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Community involvement is critical to control foreign-born TB problem

Infection screening programs should target recent arrivals

A national group of TB experts has issued marching orders to tuberculosis control divisions across the land: Focus on foreign-born residents.

In "Recommendation for Prevention and Control of Tuberculosis Among Foreign-Born Persons" (*Morbidity and Mortality Weekly Report*, R&R, Vol. 47, Sept. 18, 1998), a national working group last month called on TB controllers to develop detailed profiles of foreign-born groups in their districts, target high-risk groups for screening, and form partnerships with community-based organizations (CBOs).

"Lots of programs are already doing some very innovative and exciting things, which they can share with the rest of us," says **Nancy Binkin**, MD, MPH, associate director for International Activities at the Centers for Disease Control and Prevention's (CDC) Division of TB Elimination and a member of the working group. "But many other states are just now beginning to confront the problem [of the foreign-born] and will need to develop resources." **(See related stories on TB control programs under way in Mississippi, Seattle, and Boston, pp. 123-125.)**

Already, foreign-born cases make up 39% of the total nationwide; within the next three to five years, they may account for half of all U.S. cases, says Binkin. "We're coming down very, very quickly in our U.S.-born cases but not really declining in the number of foreign-born cases," she says. "Ultimately, the foreign-born will become the principal focus for TB activities in this country."

New role: Planners and directors

One point that leaps out from the *MMWR* article is the enormity of the pool of latently infected foreign-born persons — about 7 million. As clinicians in many parts of the country meet their first priority — to get active cases and contact investigation under control — they are beginning to shift their focus toward providing preventive therapy, Binkin says.

Programs that target the foreign-born, however, will have to rely on help from outsiders in a way that programs aimed at home-grown TB cases have not, experts say. Instead of trying to play all of the instruments

at once, so to speak, future TB control divisions will act more like orchestra conductors, providing direction, support, training, and supplies to CBOs, which will be doing a lot of the actual work themselves. Or, as the *MMWR* report says, "Emphasis should be on the community planning role of the health department and the implementation roles of other providers."

The shift toward forming more partnerships with CBOs is critical for two reasons, according to Binkin:

1. CBOs will provide the extra hands needed to extend the reach of health departments.

2. They will engender trust by providing the cultural and linguistic compatibility foreign-born populations require.

In addition to forming partnerships, TB controllers must carefully target groups for preventive therapy. "We're really putting a lot of emphasis on this point: Don't screen unless you're planning to give preventive therapy," Binkin says. "If you don't have the facility, the staff, and whatever else it takes to get people through therapy, don't screen at all."

Infection screening programs should begin by targeting recent arrivals, which the working group report defines as those who've been here for five years or less. Among most groups from high-prevalence countries, after five years, "we've found that risk for reactivation starts to go down, especially in younger age groups," she says. "So we've set five years as the limit at which we might want to be actively screening people."

Demographic trends color a striking new picture of TB control. In 1996, the United States granted permanent residency status to 915,900 people. Added to that are an estimated 275,000 undocumented aliens who arrive each year. All told, 9% of the nation's population, 24.6 million people, is foreign-born.

The composition of the foreign-born is shifting, the report adds. Of the two largest pools of immigrants — Latin-American and Asian — the latter is gaining steam. Thus, in 1994, 24% of all foreign-born persons in the United States were Asian; the following year, the proportion of Asians made up 37% of new arrivals.

The report also underscores the concentration of foreign-born populations in California, which claims 34% of the total pie; with smaller pieces (ranging from 5% to 9%) found in New York, Texas, Florida, Illinois, and New Jersey.

Though the prospect of screening so many newcomers and foreign-born residents may seem daunting, the report recommends two places to begin looking for active cases and the latently infected:

❒ **immigrant screening that occurs stateside;**

❒ **screening that occurs abroad.**

Of the 800,000 people who undergo medical screening each year, a larger proportion is screened for TB prior to their departure by physicians appointed by U.S. consuls abroad. A smaller percentage is screened after arriving in the United States, usually because they have decided to apply for a change in immigration status.

In the overseas examinations given prior to immigration, immigrants and refugees with suspected TB are divided into these groups:

❒ **Class A** (sputum-positive, active TB cases, which must undergo treatment before departure);

❒ **Class B1 and B2** (smear negative, but suspicious chest radiographs);

❒ **Class B3** (calcified granulomas).

