



Treatment of TB in a Cross-Cultural Setting with Mobile Patients

Laszlo Madaras, MD, MPH, SFHM

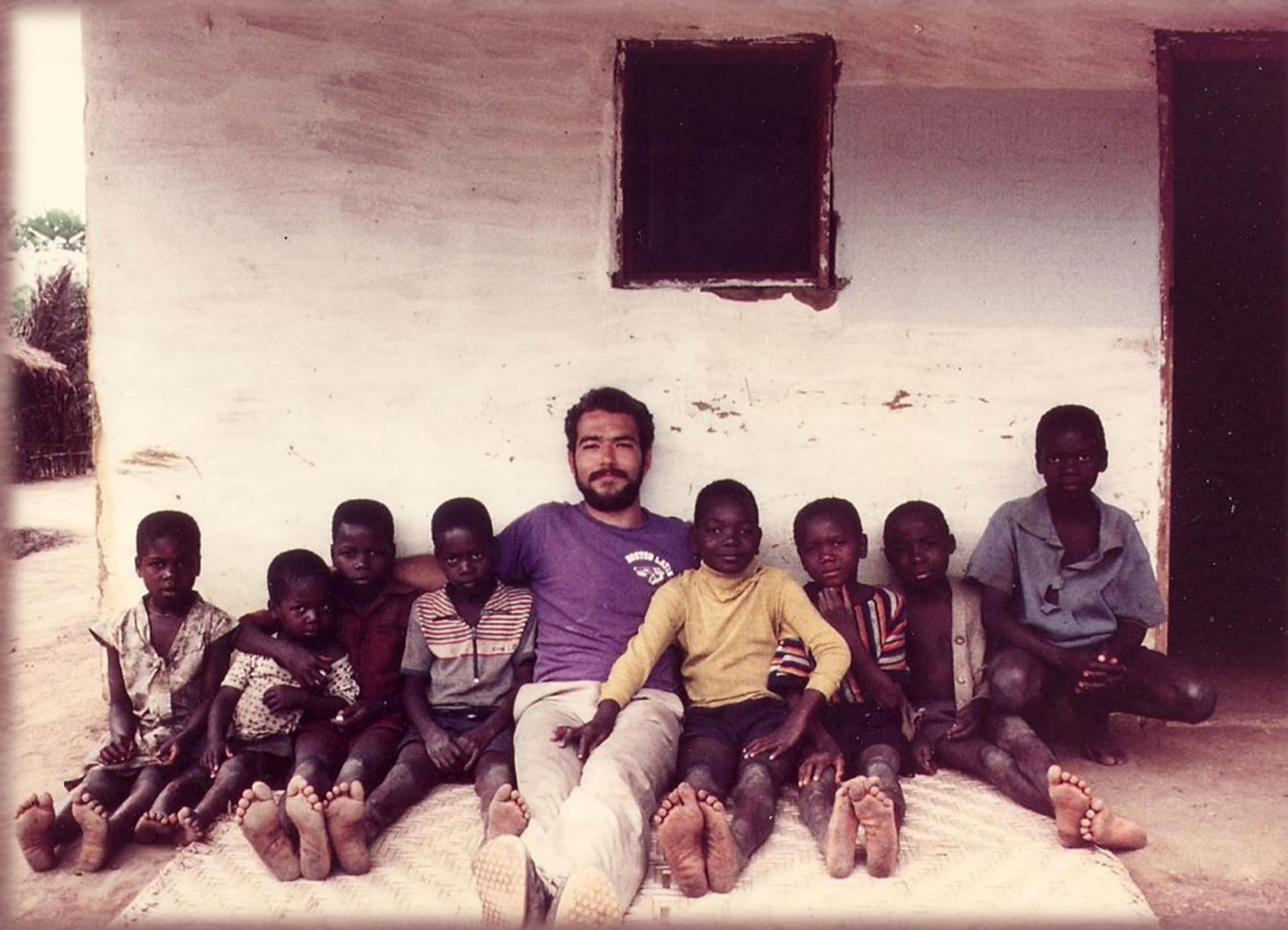


Exploring barriers to care...

Fear of isolation...



Loss of community...





Potholes in the rainy season...



Photo: Laszlo Madaras

Stalling out in 1st
gear on the way to
the health center...



Finding transportation...

Sharing the road...

