

Session #4 Principles of TST – Part 2

Introduction

In this session, participants will continue their exploration of the skills involved in performing TST; in particular, the special skills and sensitivities needed to effectively interact with diverse patient populations. Participants will learn and practice strategies for preparing and educating patients for TST, including a review of frequently asked questions. The important impact of culture on the patient-provider relationship will be presented, with ways for participants to improve their cultural competence. This session will also address the complicated issues and health care barriers faced by patients who are homeless or use substances, and how TST technicians can respectfully and compassionately interact with these patients in accordance with local program policies.

Learning objectives

Upon completion of this training session, participants will be able to:

1. Name at least two skills that contribute to good communication with patients.
2. Identify the most important information to relay to patients receiving TST.
3. Provide appropriate responses to the questions most frequently asked by patients receiving TST.
4. List five ways that people may culturally identify themselves.
5. State four ways to learn more about a specific culture and health beliefs.
6. Name at least three barriers to health care faced by patients who are homeless or use substances.
7. Identify at least two local community resources for patients who are homeless or use substances to address their non-TB-related needs.

Material in this session is adapted from:

- *DOT Essentials: A Training Curriculum for TB Control Programs*. San Francisco, CA: Francis J. Curry National Tuberculosis Center; 2003.
- *Effective Tuberculosis Interviews Course, Part II: Targeting Special Populations*. Presented by the Francis J. Curry National Tuberculosis Center on June 26-28, 1995, in Stockton, California.
- *Self-Study Modules on Tuberculosis: Module 9: Patient Adherence to Tuberculosis Treatment*, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 1999.
- *Tuberculin Skin Testing: A Model for Trainers*. San Francisco, CA: Francis J. Curry National Tuberculosis Center; 2001.
- *Tuberculosis Outreach Worker's Course*. Presented by the Francis J. Curry National Tuberculosis Center on July 20-21, 2000, in San Francisco, California.

Review of key concepts from Session 3

1. What method of TST is used by TST technicians? What are the three main steps of this method?
2. What are the supplies needed to perform TST?
3. What are three ways to properly handle tuberculin?
4. What are four examples of "universal precautions"?
5. How do licensed health care providers determine which TST reactions are "positive" or "negative"?
6. What is a "false-negative reaction"? Name a circumstance under which this can occur.
7. What is BCG? How does it affect TST?

I. Preparing and educating patients for TST

An important step in administering TST is to prepare the patient for the procedure and to educate him/her about TST and tuberculosis. Good communication skills can help TST technicians to build the rapport needed for the patient to be open to receiving information and instructions.

A. Skills that contribute to good communication

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

B. What is an open-ended question?

1. A question that cannot be answered with a simple "yes" or "no."
2. Questions that begin with words and phrases such as:
Who? What? When? Where? Why? How?
Tell me about... Explain to me...

C. Why are open-ended questions useful?

Open-ended questions are useful because they are more engaging and can lead to more information than questions that ask for "yes" or "no" answers; they help the TST technician get a clearer and fuller understanding of the patient's understanding of TST and TB.

EXERCISE

What are some examples of open-ended questions that you might ask a patient to assess his/her knowledge or beliefs about TST and TB?

D. Patient education

1. TST technicians are in a "frontline" position to educate patients about TST and TB. The purpose of TB patient information is to:
 - a. Provide information
 - b. Correct misinformation
 - c. Help allay the patient's fears about TST or TB
 - d. Help ensure the patient's cooperation with TST procedure and follow-up

2. How should the TST technician prepare the patient for TST?
 - a. TST technician introduces self and health department
 - b. Brief description of why TST is taking place
 - c. Brief overview of steps involved in TST, including follow-up visit for measurement
 - d. Explanation of consent form(s) and confidentiality policies
 - e. Screening/medical evaluation questions
 - f. Asking patient to share questions or concerns

3. Frequently Asked Questions (FAQs)

The following is a list of questions frequently asked by patients receiving TST. Some of the questions cover topics that should be addressed by the TST technician when he/she prepares the patient for TST. Some questions are based on common misconceptions about TST and TB, and they provide a good opportunity for the TST technician to share correct information.

