2018 MI World TB Day Conference
Pre-submitted questions

Text that is **bolded and underlined** indicate a hyperlink to other available resources.

1. Does the CDC endorse or support the use of electronic forms of DOT (e.g., video DOT, Skype)?
    - Yes! CDC has released a toolkit for using eDOT, **available here on CDC's website**. Helen has also compiled a set of **eDOT resources on our program website**.
    a. Are there any legal or HIPAA requirements related to these nontraditional forms of DOT?
        - In 2016 Washtenaw County discovered video DOT vs. traditional DOT, out of necessity, due to very limited TB nursing staff and time. They spoke with other states using vDOT and developed **their own protocol**. vDOT has saved Washtenaw County nurses and their clients, time and money; it allows for increased flexibility for everyone and removes many barriers. For their clients ensured privacy, they would like to invest in an encrypted program, like eMocha.
        - Minnesota TB Program has many vDOT resources and contract templates for others to use. To view these, and other resources, please see our **eDOT Resource Sheet**.

2. Is DOT required for LTBI clients?
    - DOT is highly recommended for high risk clients with LTBI, for example, young children less than five years old, clients with HIV, and TB contacts.
    - It is also recommended for any LTBI regimen with intermittent dosing.
    - In Washtenaw County, they use vDOT for their LTBI clients (if they meet the requirements detailed in their protocol).
    - Washtenaw County sees their LTBI adult clients at least once a month, plus they may text or call for any concerns.
    a. If so, how often must the nurse contact the LTBI client?
        - If you are using the 3HP regimen, **it is currently recommended** to DOT the client once a week for 12 weeks.
        - Use the CDC's **Treatment Regimens for LTBI** chart to determine dosing schedules for the recommended regimens.

3. If a known pulmonary TB client is incarcerated, what obligation does the jail have in notifying the health department that the client is incarcerated?
    - Jails are covered by the same reporting rules as other providers, meaning they should report a confirmed or suspect case of TB to their local health department within 24 hours. This applies even if the jail is not making the diagnosis directly; if they have information that TB is confirmed or suspect they are obligated to report that.
    a. What if the jail releases the client without notifying the health department?
        - The jail has an obligation to give the local health department notice before a person with TB is released or transferred to another correctional facility. If the person with TB is still infectious or possibly infectious, the local health department should be involved in and approve of the plan to release or transfer the person. This is not explicitly stated in the CD Rules or in the Public Health Code but is reasonably interpreted from both and is a responsibility of the jail as a part of county government to protect the well-being of the public.

4. What are the health department's legal requirements for TB control?
    - The Public Health Code gives broad powers and responsibilities that local health departments must prevent and control communicable diseases (including TB) in their jurisdictions. This includes testing, providing treatment, and taking actions or measures necessary to investigation and stop transmission of TB. Each local health department can work with partners in their communities to assure that necessary services are provided, but the ultimate responsibility for appropriate treatment and action rests with the local health department.

    a. What are the roles of the Medical Director, TB nurses, and Health Officer in TB control and LTBI management?
        - MDHHS Administrative Rules describe the qualifications and general responsibilities for Medical Directors and Health Officers.
        - Nursing roles are contained in the MSMS Scope of Practice manual.
        - Health Officers: planning, implementation and evaluation of public health programs.
        - Medical Directors: direct and formulate medical public health policy and program operations; policies/procedures/standing orders; advising the Health Officer on medical matters.

5. What are the county's legal responsibilities to patients who have secondary health problems related to their TB disease? For example, our client had miliary TB and meningitis, and now has possible nerve-related damage.
    - We discussed this as a group. Although there is no stated legal responsibility, there is an ethical and medical responsibility to treat or co-manage client's co-morbidities, for example, diabetes or HIV. This will help us in treating TB more quickly, with the least amount of complications, and more economically.
    - Washtenaw County manages the TB portion, and they work very closely with the client's primary doctors and specialists. Communication is really the key! If they are uninsured, they will work to get them insurance or the county health plan (which ensures a primary doctor), utilize their free clinic, or apply for hospital or other outside resources.
    - The state may help, also, with financial barriers.

6. What are the health department's financial obligations to assure clients receive needed care if they are uninsured or have a high deductible/copay?
    - It is PUBLIC HEALTH's responsibility to assure that patients receive all care needed to cure their TB. This responsibility is shared between LHD and MDHHS TB. If cost of care is a barrier, please call MDHHS TB and we'll work with you to resolve that. In this question, we would ask the LHD to pay the cost and MDHHS TB would reimburse.
    - Remember that incentives/enablers and reimbursements are also encouraged and available to overcome other barriers such as housing, transportation, food, etc.

