to do something that few others were interested in—and that was TB." "I was in the first generation of TB specialists with two lungs, because most of the TB docs before that had been patients at TB sanatoria and undergone a pneumonectomy."

When asked about career highlights, Dr. Reichman noted that "it was very satisfying to be doing something relatively unpopular and suddenly when it becomes an issue, important people are calling you for quotes." He recalls testifying in the 1970's before Senators Edward Kennedy and Congressman Paul Rogers that if Congress didn't restore categorical TB grants (as opposed to Block Grants which contained no dedicated funding for TB), there would be a resurgence of TB. Documenting the resurgence which did occur in the mid 1980s and early 1990s, Laurie Garrett (in her book *The Coming Plague*) and Frank Ryan (in his book *The Forgotten Plague*) both credited Dr. Reichman with predicting the resurgence at a time when it might have been prevented. And when the resurgence came, Dr. Reichman (who was President of the American Lung Association at the time), reminded the public about its causes and was instrumental in convincing Congress to increase TB funding from $10 million to $150 million a year.

Dr. Reichman's advice to younger readers is that we can and should all become TB advocates, as well as advocating for inclusion of neglected diseases of which TB is but one! "If we see inadequate or inappropriate use of resources, we need to speak out. Learn how to talk with the media and collaborate with partners who can support your cause." He notes that TB is getting notoriety today because influential people (non-TB clinicians) like Bill Gates (Bill and Melinda Gates Foundation) and Mark Harrington (Treatment Action Group) are calling attention to the TB problem and needs, both nationally and globally.

Not surprisingly, one of Dr. Reichman's top priorities is advocacy. "It's outrageous that anyone dies from a disease that is completely treatable and preventable. TB is the biggest infectious disease killer in the world and still not enough people know about it or care to make a difference." He notes in a recent editorial in the journal *Lancet* that while MDR and XDR TB are getting the lion's share of attention, there are still more than 9 million new active drug-sensitive ("unsexy") TB cases globally that can feed MDR and XDR TB if not appropriately treated with current strategies. In 2007, Dr. Reichman spent a 6-month sabbatical at the Stop TB Partnership in Geneva to promote the Global TB Plan to STOP TB. Most recently, he was selected to join a group of 25 experts ("Ambassadors") at Research!America's Paul G Rogers Society for Global Health Research to make the case for greater US investment in research to fight diseases that disproportionately affect the world's poorest nations. Dr. Reichman considers himself indeed fortunate to have such capable and devoted staff at the GTBI which allows him to carry out advocacy at an international level. Ultimately, he believes that these efforts will result in attracting talented, service-oriented young professionals to TB and will help garner additional resources to combat TB nationally, as policy makers truly get it that "to control TB anywhere you must control TB everywhere."

"It's outrageous that anyone dies from a disease that is completely treatable and preventable. TB is the biggest infectious disease killer in the world and still not enough people know about it or care to make a difference."

Believe it or not, Dr. Reichman does have a few outside interests. He's been an avid New York Giants fan ever since his father regularly took him to the Polo Grounds to watch the home games. He recalls sitting behind the goal posts where the college coaches would congregate. He's had season tickets for years and was ecstatic over their 2007 Super Bowl victory. He is also a serious opera buff (Wagner's *Ring Cycle* and Donnizetti's *Daughters of the Regiment* are among his favorites) and has been on cloud 9 ever since Sirius Satellite radio started broadcasting opera 24/7 on channel 78. Of course, travel has always been a passion of his and, not surprisingly, he's given invited lectures in 41 states and 43 countries. It also appears—and who hasn't noticed—he has a fetish for bow ties for which he is famous and which now number over 250. And in the fullness of time—would you believe 70 years—Dr. Reichman was blessed with a grandchild (Felix) last year. He beamed as he showed me a photo of this smiling, bright-eyed cherub at the end of our interview.

With abundant accomplishments and accolades in his nearly 40 year career in TB, Dr. Reichman could justifiably coast into retirement. However, he appears as vigorous and passionate as ever about his work and gives not a hint of slowing down! As his colleagues will attest, he still delivers, he still leads, he still inspires, and Dr. Julia Jones is smiling—for which the TB control community remains abundantly appreciative.