- a. What's going to happen today?
- b. Why am I getting tested for TB?
- c. How would I have gotten infected with TB? I don't share my coffee cup with anyone at work.
- d. Do I have TB?
- e. Will this shot give me TB? HIV?
- f. Can I give TB to my family (friends, co-workers, etc.)?
- g. Should my family be tested?
- h. Wouldn't I feel sick if I was infected? I feel fine.
- i. Since I had BCG as a child, won't my TST always be positive?
- j. Why do I have to come back on Thursday? Why can't I check the reaction myself and call you?
- k. Why isn't everyone in the factory (office, etc.) getting tested?
- l. If I have TB, can I die from it?
- m. Will this hurt?
- n. If I've had a reaction to a TB test in the past, is it OK to get another one?
- o. Can I have a band-aid in case it bleeds?
- p. I had a TB test last month at my doctor's—I don't need another one, do I?

- q. _____

- r. _____

II. Working with culturally diverse populations

A. Why a session on cultural diversity?

1. TB affects a very diverse population.
 2. U.S. statistics: approximately half of all new cases are among the foreign-born.
 3. Local statistics
-
-

4. "Diversity" refers not only to race or ethnicity. In many communities, a large number of patients are among groups with special challenges, such as the homeless and substance users. Each group has their subcultures, differing from the American "mainstream" (dominant) culture.
5. Health workers need skills to be able to communicate effectively with people from many different cultural backgrounds.
6. Health workers need to identify the many factors that affect culture and determine a group's values and rules.

B. What is culture?

Definition of culture

ADAPTED FROM: NOEL DAY, POLARIS INSTITUTE

Culture is a group's design for living. It is the group's assumptions about the world, other people, and the goals and meanings of life. It is the group's assumptions about what is right and what is wrong—and its beliefs about how to behave and how to expect other people to behave in all of life's situations.

Culture is the integrated pattern of human behavior that includes thought, speech, action, and artifacts. It depends on the capacity of humans for learning and transmitting knowledge and values to succeeding generations. It takes into account the customary beliefs, social norms, and material traits of a racial, religious, or social group.

We look at other people through our own cultural lens. This means we often make assumptions about people on the basis of one or two characteristics. These assumptions are often culturally specific and come along with judgments. Once we have made a judgment (positive or negative) about someone, it will show in the way we communicate with that person. If our view is negative, this can interfere with building rapport and/or trust. As health workers, we are often put into positions of power over our clients, which impacts individuals from different cultures differently.

Culture gives you all of the answers—even when you don't know what the questions are!

1. Is there anything you'd like to add to the definition?
2. Health workers need to understand how culture influences how a patient hears and responds to information and requests from health care providers.

C. Cultural universals

1. Certain human activities are **universal**; that is, they are a part of every culture. This does not mean, however, that they are practiced in the same way, have the same value or meaning, or are not subject to change by forces outside the culture. Everyone eats, sleeps, build shelters, mates, raises their young, celebrates, and passes on their beliefs and values to the next generations. Knowing and understanding that there are many rich and diverse customs for all of these activities will help you to become more culturally competent.
2. The following is a list of basic life practices performed by members of many cultures:
 - age-grading
 - art / theatre / drama / visual
 - bodily adornment
 - child rearing
 - cooperative labor
 - courtship / dating
 - dancing
 - death / dying
 - education
 - ethics
 - etiquette
 - family feasts / celebrations
 - folklore
 - food / food taboos / meal times
 - funeral rites
 - games
 - gender roles
 - gestures
 - greetings
 - hospitality / holidays
 - housing
 - hygiene / health / cleanliness
 - joking
 - kinship / relatives
 - language / slang
 - law / authority / punishment / prison terms
 - literacy / aural
 - marriage
 - medicine / medical providers / healers
 - mind-altering substances
 - modesty / privacy about the body
 - music /songs
 - personal / family names
 - pregnancy and labor
 - pre-/post-natal care
 - problem-solving
 - property rights
 - puberty customs
 - religious beliefs / rituals
 - sexual customs / roles / restrictions
 - social organizations
 - sports
 - status differentiation / prestige / credibility
 - trade / economics / money / barter
 - visiting / socializing

D. Cultural identification

Primary dimension

The first way we can identify ourselves consists of individual characteristics that people are born with, and experiences that they have as infants and children. These are characteristics that we cannot change.