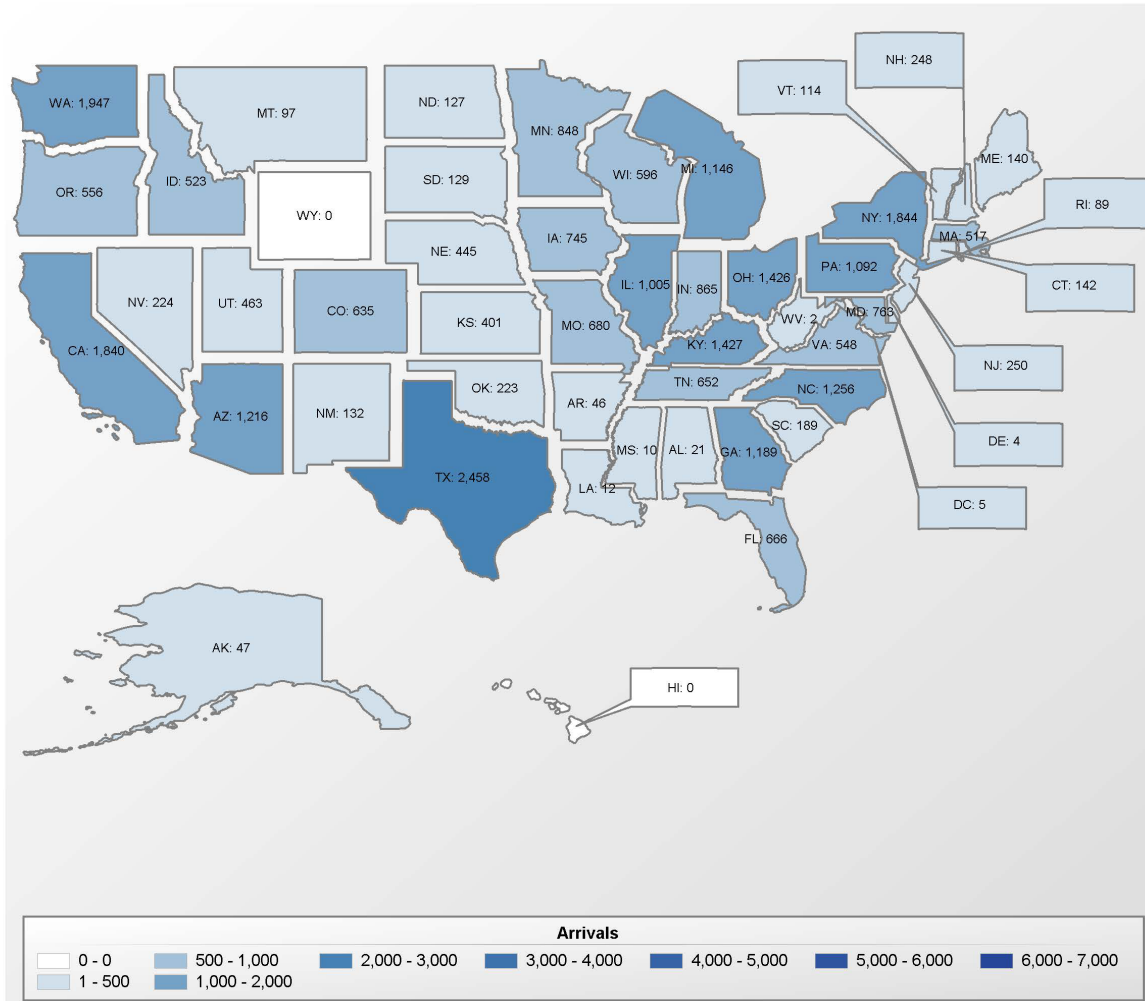


Department of State
 Bureau of Population, Refugees, and Migration
 Office of Admissions - Refugee Processing Center
 Refugee Arrivals by State

From October 1, 2018 through September 30, 2019

Cases: 12,320 Individuals: 30,000

Arrivals by State



Treating TB in a Cross-Cultural Setting



What is culture?





Cultural Humility



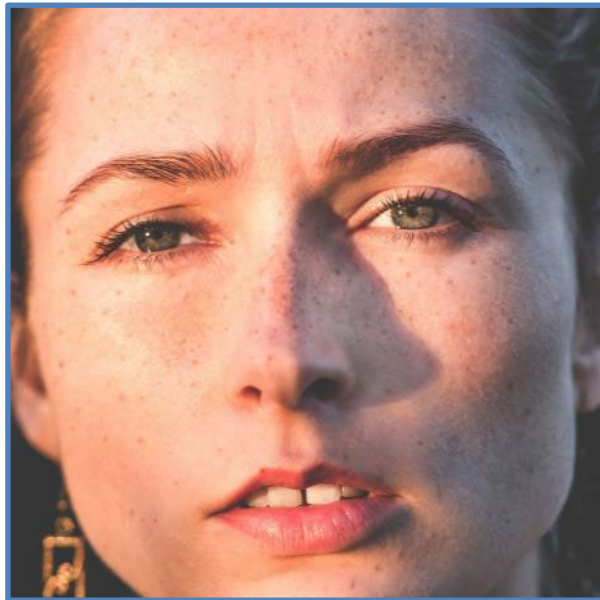
Cultural Humility

Cultural humility is an approach to sociocultural differences that is “self-first.” It emphasizes intersectionality and understanding one’s own implicit biases. This approach cultivates self-awareness and self-reflection, bringing a respectful willingness to learn to inter-personal interactions.

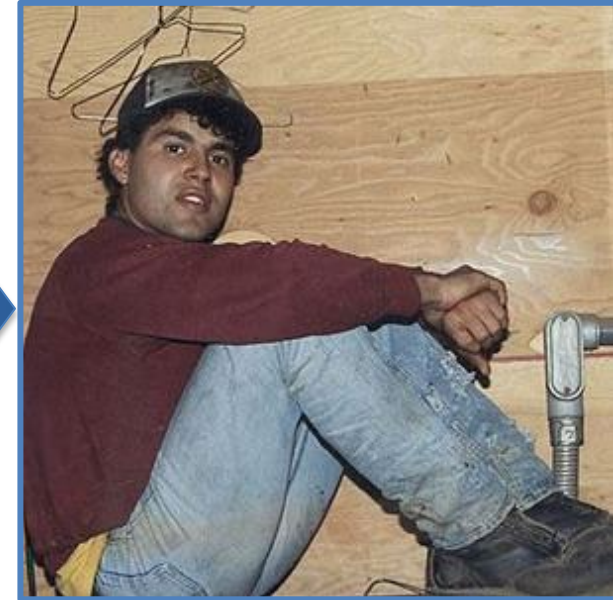


Self-Awareness

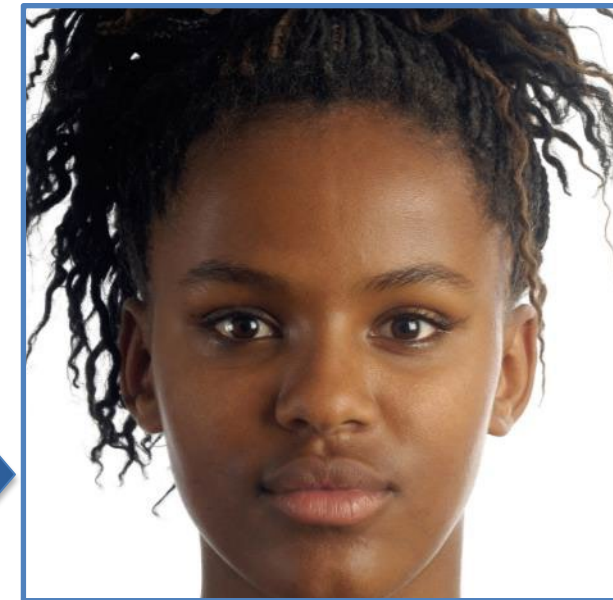
24 year old white female graduated from Yale at age 21 daughter of physician mother and lawyer father



42 year old Hispanic male, arrived into the United States "undocumented" at age 19 as a migrant farmworker



17 year old African American female with one child age 6 months





Alfredo Quinones-
Hinojosa MD



“Mary” has had substance abuse problems since her early teenage years. Presents to you for treatment of active TB following her recent discharge from her third Drug/Alcohol Rehab for chronic meth-amphetamine addiction. She is HIV and HepC positive.



- Nakisha” will be graduating from an inner-city high school in NYC this May as the Valedictorian of her class. She has scored 1540 on her SATs and has a full scholarship to college in the fall.
- Her pregnancy was the result of a rape when she was 15.
- She is scheduled to see you today because she had a positive TST when she had her college PE, she remembers being told that her grandmother died of TB when she was a young child.



Cultural Knowledge

Familiarization with selected cultural characteristics, history, values, belief systems and behaviors of the members of another ethnic group.

