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Who will blink first in standoff over OSHA's new TB standard?

Bill language expected to ask for study but not to stop new TB rule

As the war of nerves escalates in the debate over whether the country will get new federal guidelines aimed at protecting health care workers against TB, members of the House Appropriations Subcommittee have struck a verbal agreement to include language asking for a study of TB risks as part of an appropriations bill. The language intentionally avoids more drastic remedies, such as cutting off funding to the Office of Safety and Health Administration (OSHA) or asking Congress to block the proposed standard. That means, theoretically, OSHA could stay on track with its schedule, and the new TB standard could assume force of law by early next year.

Lobbyists for the Washington, DC-based Association of Professionals in Infection Control (APIC), which opposes the proposed standard, were banking hard that OSHA would blink. Specifically, the hope was that the feds wouldn't go ahead until the study was completed, lest findings unfavorable to OSHA's position would force an embarrassing retraction of an already-published standard. As this issue of *TB Monitor* went to press, OSHA officials, betting the bill language would be scrapped before it could do any damage, kept mum on the subject of what they would do next.

Special Report: The TB Standard

Last month, in what the standard's opponents describe as a fresh tactic, APIC members tried to call OSHA's bluff by asking only for the study of TB risk, instead of seeking to block the standard more directly. OSHA officials held their own cards close as they waited to see what Congress would do.

"You say they're just adding bill 'language,' but what this sounds like to me is a rider," says **Frank Kaine**, OSHA spokesman. "And the head of Senate Appropriations [Sen. **Bill Archer** (R-TX)] has made it clear he doesn't like riders," which are often viewed as sneaky backdoor maneuvers. "So it seems premature to make a comment."

The next day, Kaine called back with the agency's official statement on the subject: "Given that we've re-opened the record twice for new information, we hope Congress doesn't take any action to further delay the standard, since more delay will lead to more ways of contracting TB."

That left some observers wondering why opponents of the TB standard didn't just go for broke and ask Congress directly to stop the standard. The decision not to was a calculated gamble, says **Jennifer Thomas**, director of government and public affairs for APIC and author of the proposed bill language. "Trying to stop it altogether could cause certain members of Congress to take a lot of heat and potentially could cause huge problems," she says. "So we agreed it would be better to make it look like an objective decision — to let the science speak for itself."

Though she's not worried that a study, if commissioned and carried out, would find evidence solidly in APIC's favor, the tack still could backfire, Thomas concedes. "There's no guarantee at all that OSHA will hold off on issuing the rule," she says. "They've done it before — issued a ruling while a study was still under way."

IOM asked to conduct TB study

What the language asks for specifically is a study to be carried out by the Institute of Medicine (IOM). Three IOM members reportedly have met with Thomas and Rep. **Thomas Wicker** (R-MS), the official sponsor of the bill language. At that meeting, all present agreed on the need for a study, Thomas says; plus, the IOM representatives promised the institute would do the study if Congress asked. "That itself is a huge step forward," she adds.

Still, the language asking for the study has made it only to first base, insiders point out; that is, although verbal agreements are usually considered to be binding, they still don't hold the weight of words on paper.

That stage wasn't expected to take place until sometime after Sept. 6, and perhaps as late as Sept. 13 or 14, when the bill is expected to go to what's called "mark-up" — the lengthy and often grueling session where subcommittee members meet and literally "mark up" the text of a proposed piece of legislation, adding and subtracting portions of text as they go.

Conference eyes TB risk in low-prevalence spots

Workshop format should spark good debates

A three-day conference titled "Institutional Tuberculosis Control in Low-Prevalence Areas" will do more than address the topic named in its title, sponsors say.

"No, this is not just a conference about OSHA, but yes, we're having it in Washington, DC, so there's really no excuse for OSHA and NIOSH not to come," says **Ed Nardell,** MD, chief of pulmonary medicine at the Cambridge Hospital of Harvard Medical School and TB control officer for the Massachusetts Department of Public Health.

Special Report: The TB Standard

NIOSH and OSHA refer, of course, to the Office of Safety and Health Administration, which has been toiling for years to produce a new standard aimed at protecting health care workers against TB, and to OSHA's counterpart agency at the Centers for Disease Control and Prevention, the National Institute of Occupational Safety and Health.

Scheduled for Dec. 10 through 12, the conference will bring together some 30 experts whose job will be to give short, thoughtful overviews on a variety of topics, Nardell says. Lectures will be grouped thematically and punctuated with roundtable-style discussions. Coupled with a small audience (limited to just 70 people, to be admitted on a first-come, first-serve basis), that format should generate some thoughtful conversations on the subjects of TB risks, worker safety, and government regulation, he says.

Conference sponsors include the American College of Chest Physicians, the Infectious Disease Society of America, and the American Thoracic Society.