1. Age
2. Ethnicity/race
3. Gender
4. Language
5. Physical abilities and qualities
6. Sexual/affectional orientation
7. Childhood experiences and family factors
(family religion, place of birth and household location, family social class, parents' occupations, etc.)

Secondary dimension

The second way we can identify ourselves consists of characteristics or experiences over which individuals may have some control or choice; however, the level of control or choice can vary widely for each characteristic.

1. Education
2. Geographic location
3. Income
4. Marital/relationship status/history
5. Military experience
6. Parental status/history
7. Religion
8. Work experience
9. Current social class/class status history
10. Political affiliation/perspective

Third dimension

The third way we can identify ourselves is through characteristics that are most unique among individuals and are not shared by all populations.

1. Experiences with immigration, exile, refugees, etc.
2. Lifestyle (e.g., gay culture, new age)
3. Degree of acculturation/assimilation
4. Degree of recovery
5. Recreational drug use
6. Health consciousness
7. Gender identification/change in gender

Activity: Cultural identification

Refer to page 9, *Cultural Identification*. Within the three dimensions, select 6 or 7 different items and describe your own cultural identity in the space below.

Item	Your cultural identification
<i>Example: religion</i>	<i>Catholic</i>

E. Developing cultural competence

1. What is cultural competence?

Similar to developing any set of skills, becoming culturally competent is a **process**. We can view this process along a continuum. On one end of the continuum, when cultural competency is completely lacking, individuals or institutions can hold attitudes or practice policies that are harmful to clients. Along the way, as individuals or institutions gain awareness and understanding about cultural dynamics, competence increases. Full cultural competence is achieved when individuals or institutions not only accept and respect cultural differences, but also continuously seek new knowledge and strive to improve their approaches with clients.

2. How can health workers develop cultural competence?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

[Note: Guidelines for using an interpreter will be covered in Session 6.]

III. Working with patients with special challenges

Patients who are homeless and/or use substances face barriers to health care that are complex and difficult to overcome. These barriers are often made worse by the negative perceptions that mainstream American society holds against the homeless and substance users. Instead of compassion, people often feel annoyance or anger against patients with these special challenges.

A. What are special health care barriers for homeless and substance-using patients?

1. Lack of access to health care
2. Competing priorities (earning money, finding a place to sleep, acquiring substances)
3. Intoxication
4. Lack of stability; chaotic life circumstances
5. Distrust of authorities; legal issues
6. Denial
7. Blaming others for problems
8. Depression ("why bother?"); feeling overwhelmed by one's circumstances
9. _____
10. _____

B. What are *my* barriers to working with homeless and/or substance-using patients?

Activity: *Discussion in pairs*

It is difficult for me to work with people who are homeless because

It is difficult for me to work with people who use substances because

C. Community perceptions of homelessness and substance use

1	2	3	4	5
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

- _____ 1. People who use substances lack the willpower to stop. They have a character problem.
- _____ 2. People who use illegal substances should stop because they are breaking the law.
- _____ 3. Most people who are homeless wouldn't have to be if they were willing to work hard.
- _____ 4. Many people are homeless because they are alcoholics or drug addicts.
- _____ 5. Adults should have the legal right to use the drugs of their choice as long as they don't harm anyone else.
- _____ 6. Many people are homeless because they have mental illness.
- _____ 7. There are plenty of resources available to homeless people, but many homeless people are unwilling to utilize them.
- _____ 8. There are plenty of resources available to people who use substances, but many substance users are unwilling to utilize them.
- _____ 9. People who use substances have a chronic illness, not a moral weakness.
- _____ 10. People who use substances are exhibiting "bad behavior" that was learned in their families or communities.
- _____ 11. People who use substances have no concern for their health or welfare.

