Virtual Provider Learning Sessions for Latent TB: Session 2

- Just as an introduction, if you could chat your name and preferred pronouns, your title and role, at what organization you are from and what your favorite kind of candy is. So Mikey, can you go to the next slide please? So good morning? Everyone, welcome to our second virtual provider day session for latent tuberculosis infection. My name is Amy Sgueglia, I'm a nurse and consultant at JSI who works on the TS4SI project. I think most of you are familiar with TA4SI at this point, but if you're not TA4SI stands for Technical Assistance for Service Integration. The project's funded by the Bureau of Infectious Disease and Laboratory Sciences, and it's implemented by JSI and the project provides technical assistance to Biddles funded agencies with a focus on service integration, both across infectious disease areas such as HIV, hepatitis, STIs, and latent tuberculosis infection and into primary care. Can we have the next slide, please? So if you joined us before, like I just mentioned a moment ago, if you joined us before the session started, we had a slide up regarding introductions. Again, if you can continue to chat your introductions into the chat box, share your name, your preferred pronouns, what organization you're from, your role within the organization, your title within the organization and what your favorite candy is. So we, in addition to the session that you're participating in now, we have one remaining session scheduled for December, on Thursday, December 10th from 10 to 12:00 pm, We will have a session about reporting and analysis. The registration links to these events were included in an email from Molly Rafferty. If you're unable to find this email, feel free to reach out to anyone on the TA4SI team or your contract manager and they can put you in touch with someone from the JSI team so you can get registered for the event. Next slide, please. So the objectives for this virtual provider learning sessions are to update providers knowledge and review resources that describe latent TB infection services including risk assessment, testing, adherence, support and reporting, prepare agencies to plan for initiating or enhancing these services and to share lessons learned. Next slide, please. We have a pretty busy agenda today. Today's session's going to run from 9:30 to 11:30. We're gonna start with some introductions and then we're going to go into listening to a presentation from Robin Gordon of JRI about adherence basics. Then we're going to hear from Jennifer Cochran of DPH. Jennifer's going to discuss adherence strategies and considerations for latent tuberculosis infection. After these two presentations, we'll have some time for discussion and questions, then we're going to have a brief break before we head into Breakout Rooms for a pre-process mapping exercise as well as a case study. Finally, we are going to regroup in the main room for a wrap-up session. Can I have the next slide please? So before we begin, we have some housekeeping items to discuss. First, we recommend that you connect to this call using your computer's audio. To join this meeting using computer audio, please select the computer audio tab in the Zoom audio conference options pop up box and then select join with computer audio. It's the blue box on your screen. Next slide, please. If you are unable to join by computer audio and need to join by phone, please select join audio. Select the phone call tab and select a phone number to dial. Once you are connected to Zoom using the phone number you dial, please be sure to enter the correct meeting and participant ID numbers. These ID numbers can be found in the audio conference options pop up that is shown on the slide. You will automatically be muted. To mute or unmute yourself, please select the microphone icon on the bottom bar of your Zoom screen. If you have a webcam available, we ask that you select the start video tab next to the mute feature on the bottom bar of your Zoom screen so that we can see everyone. Next slide, please. So, as I mentioned, when we were reviewing the agenda there will be a discussion and Q&A session after today's presentations but feel free to chat your questions at any time throughout today's presentations. When we get to the Q&A portion of the

presentation, we welcome you to either raise your hand or chat your question as well. And for those questions that you chatted during the presentations, we'll read through them at that time, answer the questions. Next slide, please. So there are several colleagues from MDPH in today's session. I'd like to spend a moment thanking those who are involved in the design of this program or who are in assisting in facilitating the sessions, we really couldn't have done it without your input and your help, but I'd like to take a moment to hand it off to Linda Goldman from DPH. She's just going to take a moment to introduce her team. Linda, would you like to begin?

- Yes, hi everybody? I just wanted to say thank you all for joining us this morning. We know everyone's very busy, but if you attended the first session last week on risk assessment and testing you'll know how valuable it was that we all came together for that. And we think this session will also be really valuable and interesting for everybody. I am the director of health promotion and disease prevention services in the office of HIV/AIDS. The team I work with most closely are the contract managers and health promotion and disease prevention services unit and most of those folks are here today. We are also working with the global populations team under Jennifer Cochran's purview and we have office of health care planning staff participating this morning as well under Liisa Randall who's unfortunately unable to participate this morning. So I just encourage you all to listen and participate when we have the breakout sessions and enjoy the morning. Thank you.

- Thank you, Linda. Can I have the next slide please? So we also have several members of our TA4SI team on the call today from JSI. In addition to myself, we also have Sabrina Eagan, Technical Advisor, Molly Rafferty, Project Associate, Miira Levinson, Project Director, Molly Higgins-Biddle, Project Manager, Mikey Davis, Consultant and Christine Luong who's also a consultant. Can I have the next slide, please? So for those of you that were on last week's call, we talked a bit about the fact sheets that we had developed. So TA4SI developed, or is in the process of developing a series of fact sheets on latent tuberculosis infection services. The fact sheets address key considerations of each component of testing and treating individuals with latent tuberculosis infection. These fact sheets were developed for use by clinical and nonclinical providers in agencies receiving funding from the Bureau of Infectious Disease and Laboratory Science to provide TB testing and latent TB infection services. Next slide, please. So this graphic depicts the components for testing and treating individuals with latent tuberculosis infection. It gives an overview of the cascade of care for latent tuberculosis infection including the steps to deliver each component to the individuals that you are working with. It's important to remember that individual agencies may offer all of these components or they may only offer some of these components in their menu of services. Next slide, please. So I wanted to scroll to offer you a closeup of the bottom portion of the document that shows the steps listed under the treatment adherence support and reporting and analysis components. So the component that we're gonna be covering today is adherence support. And this includes assessing, reassessing treatment adherence support needs and providing support for adherence to treatment and retention to care. Next slide, please. All of these fact sheets that we have developed are on the TA4SI website. Additional fact sheets for evaluation, treatment, reporting and analysis and billing, excuse me, additional facts sheets for reporting and analysis and billing are being finalized and will be posted shortly. This slide shows the main TA4SI website page. You could go to the next slide, Mikey. Actually, can you go back one? I'm sorry, don't think you can see it. It's very small, but