Though Class B immigrants are referred to health departments, the question of precisely how much follow-up gets done has gone unanswered until recently. The subject receives more attention now, Binkin says.

"People didn't know how high the yield was for Class B1 and B2 immigrants, so we did a couple of studies," she says. The study results attracted notice: 3% to 14% of Class B1 immigrants and 0.4% to 14% of Class B2 immigrants were infected with active TB; half of B1s, plus a quarter of B2s, were candidates for isoniazid.

"We really tried to get the word out on that,"

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says Binkin. The strategy worked. "Now, follow-up [of Class B1 and B2 immigrants] in many places is more than 90%. Upstate New York, an area with one of the lowest rates found at first look, now boasts follow-up in the 95% range.

Examinations performed here on the 200,000 residents annually seeking to adjust their residency status are conducted by civil surgeons, who again are expected to refer those who appear to be promising candidates for preventive therapy. Unlike with incoming immigrants, the referral process here still needs work, the report says. Health departments should provide those civil surgeons (who receive no particular TB training prior to their appointment by the Immigration and Naturalization Service) with the proper training

Mississippi shifts gears to deal with foreign-born

Until recently, foreign-born TB patients have been relatively scarce in Mississippi, says state TB controller **Michael Holcombe**, MPPA, mostly because the state lies outside the routes traditionally plied by migrant workers.

That is changing. These days the state is working hard to develop profiles of its ethnic groups, train health departments, provide interpreters, and conduct contact investigations, says **Risa Webb**, MD, state TB consultant. The process speaks to what's involved when a state shifts gears from working mostly with "home-grown" TB cases to handling more cases among the foreign-born — who now account for about 10% of the total number of cases overall.

The change didn't come overnight. For years, a small community of Asian-born fishermen has plied the waters of the Gulf Coast, with fishermen going out to sea for weeks at a time, making it tough to observe therapy. In the sweet potato fields in the northeastern part of the state, the number of foreign-born laborers, many of them Hispanic, has also increased.

The state's growing poultry industry, too, is attracting foreign-born workers. Among them, several TB cases have recently occurred.

One such case turned up in a plant where workers come from a dozen different countries in Central and Latin America. The size of the work area — a single large room — meant virtually everyone had to be skin-tested. TB controllers were surprised at how many positive reactions they found among foreign-born workers and began interpreting the results.

In some of the workers' countries of origin, BCG vaccinations are given routinely. Investigators also found that many workers regularly travel to and from their homes, increasing their chances for recent exposure.

Eventually, the decision was made to offer preventive therapy to more than 100 workers. Four months later, about a fifth of that group has already disappeared — not a surprising event since turnover at the plant is high.

At first, TB controllers considered asking poultry-plant owners to obtain baseline skin test results from all workers at hire; but given the high turnover, they now wonder whether it would be the best use of resources. Fortunately, Mississippi has a good infrastructure capable of delivering directly observed therapy and has been able to add interpreters and offer foreign-language courses in some districts, Webb says.

What helped get the state off to a good start in coping with its foreign-born populations was a regional leadership conference held a few years ago where participants voted to survey the foreign-born populations beginning to immigrate to the state. Questionnaires went out to health district epidemiologists and chambers of commerce, and soon a picture began to emerge about who the populations were, where they lived, and where they received health care services.

The survey has proven invaluable, not just to TB control, but to other branches of the health department too, Webb adds. If commissioning such a survey proves too costly for a TB control division to undertake alone, the answer might be to get other divisions interested as well, since they stand to benefit from the same demographic information, Webb adds.

What the division needs most now is more interpreters and manpower to conduct follow-up in the poultry industry and to determine if any of the positive skin-test reactions from the contact investigation reflect other cases of active TB, which may be hidden in the communities where the workers live.

"If you have someone who speaks the language it's easier to win people's trust," she says. ■

and education to increase appropriate referrals, the working group concludes. **(See related story on civil surgeons, p. 126.)**

Contact tracing among the foreign-born poses special problems, the report states, especially in light of difficulties distinguishing recent infections from remote, and latent infections from bacille Calmette-Guerin (BCG) vaccination — or, perhaps, environmental mycobacteria. More studies are needed on yields that can be expected from such investigations, how completion-of-therapy rates stack up, and what incentives or enablers work to improve adherence.

