

SOCIAL SUPPORT SERVICES FOR TUBERCULOSIS CLIENTS

CHARLES P. FELTON

**NATIONAL
TUBERCULOSIS
CENTER**



AT HARLEM HOSPITAL

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
CDC	Centers for Disease Control and Prevention
DOT	directly observed therapy
HIV	human immunodeficiency virus
SSA	Social Security Administration
SSD	Social Security Disability (Federal entitlement program)
SSI	Supplemental Security Income (Federal entitlement program)
TB	tuberculosis

I. INTRODUCTION*

Tuberculosis (TB) treatment is inextricably involved in a host of psychological, social, and economic problems that interfere with the ability of TB clients to complete treatment. Clients' problems often take priority over TB treatment and potential cure. A client whose days and nights are spent in finding the means to obtain drugs will have difficulty in adhering to medical treatment. Psychiatric problems may prevent a client from understanding his condition and the need for a structured, prolonged course of medical treatment. For many people, making it through the day may be filled with so many hazards that dying of TB seems a distant threat. To help these clients with their problems, the provision of social support in a TB clinic is an essential component in reducing clients' personal and environmental problems and thereby increasing TB treatment completion rates. This *Guide* is to help providers establish and enhance social support services in a TB clinic.

Clinics vary greatly in the number of clients served and in the amount of available resources. Providing social services via certified social workers may not be fiscally feasible. Case workers, directly observed therapy (DOT) workers, outreach workers, or nurses may need to provide social support services. Therefore, throughout this Guide, "worker" is used to designate the provider of social services.

** Note: In the text, the masculine gender is used for the client; in the case history, the feminine.*

II. OBJECTIVES

The purpose of this Guide is to help the worker:

- Establish social services
- Develop a therapeutic alliance with clients
- Create an Intake Form to identify barriers to TB treatment and formulate goals to reduce those barriers and increase client functioning
- Counsel and help clients achieve their goals
- Form support groups
- Lead or participate in case management

III. METHODS

Workers should assess all TB clients to identify problems and to develop treatment goals and the means to achieve those goals. To ensure that each client is assessed:

- The social service office should be located in a prominent part of the clinic and clearly be identified; clients should feel comfortable in accessing services.
- Medical providers and nurses should refer all clients to the worker providing support services as part of written clinic protocol.
- If a client does not want to see a worker when first approached or if all workers are busy at the time, the staff member should fill out a referral form, including the date, client's name, chart number, address, phone number, presenting problem, (e.g., client needs housing) and the name of the referring person. The worker can thus independently approach the potential client at this and future visits. An example of a referral form can be found in Appendix A.
- Workers should regularly give approximately 15 minute presentations about social services to clients in the clinic waiting area; these should include an introduction by the speaker, the mission of the clinic, an overview of services, and a period for questions and answers; an example of an outline for a presentation can be found in Appendix B.

The worker's interventions are based on the development of a therapeutic alliance or helping relationship with the client that identifies problems and ways to resolve them. This relationship begins with the first encounter, even if it is a brief introduction. At this first meeting, the worker needs to convey empathy to the client through verbal and nonverbal responses such as reframing (repeating in different words what the client has said), reassuring him that he was heard, facial expressions, and body language. In addition to counseling, the worker uses intakes and referrals as tools to help clients.

A. Intake

In certain situations, the worker will have an opportunity to undertake a full biopsychosocial assessment. In other circumstances, a client may seek a worker for help with a specific problem, e.g., housing. The worker will need more information to be able to understand and help the client in a holistic manner. After addressing the presenting problem, the worker should complete a full biopsychosocial intake on the client at a time convenient to both. A biopsychosocial intake is a means of assessing the client's medical condition (bio) and life circumstances, based on psychological (psycho) and environmental (social) factors, as well as the worker's own observation. This assessment is conducted to identify goals. Some important aspects to remember are:

- The intake is a means to establish a therapeutic alliance with the client and should be conducted in a private setting.
- If the client does not want to answer any question, that choice should be respected.
- The client must be reassured that all answers are kept confidential; if confidentiality cannot be guaranteed, the question should not be on the intake; an example of a question that might raise such problems is immigration status.