under latent TB infection, there's some blue type there. If you click on that, and now go to the next slide, please, Mikey, sorry, it's very hard to see, this brings you to the latent TB infection components and resources page. And if you were to scroll down that page, it would offer you each of the fact sheets that we have developed. This only shows up to process mapping components but if you were to go onto that website today you would also see several other fact sheets that we have developed. Okay, next slide, please. So, as I mentioned earlier in the presentation if you're just joining us, please feel free to introduce yourself in the chat box. We're asking for your name and your preferred pronouns, what is your title and role, what organization you're from and what is your favorite kind of candy? "I still love chocolate and peanut butter," when I briefly looked through chat box. Next slide, please. So now we have a poll question. It's gonna pop up on your screen and the question is, "What is your agency's stage of implementation for adherence support services?" So if everyone could take a moment, I'm gonna read through the answers, the potential answers. Take a moment and answer this question. "What is your agency's stage of implementation for adherence support services?" "Are you providing adherence support services for individuals on latent tuberculosis infection treatment and for individuals on treatment for other diseases and conditions?" "Are you providing adherence support services for individuals on latent tuberculosis infection treatment only?" "Are you providing adherence support for individuals on treatment for other diseases and conditions but not for latent tuberculosis infection?" Or "Are you not currently providing any adherence support services in your agency?" So if you could take a moment and answer that question, those questions, that question, choose the answer that best describes your organization the services being offered. And give everyone another minute to answer. Give everyone another 10 seconds. Okay, Mikey, can you close the poll? Great, so 18% of you said that, "We are providing adherence support services for LTBI and other diseases and conditions. No one is providing adherent support services for individuals on latent tuberculosis infection only." 59% are providing adherence support for individuals on treatment for other diseases and conditions but not for Latent tuberculosis infection. And 24% are not currently providing any adherence support services. Great, thank you. So now, I'd like to turn the presentation over to Robin Gordon of JRI. Robin is a trainer at JRI Health and she's going to talk about adherence basics with us and she's also going to share her screen and her slides. Robin, welcome. Thank you for joining-

- Hi everybody, thank you. Let me just go ahead and do that. Okay, so welcome everybody. Again, my name is Robin. I work for JRI Health as a trainer. Before that, I spent many years working in HIV, STI and Hep C services and harm reduction. And we also have a PAC program at JRI health, which stands for prevention and access to care and treatment and so we're gonna talk about some of the adherence lessons we've learned through that program. So we'll talk a little bit about ambivalence, a little bit about motivational interviewing skills and addressing needs of clients and how we do that. We do a lot of motivational interviewing training at JRI, a lot of practice with that and sometimes it's very useful in terms of medications and linkage to care. So most of our lessons that we've learned around adherence come from this PAC program and in the program, we have community health workers who work a lot with really difficult-to-reach patients. A lot of it is home-based care. It's a little different right now during COVID. Normally it'd be home-based care or checking in with someone every day, around taking medications. That medical care, it's a lot of helping people with appointments and for some people it's direct-observed therapy where they're actually going and making sure that people are taking their meds or helping them with barriers and things around that. Most of the clients in this program are people with

HIV but they also have many other long-term chronic illnesses that they're managing. So what are some of the reasons people don't take meds? So we talk a lot about this in our trainings and with our clients because it's important for us not to make assumptions and assume why people aren't taking meds. It can be anything from people feeling forgetful, to people don't believe the medication will help, to people feeling healthy and not feeling like they need it. So when we ask a client that, we would ask them an open-ended question, "What's going on with your meds?" "What's your barrier?" "What's your struggle?" And these are some of the things that come up for people. So we know housing is an issue. A lot of people don't believe that the meds will actually help them. And sometimes they actually actively believe that the medications might hurt them and that's true for lots of illnesses. I think this would be particularly true with latent TB but a lot of people feel healthy, so they don't really understand why they might wanna take medication. We've seen this a lot with Hepatitis C as well. People will say, "I'm fine and I don't have any issues. I don't need to take medication." A lot of times they don't trust their provider, so this could be medical stuff that they've heard from, you know, like medical racism and that sort of thing that exists. It could also be just that provider said something that is stigmatizing. So I've had a lot of cases of this with Hepatitis C and I think TB has a similar stigma in the sense of people look at it as like something dirty. With Hep C we've had clients go to the doctor. We had one last year. somebody said they went to Hep-C the treatment and the doctor said, "Yeah, I'll see you next time if you're not out smoking crack." So there could be a lot of reasons why people don't trust their providers. Side effects, that's a big one. None of us want side-effects. Meds, not addressing whatever they think is the most important. So it might be that we're trying to convince them to take a medication for something and their health priorities are something different. So it's important that we address those first. Substance use, I think we all know that one. Conflicting messages from the community, so sometimes people are with their friends, their family, their church, wherever they are and they might be hearing different things about whether or not they should be taking that treatment. Negative experiences in healthcare which we already talked about. Any kind of barriers in getting to the pharmacy, transportation, we've had a lot of clients who work really long hours like 7:00 am to 7:00 pm so it makes it difficult for them to get to any appointments. Expenses and all kinds of social and structural issues. So a lot of factors can make this even harder for people to stick with their treatment. And so we know poverty, we know stigma, depression's a big one with some of our clients. And especially now during COVID, a lot of them are isolated and we've had a lot of clients who haven't wanted to leave their house for fear of COVID, we've also had the opposite where we have clients who don't wanna go to see their doctor because they only wanna do in-person appointments and their doctor may only be doing Telehealth. And we have many clients who don't like the Telehealth. So that can be an issue. Health literacy, this has also been an issue where people don't really understand why they need those meds. They maybe don't understand what TB is, they don't understand what the doctor's told them or their reading level. You know, if you're handed a fact sheet at the doctor and you're expected to read it and you can't, a lot of people are maybe too embarrassed to say that they're struggling with that or there could be a language barrier that's happening. And a large distrust of the medical system, so we've had many clients who feel like the whole system is not out to help them and there's a lot of people who believe that meds are there to hurt you or that the government created something to hurt people. But those really come out of legitimate things that have gone on in the medical system where the people have experimented on people or different things like that. So there's a lot of things that play into this. The other thing is that we know non-adherence is pretty common with a lot of different illnesses. So for diabetes for example, if we're talking about, there's a study that was done, it's a little bit older of a study, I think in 2002 in