Another issue identified in the report is the impact of rates of isoniazid resistance prevalent among some populations — 18.3% among Vietnamese, 14.7% among Filipinos, and 9.8% among Hispanics, compared with only 6.4% among U.S.-born patients. Given such rates, how effectively will a regimen of isoniazid prophylaxis hold up? What alternative might work better? Also on the working group's wish list: an algorithm for interpreting a history of BCG vaccination.

The report gives the CDC plenty of homework:

❒ **Round up more information on immigration trends, resistance rates, and treatment regimens in countries of origin.**

❒ **Start working on a national and bi-national tracking system.**

Partnerships lead to success in Seattle

A few years ago, Seattle's King County TB control program found itself confronting the same situation that faces cities like Boston today: When it came to providing services to the city's foreign-born communities, the work that TB controllers were doing was good but they simply weren't doing enough.

"We could feel good about the 1,000 patients we could reach," says **Charles Nolan**, MD, King County chief of TB Control. "But the numbers were so big that we could ratchet up our program as hard as we could and still barely make a dent in the need."

Seattle's approach to that challenge has been to form partnerships with community-based organizations that serve the foreign-born, providing backup and support to those agencies while letting them do much of the actual work.

"Our approach has mainly been to increase the interest level on the part of community health centers and clinics," he says. "Typically, we provide the medications, the protocols for the correct use of isoniazid, X-ray services if needed, provider education, patient educational materials, and convenient consultations."

It's a big job for a community clinic to take on, Nolan adds, and over the years has proven to work better in some situations than others.

One success story involves the International District Community Health Center, which provides health care mainly to Asians and Pacific Islanders. With encouragement from Nolan's division and a small grant supplied by a West Coast-based advocacy organization, the health care center began to devote some staff time to tracking patients — making sure that those who came in for skin testing returned to have their tests read or contacting patients who failed to come in for their isoniazid refills and encouraging them to come back.

Nolan credits the project's success mainly to the sense of dedication and the strong commitment to serve the rest of the community that he sees among staff members at the health center. "There's really a remarkable quality of leadership there," he says.

"They truly believe that whether you're immunizing a child or picking up a latent TB infection, you're doing a service not just to the person sitting in front of you, but to the whole community," Nolan explains.

Things don't always go that smoothly, he adds. "We've had other [partners] we've worked with who've finally said to us, 'Look, this is your job, not ours. You're the people who do TB.'"

Even so, TB control departments all need to be doing more of this kind of partnering, Nolan says. "I read on a conference poster recently that over the last seven years, Los Angeles has partnered with six or eight organizations and started 40,000 people on preventive therapy," he says.

"They can bury the rest of us with their numbers, but we all need the support of our neighbors. The more help we can get from the community, the better off we are," Nolan adds. ■

❒ **Address border issues.**

❒ **Establish lines of communication with foreign health care providers.**

In the section on training, the report mentions several resources. For example, a cultural anthropologist's perspective can be found at "Ethno Med,"a Web site established by the Harborview, WA, Refugee Clinic (www.hslib.washington.edu:443/clinical/ethnomed). In addition, compilations of material suitable for foreign-born audiences is available from a conference on training held earlier this month at the Francis J. Curry Model TB Center in San Francisco. ■

Boston program pushes preventive therapy

In Boston, TB controllers are like restaurateurs with a five-star menu and plenty of seating capacity: They'd like to see more business, especially from the city's foreign-born communities.

Clearly, it's epidemiology that's driving that desire. So far this year, 85% of the city's TB cases are foreign-born, says TB controller **John Bernardo**, MD. That's already a jump from last year's totals, in which foreign-born cases accounted for 72%.

One reason — home-grown TB is on the wane in the city. "TB among injecting drug users isn't really a big issue here," says Bernardo. Plus, thanks to better case finding and screening in shelters, the city averages only two or three cases of TB a year among its homeless population.

An analysis of data from cases among the foreign-born makes a strong case for more preventive therapy, he says. "Lots of places report it's the new arrivals among the foreign-born that are bringing TB," he says. "But here, the majority of patients have been here a little more than five years." Among age groups, there are two peaks: the first between 25 and 44 years old and a second smaller peak among those older than 65. "What that tells us is that we're missing a lot of opportunities for prevention," Bernardo adds.

In the city's network of community-based, primary-care health clinics, TB controllers have a ready-made venue for providing more preventive therapy. The clinics are staffed by members of the same population groups they serve, so that patients feel comfortable and welcome there, and TB control has provided staff members with extra TB training, shifting most of the follow-up activities away from the downtown TB clinic and into the neighborhoods. As a result, completion rates for patients on preventive therapy have jumped up to a satisfying 80%, says Bernardo. **(For more information, see *TB Monitor*, August 1998, p. 91.)**

Yet so far, only 350 to 400 foreign-born patients are getting preventive therapy from the clinics. He says that accounts for no more than 10% of the total number of potential candidates.