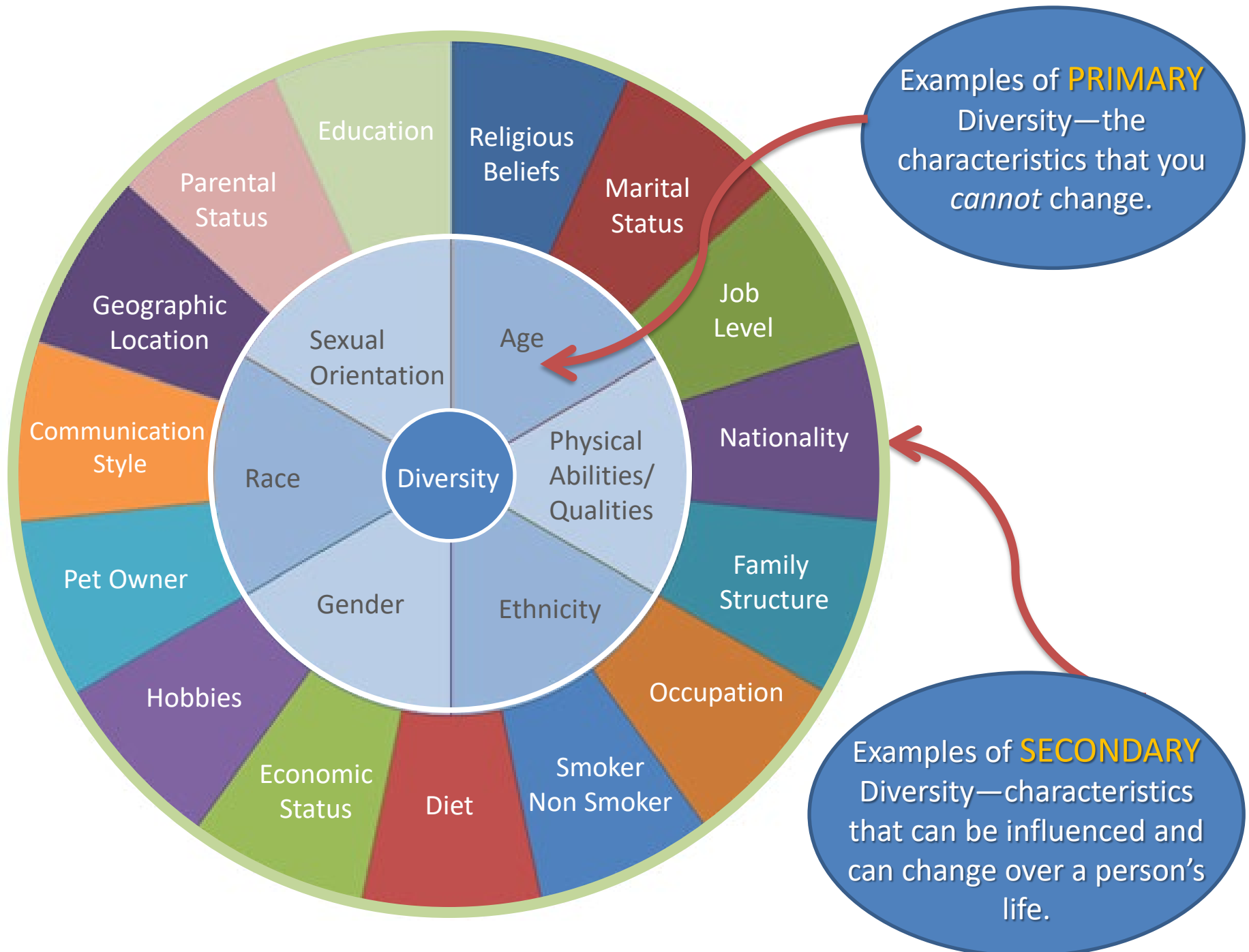
Cultural Awareness

Developing sensitivity and understanding of another ethnic group. Usually involves internal changes in terms of attitudes and values.



Cultural
Diversity
Between and
Within





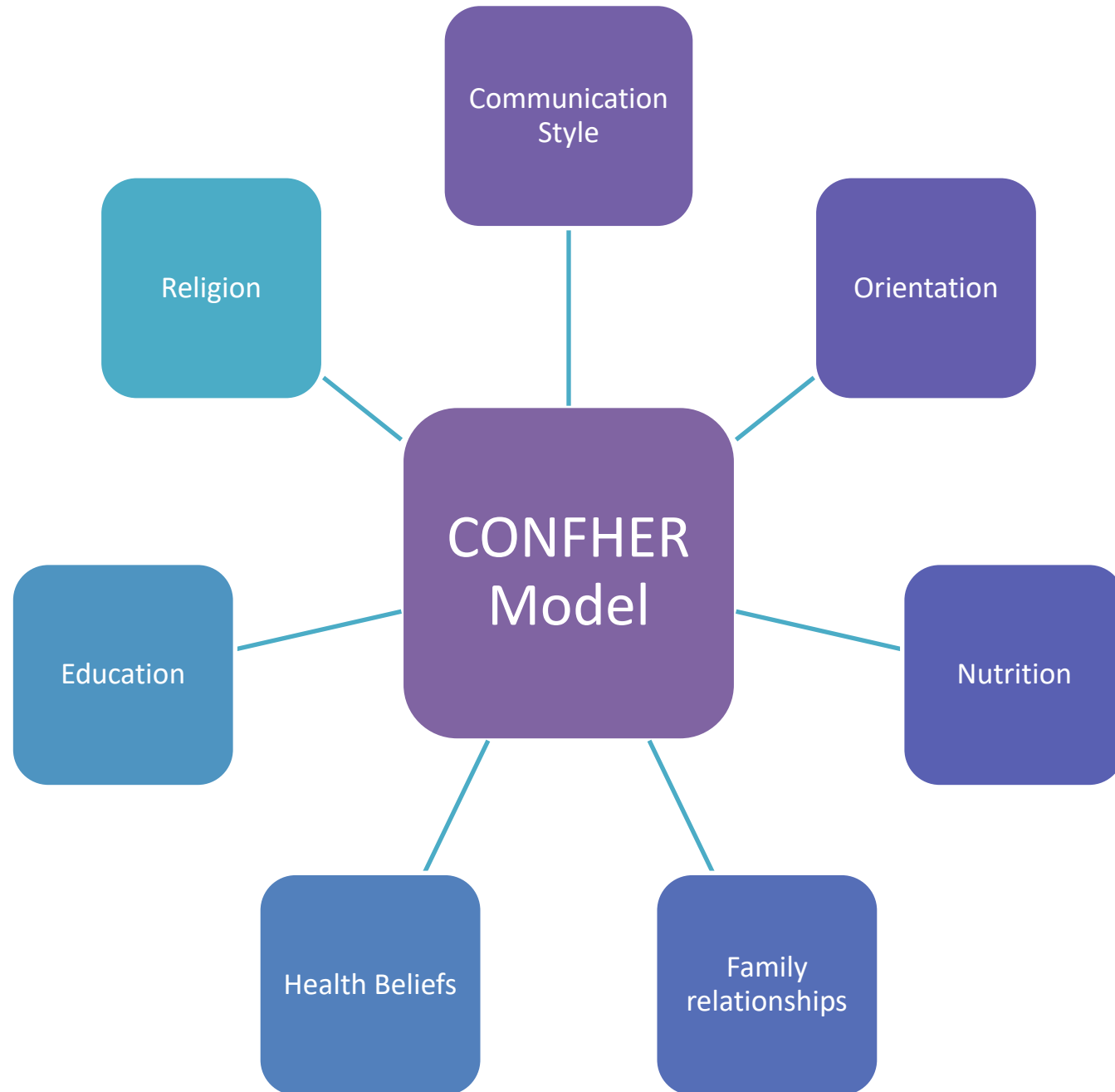
Examples of **PRIMARY** Diversity—the characteristics that you *cannot* change.