Scotland and what they discovered was people who were taking a diabetes pills, only about 30% of those folks took the pill every day as they were supposed to and when they had added pills, so they had like extra, when they had to take two, only about 15% of folks adhere to that. And they know the adherence to insulin's probably a little bit even lower. So we see this across the board with all kinds of chronic illnesses and different things. So this is happening a lot and that's just the study if anybody's interested. So, the question then is how do we talk to people about taking their meds without scaring them away or causing them to not wanna talk to you? So the two things that happen a lot of the times is people will either feel defensive if we start telling them what to do or they'll, if anyone's ever done this, give you like the yes answer, like, "Yes, I'm doing that. I'm taking my meds, yes." And we've had people who the labs clearly showed they're not taking their meds and they're still telling us they're taking them. So this is important that in terms of motivational interviewing and how we talk to people and how we bring them to a place where they might make a change. I have had this experience myself at the dentist and my dentist was yelling at me about flossing so much to the point where I was like, "Yes, I'm flossing," but I wasn't. But I was just telling her that because she was doing the whole finger thing. So just be really, really mindful about the way that we talk to people. And this is just talking about fighting the righting reflex that we all have. We're all in this job, in this position and all of our providers are here because they wanna fix things and help people. And it's really easy to fall into that place of wanting to tell someone what to do, and the righting reflex is that you are trying to tell that person, "You need to take these meds, why aren't you taking them?" And that makes people defend what they're already doing and it doesn't work. And it's very, very hard to fight this when we're a provider talking to clients. So this is sort of a conscious way to think about how can we not do that? So there's some pretty basic principles around motivational interviewing. One is empathy, which I think everyone here is probably well aware of and is good at. This is a non-judgemental approach to people. It's also recognizing what the client is doing or not doing that might poke at your own anxieties and your own stress around you know this person should or should not be doing the thing that they're doing but they're not doing it. And so sometimes our anxiety comes out as trying to convince, persuade or bribe the person to do that thing and that generally doesn't work. So the empathy is a lot of rolling with what that person is doing and being okay with it. It doesn't mean that we don't feel anxiety or frustration or even anger about what someone's doing but we don't express that to the client. Maybe we talk about that with a colleague, with providers in clinical supervision or wherever else is appropriate. We also talk a lot about looking at ambivalence which is essentially feeling the same way about two different ways about the same thing whether or not they wanna do something. So for me at the dentist, for example, I was told a year ago that I have to get a procedure with my gums like my gums have to be operated on, like dropped down. I haven't done it. I'm well aware that it should do it, that I don't wanna lose my teeth someday and I haven't done it because it's $500 and I have a lot of anxiety and fear around the dentist. So that's like the ambivalence that we're talking about, when you feel two ways about the same thing and then rolling with the resistance is the other key principle. Not being argumentative with somebody when they're not doing the thing that you want them to do or rather rolling with it and asking more questions and being curious. Okay, so there's a lot of different strategies you may have heard of motivational interviewing of the OARS which stands for Open-ended questions, Affirmation, Reflection and Summary. So we're gonna talk about two of those that are probably most useful for adherence. So one of those is open-ended questions. When we do trainings for this for providers, it's not that there's not a place for closed questions, there are, there's lots of places for closed questions. You have paperwork you need to fill out, you have things you need to know but getting more information from the client about what's going on,

why they may not be taking their meds or going to their appointments and getting curious about that, so if you look at the questions, you know a lot of the closed questions are starting with words like are and do and that opens up for like a yes or no answer. So "Are you worried about passing TB to someone else?" When you can open that up and say something like, "What do you think this treatment could do for you?" And that's gonna get you a lot more information and help you figure out where somebody's at. "Are you gonna follow up?" Or somebody might say "Are you gonna make another appointment?" And sometimes people feel that the need to say yes because they know that you're sort of asking that in a lead way, so you might change that to something like, "What are the reasons for you not to start the treatment? And what's your top priority right now?" Rather than, "Do you care about your health?" I worked with somebody who asked that question a couple of times and people got really upset about it. Of course they care about their health, it just might not be their priority right at the moment. So this is just some ways that open and close questions start. "Tell me more, say more about that." You know, I like to use, "What are your thoughts about something?" Or "How are you feeling about that?" We usually talk about why as a really tricky one that we avoid unless you really know someone really well. And the reason for that is it can sound really judgy. So if you're saying something like, "Why aren't you taking your meds?" That sounds a little more judgy than if you can say something like, "Tell me about how it's going with your meds?" And you can see a closed question is, all of these over here, is, are, do, will. This is something that seems really easy when you're looking at it, but anytime we do practice with people, it's always harder than they think. So it's something you really have to consciously think about. It doesn't feel natural in a conversation with a client to talk this way. So it's just something to keep in mind to try when somebody isn't taking their meds or doesn't wanna start their meds. So these are just some examples that you can use. "What's the hardest thing about taking your meds?" That's a really good one because you're gonna find out what's really going on with them. Is it just that they're forgetting? Is it that they don't think they need it? "Tell me more about that," "Help me understand," "What gets in the way of taking meds?" And "What do you know about your diagnosis?" This is important because sometimes we've had clients come in, they're not taking their meds they're not going to their appointments. They don't really know that much about what they're dealing with. Sometimes doctors don't always describe things in a way that people understand, so if there's a health literacy issue, if there's a language barrier or if the doctor just isn't great with explaining stuff, it's helpful for you to know do they really understand what's going on? And the same thing with their meds, "So what do you know about your meds and how they work?" That's really important too. I have a teenage daughter that we adopted a few years ago and when she came to us, she was taking different kinds of medications. Turns out she had no idea what she was taking as a 13 year old. Didn't know... I'm sorry, my cat . I have a mischievous cat here. So she didn't understand what she was taking, why she was taking it and it explained a lot of why she was feeling frustrated to have to take them, and once she understood, it actually went a long way for her to be like, "okay, I get it." And the other questions that I like, we do a lot of pros and cons. This can feel really counterintuitive with somebody. So I might say to someone, "What are all the really good things about not taking your medications?" This is an interesting question, it doesn't mean that I agree with them. It doesn't mean that this is like, I think they should be doing, but it's gonna help you figure out what are all the positive things for them? What are all the reasons? Yep, and then, "What are the not-so-good things about not taking your meds?" So these are just some questions that'll help you get at that. And I have a poll. Can we launch that, Mikey? So I'm gonna ask just two questions if people could go ahead and answer that. Yep, thank you. All right, thank you. All right, so let's check this out. So this is a poll, we can pick as many as you wanted. So it looks like a lot of people...