Two factors are keeping people away, according to Bernardo:

1. There is a stigma surrounding TB. "People are afraid of TB," he says. "They're afraid of being labeled."

2. One of the two systems that traditionally have channeled patients to the clinics may soon shut down. "People come into the clinics either because they need a TB screening for their jobs or because their children were required by the schools to get periodic TB screening," Bernardo says.

The effect of a recent change in state law may cut back the number of school kids who are skin tested for TB, though, by leaving the decision of whether or not a child is at risk up to individual physicians. Bernardo worries that family physicians who are already pressed for time, or simply unaware of the risk factors involved, may elect to waive the screening.

The solution, as Bernardo sees it, is to form partnerships with community-based organizations (CBOs) that can help with education, outreach, and training. "We've got three CBOs champing at the bit to get going," he says. "The leaders within these communities have bought into the concept of prevention, and they see it as a need. Once you get the trust of the leadership, a lot of the mistrust about who we are and what we do tends to dissipate."

For starters, the project will hone in on two populations, Chinese and Hispanics, with strong family structures in which the mother is particularly influential, says Bernardo.

The idea is to convince mothers that it's important to get their families — especially their children — to come into clinics for screening. "We're focusing on youth because they're the ones who are going to come down with TB, according to the epidemiology we're seeing," he adds.

His department has limited its own role in the project to persuading CBOs of the importance of providing more prevention and to

make the commitment to help, says Bernardo. He trusts that CBOs know their own communities well enough to come up with strategies for outreach and training that will work. TB and TB prevention won't be the only items on the agenda, either. CBOs will try to increase awareness about the importance of screening for sexually transmitted diseases and HIV as well.

Finding new ways to reach out to the foreign-born has become "the heart and soul of our program," Bernardo says. "We have to become more attractive to our foreign-born communities. They're either going to run away from us or run toward us." ■

Conference reaches out to area civil surgeons

Nationwide, an opportunity for referrals

In San Diego, TB controllers have tapped into a ready-made referral source of foreign-born candidates for preventive therapy by reaching out to civil surgeons, physicians who are appointed by the U.S. Immigration and Naturalization Service (INS) to screen residents seeking to adjust their immigration status.

"We're always looking for opportunities to do preventive therapy," says **Kathleen Moser**, MD, MPH, TB control officer for the San Diego County Department of Health Services. "And here's this great population." Last summer, Moser, in cooperation with the Centers for Disease Control and Prevention (CDC), held a conference for San Diego County civil surgeons.

Those in attendance had many questions about TB infection, skin testing, and how and when to refer patients to the health department, she says. Since then, Moser has gotten lots of telephone calls seeking advice and says she feels as if she's successfully made contact.

More health departments should consider doing the same kind of outreach work, says **Nancy Binkin**, MD, MPH, associate director for international activities at the CDC's Division of TB Elimination, given that every year civil surgeons screen some 200,000 foreign-born residents for TB. Plus, since it's a simple process, some health departments might want to have the TB controller — or another physician on board — become a civil surgeon, adds Binkin.

In Denver, the city's TB control officer, **Randall Reeves**, MD, is a civil surgeon; he likes the way the process gives his division the chance to review patients' chest radiographs and evaluate them for preventive therapy.

Throughout the United States, about 3,000 people have been approved by the INS as civil surgeons, says Binkin. The requirements are straightforward: the applicant must be a medical graduate licensed to practice in this country and must have four years' practice. The INS provides no special training.

Newly appointed civil surgeons receive a booklet that describes the exam they must perform. Along with screening for sexually transmitted diseases, including HIV, and a check to make sure immunizations are in order and up to date, the physician must place a TB skin test, says Binkin.

For reactions equal to or greater than 5 mm, the procedure requires a chest radiograph. In the event that the X-ray is compatible with TB, the physician must refer the patient to a health department. However — and here, say Binkin and Moser, is the interesting part — for those with reactions equal to or greater than 10 mm, physicians are encouraged to refer patients for evaluation for preventive therapy.