Examples of **SECONDARY** Diversity—characteristics that can be influenced and can change over a person's life.



Cultural Sensitivity

Knowing that cultural differences as well as similarities exist, without assigning values to those differences.



Explanatory Model

- ✓ Patient/Client centered
- ✓ Doesn't require exhaustive knowledge
- ✓ Recognizes individuality
- ✓ Allows cultural humility
- ✓ Allows collaboration and negotiation



Photo: Ed Zuroweste

Sample Questions

What do you think is causing your illness?

Do you have an explanation for why it started when it did?

What have you done to treat this?

What does your sickness do to you; how does it work?

Have you asked anyone else to help you?

What kind of treatment do you think you should receive?



Translation and Interpretation





Translation
is written

Interpretation
is oral



Plan
ahead

Avoid
jargon or
technical
terms

Ask one
question
at a time

Think of
several
ways to
restate



Encounters in Context



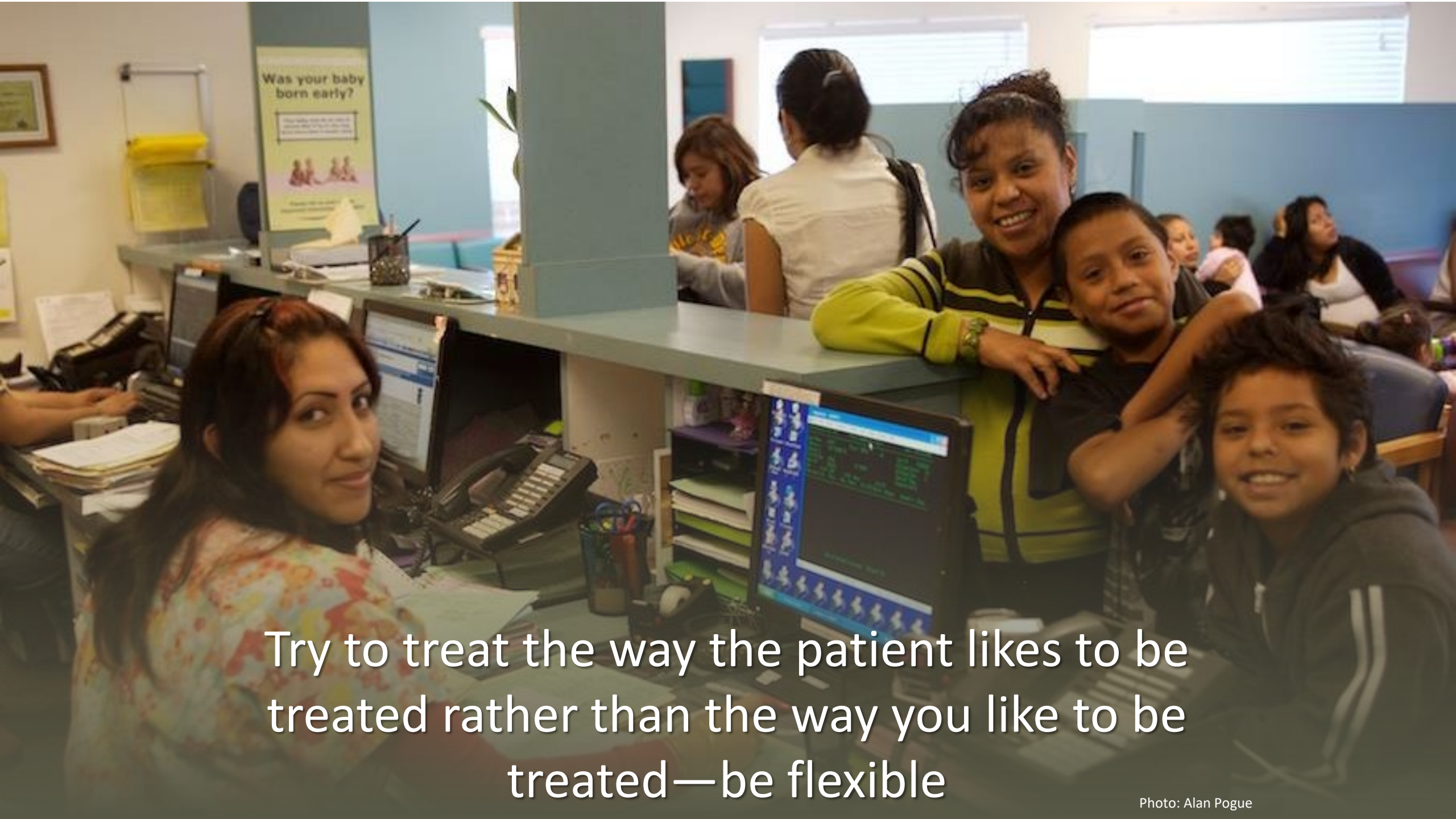
Impatience and annoyance may be your
signal of an intercultural misunderstanding



Personal questions asked of you by a patient may reflect a cultural need for trust and reassurance



Hesitation may
indicate you've hit
a cultural wall...



Try to treat the way the patient likes to be treated rather than the way you like to be treated—be flexible

If patients repeat your instructions in exact form, there is a likelihood they do not understand. Rephrase and ask them to restate.