"What are the good things about not taking meds?" So not worrying about people finding out but most people put, "I don't have to remember to take something every day," and some people put none of the above. So the reason why this is important to take a look at is that whatever the person is telling you, the reason they're not taking their meds is a reason for them, and it's probably a good reason or they wouldn't do it, right? So it's important for us to reframe our brains a little bit. So if we said none of the above, we might wanna rethink like, yeah, they're not good reasons in our head and it might be hard for us to, it's sort of counterintuitive for us to think about like, "Why are people not taking the meds?" But in that person's head, these are the good reasons. So we don't wanna say to them like, "That's a bad reason," or "That's not a reason." I think a lot of times as providers we get caught up in, "Hey, that person's making excuses for why they're not doing the thing they're doing," when really they are the reasons. Let's see, what did people vote for this other one? A lot of people wrote, "They'll feel healthy so there won't be any more side effects." It was a mix here, and some people still put none of the above. So I think it feels like none of the above for us because we want people to do this thing. And I just wanna remind people like all of these are good reasons. Good doesn't mean I approve, good doesn't mean it's good for their health, it just means in their head, "This feels like a good reason to me." And not having to deal with a medical provider anymore, we've heard that a number of times, depending on how their experience has been, medical expenses will go away, feeling healthy again. So if they have side effects, that can be a real reason why people stop taking their meds. Does that make sense to people? Okay, all right. So let's continue. So it does feel counterintuitive, but I'm just, we wanna think about what is going on for people and try to have some empathy around what their reasons might be. Okay, so the other part of the OARS that we'll talk about today if I have a few more minutes is the R part which is called reflective listening. This is another one that feels really easy, and when you see it on paper but it's harder to in practice. This is talking about actually reflecting what the person is saying without moving right to fixing their problem. This is very hard to do for most of us, I'd say. So when I try to capture what they're really feeling, so a reflection can be a simple reflection where you're just rephrasing and making sure you understand, it also can help be a light bulb moment for somebody if you're getting at what they're really feeling. And it does show that you're listening and not trying to persuade them immediately. So these are some examples. So the patient says, "I can't deal with this treatment right now, I don't wanna infect anyone but it causes a lot of side effects and people will think my family is dirty and not wanna associate with us." And as the staff we say, "You wonder if starting treatment could make you feel sick or hurt your family's reputation and you also wanna make sure not to infect anyone else." So it's kind of a double-sided reflection 'cause it's showing the ambivalence there of both sides of how that person is feeling without moving right to a solution. And here's the other one. "I don't feel ready to do this. It'll just be another thing to try and manage and I'm already dealing with my kids, my mom, and losing hours at the store. This is not where my head is at right now." And, sorry if you can hear that, my cat difficult. "You are overwhelmed and have so much going on and it may not be the right time to try this." So this is naming the feeling, they're feeling overwhelmed, they're feeling stressed and there's just too much going on. And it's okay to name that even if you don't agree with it. And there might be a time where we have to make peace a little bit with the fact that maybe this person's not gonna try their meds right now but they're coming back to see me, they're talking to me and I'm developing a relationship with them. So the last concept that we had talked about was this idea of rolling with resistance. So there's two pictures here. So this is kind of two different ways you can respond. When somebody is being resistant, when they're sort of not wanting to do something or they're fighting with you about it or not engaging in some way, there's two ways that you can handle

that. One is this wrestling picture where we kind of fight and argue with them or try to convince them and that generally doesn't go as well because people will try to fight with you back or sort of maintain their status quo. And then dancing is a little bit more of following the person's lead. So if somebody is acting resistant or not doing the thing we want them to do, it's you rolling with that, asking more questions and doing a lot of reflecting and that's gonna get a better response from people. Okay, so this is just a couple of quick tips of building rapport with somebody around treatment. So one is a quick-needs assessment like "What are your top priorities today and how can I help you?" Find out what's important to them. "Supported referrals to other agencies," if something else is important to them, maybe they need a counseling referral, maybe they really need to go see their primary care, whatever it is, making sure that you help them with those things as well. Respecting the patient's priorities and immediate needs and the idea of rolling with resistance which is really avoiding arguing and trying to figure out what's going on. So that is it. So thank you everybody. Amy, is it okay if I stop sharing?

- Yep, that's great, thank you.

- Okay, yep.

- Thank you. So we're gonna move into our next presentation. We have Jennifer Cochran here who is the director of the division of global populations and infectious disease prevention at MDPH. We're gonna listen to a presentation from her and then we'll go into a Q&A session with both Robin and Jennifer. Jennifer, are you there?

- [Jennifer] I am, you can hear me, right?

- I can hear you, yes. Loud and clear.