Experts review TB component of exam

To see whether that kind of referral was taking place, the CDC conducted a four-site study — in San Diego County, San Francisco County, and the states of Massachusetts and New York — in which TB experts reviewed the TB component of the exam, says Moser. It didn't look as if civil surgeons were missing any cases, she adds; but when TB experts cross-matched likely candidates for referral with health department records, it was clear that the yield was skimpy.

"It's hard to say whether the civil surgeons were referring people to us or not," adds Moser. "It's easier to say that if they did, not many showed up."

She decided to hold a conference, partly to provide education and training and partly to make contact. A call to the district INS office produced a list of the 125 designated civil surgeons in the county. Since the INS permits physicians to charge a set fee for the exam, it's possible to "make a pretty good living" doing just the exams, says Binkin. Moser discovered that of the 125

civil surgeons in the county, about 50 did many exams; she targeted that group specifically for the conference, making sure dates were convenient for them.

In the letter that went out, Moser asked what kind of information the civil surgeons already had, what type of information they'd like to have, and whether they would come for training and continuing medical education credits.

The response was "pretty good." About 70 civil surgeons and staff assistants (who usually do the actual placement of the skin tests) showed up. Speakers were recruited from the CDC's Divisions of Quarantine and Immunization and from the district INS office. For a presentation on the basics of TB, there was Moser herself.

The question-and-answer session was lively, she says. Participants wanted information about cutoff points for skin-test readings since INS exam instructions specify a chest X-ray when skin-test reactions are greater than or equal to 5 mm, not the conventional 10. They had many queries about bacille Calmette-Guerin vaccinations. "As elsewhere, that was probably the area of greatest confusion," notes Moser. Finally, participants asked questions about how and when to refer patients to the health department.

"We began to get the sense that they weren't referring patients because they didn't know how," she adds. "They asked stuff like, 'Who do you accept? How do you refer for disease, vs. infection?'"

By the end of the day, Moser says the lines of communication had been established. "There's only so much training you can do at one session that people can retain," she says. "So it helps a lot if they learn who you are and that they can call you."

And call they did. Many calls, she says, have concerned proper procedure: "Do I do an X-ray now? A sputum?" The phones at the division of immunization are ringing, too. At one time, Moser says, she had considered becoming a civil surgeon herself. "What's complicated about it is that most big health departments are categorical," she says.

"I have TB staff here, but not immunization staff, and I don't know much about mental health." It would take some work to figure out how to put together the requisite structure to do the exams, she adds.

Plus, she's decided that simply meeting the civil surgeons in the area has gone a long way to accomplish her goal. "Once I got to know the civil surgeons, I saw that they just needed some education," she says. "They needed to know our phone number and that we were here to answer their questions." Plus, since many civil surgeons are foreign-born or foreign-trained, their patients may feel more comfortable with them, says Moser.

In Denver, TB controller **Randall Reeves**, MD, is a civil surgeon and likes the way his position affords him oversight and access he might not otherwise have. He's been signing off on civil service exams since he first assumed his post in 1990, he says.

This is the way the system works, explains Reeves: Physicians within the city's system of neighborhood-based, primary-care clinics begin the examination process by applying the skin test and ordering a chest radiograph if indicated. (In some cases, the patient starts out with a private practitioner.) Then, instead of having the chest X-ray sent to a radiologist to be read, Reeves asks for doctors to send the films to the health department for interpretation, and he completes the paperwork process.

"That way, we get a chance to sort out whether they have active TB or inactive TB, or [if they] might be a candidate for preventive therapy," Reeves says. "Most of these X-rays are normal, of course. But that's fine with me. I'd rather they come here with a film than have a radiologist read it who might not be thinking that much about TB."

Moser and other TB experts at the CDC are working on training materials for other health departments that might want to hold a conference for civil surgeons, says Moser. The material should be ready in about a year. ■

OSHA seeks unique TB standard for U.S. shelters

Hearings convince agency revisions are needed

The nation's approximately 10,000 homeless shelters may get a break from the Occupational Safety and Health Administration (OSHA) as the federal agency goes back to the drawing board for its proposed TB standard.

"It looks like what we proposed isn't going to work, given the constraints and the situations which most shelters face," says **Mandy Edens**,

MPH, OSHA's project officer for the proposed TB standard. "Shelters pose a unique problem, one that will probably take a unique solution."

Most likely, the solution will not take the form of a separate standard for shelters — the solution one advocacy shelter group had hoped for — but of a carve-out within the existing standard, according to which shelter service providers would be held to less stringent standards than other employers, says Edens. "It may come down to what can you reasonably expect [shelters] to do, not what you would like [them] to do," she says.