Language

Use professional medical interpreters whenever possible
or:

- ✓ Bilingual trained staff
- ✓ Language line
- ✓ A former patient from community
- ✓ Other unrelated bilingual individual (only in emergencies)



Photo: Ed Zuroweste

Interpretation Dos



- ✓ Have interpreter sit beside and slightly behind patient
- ✓ Establish “ground rules” with interpreter before patient interview
- ✓ Speak directly to the patient not to the interpreter
- ✓ LISTEN to patient
- ✓ Pay close attention to “body language”

Interpretation Don'ts



- ✓ Do not use family, especially children!
- ✓ Do not use an unqualified interpreter.
- ✓ Do not speak directly to the interpreter or phone.
- ✓ Do not ignore cultural differences (i.e. some cultures do not appreciate looking you in the eye).

Communication Skills



Do not rely
on brochures

Don't
shout

Avoid slang
or jargon

Encourage
questions

Pay attention to
nonverbal cues

Respect privacy,
modesty

First Encounter with a TB Patient

Spend as much time as possible during first nursing, outreach, physician encounter

Establish caring, open relationship

Explain TB in simple terms to make sure patient understands

What does Dx TB mean to you?

Have you known anyone with TB?

What treatment have you already tried/from whom?

How is TB treated in your home country?

What is your greatest concern?

Follow-up encounters

- ✓ How do you feel about someone coming to your home or work for DOTS?
- ✓ Do you plan to move before treatment completion?
- ✓ What problems or issues might prevent you from completing your treatment?



Other Considerations...

- ✓ Providers are not able to understand all cultural aspects of TB patients from very large global pool
- ✓ Be open-minded and non-judgmental
- ✓ Ask questions and respond with empathy.
- ✓ Make adjustments to protocols when necessary without compromising treatment outcomes



Photo: Ed Zuroweste

Team may need to be enlarged to include:



- ✓ Interpreters
- ✓ Community health workers
- ✓ (*Promotoras*)
- ✓ Spiritual leaders
- ✓ Non-traditional healers

Educational Materials

- *Cultural Competency and Tuberculosis Care: A Guide for Self-Study and Self-Assessment*
- *TB & Cultural Competency: Notes from the Field (newsletters)*
 - <http://www.umdj.edu/globaltb/products/newsletter.htm>
- CDC ethnographic guides – Mexican, Vietnamese, Hmong & Chinese
 - <http://www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/default.htm>
- Southeastern National TB Center – cultural snapshots.
 - 31 country guides (<http://sntc.medicine.ufl.edu/Products.aspx>)

Multimedia Resources

- Virginia Dept of Health Division of TB Control
 - Web video and mobile video on 7 different topics
 - <http://www.healthyroadsmedia.org/topics/tuberculosis.htm>
- Minnesota Department of Health – Refugee Health & TB Program
 - 20 min clip (video/DVD) TB awareness message, available in 7 different languages
 - <http://www.health.state.mn.us/divs/idepc/diseases/tb/echo.html>
 - *TB & One Man's Story* (26 min DVD in Somali)
<http://www.health.state.mn.us/divs/idepc/diseases/tb/videos.html>

Interpretation Resources

- *Making the Connection: An Introduction to Interpretation Skills for TB Control, 2nd Ed*
 - http://www.currytbcenter.ucsf.edu/products/product_details.cfm?productID=EDP-09W
- International Medical Interpreters Association
 - <http://www.imiaweb.org/>
- Translation Plus
 - <http://www.translationplus.com/>



Health Network



A Care Coordination Program
for Patients Who Move
During Treatment

MIGRANT CLINICIANS NETWORK



Health Network

Eliminate health
disparities due
to patient mobility



©Earl Dotter

A photograph showing four men walking through a field of young corn plants. The man in the foreground on the left is wearing a blue headwrap and a striped shirt. The man on the right is wearing a white t-shirt and a cap, holding a wooden tool. Two other men are walking further back in the field. The background shows a line of trees under a clear sky.

Health Network
28 Years of Innovation



MCN's Health Network does
not discriminate on the basis
of immigration status and
will not share personal patient
information without
patient permission.

CONFIDENTIAL

- ✓ **Confidentiality is critical to all MCN staff and all Health Network procedures conform to HIPPA standards**
- ✓ All patients are asked to sign (or have a witness sign) a consent form before enrollment in Health Network

Migrant Clinicians Network
 PO Box 164285
 Austin, Texas 78716



Business Phone: (512) 327-2017
 Confidential Fax: (512) 327-6140
 Confidential Phone: (800) 825-8205

ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic	Clinic phone number(s)	
E-mail address	Clinic fax number(s)	
Contact person at Clinic		
Security Question #1:	Patient's city of birth?	
Security Question #2:	Patient's father's first name?	
Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent.	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> HIV
	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> General Health
	<input type="checkbox"/> Cancer	
	<input type="checkbox"/> Diabetes	



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PERSONAL INFORMATION SHEET | MCN HEALTH NETWORK

*REQUIRED

Last Name(s)			
Birth Date (Month / Day / Year)			
Gender:	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Other:
	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	
Non-Hispanic/Latino	<input type="checkbox"/> Black – Non-Hispanic/Latino	<input type="checkbox"/> Hispanic/Latino	

Forms Required for Enrollment

protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization.
 I do NOT authorize MCN or future health care providers to have access to my medical records around issue(s) listed here:

(attach additional page if needed)

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES OF ANY KIND WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTING FROM MY ENROLLMENT IN THE HEALTH NETWORK.

*REQUIRED

*PARTICIPANT SIGNATURE (or Signature of Legal Representative)	Date
Relationship of Legal Representative to Patient	Witness Signature

We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment form when it is completed.

ENGLISH – THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DATE OF SIGNATURE

Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
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LOCATION FOR PARTICIPANT (Place you normally move to):			
PO Box	City	State	Zip/Country

Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
---	---	------------

someone we can contact if we cannot reach you at either of the locations you provided. In doing this act that family member or friend to assist you in receiving continued health care, which may require s) with this individual. You do not have to provide this additional contact information.