D. Learning more about homelessness and substance use

1. Who are the homeless in the U.S.?

ADAPTED FROM "WHO IS HOMELESS?" NCH FACT SHEET #3, PUBLISHED BY THE NATIONAL COALITION FOR THE HOMELESS, MAY 2004

AGE

In 2001, the U.S. Conference of Mayors' survey of homelessness in 27 cities found that children under the age of 18 accounted for 25.3% of the urban homeless population (U.S. Conference of Mayors, 2001). This same study found that unaccompanied minors comprised 4% of the urban homeless population. However, in other cities and especially in rural areas, the numbers of children experiencing homelessness are much higher. On a national level, approximately 39% of the homeless population is children (Urban Institute 2000). A 1987 Urban Institute study found that 51% of the homeless population was between the ages of 31 and 50 (Burt, 1989); other studies have found percentages of homeless persons aged 55 to 60 ranging from 2.5% to 19.4% (Institute of Medicine, 1988).

GENDER

Most studies show that single homeless adults are more likely to be male than female. In 2001, the U.S. Conference of Mayors' survey found that single men comprised 41% of the urban homeless population and single women 14% (U.S. Conference of Mayors, 2003).

FAMILIES

Families with children are among the fastest growing segments of the homeless population. In its 2003 survey of 25 American cities, the U.S. Conference of Mayors found that families comprised 40% of the homeless population, a definite increase from previous years (U.S. Conference of Mayors, 2003). On a national level, the numbers are higher: the Urban Institute found that children comprise approximately 39% of the homeless population (Urban Institute 2000). Research indicates that families, single mothers, and children make up the largest group of people who are homeless in rural areas (Vissing, 1996). As the number of families experiencing homelessness rises and the number of affordable housing units shrinks, families are subject to much longer stays in the shelter system. For instance, in the mid-1990s in New York, families stayed in a shelter an average of five months before moving on to permanent housing. Today, the average stay is nearly a year (Santos, 2002).

ETHNICITY

In its 2003 survey of 25 cities, the U.S. Conference of Mayors found that the homeless population was 49% African-American, 35% Caucasian, 13% Hispanic, 2% Native American, and 1% Asian (U.S. Conference of Mayors, 2003). Like the total U.S. population, the ethnic makeup of homeless populations varies according to geographic location. For example, people experiencing homelessness in rural areas are much more likely to be white; homelessness among Native Americans and migrant workers is also largely a rural phenomenon (U.S. Department of Agriculture, 1996).

VICTIMS OF DOMESTIC VIOLENCE

Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998). In addition, 34% of cities surveyed by the U.S. Conference of Mayors identified domestic violence as a primary cause of homelessness (U.S. Conference of Mayors, 1998). Studying the entire country, though, reveals that the problem is even more serious. Nationally, approximately half of all women and children experiencing homelessness are fleeing domestic violence (Zorza, 1991; National Coalition Against Domestic Violence, 2001).

VETERANS

Research indicates that 40% of homeless men have served in the armed forces, as compared to 34% of the general adult male population (Rosenheck et al., 1996). In 2003, the U.S. Conference of Mayors' survey of 25 American cities found that 10% of the urban homeless population were veterans—however, this does not take gender into account (U.S. Conference of Mayors, 2001).

PERSONS WITH MENTAL ILLNESS

Approximately 23% of the single adult homeless population suffers from some form of severe and persistent mental illness (U.S. Conference of Mayors, 2003). It is estimated that only 5-7% of homeless persons with mental illness require institutionalization; most can live in the community with the appropriate supportive housing options (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

PERSONS SUFFERING FROM ADDICTION DISORDERS

Surveys of homeless populations conducted during the 1980s found consistently high rates of addiction, particularly among single men; however, recent research has called the results of those studies into question (Koegel et al., 1996). Briefly put, the studies that produced high prevalence rates greatly over-represented long-term shelter users and single men, and used lifetime rather than current measures of addiction. While there is no generally accepted "magic number" with respect to the prevalence of addiction disorders among homeless adults, the U.S. Conference of Mayors' number was 30%, and the frequently cited figure of 65% is probably at least double the real rate for current addiction disorders among all single adults who are homeless in a year.