That's not to say shelters will get off scot-free, even if they won't be asked to abide by the same rules as others named in the TB standard — including hospitals, drug-treatment centers, correctional centers, home care agencies, and facilities which provide long-term care for the elderly. Some examples of simple but effective measures, which are still hypothetical at this point, Edens explains, that OSHA might ask shelters to implement include: getting guests to cover their cough with a tissue; or, as a way to separate a TB suspect, putting someone temporarily into a small room equipped with an exhaust fan.

Somewhere on middle ground

The final version of the TB standard will "probably wind up somewhere in the midground" between what OSHA had first proposed and what shelter advocates would like to see happen, Edens says.

What helped convince OSHA staff to revisit the shelter portion of the TB standard were the arguments presented by various advocacy groups and service providers during four all-day hearings, which OSHA held in different cities around the nation, Edens says. Half of the sessions examined the standard's potential impact on homeless shelters. "We learned a lot about what some communities are trying to do about TB in the shelters," she says. "We found that in other communities, they're just trying to get people in off the streets, and they don't have the resources to do much more than that."

Shelter advocates attacked the proposed standard on a variety of grounds, saying it groups too many kinds of facilities and services under the broad term of homeless shelter, makes providers responsible for getting guests to do things they won't want to do, asks lay people to make complicated medical judgments, and will effectively put more homeless people on the streets with no resulting decrease in TB transmission.

"We hear what people are saying," Edens says. "They've given us lots to think about. Now we have to go back and figure out what's the best tack to take."

One thing the final version of the standard will still have to do is provide for some means of surveillance, Edens says. Without a way to monitor skin-test conversions, "you'll never know if you have a problem."

That strikes many shelter advocacy groups as reasonable, according to **Robert Reeg**, MPA, policy analyst for the National Coalition for the Homeless, a Washington, DC-based agency which represents about 2,000 coalitions of homeless shelter service providers. "We have some concerns about how shelters would pay for skin testing," he says. "We'd expect local health departments and hospitals to pick up some of the responsibility."

"Maybe there will be some way to hook [shelters] up with the local health departments so they can get skin tested and get some kind of rudimentary training program," Edens replies.

Shelter advocates also have objected to the OSHA requirement that they screen arriving guests for signs and symptoms of TB. To be effective, such screenings would be too complicated for intake workers without clinical expertise and too time-consuming besides, shelter advocates protest.

Emergency departments overwhelmed?

Not screening guests at all isn't the answer either, says Edens. "The consequences would be too great for staff and even more for other guests whose immune status may be compromised by poor nutrition, HIV infection, or other factors.

"Unfortunately, most shelters don't have access to clinical people, such as you would expect to find in other settings," she adds. "We asked a lot of people what kind of [screening] system they used, and the answers varied all across the board. Some do have an entry point where they can ask questions, but the people doing the intake don't have the expertise to distinguish suspects." Plus, she adds, echoing a widespread criticism of the current proposal, "in the flu season, everyone may look suspicious. They've got a cough, they're underweight because they're malnourished, and they have night sweats because they sleep in all their clothes.

"The result would be either that emergency

departments would be overwhelmed, or guests would realize that to gain admittance, they need to answer 'no' to questions about symptoms," Edens adds.

OSHA has acknowledged another problem in the current standard — the "isolate-or-transport" requirement. That is, if it proves impossible for a shelter to see that a TB suspect is transported to a clinic or emergency department within five hours' time, the guest must be isolated.

"Our concern is both how this would impact people who use the shelters and how the shelters would implement it," says Reeg. Shelters that admit guests in the evening, at night, or on weekends may find it tough to transport someone during off-hours, he says. Rural shelters might not have ready access to a suitable facility at all. And ambulance services may balk at the idea of picking up a nonemergency case identified as a TB suspect.

Nor will homeless people take to the idea of being hauled off to a hospital, Reeg adds. "There are civil rights aspects," he says. "A shelter isn't in control of a person's life. They can't force someone to go to the hospital. And even though they're not supposed to simply turn someone out onto the streets, that may be what happens."

Despite the problems, that doesn't mean shelters shouldn't try, Edens says. Not isolating someone who's infectious will endanger staff and guests alike. "It poses the greatest danger to guests since many may be immunocompromised due to poor nutrition or having HIV or other factors," she says. As for the isolation part of the clause, "we never envisioned that shelters, with their limited resources, would be able to provide a conventional isolation facility," Edens adds.