- So thanks very much. And thank you to Robin for really a great presentation on adherence support and I think what I'm gonna try to do in the next 10 minutes or so is focus in on the TB section because a lot of what you've covered is very much the reality for people who are thinking about taking treatment for latent TB infection. So if I can have the next slide. As Sabrina, sorry, as Amy mentioned earlier, there is a fact sheet on the TA4SI website on adherence support and that's all my presentation is gonna try to be true to that fact sheet and walk through some of the highlights. I also wanted to thank again, our colleagues at JSI, MDPH who've assisted with these fact sheets which we really hope will be helpful to all of you. And then I'd like to thank our team of community health workers at the division of global populations, because I think they, not only are they just doing amazing work in terms of helping in providing support to newly arrived refugees, to people who are experiencing homelessness, to children, to people who are contacts, to someone with infectious TB, they are the people who are really my teachers in much of this and they are supporting people through that process. So if I can have the next

slide. So, you know, the basic question is why is it important for TB infection? And the bottom line is if the pills don't get into the belly, then the TB germs persist in the body. And as long as TB germs are there, then there's always an opportunity for them to move into a disease state as they begin to multiply. And certain people are at especially high-risk for that progression and for many reasons we wanna focus on these if we have limited resources and we would wanna look at people with recent infection, that's why we asked the question about migrations or people who are coming from countries where TB is endemic have a greater chance of a recent infection than somebody who's never left the United States. Someone also might have recent infection because somebody in their household had TB or somebody who they work with had TB. So it's not limited to coming in from overseas or from another country. We do see some transmission here. There's also certain medical conditions that can make that progression from TB infection to TB disease more likely. Includes conditions such as HIV, certain cancers, certain other medical conditions, really that are tamping down on the immune system and then taking medications that may alter immunity and there we think about some of the currents, the biologics that are given for conditions such as from Durham or some of the other conditions, sorry, I'm just blanking for a moment, but they are the ones you see on TV, Tell your doctor if you've been in or have TB infection. So completing the treatment for latent TB infection does reduce the risk of TB disease by about 90%. And we also wanna balance that by thinking that not everybody who has TB infection is going to go on to get disease. So we understand some of the ambivalence here but we also know that treating TB infection is definitely easier compared with treating TB disease. Not only that, it prevents future spread of TB disease and really what can be a pretty, call it aggressive or invasive process for people who are diagnosed with TB disease as the public health responds around them. And so often taking treatment for TB infection is seen as being an easier and an opportunity and people may reflect later, "I wish I had taken that treatment for infection." If I can have the next slide. So I think this follows Robin's presentation as well, it's like who needs adherence support? Really everyone does, anyone does, everyone at some point during treatment. The reality is every person from every social strata, from every community does need support with adherence. And that these challenges presents really at any time and they may be unexpected and they may change over time as well. And we can think about categories or people who are experiencing in certain groups these challenges more than others and so may need solutions that are really tailored to their situations. Next slide. And thinking as well about who provides and who's important in providing adherence support and the bottom line here is everyone. So anyone who's a member of the team really plays an important role. I think we fill different niches even as people are asking open-ended questions, patients may speak differently or speak more openly with community health workers or peer educators than they may with their provider where they may expect some response or feel like they may be judged if they open up and speak more clearly but that doesn't mean providers aren't really important and in open, in asking these open-ended questions to patients. We hear a lot about the support that nurses provide that they are there for people, they're often seeing people in the monthly visits for TB infection treatment, and so the patients will build more rapport and have opportunity to talk with nurses. But it's also the pharmacists have been playing an important role that we know that some of the clinical pharmacists have in some of the middle splendid sites are doing adherence support with some of the other conditions and then the patients, and we can't think about it here in support without dialogue and without thinking of patients, their own resources where they think their strengths may lie and what strategies will work for them in terms of adherence support. And some people use their support network or not. You know, I think for some people, it's how people decide to use supports around them is an individual decision. And the next slide. So I'm actually not going to go

through this slide because it's a lot of what Robin touched on already except to say, when we think about adherence barriers really fitting in two categories, into these two large categories, one being systems based like what are our systems put up that become difficult for people to work with and then what are individual based? And so we wanna think about both of those. So a system based may be, can we offer early morning appointments? Can we offer drop in appointments? Can we offer a transportation, a taxi voucher or some kind of a transportation voucher? And at the personal level, it may be something like "I can't come because I'm working at different hours," or "I don't feel comfortable with this treatment for this particular condition." And the next slide. And here, I wanted to spend a few minutes thinking about latent TB infection and regimen choice. And we talked about this a little bit earlier I believe, but now I'm thinking that maybe we didn't. That there are shorter courses now available for treating TB infection. That standard course has been nine months of INH which is known to be a long, it's a long haul to get through, and so as we look at these shorter courses which include Isoniazid and Rifapentine which we refer to as 3HP is given once a week for three months, so we call it 12 doses or Rifampin which is given daily for four months. People tend to complete at higher rates on these shorter course regimens. I think if it's hard to take meds for four months, it's really hard to take them for nine. It sounds daunting at the outset. And so CDC and we at DPH do recommend the shorter course regimens when possible, recognizing for a lot of people the short-course regimens really aren't feasible. So that said, it's why I put the last bullet in here too. We can, patients do successfully complete the longer regimen, I think it means a real concerted engagement on the part of the treating team and the adherence support teams to help people through that nine months 'cause there are ups and downs along the way and helping talk people all the way through that. So the next slide, and here we wanted to look a little bit about with directly observed therapy or DOT. So DOT requires a trained health worker to observe somebody taking meds. And purpose of this is both to ensure that the person's taking the medications as prescribed. Robin touched on when you add a second pill in, sometimes people will take one, but not the other. So this would be to make sure that if the prescription or the recommendation is for two pills, that the two pills are taken at the same time, or as prescribed. It's also an opportunity to ask people how they're feeling. You should feel pretty normal when you take these meds and so asking specific-pointed questions about how people are feeling allows that DOT worker to see if it's appropriate to take that next dose or perhaps somebody needs to check in with the provider before continuing their dosing. So we recommend that the intermittent regimen which would be the 3HP given just once a week, that that always be done by DOT. It's particularly difficult to remember a dose when it's only taken once every seven days. It's hard enough to remember every day, but on the once every seven days, there are studies that show those are harder to remember without a lot of reminders. So we prefer that that regimen be done by DOT. So there are also some cases, and in children is the example that's given here where either somebody's at particularly high risk for progressing to disease or it's sometimes just easier to provide the dose by DOT and kids kind of fit in both categories. It can be hard for kids to take meds, it can be hard for a parent to give meds to a kid, to the little ones and sometimes it's easier to have an external person be the, we'll call them the bad guy, but you know, the person who's tells the kids they have to take the meds and separates a little bit. So those can be done by a DOT worker. And it can be considered for people who are not comfortable or are maybe at high risk for missing doses or appointments or those refills. We would generally start people on self administered, but recognize that in the constellation of services that are provided here, you may have the ability and the resource to actually provide this treatment by DOT. So to the next slide, self-administered therapy which we sometimes call SAT is given for the majority of patients. So this would be anybody who's not