EMPLOYMENT

Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent (National Low Income Housing Coalition, 2001). In fact, in the median state a minimum-wage worker would have to work 89 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable housing (National Low Income Housing Coalition 2001). Thus, inadequate income leaves many people homeless. The U.S. Conference of Mayors' 2003 survey of 25 American cities found that 17% of the urban homeless population were employed (U.S. Conference of Mayors, 2003). In a number of cities not surveyed by the U.S. Conference of Mayors—as well as in many states—the percentage is even higher (National Coalition for the Homeless, 1997).

IMPLICATIONS

People who become homeless do not fit one general description. However, people experiencing homelessness do have certain shared basic needs, including affordable housing, adequate incomes, and health care. Some homeless people may need additional services such as mental health or drug treatment in order to remain securely housed. All of these needs must be met to prevent and to end homelessness.

REFERENCES

- Burt, Martha and Barbara Cohen. America's Homeless: Numbers, Characteristics, and Programs That Serve Them, 1989.
- Federal Task Force on Homelessness and Severe Mental Illness. Outcasts on Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness, 1992.
- Homes for the Homeless. Ten Cities 1997-1998: A Snapshot of Family Homelessness Across America.
- Institute of Medicine. Homelessness, Health, and Human Needs, 1988. Washington, DC: National Academy Press.
- Koegel, Paul et al. "The Causes of Homelessness," in Homelessness in America, 1996, Oryx Press.
- National Coalition for the Homeless. Homelessness in America: Unabated and Increasing, 1997.
- National Low Income Housing Coalition. Out of Reach: Rental Housing at What Cost?, 1998.
- Rosenheck, Robert et al. "Homeless Veterans," in Homelessness in America, Oryx Press, 1996.
- Santos, Fernanda and Robert Ingrassia. "Family surge at shelters." New York Daily News, August 18th, 2002.
- U.S. Conference of Mayors. A Status Report on Hunger and Homelessness in America's Cities: 2003.
- U.S. Department of Agriculture, Rural Economic and Community Development. Rural Homelessness: Focusing on the Needs of the Rural Homeless, 1996.
- U.S. Department of Agriculture, Rural Housing Service, Rural Economic and Community Development, Washington, DC.
- Urban Institute, The. A New Look at Homelessness in America. February 1, 2000.
- Vissing, Yvonne. Out of Sight, Out of Mind: Homeless Children and Families in Small Town America, 1996. The Lexington, KY: University Press of Kentucky.
- Zorza, J. "Woman Battering: A Major Cause of Homelessness," Clearinghouse Review, 25(4) (1991). Qtd. In National Coalition Against Domestic Violence, "The Importance of Financial Literacy," Oct. 2001.

F. Local resources for homeless and substance-using patients

Patients who face the special challenges of homelessness and/or substance use have a full range of needs: medical, social, economic, and psychological. Health care workers certainly cannot personally address all these competing needs, but can help communicate information about the patient's circumstances to other program staff. In turn, community resources can be identified to help the patient manage these issues. These resources can include: substance use treatment or rehabilitation centers; housing assistance organizations; HIV treatment programs; mental health programs; Veterans Administration facilities; harm reduction education; and job training.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Participant evaluation

Your feedback about this training session is important. Please read each statement and circle one number to indicate the level of your agreement/disagreement. Include any comments on the lines provided below.

Name _____ Date _____

Instructor _____ Session # _____

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

1. Topics are covered comprehensively. 1 2 3 4 5

2. Session meets its objectives. 1 2 3 4 5

3. Session length is appropriate. 1 2 3 4 5

4. The information is well organized. 1 2 3 4 5

5. The session maintained my interest. 1 2 3 4 5

6. The level of the material is appropriate. 1 2 3 4 5

7. The printed materials are useful. 1 2 3 4 5

8. The delivery of the material was effective. 1 2 3 4 5

9. I now feel more prepared to perform my TST duties. 1 2 3 4 5

10. Overall, the session was excellent. 1 2 3 4 5

What do you recommend to improve this session? _____

What additional training do you need? _____

Other comments: _____