Last Name	Relationship to Participant		
City	State	Zip/Country	

Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	*INITIALS:
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Security Question #2:	Patient's father's first name?	
Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent.	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV <input type="checkbox"/> General Health

Gives MCN staff legal permission to transfer participants' medical records and contact participants

CONSENT FOR RELEASE OF MEDICAL INFORMATION

First Name	Last Name(s)
Alias, Nicknames, Etc	Birth Date (Month / Day / Year)

The Health Network currently helps with continuity of care for people with infectious chronic illnesses or other healthcare concerns. (i) MCN is a non-profit company coordinating my enrollment in the Health Network at no cost to me; (ii) MCN may not be able to obtain health care providers that are available to care for my condition at no cost to me; (iii) the health care providers who will be providing my treatment are independent and not employees of MCN; and (iv) MCN does not provide, and is not responsible for, any health care treatment, or the outcomes of such treatment, in connection with any or all of the Health Network projects.

I agree to notify my future health care providers of my enrollment in the MCN Health Network to help facilitate the transfer of my medical records. I understand and consent to MCN maintaining records of my medical history containing sensitive health information (example: HIV status and information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening.

I agree to participate in the Health Network, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization.

Authorized individuals from MCN may contact me by phone, email, or in person regarding follow up and referral for my treatment for these conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. This consent form will remain in effect for two years (24 months) from the date signed or until my participation in the Health Network has ended for another reason. I can submit a written request any time to leave the Health Network and limit the health issues that MCN is authorized to address. I also understand that I have a right to receive a copy of my medical records file with MCN upon written request.

I do NOT authorize MCN or future health care providers to have access to my medical records around issue(s) listed here:

(attach additional page if needed)

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND WAIVES ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES OF ANY KIND WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTING FROM MY ENROLLMENT IN THE HEALTH NETWORK.

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Must have the participant's signature



Valid if sent within 5 business days of being signed by patient, remains valid for 24 months from the date signed

Participants may renew their consent after it expires if they still need assistance


PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK

*REQUIRED

First Name		Last Name(s)	
Mother's Maiden Name		Birth Date (Month / Day / Year)	
Place of birth:	City	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
	State	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other:	
	Country	<input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Race/Ethnicity:		<input type="checkbox"/> White – Non-Hispanic/Latino <input type="checkbox"/> Black – Non-Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian – Non-Hispanic/Latino <input type="checkbox"/> Indigenous <input type="checkbox"/> Other:	
Language(s) Spoken:		Language you prefer to be contacted in:	
<input type="checkbox"/> English <input type="checkbox"/> Creole <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
Occupation(s) (from past two years):	<input type="checkbox"/> Farmworker		<input type="checkbox"/> Construction
	<input type="checkbox"/> Homemaker		<input type="checkbox"/> Factory
	<input type="checkbox"/> Student		<input type="checkbox"/> Child care
Current Residence:	<input type="checkbox"/> Farmworker Camp Housing		<input type="checkbox"/> Jail
	<input type="checkbox"/> Home		<input type="checkbox"/> ICE Detention Center
			<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other:
		<input type="checkbox"/> Homeless <input type="checkbox"/> Other:	
CURRENT CONTACT INFORMATION FOR PARTICIPANT:			
Street / P.O. Box		City	State Zip/Country
*PHYSICAL ADDRESS:			
*MAILING ADDRESS:			
*PHONE NUMBER (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No *INITIALS:
OTHER CONTACT INFORMATION FOR PARTICIPANT (Place you normally move to):			
Street / P.O. Box		City	State Zip/Country
Physical Address:			
Mailing Address:			
*PHONE NUMBER (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? <i>(if you do not check off either box, or you do not initial, your answer will be "No")</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No *INITIALS:
<p>Additional Contact: Please list someone we can contact if we cannot reach you at either of the locations you provided. In doing this you give MCN permission to contact that family member or friend to assist you in receiving continued health care, which may require discussing your health condition(s) with this individual. You do not have to provide this additional contact information.</p>			
First Name		Last Name	
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Street / P.O. Box		City	State Zip/Country
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Single Point of Contact at the Health Center

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Austin, Texas 78716




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Please contact us at 512-327-2017 or www.migrantclinician.org/network for more information on the MCN Health Network.

02-07

Page 1 of 2

These enrollment resources are available:

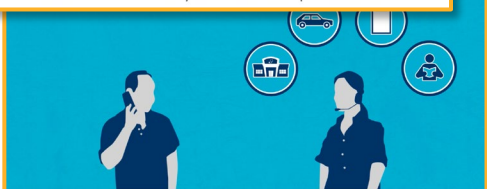
www.migrantclinician.org/health-network/enrollment



La Red de Salud es un sistema de administración de casos para pacientes móviles creado por Migrant Clinicians Network.



Cualquier proveedor de salud que trabaja con migrantes que tienen la intención de marcharse y se encuentran bajo tratamiento



La Red de Salud también puede proveer al paciente con educación necesaria acerca de temas clínicos.

Informational Videos about Health Network

Download Enrollment Packets in English, Haitian Creole, Portuguese and Spanish

HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into effective [date] (the "Effective Date"), by and between Migrant Clinicians Network ("MCN", "Business Associate", or "Party") and <<organization>> (the "Covered Entity" or "Party") (collectively referred to as the "Parties").

Business associate and covered entity have a business relationship (the "Relationship" or the "Agreement") in which business associate may perform functions or activities on behalf of covered entity involving the use and/or disclosure of protected health information received from, or created or received by, business associate on behalf of covered entity. Therefore, if business associate is functioning as a business associate to covered entity, business associate agrees to the following terms and conditions set forth in this HIPAA Business Associate Agreement.

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean MCN.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [insert Name of Covered Entity].

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

Business Associates Agreements

Required to be compliant with HIPAA

Recap of Health Network Enrollment Criteria

1 Patient is:

- ✓ Mobile / Migrant
- ✓ Thinking of leaving area of care

2 Patient has:

- ✓ Need for clinical follow-up
- ✓ Working phone number or family member with phone number
- ✓ Signed MCN consent form
- ✓ Clinical base or enrolling clinic



Steps to Maintaining a Patient in Care

MCN's Health Network Associate:



✓ Contacts patients on a scheduled basis



✓ Contacts clinics monthly, other healthcare clinics receive updates as requested, and when treatment has completed.



✓ Assists patients in locating clinics for services and resources



✓ Reports back to the enrolling clinic and notifies them of final outcomes



The Patient's Role...

As many
phone numbers
as possible

###-###-####

###-###-####

###-###-####



**Inform Health Network (HN)
Associates of any phone or
address changes and
contact HN staff after
arriving in a new area**





**Continue
treatment as
long as
indicated by
their physician**



**Over 15,100 total
HN enrollments**



Over 3,000 total clinics in U.S. and over 114 countries engaged to eliminate mobility as an obstacle to continuity of care



MCN's Health Network program began
initially as TB NET

2,125

Treatment Recommended

(26 MDR; 65 resistant to at least one drug)

37 deceased

A faint, light blue world map is visible in the background of the slide, centered behind the text.