OSHA and NIOSH have been invited to take part in the program. Although OSHA is expected to send a representative, the agency's own rules prevent the representative from doing much more than just listening, Nardell says. ■

COMING IN FUTURE MONTHS

- Update on the fight against TB in Russia
- What's new with Paul Farmer's drug-buyer cooperative
- TB rates are down in Texas prisons, and screening is up in Texas jails
- OSHA: The saga continues
- TB policies to protect U.S. marshals

Along with Wicker, the designated "water-carrier" for the language, there are said to be other anti-OSHA allies in Congress. Most importantly, **Rep. John Porter** (R-IL) — chair of the House Appropriations Subcommittee that apportions out funding to labor, health and human services, and education — has agreed to lend his behind-the-scenes support for the move, Thomas says. Though Porter reportedly can't lend direct support (which wouldn't be politically kosher because he's the subcommittee chair), he's still said to be eager to corral votes and mediate disputes when the time comes.

Trying to predict the outcome of anything related to the appropriations process is notoriously tricky, says Thomas. "I hear labor groups are really upset about this latest move. I expect we'll be taking a pounding from them."

If the dour mood in the headquarters of one union is any sign of what lies ahead, Thomas might want to break out the champagne. "Quite frankly, I'm sick of all this," says **William K. Borwegen**, MPH, occupational safety and health director of the Washington, DC-based Service Employees' International Union, which represents about 650,000 health care workers. "I feel like there's nothing more I can do. I'm ready to move onto other stuff." ■

StaffTRAK as software instead of OSHA-killer

Study finds declining TB conversion rates

These days, some opponents of the new federal TB standard proposed by the Office of Safety and Health Administration (OSHA) are using the study known as StaffTRAK as a club to beat up the feds. That's because the study's preliminary conclusions show conversion rates among health care workers are down, down, down — without the help of a new federal law.

All the fuss makes it easy to forget StaffTRAK is also a useful piece of software. Developed in the '80s in the old DOS style, it originally was designed to track TB conversion rates among health care employees.

Four years ago, the software was first shipped out to sites interested in tightening up their skin-testing protocols and eager to try a new product designed to help them do so, explains **Lauren Lambert**, MPA. Lambert, project manager for StaffTRAK, is a public health analyst at the Surveillance Section of the Division of TB Elimination at the Centers for Disease Control and Prevention in Atlanta.

The aim of the StaffTRAK study, she adds, was threefold: to see how well selected sites were monitoring skin-test conversions; to find out what some of the actual rates looked like; and to test a new product — namely, the StaffTRAK software — intended to make tracking those rates less of a headache.

"In lots of places, it's all still done manually," says Lambert. "When I worked in New York City, we had everything on little note cards. At the time, they were trying to get the system computerized; but basically you'd go for your skin test, and they'd stick your card back in the file. It wasn't the best way."

Sites get personal service as well

Enter StaffTRAK. The software comes with a formidable, three-inch-thick manual; a Y2K-compatibility diskette; and Lambert herself, whose expertise is available only to sites chosen for the study.

Overall, the software seems to have gotten a thumbs-up. "To many of the sites, this has been a real godsend," Lambert reports. "People are definitely more compliant about getting their test and, when it's indicated, their follow-up evaluation. Plus, now all these sites can say with certainty that 100% of their workers are getting tested every year."

Among the program's special features is a "delinquent" list, which keeps tabs on those who've been remiss about getting their annual screening. The list automatically fires off letters to skin-test slackers, reminding them to come in for a test or follow-up.

As for the declining conversion rates the project so famously has found, the data are still undergoing analysis, Lambert cautions. Still, preliminary results do show a substantial decline for most job categories. (The exceptions include pathologists and morgue techs.)

Sites were selected mostly on the basis of how well they responded to proposals, not according to geographic representation, she notes. At the

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Hitting the high spots in the OSHA debate

It's fair to say the TB standard proposed by the Occupational Safety and Health Administration (OSHA) has prompted a sustained series of gripes, indignant howls, and general grousing from the various camps that oppose it.

Foremost among OSHA-targeted gripes is that the most current data on skin-test conversions — still the best available gauge of how many health care workers are exposed to, and infected by, patients they encounter at the workplace — show emphatically that rates are way down.

"These data basically say that rates of transmission are now so low they can hardly be distinguished from background rates" in the surrounding community, says **Edward Nardell**, MD. Nardell is chief of pulmonary medicine at the Cambridge Hospital at the Harvard School of Medicine and TB controller for the Massachusetts Department of Health. As for the few workplace conversions that do occur, "there's pretty convincing evidence that community transmission accounts for at least some of [that]," he adds.