Submitted by Chris Hayden
Consultant, Medical Consultation and Evaluation Activities
NJMS Global Tuberculosis Institute

Bow Ties! How Did THAT Get Started?

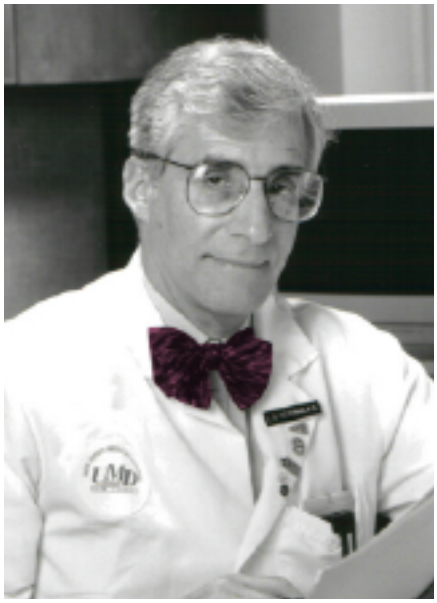
If you read the Profile article in this issue of the Newsletter, you will know that Dr. Reichman now possesses 250 bowties. In some future age this exquisite collection will likely be auctioned off by Sotheby's for some enormous sum which will be donated to the NJMS Global Tuberculosis Institute, assuming TB has yet to be eradicated from the planet.

What you probably don't know—and which all inquiring minds are eager to learn—is the origin of this stylish fetish.

Here are some possibilities, only one of which is true:

A. Donning a bow tie enabled him to stand out among his giant colleagues (Reynard McDonald and Mike Iseman) during his pulmonary residency at Harlem Hospital

B. The co-eds at Oberlin thought he looked soooo cute in a bow tie and would compliment him whenever he wore a new one.



C. Dr. Julia Jones, his mentor during residency, always gave him higher grades when he wore a bow tie.

D. During medical school his mother complained that his regular ties invariably reeked of formaldehyde and were soiled after anatomy class.

E. A week before his first grand rounds presentation, he pictured himself at the lectern and sensed that the gorgeous bow tie he was wearing imbued him with prodigious podium pizzazz and an almost mystical fortitude.

F. Early in his career, he realized that if he ever hoped to one day achieve "TB Poster Child" status, he would need to mint his intelligence, devotion, and leadership with some distinguishing brilliance of style.

Click on the bowties for the correct answer:

Empowering TB Case Managers: Assessing and Improving Staff Performance

When working with TB control programs to conduct an on-site training for program staff, the GTBI collaborates closely with program staff to identify needs and develop (or modify) a training course tailored to the local situation The New York City's Empowering Case Managers course, held on December 10-11, 2008, was indeed a collaborative effort, which began with conversations between the GTBI Training and Education and NYC Bureau of TB Control (BTBC) Outreach and Training Departments in early 2008 to discuss the training needs of the BTBC. The NYC team, consisting of several BTBC senior staff, had identified specific training needs for supervising case managers and wanted to really focus in on those needs.

So the GTBI and BTBC team got to work to identify key content and objectives. The goals of the course were to strengthen the supervisory and case management skills of the supervising case managers (who supervise front-line TB control staff) and to help ensure more uniformity of practices. To achieve these goals, a curriculum was developed to cover a wide range of topics including: the role of the supervising case manager, documentation from a supervisor's perspective, case review and monitoring, providing feedback and follow up to staff, accessing and using management reports as supervisory tools, identifying training needs, and implementing staff development and training for performance improvement.

Because some topics were based on local policies and procedures, the NYC managers played a significant role in developing the lectures and content of the exercises. As a result of many conference calls and numerous emails between GTBI and BTBC staff the course was implemented in early December.

