

Diminished Resources in the Face of Ongoing TB: Sharing solutions

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I. Challenges we face

- A. Ongoing threat of TB
- B. Diminishing federal resources. Centers for Disease Control and Prevention (CDC) funding comprises approximately half of the state TB budget and the state awards to local health departments (LHDs), and 20% of the collective TB budgets of the 41 LHDs reporting the highest number of TB cases.
 - 1. 10% cut 2005-2007 which State TB Branch shouldered internally
 - 2. plus an additional 25% cut over next 5 years (CDC suggests planning for 5% per year)

II. Branch Responses to diminished funding in the face of the ongoing threat of TB

Three strategies

- A. Augment resources (*Show Me the Money*) e.g. advocacy to increase TB funding or avoid cuts, maximize available resources, leverage partners' resources
- B. Redirect resources from low to high yield activities (*Eyes on the Prize*) e.g. cases detection and treatment, contact investigation, testing and treatment of latent infection
 - Use data to prioritize interventions and improve programs: TB Indicators Project, cost effectiveness analysis
 - Use information from outbreak investigations and field studies to highlight needed improvements
 - Facilitate case conferencing
- C. Find possible efficiencies (*Lean Machine*) e.g. how TB services are delivered, staff utilized, structure/organization of program

Bullets below are a few examples the TB Branch is pursuing.

<p>A.</p> <ol style="list-style-type: none"> 1. Advocacy to increase TB funding or avoid cuts <ul style="list-style-type: none"> • Federal budget, legislation, State budget, CDC 2. Maximize available resources <ul style="list-style-type: none"> • Facilitate billing Medi-Cal • Assist with local health department budget management 3. Leverage partners who can extend our efforts <ul style="list-style-type: none"> • American Lung Association of CA (ALAC) housing CTCA • Curriculum to cross train TB, Bioterrorism, Sexually Transmitted Disease field investigators 	<p>B 1. Case detection and treatment</p> <ul style="list-style-type: none"> • Emphasizing case finding through evaluation of Class B immigrants and refugees (vs. lower priority activities like treating TB 2s) <p>2. Contact investigation</p> <ul style="list-style-type: none"> • Help local programs set priorities during extended contact investigations (CIs) and outbreak investigation • CTCA/CDHS CI guidelines emphasize evaluation and treatment of highest risk contacts before expanding CI to lower risk contacts • Redirect airline CI resources to higher priority CIs <p>4. Testing and treatment of latent infection</p> <ul style="list-style-type: none"> • Discontinue low yield testing for latent infection (e.g., school teachers) • Early intervention programs to detect and treat LTBI in HIV infected clients 	<p>C.</p> <ol style="list-style-type: none"> 1. Service delivery <ul style="list-style-type: none"> • Suggest intermittent DOT for selected patients 2. Staffing <ul style="list-style-type: none"> • Facilitate use of disease investigators by developing core competencies, model duty statement • Provide consultation on nursing efficiencies, such as staffing by patient acuity, use of TB-dedicated nursing 3. Regionalize or centralize to maintain expertise or achieve economies of scale <ul style="list-style-type: none"> • State TB Branch Services (such as Outbreak Response, MDR, Patient Locating, etc) • Reg. Civil Detention Site in San Mateo Co. • Molecular beacons, State TB Lab genotyping
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III. Local responses to diminished resources in face of ongoing TB threat—instructions for small groups

A. Discuss:

1. What approaches have you tried so far in response to tight budgets and the ongoing threat of TB? Why choose this approach? How did it work?

2. What would you like to try in your TB program and why?

B. Focus on selected strategy (per name of your group). But record ideas that fall under other strategies, too. Pick the best category if your idea fits under more than one.

C. Select the one idea you think will be most instructive to your peers and the Branch, and present it. The rest of ideas will be compiled and disseminated after the meeting.

Purpose of these small groups: --Together we are smarter than any one of us. Learn from each other
--how can the Branch help counties pursue the most potentially fruitful strategies?
--how can CTCA help?

IV. Small groups

Self select by strategy (+ Group on phone); Select TB controller to report back; Branch staff role—note taker

V. Report back and discussion

VI. Articulating next steps:

A. Local health jurisdiction representatives

a. Articulate ideas you are likely to act on from this discussion

b. Share the notes from this meeting when they are distributed with your local TB program staff. Call your State program liaison with more ideas, or if you want assistance implementing any of the strategies.

B. CTCA

a. Disseminate the suggested strategies from small groups and overall discussion within the minutes for this meeting by the end of May

b. Discuss within CTCA Executive Committee, then report back to membership by the end of July

C. TBCB

a. Articulate ideas we are likely to act on from this discussion

b. Share the notes from this meeting with the rest of the TB Branch Staff

Examples from California Local TB Programs

(If group needs a little help getting started)

Strategy A: Augment resources (*Show Me the Money*)

1. Enlist/oversee care in the private sector, use of standard letters and forms
2. Maximize Medi-Cal reimbursement (e.g., move revenue-generating staff to county funding so their salary can be subsidized by Medi-Cal)
3. Redirect acute care hospitalization savings into housing infectious, homeless TB patients
4. Utilize Emergency preparedness program staff to help with TB contact investigations or outbreaks
5. Utilize HIV/AIDS resources for case management of co-infected patients, HIV testing, funding TB medications or DOT
6. Enlist hospitals or large companies to do workplace contact investigations with local TB program oversight
7. Use of Health Care for Homeless service providers to screen and treat homeless patients
8. Provide mutual aid across local programs (e.g., peer program review). To avoid reinventing the wheel, seek models, sample protocols from colleagues, regional groups, State TB Branch, etc.
9. Utilize State TB Branch services (see handout)

Strategy B: Redirect resources from low to high yield activities (*Eyes on the Prize*)

1. Review of cases counted on the basis of “Provider” judgement to see if they should be considered TB cases
2. Supervisors oversee CIs to maintain focus on highest priority contacts
3. Establish and use clear criteria for launching resource-intensive extended CIs. Have a designated manager with TB expertise review decisions to expand
4. Eliminate placing unnecessary 3rd TST on contacts more than 8-10 weeks post exposure
5. Limit source case investigations to youngest child TB cases
6. Limit LTBI treatment in county clinics to highest risk (ie contacts); refer out low risk reactors

Strategy C: Find possible efficiencies (*Lean Machine*)

1. Provide the option for DOT in clinic, or in field (including via video)
2. Increase use of incentives and enablers to reduce need for more costly interventions (ie multiple home visits, legal orders)
3. Request molecular beacon testing on specimens from patients suspected to have drug resistant disease, so correct regimen is started earlier
4. Train Tuberculin Skin Test (TST) Technicians to place and measure TSTs in field
5. Maintain use of TB specialist nursing staff (vs. generalist)