Special Report: The TB Standard

Another gripe has to do with the way the OSHA standard would have hospitals and other institutions use respiratory isolation like a big, heavy-handed club when something more subtle would work a lot better.

"In many low-prevalence areas, we're over-isolating patients at a ratio of as much as 200 to 1 to rule out TB," says Nardell. "In my own institution, the isolation rooms are almost always full; but in my hospital, and in most places, there are very, very few cases of actual TB." The practice of over-isolation siphons resources from other areas and, sooner or later, is bound to generate a backlash, he says.

The fact is, Nardell adds, some undiagnosed cases always will slip through; trying to operate at zero-risk levels is not only foolish, it's unconscionably expensive. Far better to spend the money looking for "better ways to diagnose infection and disease," he explains. Tools already available include ultraviolet air disinfection and molecular probes (such as the Gen-Probe Amplified Mycobacterium Tuberculosis Direct Test, which can help to quickly rule out TB in patients in isolation).

Lower conversion rates will be considered

As might be expected, OSHA officials see things in a different light. For one thing, OSHA is well aware of the existence of data documenting lower conversion rates and is studying it, says **Amanda Edens,** MPH, OSHA's project officer for the TB standard.

"We're looking at new data right now, and it's something we'll certainly take into consideration. If it seems to be appropriate, we'll make adjustments in what we're proposing," Edens says.

Still, falling conversion rates don't obviate the need for a federal guide. If anything, they demonstrate that the proposed standard, which hews closely to CDC guidelines, actually does what it's supposed to, says Edens.

"What these new data show are that when you do the right thing, you can have a risk reduction," she adds. "That's the whole point of having guidelines."

As for the difficulty of addressing the problem of "the undiagnosed case," Edens disputes that a new standard inevitably would fail in that regard.

"To my mind, there are two kinds of scenarios involving what people call the 'undiagnosed case,'" she says. "In one instance, you have a good identification system, you're doing all the right things to identify cases that come in, and there may still be cases that slip through. And yes, that's a real possibility."

In the second scenario, the undiagnosed case escapes notice because there are no systems in place; people are not "doing the right thing."

The problem is deciding whether most exposures and infections result from scenario No. 1 or 2, she says. Right now, OSHA statisticians are sifting instances of undiagnosed cases to see if they can spot the prevailing trend. ■

outset, sites were checked to make sure they had isolation facilities in place, airflow properly under control, and were administering and reading skin tests by the books — preconditions that leave OSHA officials arguing that the data aren't representative of other places in the nation.

True enough, says **Yvette Davis**, MD, MPH, epidemiologist with the Surveillance Section of the CDC's Department of TB Elimination and chief analyst for the StaffTRAK data. OSHA needs to remember, she adds, that most of the data date back to the days of higher TB rates and thus don't altogether reflect today's lower rates. That means the StaffTRAK conversion rates, low as they are, probably are still much higher than the national average these days.

The study is headed into a second and third phase. For one thing, epidemiologists are now using it to measure conversion rates among laboratory workers. In addition, they want to use the software to try to get a handle on how much it costs a facility to implement an effective skin-testing program, says Lambert.

Sites that would like to have a crack at plugging in the software on their own can do so, Lambert adds — even though they'll have to go it alone. "For a DOS program, people say it's fairly user-friendly," she reports. Sites that already have data on conversions ready to download may find the task of using the software easier, she adds.

Among those who've taken the plunge, ordering the hefty manual and software package, are the Santa Barbara Health Care Services; the New England Medical Center Hospital; the Portland, OR, Health Division; and sites as far afield as Thailand; Lima, Peru; and Australia. Some places content themselves by getting only the four handy forms the software uses to collect the skin-test data, Lambert says.

Anyone who wants to give StaffTRAK a shot is free to do so. Requests for forms or software and manual should be written and accompanied by an explanation of what the intended use of the software will be. Contact Lauren Lambert, CDC NCHSTP, Division of TB Elimination, Mailstop E-10, 1600 Clifton Road N.E., Atlanta, GA, 30333. ■

Somalia, Minnesota meet as TB rates begin to soar

Plentiful jobs, generous hearts draw newcomers

Mary Tyler Moore probably wouldn't recognize her old digs in Minneapolis. Here in the Twin Cities area, newcomers from Somalia are the latest in a long line of immigrants and refugees who've altered the texture of daily of life in ways the intrepid sitcom heroine could hardly fail to notice.

"We have Somali restaurants. There are Somali shops. You see the women walking about the city," says **Deb Sodt**, RN, state TB control officer of Minnesota.