2,088 Followed for Active TB

211 lost to follow up
106 refused treatment

1,771 Complete Treatment



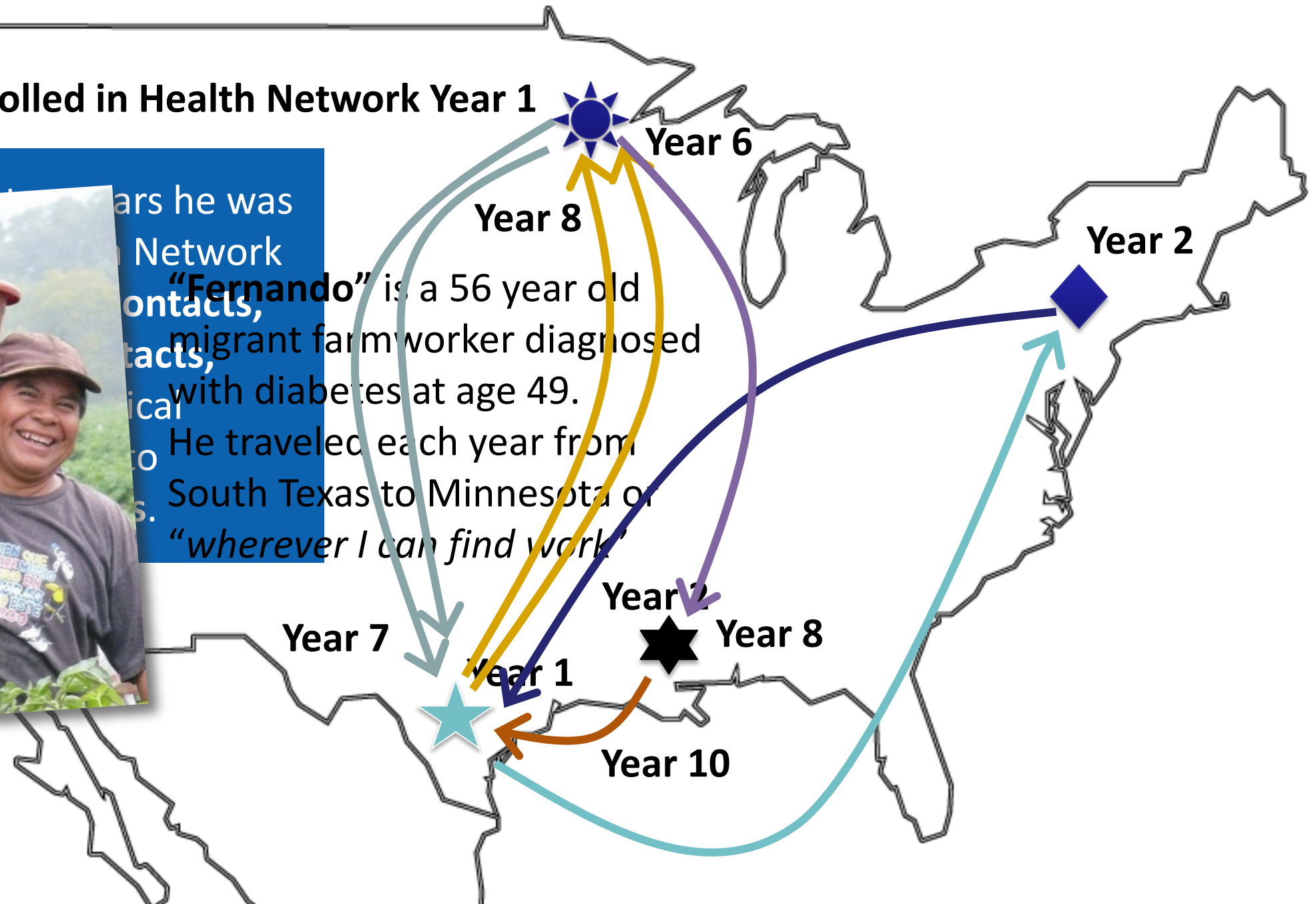
84.8%

Enrolled in Health Network Year 1

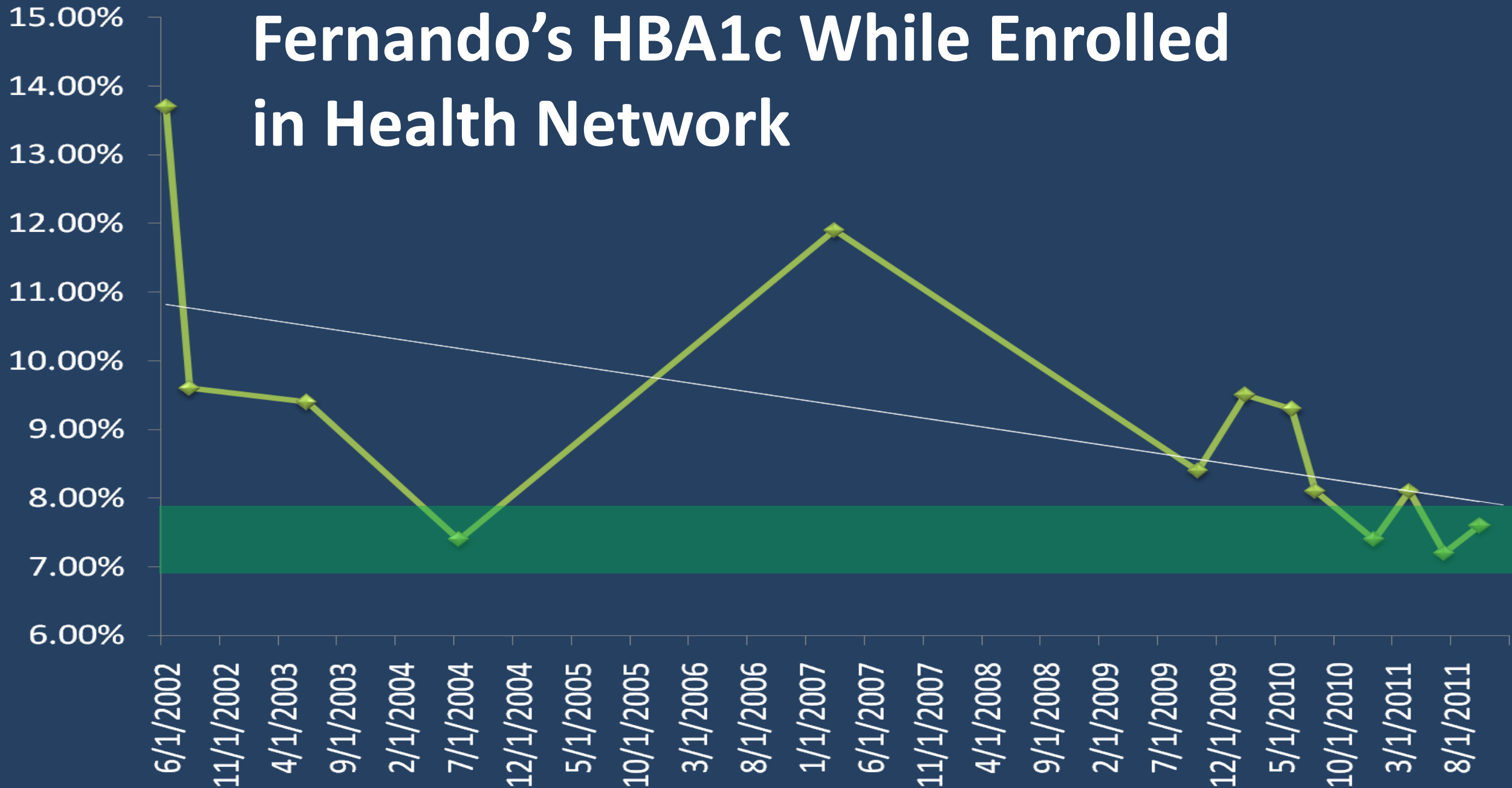


Over the next 10 years he was
in the Health Network
through his contacts,
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migrant farmworker diagnosed
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He traveled each year from
South Texas to Minnesota or
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Fernando's HBA1c While Enrolled in Health Network



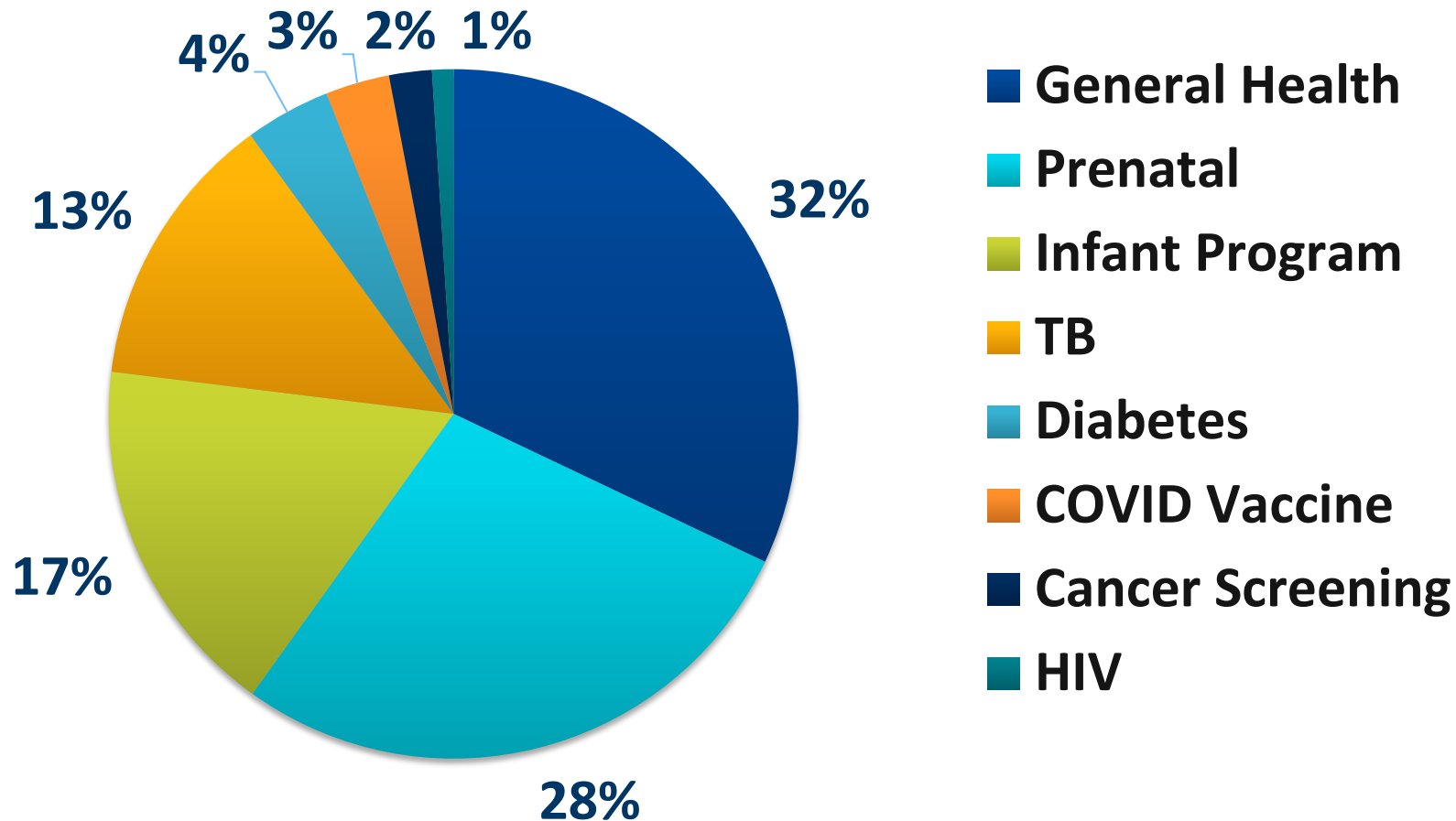


How Can MCN's Health Network Have such a high completion rate to 114 countries??

- Multilingual/multicultural case managers who use multiple communication techniques.
- MCNs' Case managers speak multiple languages (English, Spanish, Haitian Creole, French and Portuguese and use Language Line for all others)

MCN Health Network

Percent of Health Network Enrollments by Primary Diagnosis





What is the SCAN Program?

SCAN stands for the
Specialty Care Access Network

SCAN's primary goal is to assist with the coordination of pediatric patients into sub-specialty care.

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Contact Us

- Health Network telephone:
800-825-8205 (U.S.)
- Health Network fax:
512-327-6140
- MCN website:
<http://www.migrantclinician.org/>

For questions when enrolling your patients, please contact Alma Colmenero
acolmenero@migrantclinician.org
(512) 579-4510

To Schedule additional trainings like the one today, please contact Theresa Lyons-Clampitt
tlyons@migrantclinician.org

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