on the 12-dose regimen and many other people. And some of the strategies that are done here are to regularly discuss it here in support and regularly in an ongoing way talk with the individual about what might work. And I wanna stress, can't stress enough we've non judge mental, it's completely normal to miss doses. And it's not the end of the world. I mean, this is doses. If somebody stopped taking meds, then we would like to know that. Or if somebody's missed two weeks, the question is how many doses that are missed become particularly relevant here. But missing a dose, taking a day off from meds is a completely normal thing that most everyone will do at some point. There's a lot of strategies that can be looked at. These are on the fact sheet and they're actually on one of our supportive materials. And I encourage you to look at those. And then I also want to say, checking in with people in between appointments can be particularly helpful. I know on our teams, we often check in soon after people agree to start meds, because how somebody feels when they're leaving the doctor's office, and if they're like, "Got it, okay, so I'll take meds," but then they get home and they may talk with family members, they may think about this more, they talk with community members. They may ask themselves how they feel, truly about starting meds and may find that they have more questions or just aren't feeling comfortable it's about starting right away and didn't have those questions come out when they were at the provider. So following up soon after can be a time to really explore what somebody did understand or does understand and where they think they may like to go in terms of treatment. And the next slide. So in general, we feel like each person should be regularly assessed for adherence challenges, and by that, we mean every time you talk with them, and as that's happening too, think about how does this individual understand their diagnosis of latent TB infection. We recognize from the outset this is a really challenging diagnosis because for many people TB's a very familiar disease and latent TB infection looks nothing like that. So when somebody has TB, they're generally thinking of somebody who's symptomatic, who separated from the family, they may be aware or feel some of the stigma that's associated with that. We generally come back to saying the risk for latent TB infection is breathing. It's not something necessarily that could have been prevented, but once there, it is something that can be treated. And then thinking about concerns about taking meds, some people just are averse to taking medications unless they absolutely need to. So we can talk through these things about how somebody feels and how they may integrate the treatment into their daily lives. And the next slide, I think too, we also look at the follow-up visits as an opportunity to explore adherence. This is when someone's on treatment for latent TB infection. We recommend that the patient, the individual have a monthly clinical assessment it's generally done with a nurse and the purpose of this visit is safety. So it's really looking at side effects, how people are doing, taking the meds, whether they're taking it correctly and adherence. So, to what extent somebody's actually taking the meds as prescribed. And as we said it earlier, to really explore that adherence through open-ended questions, not to say, "Are you taking your meds every day?" The answer will usually be yes to that and to look for shared solutions and any adjustments that may be needed. I think that for follow-up visits, if it's possible to include community health workers or other members of a multidisciplinary team, it can be very helpful. We've also noted that there is a drop-off that happens, like people may leave at the first month ready to start this treatment and they may make it back for the second month but there's a known drop off say at around, with the nine month INH, say around month four or five where it's just starting to feel very long. So I think that continued support and recognition that it is a long time, but that there is a reason to be doing this, that makes sense. And if somebody does need to drop off, we can return to it in the future. I wanted to back up and just say, in terms of missed doses and getting through treatment that even though we talk about 12 doses and three-month regimen for 3HP and 12 doses and four months of Rifampin, we are given these

windows to complete that regimen so that the three-month regimen needs to be completed within four months. The four-month regimen needs to be completed within six months and the nine-month regimen completed within 12. So that has a built-in recognition that not everybody's going to take one pill a day for the next 270 days. And so the next slide has some resources, some links and I really wanna call out under the DPH, keep taking your medicine and that these are materials that are in over 20 languages. They are bilingual. So everything is in English as well, thinking that in some households, some people are reading in one language and sometimes the younger kids are reading in English and they are developed with a health literacy framework. So there's not a lot of words on these, but they invite a dialogue, I think between provider, a community health worker and patient in identifying a strategy for adherence support that will work in individual patients. So I invite you to take a look at those. There are other resources here and the CDC has a treatment tracker, a medication tracker and other people use calendars and other resources and the last is the TA4SI website. So, thank you.

- All right, thank you very much, Jennifer. And thanks to Robin also, both of those presentations were really, really interesting and I like the learning about adherent support strategies in general that Robin presented and then Jennifer's more specific take on latent TB infection. I do wanna remind people, go ahead and put your questions in the chat box. We've now got time for some discussion and Q&A with both Robin and Jennifer and anybody else who wants to pipe in. I know based on the poll, it looks like a lot of people on this call have experience with adherence support in one way or another even if it's not for latent TB infection. So we would like to hear from others who have things to offer. We have a couple of questions prepared since we haven't received any on the poll yet, but do go ahead and let us know. The other thing before I forget, because the last slide did have all those links to the resources, we will be sharing the slides and the recording after today. So you will be able to actually get those slides and click on things instead of trying to search for them. So I think one of the questions we wanted to start off with is directed at Robin. And I know what we're gonna ask agencies to do when we go into the Breakout Room is start doing a little bit of planning for either starting their adherence support services or scaling them up to include latent TB infection. Can you talk a little bit about how your clinic handles adherence support in terms of the staff involved? How do you set up systems so that your staff can communicate with each other so that you guys can track your patients' progress and alert each other if there's an issue that somebody needs to take action on?