7. Are there any legal measures a health department can take to compel an infectious index case to identify contacts?
    - In theory, yes, the Public Health Code could be interpreted to allow this. However, in real life this is unlikely to be upheld in court and is also unlikely to succeed with a patient, even if the court agreed to it. Revealing contacts necessitates the patient's choice to share private information, and a far more effective way to achieve this is to work with the patient to build trust and bring them to invest in the importance of offering testing to their contacts. It's also important to realize that there are many ways to elicit useful contact investigation

information without forcing the patient to share names. More open-ended discussions or observations about the patient's household may reveal other people who were present, or events the patient attended where others may have been exposed. Similarly, discussions about the patient's work site may reveal info that could allow the health department to prioritize parts or areas of the work site, that are of high priority. The health department could then approach the employer more discreetly to discuss testing of employees in those areas.

8. If a health department doesn't provide treatment for LTBI, how are primary care and other providers being educated on appropriate treatment?
    - This is a good question. Because LTBI treatment is optional (not required), health departments are not obligated to provide medication and DOT (if necessary) for those being treated for LTBI. Some health departments in Michigan have managed systems to treat their patients for LTBI; and these are funded with a variety of ways (free of charge, fee-for-service, insurance reimbursement, Medicaid, etc.). However, we cannot assume that all health departments are doing this.
    - The US Preventive Service Task Force (USPSTF) released updated recommendations for LTBI screening in September, 2016. The USPSTF recommendations emphasize testing for TB infection among two groups of people: (1) those who were born in, or are former residents of, countries with increased tuberculosis prevalence; (2) those who live in, or have lived in, high-risk congregate settings (e.g., homeless shelters and correctional facilities). LTBI risk assessment tools are available on the MDHHS TB Program website.
    - Local health departments are encouraged to contact providers in their area, especially those who provide care to individuals at high risk for LTBI and share these tools to engage and educate your providers.

9. Can we bill for DOT?
    - There is currently no code that has successfully been used for billing for DOT in MI.
    - MDHHS TB Control created a survey for health departments (finance and communicable disease divisions) to complete. This survey was designed to help us better-understand why health departments do or don't bill for TB and LTBI services, to address billing issues, like not being able to bill for DOT. This is the first step in a LONG process, so please be patient as we analyze the results of the survey.

10. What are the requirements for refugee health assessments?
    - Answer coming soon

11. What is best practice steps for ambulatory practices to accommodate all patients with appointments when one patient presents and is exhibiting TB-like symptoms in a common area, such as a waiting room?
    - If TB specifically is suspected, the best option would be to ask the symptomatic person to reschedule on a different day; preferably after they can be fully evaluated for TB. The problem is that "TB-like symptoms" are common to other respiratory infections, and these other infections are more common and likely than TB. A person with concerning cough should be asked to reschedule their appointment if possible or be escorted to a private room or waiting area if the appointment is necessary, to minimize exposure of other patients. This is in keeping with general respiratory infection control practices, and not necessarily specific

to TB. Contact your local health department for more specific guidance or concerns about a specific situation.

- If a clinical setting learns that patients in a waiting area were exposed to TB (for example the local health department calls them as part of a contact investigation), the clinic should work with the local health department to identify which other patients should be tested.

12. Are people living with HIV aware of tuberculosis risks? How are they informed?
    - Ideally, people living with HIV should be given equal opportunities to learn about their risks for tuberculosis infection. The burden of providing these learning opportunities rely heavily on the counselor or physician who is working with the patient. Unfortunately, as we know, people living with HIV are at risk for a lot of infections and diseases that would otherwise not affect someone with a healthy immune system. Because of this, health educators must address the risk of many diseases, some of which occur in the U.S. more often than TB.
    - Understandably so, people from countries with a higher HIV and TB burden may be given more resources (screening programs, educational information) to address the higher co-infection rates in their country.

    a. How do we know they can "understand" the information they receive?
        - It is also the responsibility of the health educator or provider counseling the patient, to use communications skills to check if the patient seems to understand or accept the information provided. For example, open-ended questions about the material just shared can help to asses a patient's understanding or intake of that material. Asking the patient to describe how they feel about the information provided may help to gauge how comfortable or receptive the patient is to that material. Asking a patient to repeat information just given to them or asking if they "understand what was just discussed", are often unsuccessful in assessing true understanding or acceptance because they don't encourage the patient to express their own thoughts.

13. Who is NOT a candidate for LTBI treatment?
    - Answer coming soon

14. What are the requirements for LTBI follow-up?
    - Answer coming soon