One less-than-desirable result is while most of the rest of the country basks in declining case rates, Minnesota TB controllers are looking at rates Sodt terms as "skyrocketing." Most of the state's cases occur in its burgeoning foreign-born populations; in fact, Minnesota ranks second only to Hawaii in the percentage of TB that occurs among the foreign-born. No longer a stronghold of blond-haired farmers of German and Scandinavian descent, Minnesota is now a place where one resident in 20 is foreign-born. "A lot of people don't realize this," says Sodt. "They still think we're lily-white."

In terms of population shifts, the main reason is that the state has become one of the principal sites in the United States for so-called secondary migration — meaning that many immigrants head here after first landing somewhere else, such as California or Texas.

That trend, in turn, is partly the result of a long-standing history among Minnesotans of reaching out to those in need. During the Kosovo crisis, for example, fully half the calls that went out across the nation to one big donor organization came from Minnesotans, whose stout Lutheran heritage encourages them to open their arms, their houses, and their wallets to those in need.

From a spate of new restaurants serving up exotic fare to plenty of workers for industries with low-paying jobs available, most of the changes the foreign-born bring have been welcome; but TB controllers say they are beginning to feel the pinch.

Over the past decade, Minnesota has seen a jump in TB cases of 77%; by July of this year, reported cases were 48% higher than the same time last year, according to **Wendy Mills**, MPH, epidemiologist for the state's TB program. Last year, cases among the foreign-born accounted for

71% of all cases, with Somalis, along with other northern African groups, fueling the lion's share of the load.

Another big group of foreign-born is made up of Hmong, members of a mountain tribe from Vietnam who, having sided with American troops during the Vietnam War, sought sanctuary in this country after the fall of Saigon. Now 70,000 strong, the Hmong community here is either the largest or the second-largest in the nation, depending on whom you ask. Many other Southeast Asian groups are putting down roots here as well, including Vietnamese and Laotians. Southeast Asians accounted for most of the TB among the state's foreign-born residents until recently.

Epidemiology in the state's Somali community helps show how the change in population composition has affected TB rates. With its almost decade-long history of civil strife, Somalia already suffers from a rate of TB the World Health Organization estimates at 174/100,000. On top of that, many Somalis have had to endure long waits in crowded refugee camps before winning permission to emigrate.

Since many Somalis arrive in Minnesota only after spending time somewhere else, only about 20% of the state's foreign-born cases are picked up through the ordinary immigration screening process; that means the majority of cases here result from reactivation of latent infection.

Immigrants are drawn by jobs

Probably the strongest single draw for the immigrants is the promise of jobs. The Twin Cities area boasts only a 1.6% unemployment rate (compared to about 4.6% nationwide), which is far better than any other urban area of comparable size. Many Somalis have found jobs in the meat-packing industry or in the computer-repair shops that dot the surrounding area; industries here are unusually willing to hire non-English-speaking workers and give them training, observers say.

In addition, the state's schools admit students up to age 21, which means young Somalis whose education was interrupted by stays in refugee camps can finish high school. State welfare benefits are relatively generous, too, although few Somalis seem inclined to accept welfare, says Sodt. "You hear they have an incredible work ethic. Many work two and three jobs."

Their admirable qualities notwithstanding, the Somalis pose unusually tough challenges to TB controllers. To begin with, many don't speak English, which means interpreters are necessary. But the long civil war has done lasting damage to relations among countrymen, and Somalis from opposing clans still regard one another as enemies. Clan members settle in the same areas, go to the same community organizations for help, and generally recreate old rivalries, even after leaving their homeland far behind. Practically speaking, this means an interpreter from one clan will refuse to speak to a patient if he is from another clan, or vice versa.

Somalis resist preventive therapy

To make things worse, TB bears an exceptional stigma among Somalis, who regard the illness as a death sentence or fear they will be torn from their families. Outreach workers must be delicate, inquire only about symptoms, and not mention the disease by name. Contact investigations are especially tough because patients are unwilling to have family members discover their disease. Finally, the concept of preventive medicine — taking isoniazid for a latent TB infection, for example — generally meets with misunderstanding and resistance.

As the Somalis migrate outward from Minneapolis and its surrounding counties to more rural parts of the state, increasingly fewer resources are available for dealing with tuberculosis, TB controllers say. In rural Minnesota, most health care must be supplied through private practitioners. Physicians who staff public health clinics scattered in rural areas often are not familiar with TB symptoms.

Finally, TB controllers still have their hands full dealing with other refugee groups. Members of a tiny band of Tibetans who arrived earlier this decade are now financially solvent enough to start bringing over family members. Among the original 200 Tibetans, whose passage was specially arranged by the Dalai Lama, TB infection rates stood at about 95%, and drug resistance complicated many of those cases. Recently, TB controllers from Canada called to ask about rates of MDR-TB among Tibetans. That signaled to health authorities here that some Tibetans had begun to trek further north, carrying the seeds of illness with them.