Since most shelters don't have access to a medical professional equipped to decide whether someone should be isolated, one question for OSHA to answer is how long it makes sense to let someone wait for evaluation, Edens says.

Defining the term 'shelter'

Another concern for OSHA representatives is how they will define the scope of shelters to which the standard will apply. "People have asked us whether we mean battered women's shelters, or places that serve street kids, or soup kitchens, or units that function as single-family homes," Edens says. "Obviously, the riskiest setting is the big, congregate-style shelter [that] people are trying to move away from." In fact, it is only for that type of shelter that the National Health Care for the Homeless Council would like the standard to apply.

The deadline for comments on the standard was Oct. 5. An earlier deadline, Sept. 4, marked the last time stakeholders could submit new data for consideration. As the Oct. 5 deadline drew near, OSHA officials weren't expecting any new issues to surface. "The basic issues are already out on the table," says Edens.

Most of the dispute has centered around whether or not a legitimate need exists for more federal regulations, and if most facilities are already abiding by recommendations issued by the Centers for Disease Control and Prevention. Unions, by and large, would like to see more regulations; groups representing health care professionals and health care facilities tend to be divided.

Unions, for example, would like the new standard to cover some groups more broadly than what's currently proposed. In the case of social workers and law-enforcement officers, the proposal extends not to every setting possible but only to situations where someone must enter a setting where there is already a known or suspected TB case, Edens says.

Departure from other OSHA standards

The new standard departs from traditional OSHA standards in the way it explicitly names a variety of workplaces, she explains. "This is different from the tack we took with the bloodborne pathogens standard. Typically, we don't [list settings] with our substance-specific regulations. For example, we say 'occupational exposure to cadmium,' not 'cadmium smelters and cadmium batteries,' and so forth." With TB, OSHA made an exception, because so many settings involved seem to pose an especially high risk to workers, she says. "We tried to pick settings where [risk for TB exposure] is higher than in the general population," she says.

Along with shelters, settings include drug-abuse treatment centers and home health care agencies. The proposal to include drug-treatment centers has evoked little protest, perhaps because unlike many shelters, most drug-treatment centers already maintain close ties to the health care establishment, Edens says.

Bringing the home health care industry under the TB standard poses another set of problems, industry advocates say. Most of the nation's approximately 12,000 home health care agencies

are already under the gun thanks to a new interim system of payments which effectively curtails the number of patient visits for which an agency can collect reimbursement, says **Mara Benner**, a spokeswoman for Home Health Services and Staffing Associations, an Alexandria, VA-based advocacy group that represents 2,000 agencies across the nation. With many agencies already financially stressed, the prospect of shouldering more demands is evoking protests.

"We don't normally see TB cases anyway," she adds. "They've already been treated by the time they reach us, and they're no longer infectious." But the extra paperwork it will take to document baseline and periodic skin testing will seem onerous, says Benner.

More troubling is a stipulation requiring home care agencies to pay employees who contract TB on the job up to 18 months' salary and benefits. "That's really a concern for us," Benner says. "We'll work with OSHA on the rest of it, as long as the requirements aren't so dramatic."

Yet most employees won't need more than a few weeks' therapy before they're noninfectious and can come back to work, says Edens. "It's an incentive for employees to report possible symptoms instead of walking around sick, scared they'll lose pay," she says. "Plus, workers' compensation doesn't necessarily cover full pay."

Other home care providers have bridled at the requirement that employees wear their respirators when entering the home of a suspect or known TB case. "Employers say since they're not there, they can't ensure that," says Edens. "But we say they can ensure other rules are enforced, so they must have some way to monitor their employees." ■

Jurisdictions collide: Public health vs. INS

Incidents don't reflect policy, says spokesman

In two recent instances, agents who work for the U.S. Immigration and Naturalization Service (INS) are said to have denied TB victims the treatment they needed and put others in danger of exposure to tuberculous (as well as AIDS)..

In Sacramento County, CA, an infectious tuberculosis patient co-infected with HIV was jailed for noncompliance. Because he was an undocumented alien, he was seized by INS agents and placed on a bus bound for Mexico. Public health authorities tried unsuccessfully to obtain information about where the patient had been sent. Later, the patient crossed the border back into the United States and turned up in jail once again. Though he's said to be suffering from full-blown AIDS, he's finally completed his anti-TB regimen.