- [Robin] Yeah, so in the program that I worked in, it wasn't like a health clinic, so we were doing everything with the HIV staff nurse practitioner and we, at this point, Izzie you're on the call, so you might be able to say I don't think we're doing teeny stuff yet, but for HIV, Hep C, we had a lot of follow-up with people. So if we were able to talk to them, get them into care or referral for some stuff that we didn't have on site. So HIV care and Hep C were not on site. So we'd have case managers who would actually bring people to their appointments, if needed, a lot of transportation options for people and a lot of follow-up notes and a lot of phone calls. So like if I were to refer someone for Hepatitis C treatment and they went to it, I would be calling a couple of times to remind them to go to the appointment then I'd be calling them after to check on them and find out whether or not they were able to make it, and if not, what happened and what was the problem? And so, it was a lot of follow-up, a lot of conversations with other staff around that stuff. With the PAC team, it's a little different because

they're doing more direct observed therapy and there're community health workers who are actively working with healthcare providers. And I think that's a great system. It's not applicable in every scenario but they are able to work directly with providers to talk about what to do and they are able to go to those appointments, translate, help with literacy and also just whatever barriers come up. So there's a lot of things going on.

- Okay, thank you. And I think related to that and building on that, Jennifer, if you can just talk a little bit about as clinics or agencies are considering scaling up adherence support for latent TB infection, if they already have other adherence support programs going what would you recommend that they add for latent TB infection? Or is it something that they can carry over? A lot of the principles are very similar but are there any differences that you see and recommendations you would make?

- Yeah, I think that there are a lot of similarities. For the agencies that are here and are taking on TB infection work, I would start with a resounding, "You know a lot of this already, and build on your own strengths and your own systems. and don't think necessarily that, 'Oh my God we're gonna have to do something completely new for TB infection.'" I think that some of the differences that we might see are the basic questions might be a little bit different from individuals in terms of why, why now, why me that we talked about a little bit more and I think exploring these questions is really a validating process. So I think for agencies to learn as much as you can and learn from clients about their thoughts about TB and what their community knowledge is can be extremely valuable. I think another piece and Amy, this is a little more similar to Hep C is that it's a time-limited engagement. So you don't have time really to build a long-term relationship with people. If we're gonna dive into TB, we have this beginning, middle and end of treatment that we want to try to get to. So it's scaling up a relationship, getting it going and trying to keep people engaged for those really three to nine months. Now, if you're working with patients who are already working within your integrated infectious disease team, then you have that added advantage of already having those relationships. And then I think becoming a little more familiar with the drugs themselves. We do reassure people, "You should feel normal and if you don't, just talk to your provider," and so definitely don't want to have people think that all of these side effects are going to be there. They really don't have to be. You know, we can address many, many of those through their timing of medications or changing to a different drug.

- Thank you, and a little bit related to that, to thinking about things like DOT and I know that there's DOT for some other conditions, but DOT specifically for latent TB versus self-administered therapy, do you have any advice for agencies that are looking at that? Is it a similar structure for DOT and self-administered therapy in terms of how they can organize them, their staff, how they can organize chart reviews, visits, that kind of thing?

- Sure, and I look here that most of the DOT that we're familiar, really truly familiar with with latent TB infection would be, and this way, that'd be following a routine screening would be for people taking 3HP, so the once-a-week regimen. And for a lot of people, this turns out to be a very, it's a cast, it can be

a really effective regimen because the patient's channeling a little bit of work. You know, my job is to show up. Somebody's gonna help me and just ask me how I'm feeling, they'll store the meds over here and it's easier for me to do that than to remember to take meds every day. I think that where done successfully, there's a lot of flexibility. So we do DOT day on Tuesday from 7:00 am til 7:00 pm. So long as you come in during that window, we'll have you in and out. I think that some places they're bypassing registration so they're registering right with the nurse who's gonna do the DOT. They're just trying to find ways to keep it as simple as possible. Certainly, if you were in a clinical setting and you have to wait in one line for a while and had to wait in another line, it can be discouraging. We have seen some sites and we'll be open to talking further about this and trying to connect people, actually offer group appointments for DOT. So scheduling a group of people becomes a little bit of a support group. For some patients, this seems to work well. For me, it's not intuitive that it would but for some sites and some individuals, it does seem to work.

- Super, thank you. We've got a couple of minutes left and I want to just check in and see if any of the participants have questions. We have a couple other things that we can ask, but if folks have questions of your own please do, I think you can raise your hand or pop up in the chat box. I think you can unmute yourself too. Okay, while people are maybe thinking of questions, I wanna go back to Robin, something that you had mentioned, you were talking about doing Telehealth with your clients from adherence support. You said some of them really like it and some of them really don't. Can you talk more in particular about the ones who don't and if you have any recommendations for adjustments to be made?

- [Robin] Yeah, so I was just talking to the case manager, supervisor doing about this the other day. I had expected it to be the opposite, like people maybe were fearful of going to the doctor because they don't wanna get COVID kind of stuff and he had quite a few older clients who had quit going to appointments, quit seeing support groups, quit going to the doctor because they were only seeing people on Telehealth. And some of them, even when a lot of stuff opened back up in June and July, some providers were still not seeing people in person. So people really just didn't like it and there was another section of people who were also really struggling with technology and even when he had given some of the clients like iPhones so that they could work on those appointments on their iPhones, a couple of them gave the phones back because it was too complicated or confusing and they just couldn't wrap their brains around it. So their major adjustment that they made was actually just doing everything with that client by phone rather than worrying about anything. So they started checking in with those clients once a week by phone rather than trying to get them online. And there was a few clients, they actually, this is more of a COVID issue but they actually switched a few providers for people who were seeing people in person at this point. But I think the phone check-ins for those folks were really, really important and adapting to what they needed 'cause sometimes the thing that we think they need which is maybe they need a better phone isn't always the solution if they are not going to be able to figure out that phone or if it's too complicated, they're too confused or they just don't want to do it. Some of them just didn't wanna do it. So it was really about adapting to what worked for them and the phone calls weekly seems to be working for those clients.