TB controllers expect the rise in rates will continue well into the next century, says Sodt. At least on paper, the solution is simple, she adds: "We need more resources." ■

FDA to clear Gen-Probe for smear-negative use

Label wording may limit test to higher-risk patients

The U.S. Food and Drug Administration (FDA) is expected to give final approval soon to the Gen-Probe Amplified Mycobacterium Tuberculosis Direct (MTD) Test for use on smear-negative patients.

Until now, the test has been approved officially for use only on specimens from smear-positive patients, although some laboratories have been using the test all along on smear-negative specimens and for other "off-label" purposes as well.

"This just takes it out of that iffy, never-never land where you don't know whether or not you'll be challenged, or even sued," says **Antonino Catanzaro**, MD, professor of medicine at the University of California School of Medicine in San Diego.

The FDA is still debating exactly what the product's new label will say and how closely the wording will circumscribe when and how the test should be used on smear-negative specimens. That's because a recent clinical trial showed the test performs well on such specimens, but only when they come from patients judged by physicians to be at least fairly likely to have TB.

At the same time, the trial showed that as a screening device used on a strictly pro-forma basis among low-prevalence populations, the test has little value. If someone hauled 100 people in off the street and tested them, the only positives would probably be false.

"What all this means is that the best [new] use for this test is when you have a patient whom you think has TB, but who is still smear-negative," says Catanzaro. Before the FDA's latest move, he adds, the only choices available in such circumstances were as follows: "You can either say you must have been wrong, or you can keep 'em in the slammer, which means if it's really not TB, then they're not getting treated for what's really the matter. Or, for $1,000 you can order a bronchoscopy."

With the Gen-Probe test, physicians "have a fast, relatively inexpensive way to rule out TB that lets them get on with finding out what's the real problem," he says.

Expressing all this in a package insert has proven more contentious work than might be imagined, with Gen-Probe offering strong resistance to the FDA's desire to include qualifiers such as "highly suspicious."

"We're trying not to have them include phrases like that, because we think that kind of qualifier is just too subjective," says **Vivian Jonas-Taggart**, MS, the molecular biologist who guided the development of the test. "If you pull 10 pulmonologists into a room and ask them what they mean by 'highly' suspect, they'll have an argument about it. It's very subjective."

Also, of course, more restrictions could mean fewer sales. With only about 100 steady U.S. customers for the technology so far, there's room for sales to grow, and they ought to, Catanzaro contends. "I think that in their zeal to prevent overuse of this test, the FDA has actually created a tremendous under-use of it," he says. "The whole concept of early diagnosis is very important to TB control, and that's exactly where this test can help."

Wasting precious dollars on isolation

Hospitals, for one, should jump at the new chance to cut down on needless isolation, he adds. "Our calculation is that 67% of the dollars spent to 'treat TB' is actually spent treating people who don't have TB. A lot of that is money wasted on isolation or on giving anti-TB drugs to TB suspects for six, seven, or eight weeks, only to find out eventually that patients don't really have the disease."

Even used judiciously, some experts add, the test isn't a "magic bullet"; both in an original trial and in the most recent one, it did yield some false results.

But that doesn't dampen Catanzaro's enthusiasm. "Think about it. You give a patient a cup for the specimen, and he puts in his girlfriend's spit instead. Or maybe he doesn't cough deeply enough. Or maybe he coughs deeply, but the area that's got TB is temporarily plugged up," he explains.

Even the test's manufacturers may have contributed to initial disenchantment with the test by claiming too much for it, he adds. "It was like, 'Well, you can all hang up your stethoscopes, 'cause this test will do all the work for you,'" he says. "But it wasn't that extraordinary — it was a human test."

Modifications incorporated in the second-generation version of the test try to take into account such limitations by designing the test to work with a larger amount of specimen than before. The newest version of the test also takes less time,

so "same-day results" can truly make it back on the same day, not early the next morning.

Even the most cautionary skeptics — for example, **Leonid Heifitz**, MD, director of TB laboratory services at National Jewish Hospital — agree the test offers genuine value in two specific situations: namely, to rule out TB meningitis and to rule out TB among HIV-negative patients.

That's because in the first case, the cerebrospinal fluid of patients is nearly always smear-negative, Heifitz points out. Yet if other indicators are present, such as decreased levels of protein and glucose, then a quick positive result from a Gen-Probe test can speed the patient more quickly to life-saving therapy.

The same applies to HIV-positive patients with pulmonary symptoms because their sputum is often scantily supplied with TB organisms.

"No matter how good, we cannot rely on any one test alone," adds Heifitz. "It's good that people are using this test, but there always needs to be a backup, and the lab report should have the disclaimer that we don't guarantee 100% if the test comes back negative."