The many hours of hard work paid off and the course was perceived a success by all. One of the highlights of the course was the interactive session outlining the vision for TB Control in New York City presented by Dr. Chrispin Kambili, the Assistant Commissioner for the Bureau of TB Control, NYC Department of Health and Mental Hygiene. Participants rated the course very highly and made comments such as "We should have a similar course once a year", "This was a much needed review", and "I will use the knowledge I received from all of the presentations." The BTBC trainers, who were also senior level managers, felt the training was very practical and therefore useful. A six-month post course survey will be sent to participants to assess the degree to which course content has been translated into program practice. We at the GTBI were pleased to have truly met a specific need for a program and look forward to working together with the BTBC again in the future.

Submitted by Valerie Gunn
Health Educator
NJMS Global Tuberculosis Institute

Dear Colleague

continued from page 1

addition, we summarize a collaborative training effort with New York City's Bureau of TB Control targeted to Supervising Case Managers. Finally, my protests notwithstanding, this issue features what my staff insisted was an obligatory profile of the current—and I guess founding—Executive Director of the NJMS GTBI.

And, as usual, if you have any feedback for any of us, on any TB related topic, I invite you to contact me or a member of our RTMCC staff at 973-972-3270.

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

Upcoming NE RTMCC Training Courses - 2009

(COURSE DETAILS AND REGISTRATION CAN BE ACCESSED AT http://www.umdnj.edu/globaltb/courses.htm**)**

Please note that this is a preliminary schedule. We will be finalizing our training calendar and updating our web page, so please check back regularly for updates.

NAME OF COURSE	TARGET AUDIENCE	DATE(S)	LOCATION
TB Medical Consultants Meeting	Lead TB program medical consultants in NE Region	April 21-22	Newark, NJ
TB Intensive Workshop	Physicians, nurses, and TB control staff	April 28-30	Newark, NJ
Regional TB Update	Physicians, nurses & TB control staff	Spring	Massachusetts
TB Interviewing for Contact Investigation	Disease investigators and public health nurses	May 5-7	Newark, NJ
TB Update for Nurses	Nurses who provide TB services	May 7	Vermont
Program Manager's Workshop for Regional and Local Staff	Nurses, physicians, & other health professionals working as TB program managers	May 27-29	Newark, NJ
TB Cohort Review Process	Lead TB program staff	July	New York City
Advanced TB Training for Clinicians	Experienced physicians and nurses	July 10	Washington DC
Medical Update in TB Control #1: Management of Tuberculosis in Patients on TNF-a Inhibitors	Physicians and nurses and TB program staff	September 16	Web-Based Seminar
TST Train-the-Trainer Workshop	Nurses who train HCWs to perform skin testing	September 30-October 1	Newark, NJ
TB Intensive (With OH, IN,MI & Detroit)	Physicians, nurses, and TB control staff	October 22-23	Indiana
Medical Update in TB Control #2: Management of TB in Emergency Department Settings	Physicians and nurses and TB program staff	November 19	Web-Based Seminar
Cultural Awareness in TB Control	TB program staff	Fall	Newark, NJ
Best Practices in TB Control #2 (series of 2 web-based seminars)	TB program staff	Fall	Web-Based Seminar
Regional TB Update	Physicians, nurses & TB control staff	Fall	Massachusetts
TB Intensive Workshop	Physicians, nurses, and TB control staff	Fall	New England

The real origin of Dr. Reichman's fetish for bowties is:

D. During medical school his mother complained that his regular ties invariably reeked of formaldehyde and were soiled after anatomy class.

Lesson Learned: Follow your mother's advice and the rest of your dreams just might come true!