- Great, thank you. I think just the last question before we wrap up, Jennifer and Robin, both, do you guys have any lessons learned or things that you would recommend based on the experience with adherence support and adjustments during COVID? So again, link to that Telehealth question and do you have recommendations you could make as we go forward, knowing that this is not, this is an adjustment that will probably last a long time?

- [Robin] I think just just the same thing as adapting to what works for that person and trying, if they don't wanna go to that provider because they're not seeing in person, looking for someone who is seeing people in person or vice versa, you know, it could be somebody who doesn't wanna go to the office but only wants to do Telehealth. And sometimes we need to not try to convince people if they're really just not wanting to do that thing and sort of about trying to figure out what's gonna work for them. I don't know if I have any more specific things but that's sort of a general.

- Yeah, and I think the only thing I would add to that is orientations. Orientations for people who are the patient side, you know, sometimes there's just this assumption that we're pivoting to Telehealth and being able to walk people through the process, do you need to put a new app on this phone and actually guiding people through that, and if there's gonna be an interpreter on that line how is that managed? There's a lot of logistics, I think, from the patient side that it is new and helping to support people through that I think would be helpful.

- Okay, thank you. And there was one final question that came in, Andrea put it in the chat and Jennifer, I think you might have the best answer for this but Robin, obviously jump in if you have advice. So for agencies that don't have clinical staff and so they'd be referring their latent TB clients to an external treatment provider, how can those agencies help with adherence and do you have any recommendations for them?

- Oh, yes. I think many and I think that much as the non-clinical sites are working with providers for HIV or Hep C, it would be similar. So to know where somebody's getting that care I think too, if there's an established relationship there that you can introduce yourself to the provider and explain you're working with this person, you can assist with adherence support, to know when that next appointment's going to be, to think of, are they this, does the clinical provider have somebody on their team who is helping with adherence? So you're kind of on the same team. If they already have somebody assigned to that then maybe you can just be supportive. I think it would be that coordination piece that would be so important. I think again, almost everybody's gonna struggle with things like transportation, getting there, managing prescriptions, knowing where they're going to be filled and that next appointment. So yes, I think that working in collaboration with the providers should be very much welcomed.

- Great, thank you. Some nice practical tips there. So that concludes our Q&A portion. If you guys have questions, keep asking them, we can then maybe have the presenters write up some responses and

send them back to you. So if other things occur to you, feel free to put forward that question. So what I'm gonna do is I'm about to hand it over, we're in our last kind of 10 minutes, and I'm gonna hand it over to Linda in a minute. She's gonna give us a wrap up and she's gonna talk about next steps. I will come back for just a minute at the end but I first wanna thank everybody. I wanna thank our presenters. I wanna thank Robin and Jennifer for presenting today. Really, really interesting presentations. And I wanna thank Linda for being our main representative for MDPH today, and I certainly wanna thank all the participants for being so engaged. So Linda, do you wanna go ahead and give us a wrap up and talk about next steps?

- [Linda] Sure, so first I also wanna extend my thanks and our thanks on behalf of DPH, first to JSI for organizing all the work leading up to these sessions. The fact sheets are really a tremendous resource and if you haven't started looking at them yet, I would encourage everyone to do that. We've already been hearing some good feedback on them, so we hope they're gonna continue to be useful to everybody. I really appreciate Robin's presentation. I think that as many times as I think we've all seen adherence presentations, or gone to adherence-related trainings, I felt like there were some new points that were made and I always feel like it's helpful to reinforce a lot of the strategies and to be continually be reminded of the intersections of stigma and the work that we're all doing. So I found that really useful. Jennifer's presentation also, I found helpful and sort of thinking about some of the unique elements associated with latent TB infection and adherence. So I hope you all found that as useful as I did. Whenever I hear adherence presentations, especially if they incorporate motivational interviewing, I also think of all the other applications those approaches have in other areas, professionally and personally. So they're also important messages, I think, for those other types of applications. So in terms of next steps, we'd like you to continue working on your process mapping and adding the adherence-related components to that. You're all sort of on a different timeline as far as scaling up latent TB infection or adding to what you currently offer in your service programs, and that's fine. We'll just continue to talk about your agency-specific timelines. If there's any help that you need with the process mapping, please let your contact managers know and we will make sure that you have the help you need. As Sabrina mentioned, if you have additional questions, please enter them in the chat or let us know another way and we'll respond to you. And we've got our third session coming up in December, so we hope that if you haven't registered already that you will register and you can open it up to other folks in your agencies who are doing this work. Even though our invitations went to a particular group of people, we don't necessarily need these sessions limited to that group of people. So just please feel free to openly invite your colleagues and we'll be looking forward to that. And I just wanna wish everybody a happy Thanksgiving if you celebrate that next week and stay safe and we'll see you again soon, thank you.

- Great, thank you, Linda. Miira just chatted out the link to the evaluation for the session, so we really wanna thank you guys for attending today. We wanna thank you in advance if you can fill out that evaluation form and let us know what you thought if you had any ideas for how we can improve this. As Linda mentioned, we do have one final session coming up in December, well after the holiday break and World AIDS Day and all of the busy-ness of that week. So go ahead and register for that, if you have questions, please reach out to the TA4SI team, myself, Amy, Molly Rafferty. We will also, in addition to

the link that Miira has just included in the chat box, we'll be sending out the evaluation form if you're not able to complete it now but you can complete it for us later, that would be great. And like I said, we will also be sending out the sides and the recording from today, along with any other responses to questions that may have come up after our Q&A session. So again, thank you to everybody for attending. I know taking two hours of your time on a busy Thursday morning is a big ask but we really appreciate the engagement and the discussion and have a good afternoon.

- Thank you.

- Thank you.

- [Robin] Thank you everybody.