That doesn't mean people shouldn't use the test under some circumstances, says Catanzaro. "Just because something is complex doesn't mean we shouldn't use it," he says. "Lots of things about modern life are more complex. We use them anyway because they help us do a better job." ■

New TB satellite courses dramatize frontline jobs

Aimed primarily at nurses, outreach workers

Early next year, as many as 5,000 men and women who work on the front lines of TB control will settle down at libraries, hospitals, or, if the past is any indication, maybe even a sports bar or two, to take in the latest satellite TB courses.

The coming series, a three-parter, is targeted specifically at TB nurses, outreach workers, and their supervisors. The audience is expected to include as many as 5,000 people, watching from as many as 500 downlink sites across the country, says **Kay Wallis**, MPH, distance learning projects coordinator for the Francis J. Curry National TB Model Center in San Francisco.

Production for next year's series is currently under way, says Wallis. The topics include contact investigation, confidentiality, surveillance and case management in hospitals and institutions, and patient adherence. Broadcasts, which will air simultaneously in four time zones, are set for Jan. 27 (the date for the first topic), Feb. 3 (when the next two topics will air), and Feb. 10 (devoted to the fourth topic). Broadcast times will be 1 p.m. to 3 p.m. Eastern, noon to 2 p.m. Central, 11 a.m. to 1 p.m. Mountain, and 10 a.m. to noon Pacific.

The series moderator will be Gisela Schecter, MD, MPH, the former medical chief of TB control in San Francisco and now a physician in private practice. Course speakers will include Paula Fujiwara, MD, TB control officer for New York City, who'll talk about contact investigation; Carol Pozsik, RN, MPH, TB controller for South Carolina and the head of the National TB Controllers Association, who'll talk about adherence; and Barbara Cole, RN, from the Riverside County, CA, TB control program, who'll discuss patient confidentiality.

Courses to follow workers in the field

"With these topics, as you can see, there's a lot of meaty content," says Wallis. The production company charged with making the series come to life plans to go into the field and follow outreach workers under real-life conditions. Filmmakers also will create various role-playing situations, with actors demonstrating the right and wrong ways to handle various situations, and there will be a montage of historical film footage.

The series is a collaboration between the Curry Model Center and the Centers for Disease Control's Division of TB Elimination, which developed the content of the modules. Downlink site registration information is already available on Curry's Web page, and a liaison for each state in the country is working with the center to ensure that everyone who wants to watch the series will be able to do so, says Wallis. Participants will receive a set of self-study booklets to read before the dates of the actual broadcasts, she says.

Two years ago, a satellite series aimed at a physician audience was watched by an estimated 17,000 people. This year's audience is expected to be smaller because the target audience is much more specific, Wallis says.

[Editor's note: For more information, contact TB Frontline at (415) 502-7904 or check the Model Center's Web site at www.nationaltbcenter.edu.] ■

Some states run aground on TB-related Medicaid

Anguished lament: 'It's the paperwork, stupid'

(Editor's note: Last month, we reported on how one county in California is benefiting from a 1993 amendment to the Social Security Act, which made Medicaid benefits available to anyone with a positive tuberculin skin test. In Wisconsin, by comparison, TB controllers hadn't decided whether all their diligent efforts to make the program pay off were worth it. This month, we report on experiences of three other states.)

In Oklahoma, TB controllers tell what appears to be a cautionary tale about their experiences with TB-related Medicaid.

"We have definitely had some problems," sighs **Julie Cox-Kain**, financial officer for the state's Acute Disease Service. For starters, both health department staff and TB patients alike are anything but keen on the notion of spending time filling out forms for a service everyone knows will be provided, whether paperwork gets done or not.

"Especially among our older patients in rural areas, there's still quite a stigma attached to welfare, and they don't want to be on a program they consider to be a welfare program," she says. Health department employees have their own quarrel with the program, she adds: "They feel like we've provided TB services all these years free of charge, and without making people go through all this, and that we should still do it that way."

From the start, state officials worked hard to bring human service and public health employees on board. Upper-echelon staff took off on a statewide tour to explain and promote the TB-related Medicaid benefits package.

"We held meetings in every single county and trained everyone," says Cox-Kain. In retrospect, she's not sure all the work had much impact. A year later, a spot-check showed that even clinic staff in high-prevalence counties were turning up their noses at the new funding formula.

To complicate matters, state legislators, in a bid to introduce managed care to the state's health care system, decided to split off the chunk of the department of human services that previously handled Medicaid claims and to entrust it to a newly created entity known as the Oklahoma Healthcare Authority.

No one seemed certain what part of TB care would be covered by the new capitation rates under this new system, Cox-Kain says, and when doctors went to collect, coverage often was denied.