Upcoming TB Program Training Courses - 2009

TB PROGRAM SPONSOR	NAME OF COURSE	TARGET AUDIENCE	TARGET AREA	DATES	LOCATION	CONTACT PERSON
MD	TST Training	Licensed health care staff	MD	03/24/09 03/25/09 04/23/09 04/29/09 05/05/09	Westminster Columbia Salisbury Silver Spring Baltimore	Arlene Hudak 410-767-6698
MD	TB Today	Nurses, PH staff	MD	03/31/09- 04/02/09	Clarksville	Arlene Hudak 410-767-6698
MI	TB Barriers, Borders, Buses, and Planes	Physicians, Nurses, & Allied Health Professionals	MI	04/02/09	West Campus of Lansing Community College	Michigan Department of Community Health 517-335-8165 (Gail Denkins)
Delaware	TB Program Annual Retreat	DE TB Program staff, central office, and guests	DE	April 14	St. Jones Preserve, Dover, DE	Jeannie Rodman 302-744-1052 jeanette.rodman@state.de.us
MI	TB Nursing Certification	Nurses	MI	June 23,24, 25 2009	Ingham County Health Dept. Lansing MI	Michigan Department of Community Health 517-335-8165 (Gail Denkins)
DC	Building Stronger Partnerships in TB Treatment and Elimination	Community Partners and Providers	Wash. DC	July 9, 2009	TBA	Jeannette Hinnant 202-698-4035 jeannette.hinnant@dc.gov
Delaware	Tuberculin Skin Test Administration and Intro To Quantiferon testing	Nurses in Delaware	Delaware	Sept. 16 1:00 PM to 3:30 PM	Second Floor Conference room, Thomas Collins building, 540 S DuPont Hwy, Dover, DE	Jeannie Rodman 302-744-1052 jeanette.rodman@state.de.us
MD	Maryland Annual TB Meeting	HD TB staff and others working in TB control	MD	Sept 17	Clarksburg	Arlene Hudak 410-767-6698
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 Frank.romano@odh.ohio.gov 614-466-6563
Ohio	2 HIV Testing Courses	Public Health Nurses working with TB	Ohio	TBA TBA	TBA	Frank Romano CDC Public Health Advisor Frank.romano@odh.ohio.gov 614-466-6563

continued on page 12

TB Medical Consultation

Medical Consultation Services: NE RTMCC physicians respond to requests from providers seeking medical consultation through:

- Our toll-free TB Infoline: 1-800-4TB-DOCS and
- Email: http://www.umdnj.edu/globaltb/emailform.htm

During each consultation, the NE RTMCC physicians 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.

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 in June 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.

Upcoming TB Program Training Courses - 2009

continued from page 11

MI	Directly Observed Therapy Seminars	Public Health TB Staff	MI	TBA	TBA	ALA of Michigan 800-678-LUNG www.michigantb.org/hcp/trainings.asp
MI	Contact Investigations for TB	Public Health TB Staff	MI	TBA	TBA	Michigan Department of Community Health 517-335-8165 www.michigantb.org/hcp/trainings.asp
MI	TB Case Management	Public Health TB Staff	MI	TBA	TBA	Michigan Department of Community Health 517-335-8165 www.michigantb.org/hcp/trainings.asp
MI	Tuberculin Skin Testing Workshops TST	Pubic Health TB Staff who regularly perform	MI	Various	Various	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

WHAT'S NEW

What's New

TB and Cultural Competency – Notes from the Field The ninth issue of the Cultural Competency Newsletter is now available. This issue explores the challenge of navigating language issues and describes one health care worker's experience as he attempts to communicate with a patient through family members. This issue also includes a topic related article, tips for working with untrained interpreters, and a glossary of common interpretation terms. Also included in the electronic format is a link to a brief survey we are conducting on how to handle offers of food during patient home visits. With your input, this will be a topic in an upcoming cultural competency newsletter. The Newsletter can be accessed at http://umdnj.edu/ntbcweb/downloads/products/Newsletter%20(Winter%2008).pdf