Suspect released onto the streets

In DuPage County, IL, INS agents took an undocumented worker to the local jail. A week later, the man was found to have infectious TB. Authorities at the jail told the INS to retrieve the prisoner, and after several unsuccessful attempts on agents' part to persuade homeless shelters to admit him, the man was released onto the streets. His case came to light after his lawyer went to court for his deportation hearing, found him missing, and made inquiries.

Such cases aren't supposed to happen and don't reflect INS policy, says **Greg Gagne**, senior spokesman for INS headquarters in Washington, DC. "For people with an infectious disease such as TB, INS policy is that we don't bond people out, we don't put them on the street, and we don't deport them," he says.

For patients with active but noninfectious TB, "we give them the appropriate medications and instructions on how to use them and send them home." Exceptions to that policy, he adds, "are anomalies and result when either someone is misinformed, has misconstrued something, or both."

Keep communication lines open

The best way to avoid such incidents is to maintain proper communication with immigration and correctional authorities, experts say. "Awareness, education, and dialogue are all essential," says **Subroto Bannerjee**, TB controller for Alameda County, CA. "Of the three, dialogue is the most important. If there is an INS holding facility, as there is in Alameda County, I make sure that we meet with [INS staff] and that we have a channel to talk to them."

Nationwide, in some counties, the INS has its own holding facilities for detainees; in many locations, however, the agency uses local jails or

prisons. Human rights groups, notably the watchdog organization Human Rights Watch, have condemned the practice of housing undocumented persons in prisons alongside criminals.

Bannerjee says he's not aware of instances in Alameda County where the INS has taken custody of a TB patient without the knowledge of public health authorities. But in Sacramento County, TB controller **Luis DeSouza**, MD, says he's heard of other such cases. "I know of at least three other cases where people just disappeared because Immigration moved them out," he says.

In the case of the patient co-infected with HIV and TB, DeSouza says he was frustrated in his attempts to get information from the jail and the INS. "One day he was there; the next day he was gone, sent across the border," DeSouza says. "I don't know how many people he may have infected on the bus, but I'm pretty certain it's a long drive from Sacramento County to wherever he went."

DeSouza isn't sure how the INS discovered the man was undocumented, he adds. "We don't report people as illegal," he says. "But there must be some kind of connection."

He says attempts were made to find the patient in his hometown in Mexico. Eventually, he resurfaced again in the United States as TB controllers had suspected he would. But by the time he was found for the second time, "he was almost blind from AIDS," DeSouza says.

Since then, INS and public health authorities have met to talk about what went wrong and how to keep such an episode from being repeated.

Human rights group denounces abuses

In DuPage County, IL, INS agents routinely use the local jail to house those suspected of being undocumented aliens, says **Jennifer Bailey**, JD, a research associate with Human Rights Watch. The human rights group recently released a scathing report that detailed a variety of abuses of detainees by jailers over whom the INS has no control.

In DuPage County, a week after INS agents had taken a Honduran man to the county jail, he began exhibiting symptoms of TB, says Bailey. County personnel notified the INS and asked that the prisoner be removed, she adds.

INS agents attempted to place him in a couple of local shelters, but they refused to accept him, according to Bailey. Eventually the man was released onto the streets, she says.

In court, **Roy Petty**, former director of the Midwest Immigration Rights Center and the attorney for the Honduran man, asked what had become of his client, Bailey says. "They looked up the case, and said, 'Oh yes, he's been released.'" says Bailey. "But this man had no resources. He had nothing."

Petty, now an attorney with the American Immigration Lawyers Association in Washington, DC, never heard from his client again.

To make certain such instances don't happen, agents who don't adhere to INS policy need to have a clear understanding of the consequences, says DeSouza.

"The law clearly says that if a patient is going to be released from the jail system, the health officer must be notified," he says. The INS agents "know the telephone number [of the health

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officer], and there is the law," says DeSouza. "But the law does not say what happens if someone breaks it. Who is the INS responsible to? Someone has to be responsible." ■

CE objectives

After reading the November 1998 issue of *TB Monitor*, readers taking part in the continuing education program should be able to:

- list two main points from the recent report and recommendation on the foreign-born;
- tell how many civil surgeons there are estimated to be in this country and what they do;
- describe how OSHA's current TB regulations might change in respect to homeless shelters;
- discuss how TB controllers can form partnerships with community-based organizations to serve the foreign-born. ■