Fairly high employee turnover in both departments — the old human services department and the new health care authority — doesn't help, either. "We'll have someone at the state level who understands what the cap covers, and then suddenly we'll lose them," she says.

That has meant, among other things, that when Cox-Kain tried to reduce the paperwork load as a way of bringing balky employees at the county level to heel, she was rebuffed by stressed-out state bureaucrats who assured her that changing the paperwork now would only confuse their employees more.

The upshot of it all is that for the moment, TB-related Medicaid benefits are managing to pay for no more than the salary of the single person who rides herd on the paperwork.

"I didn't think it was going to be this hard," says Cox-Kain. Still, she's not ready to throw in the towel. "The health department needs to pay attention to as many funding sources as possible. We need to try one more time to get out the word on this thing."

Minnesota sets up emergency fund

In Minnesota, TB controllers took a long look at the package of TB-related Medicaid benefits, and stepped away. What they did instead was to convince state lawmakers to set aside a fund specifically for TB emergencies. Last month, TB controllers dipped into the emergency fund for the first time, using some of the money to place a homeless, noncompliant TB patient with a history of alcohol abuse into a residential treatment center, where he would finish the rest of his therapy.

With only about 200 cases a year, having an emergency fund set aside to cover costly, uninsured patients has worked well so far. Plus, it didn't seem as if the trouble of setting up the program would be worth it.

But times are changing. The state's foreign-born population of TB cases has begun to increase dramatically **(see related story, p. 89)**, spurred on most recently by an influx of Somali refugees. Many of the refugees work in low-paying jobs and are reluctant to spend their hard-earned money on insurance, which means when

they reactivate with old TB infections, the state is left holding the bag.

That's why TB controllers around the state have decided, albeit a bit reluctantly, to take one more look at the TB-related Medicaid option, says **Alain Hankey**, MS, MPH, division manager for Health Protection Services in the Hennepin County Health Department. What worries Hankey is that the Somalis, though poor, may not be poor enough to be Medicaid-eligible. "So I'm still not sure it's going to work," she says.

In Tennessee, as in Oklahoma, managed care seems to have collided with early attempts to get the TB-related Medicaid machine running. Armed with a federal waiver, Tennessee was one of the first states to march boldly into the managed care arena; enrollment for indigent residents grew rapidly from a half-million to 1.2 million enrollees, then the program started to have financial troubles, and physicians began bailing out.

"One problem is that poor people tend to wait until they're sicker than hell and then access their care through the emergency room," says **Bill Moore**, MD, MPH, state epidemiologist and TB control officer. The result is that with TennCare enrollment closed to all but those under 18 and the disabled, lots of uninsured and underinsured TB patients have out in the cold without coverage, and the state health department gets stuck with the bill. ■

Preventive guide leaps hurdles, nearing print

Just a few changes in emphasis, then out the door

The new guidelines on preventive therapy for latent TB infection have passed another milestone, bringing them to the last step before publication. The guidelines should be out by the end of the year, says **Rick O'Brien**, MD, chief of the Research and Evaluation Branch at the Division of Tuberculosis Elimination at the Centers for Disease Control and Prevention in Atlanta.

The guidelines' last big hurdle was approval by the American Thoracic Society (ATS). Pending two editorial revisions, that approval has been granted, says O'Brien.

First, the ATS asked that the final document give slightly more emphasis to the risk of isoniazid-associated (INH) hepatitis, he says.

The second change is more subtle. The ATS has asked that the document emphasize more strongly that even though analysis of data suggests nine months of INH is probably just as effective as 12 months, the data supporting 12 are actually "more solid data," says O'Brien. "The argument that nine months is comparable is based on sub-analyses of older clinical trials and constitutes what's termed a post-hoc analysis. We argue, and the ATS agrees, that the really strong evidence still favors 12 months of INH."

None of this editorial tweaking means the content of the actual recommendations will change; thus, state programs will retain the option to use nine months or, if administrators agree that circumstances are sufficiently compelling enough, six months of INH.

The guidelines will hit print at roughly the same time in two publications: the *Morbidity and Mortality Weekly Report* and the ATS *Journal of Respiratory and Critical Care Medicine.* ■

Diagnostic guide retool brings in kids, technology

ATS guide addresses HIV, molecular probes

A reference document used to diagnose TB by nurses, physicians who don't see the illness on a regular basis, and international health care providers has been updated and should be available by the end of the year.

One of the changes in "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" is reflected in the name, which until this year didn't make any reference to kids. "It should have included children in the past — they get TB, too — but it didn't because, historically, the American Thoracic Society [ATS] has been made up of mostly internists who don't take on children," explains **Nancy Dunlap**, MD, PhD. Dunlap is a medical consultant to Alabama's TB control program and chair of the ATS statements committee that has retooled the document.