TB & CULTURAL COMPETENCY
Notes from the Field
Northeastern Regional Training and Medical Consultation Consortium Issue #9 Winter 2009
My Interpretation
By Lauren Moschetta-Gilbert
Based on interviews with TB control staff
Introduction
Language issues remain a significant challenge when working in cross-cultural situations. Improvements to language access have been made, but are not perfect. For instance, many hospitals now offer medical interpreter training programs for bilingual staff, and telephone interpreter services have expanded, increasing both the number of languages available and the hours of service availability. However, often there is no additional pay for staff members who take on an interpreter role, making specialized training less appealing for some. Telephone interpreter services can be cost prohibitive for smaller organizations, and without the latest hardware, passing a telephone receiver back and forth has been described by some as cumbersome and time consuming. In this edition of our newsletter, we will hear about one healthcare worker's experience as he navigated language barriers with a patient. We will also examine the common pitfalls of using family members or untrained persons as interpreters, as well as provide guidance on how to do this more effectively when it is the only option.
*Names have been changed.
The Patient
Amina* was diagnosed with TB after being seen in the Emergency Department with prolonged cough, fever, chest pain and weight loss. Her children urged her to go to the Emergency Department after an episode of hemoptysis. She was prescribed the standard four anti-TB drug regimen and referred to the TB clinic for continued care and monitoring. Originally from Pakistan, Amina had been in the US with her husband and children for about two years. Her husband had recently returned to Pakistan for a one year business venture. The family was Muslim and spoke Urdu, and the three children, aged 17-25, spoke English fluently.
Nurse case manager
I had been informed that the patient's first language was Urdu, so I set up the language line interpreter service before she arrived at the clinic to speed things along. When Amina arrived with her English speaking eldest daughter, Yasmin,* I introduced myself, and explained that we would be using a telephone interpreter. I began describing how and why the interpreter language line is used. The patient stated that she preferred to use her adult daughter to interpret for her. I then explained that medically accurate and reliable interpretation of information is critical to her care and treatment, and this is best achieved by using a certified interpreter. Amina seemed to get upset and stated that her daughter "spoke for her" and that she relied on her to know that everything is ok. Yasmin then said that her mother didn't believe in taking medicine and that if she were not involved, her mother would likely not cooperate with her own treatment. At this point I was feeling very conflicted about how to proceed. I knew it was not 100% reliable to communicate through the daughter, but I didn't want to lose the
Yasmin then said that her mother didn't believe in taking medicine and that if she were not involved, her mother would likely not cooperate with her own treatment. At this point I was feeling very conflicted about how to proceed.
patient's trust and cooperation, so I didn't push the matter any further and decided to use the daughter as the interpreter. This seemed to work out o.k. as we began the contact investigation.
As the nurse case manager, I also needed to assign an outreach worker to this case for DOT. My personal experience working with Muslim families has led me to believe that both
Continued on page 2

Plan to Combat Extensively Drug-Resistant Tuberculosis In February 2009, CDC published this document that was developed by the Federal Tuberculosis Task Force. Multidrug-resistant TB (MDR TB) is defined as TB that is resistant to the two most effective first-line therapeutic drugs, isoniazid and rifampin. Extensively drug-resistant (XDR) TB is defined as MDR TB that also is resistant to the most effective second-line therapeutic drugs used commonly to treat MDR TB: fluoroquinolones and at least one of three injectable second-line drugs used to treat TB (amikacin, kanamycin, or capreomycin). XDR TB has been identified in all regions of the world, including the United States. Because of the limited responsiveness of XDR TB to available antibiotics, mortality rates among patients with XDR TB are similar to those of TB patients in the preantibiotic era. The recommendations provided in this report include specific action steps and new activities that will require additional funding and a renewed commitment by government and nongovernment organizations involved in domestic and international TB control efforts to be implemented effectively. A complete PDF copy of these new recommendations is available from CDC at: http://www.cdc.gov/mmwr/PDF/rr/rr5803.pdf

Updated Guidelines for the Use of Nucleic Acid Amplification Tests in the Diagnosis of Tuberculosis. Published in January 2009 by CDC, these new guidelines state that NAA testing should be performed on at least one respiratory specimen from each patient with signs and symptoms of pulmonary TB for whom a diagnosis of TB is being considered but has not yet been established, and for whom the test result would alter case management or TB control activities. The complete updated guidelines are available on the internet at: http://www.cdc.gov/mmwr/PDF/wk/mm5801.pdf. (See page 7.)

Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents Published in March 2009 by CDC, these guidelines update and combine earlier versions of guidelines for the prevention and treatment of opportunistic infections (OIs) in HIV-infected adults (last published in 2002) and adolescents (last published in 2004. Major TB-related changes in the guidelines include 1) greater emphasis on the importance of antiretroviral therapy for the prevention and treatment of OIs; 2) information regarding the diagnosis and management of immune reconstitution inflammatory syndromes; 3) information regarding the use of interferon-gamma release assays for the diagnosis of latent *Mycobacterium tuberculosis* (TB) infection; and 4) updated information concerning drug interactions that affect the use of rifamycin drugs for prevention and treatment of TB. The section on Mycobacterium tuberculosis Infection and Disease begins on page 19. The entire document can be accessed at: http://www.cdc.gov/mmwr/pdf/rr/rr58e324.pdf

For more information on the new or revised GTBI products below, please see page 2-3 of this newsletter

- **Diagnosis and Treatment of Latent Tuberculosis Infection (LTBI) Pocket Card. March 2009**
- **Patient Education Flipbook Patient Education Flipbook. March 2009**
- **Tuberculosis Education and the Congregate Setting Contact Investigation: A Resource for the Public Health Worker. March 2009**

LINKS

Other TB Resources

DIVISION OF TUBERCULOSIS ELIMINATION

The mission of the Division of Tuberculosis Elimination (DTBE) is to promote health and quality of life by preventing, controlling, and eventually eliminating tuberculosis from the United States, and by collaborating with other countries and international partners in controlling tuberculosis worldwide. http://www.cdc.gov/tb/

TB EDUCATION AND TRAINING RESOURCES WEBSITE

This website is a service of the Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination. It is intended for use by TB and other healthcare professionals, patients, and the general public and can be used to locate or share TB education and training materials and to find out about other TB resources.
http://www.findtbresources.org/scripts/index.cfm

TB EDUCATION & TRAINING NETWORK (TB ETN)

The TB Education and Training Network (TB ETN) was formed to bring TB professionals together to network, share resources, and build education and training skills.
http://www.cdc.gov/tb/TBETN/default.htm

TB-RELATED NEWS AND JOURNAL ITEMS WEEKLY UPDATE

Provided by the CDC as a public service, subscribers receive:

- A weekly update of TB-related news items
- Citations and abstracts to new scientific TB journal articles
- TB conference announcements
- TB job announcements

To subscribe to this service, visit:
http://www.cdcnpin.org/lyris/ui/listservs.aspx#journal

TB BEHAVIORAL AND SOCIAL SCIENCE LISTSERV

Sponsored by the DTBE of the CDC and the CDC National Prevention Information Network (NPIN), this Listserv provides subscribers the opportunity to exchange information and engage in ongoing discussions about behavioral and social science issues as they relate to tuberculosis prevention and control. You may subscribe by going to:
http://www.cdcnpin.org/lyris/ui/listservs.aspx#tb_behav

NEW ENGLAND TUBERCULOSIS PREVENTION AND CONTROL WEBSITE

At the beginning of 2005, the six New England TB Programs joined together to promote a regional approach to TB elimination. This web site represents a step toward building collaboration, exchanging experiences and practices, and enhancing program capacity. The web site can be accessed at http://www.newenglandtb.org/

OTHER RTMCCS

The Francis J. Curry National Tuberculosis Center serves: Alaska, California, Colorado, Hawaii, Idaho, Montana, Nevada, Oregon, Utah, Washington, Wyoming, Federated State of Micronesia, Northern Mariana Islands, Republic of Marshall Islands, American Samoa, Guam, and the Republic of Palau. http://www.nationaltbcenter.edu

The Heartland National Tuberculosis Center serves: Arizona, Illinois, Iowa, Kansas, Minnesota, Missouri, New Mexico, Nebraska, North Dakota, Oklahoma, South Dakota, Texas, and Wisconsin. http://www.heartlandntbc.org

The Southeastern National Tuberculosis Center serves: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, Puerto Rico, and the U.S. Virgin Islands.
http://sntc.medicine.ufl.edu/