Other changes are just as pertinent. Since the document was last revised in 1990, HIV disease has arisen to change the face of TB. In addition, new technologies involving molecular-based tests have changed the way laboratories diagnose TB.

The document has taken a relatively conservative stance on the new array of molecular tests

available because some of the applications are still being worked out, Dunlap says. "For example, we talk about the Gen-Probe test **(see story, p. 91)**, but we stress that it's still not clear how it will be used for smear-negative specimens. We've also added a little more about how you use molecular genotyping, and we've provided references for all that new information."

According to the ATS, the new document should be printed by the end of the year. ■

TB lands starring role in popular soap opera

TB's on the screen in Hollywood, publicist says

The patient, Taylor Forrester, is young and restless — actually, make that bold and beautiful. She's endured a stormy marriage to wealthy fashion-apparel-scion Ridge Forrester, partly for the sake of her beloved child and now for the sake of her unborn twin girls. But wait! What's that strange knocking beneath the deck of the couple's spacious and romantic seaside cottage? Why, it's a homeless man, disheveled and incoherent, and coughing right in Taylor's face! Soon, doctors solemnly deliver the worst possible news: The homeless man has died from TB! And now Taylor is coughing, too, and suffering from night sweats, and oh, so many pills to take. And how can Taylor be sure the twins will be safe?

Sound familiar? It certainly does to the six million Americans hooked on the lives and loves featured in the popular CBS daytime soap opera, "The Bold and the Beautiful." The TB storyline is part of the thicket of plot twists besetting the character played by actress Hunter Tylo.

As daytime soaps go, "The Bold and the Beautiful" ranks second in audience size only to "The Young and the Restless," the grizzled 27-year-old veteran of the small screen that's still the top-ranked soap. With that kind of audience share, who cares if the show may have played a little loose with the medical details? (Has anyone, for example, ever progressed so quickly from exposure to active disease?) "Hey, this is entertainment," says **Kevin McDonald**, a CBS publicist.

As to why TB, and not, say, cancer, McDonald

CE objectives

After reading each issue of *TB Monitor,* health care professionals will be able to do the following:

- Identify clinical, ethical, legal, and social issues related to the care of TB patients.
- Summarize new information about TB prevention, control, and treatment.
- Explain developments in the regulatory arena and how they apply to TB control measures.
- Share acquired knowledge of new clinical and technological developments and advances with staff. ■

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admits he's clueless. "Well, TB's contagious — that's all I can think of," he says. "I'm no expert, but even I know that there's been a resurgence and that TB is coming back again."

Will Taylor survive her bout with TB? Stay tuned . . . ■

For manageable MDR, a special adult 'day unit'

One way to cut costs for MDR treatment

The Adult Day Unit at National Jewish Hospital in Denver offers a haven for TB patients who don't need 24-hour nursing supervision but do need specialized treatment, says **Gwen Huitt**, MD, co-director of the unit. The unit serves a mix of patients, some suffering from atypical mycobacterial infections and others from multidrug-resistant TB, usually with the proportions tilted toward the former, she says.

One reason the unit was created was to cut costs, Huitt says. "Generally speaking, these patients are a little less ill, and they're tolerating their medications fairly well," she says. That usually means they don't need all three shifts of nursing care and can manage on their own between 5:30 p.m. and 7:30 a.m. However, if a need develops, nursing care is available immediately.

The first week of patients' visits to the day unit, they are treated on an inpatient basis, and doctors see how well they tolerate their regimens. During their stay, they are housed on the hospital campus, Huitt stresses. "We're not sending them out into the community to sit in a motel while they're smear-positive. They are still spending the night here, even if they don't need nursing services all night long."

Although it functions as one, the day unit isn't just a cost-savings device, she says. "We have the luxury of being able to administer meds two, three, and four times a day. That helps when you're searching for a regimen the patients can tolerate and not [vomit] all the time." Most patients at the hospital are referrals, in part for the simple reason that Colorado has few MDR-TB patients.

Along with enabling staff to provide attention to issues related to toxicity and side effects, the unit also affords a place where patients can receive therapy for the social, emotional, or drug-related problems, says Huitt. ■

Correction

Last month's story on TB guidelines recently issued in California should have stated that Jayne Ash, director of the California Tuberculosis Controllers' Association (CTCA), holds an MPH degree and that the guidelines issued represent a joint effort on the part of the CTCA and the California Department of Health Services TB Control Branch (CDHS/TBCB).

In addition, the article should have stated that CTCA and CDHS/TBCB met with representatives from refugee health, correctional health, and the private sector in 1994 to develop an overall strategic plan, a broad endeavor in which development of state TB guidelines was made up only one part. At present, the CTCA and CDHS/TBCB have no plans to develop guidelines for TB elimination. We regret the errors. ■