- The worker may identify observable problems about which the client is in denial; for example, the client may want housing services, but denies any alcohol use even though there is a strong smell of alcohol on his breath. The discussion of alcohol dependency should be noted as a treatment goal and a potential barrier to treatment completion.

Below is a description of the information to be collected from the client on the intake form (Appendix C) and guidance on how to utilize this information.

SECTION I: PATIENT INFORMATION

The purpose of the questions in this section is to gather core information about the client that will be needed for most standard applications for assistance. The questions should be asked in a matter-of-fact manner to put the client at ease before asking the more personal questions which follow. From this section one learns:

- The client's living situation and gains insight into the strengths and weakness of his support system
- The client's country of origin, job skills and work history, which are pertinent in determining eligibility for entitlements and referrals
- The client's financial supports or lack of them
- The client's medical condition, including whether he has TB disease or infection, human immunodeficiency virus (HIV) infection, or other medical complications (This information may have to be verified by the treating medical provider or from the medical record.)

In filling out this section, one should keep in mind:

- The client's marital status is not asked for on this form as many clients and professionals feel this question is too intrusive and unnecessary. The intake form is structured so that information on relationships and significant others can be found in questions about contacts and household composition. If the client discloses marital status, it should be noted.
- The primary medical purpose is the completion of treatment for TB. If the client is an undocumented immigrant or has an outstanding police warrant, these matters should be left to the proper government agencies. If the client distrusts the clinic staff, he may stop receiving treatment. This situation may lead to the community being exposed to someone with infectious TB.
- A client who is infected with HIV and has TB disease fulfills the diagnosis criteria for AIDS, as defined by the Centers for Disease Control and Prevention (CDC). This can have an emotional impact and may affect his eligibility for certain entitlements. If the client's HIV status is unknown, he should be referred for HIV counseling and testing, as HIV status is important in making decisions about medical treatment and may affect long term outcomes for the client.

These factors will be part of the assessment and social work treatment plan.

SECTION II: REASON FOR REFERRAL

In this section, the worker learns why the client is asking for social support services, the client's motivation at this particular time, and the referral source so that one may confer with that person at a later time. The client may have been referred as per clinic procedures or have been self-referred. The client, however, may also be in a crisis situation. A case history is presented here to illustrate some of the issues that arise in an intake, and ways the worker may respond to them are suggested.

Case History: Ms. H

Ms. H is a 36-year-old woman, recently diagnosed with TB who has just received a notice terminating her public assistance case. The client has sought out a social worker because she feels overwhelmed. One may have to use crisis intervention techniques of immediately working on this problem and only ascertain the information related to the crisis. The rest of the intake may be completed later. Ms. H says she has food and some savings. She is tearful and feels a need to share her frustration. The worker assesses that Ms. H needs to talk and be listened to. The intake, therefore, can proceed, as long as the worker is cognizant of her emotional state and responds with empathy.

SECTION III: PSYCHOSOCIAL HISTORY

In this section, the worker obtains information about the client's background and development, including, but not limited to, such factors as childhood abuse, serious past illnesses, psychiatric problems, chemical dependency history, participation in substance use treatment programs, and history of incarceration. This information gives the worker insight into the client's current psychosocial problems. Many clients may feel uncomfortable in giving this information at first, so it is important not to push the client on these questions. Once the worker gains the client's trust, the client will eventually fill in these gaps.

Case History: Ms. H

Ms. H states that she had a very happy childhood but that her parents are dead and she has lost touch with her two brothers and three sisters. She has two children, a ten-year-old boy and an eight-year-old girl, both in foster care. She says she was a good mother, but troublemakers took them away. While she is not allowed to visit them, she expresses a wish to be reunited with them and asks the worker to help her attain this goal in the future. She does not know where their fathers are. She says she feels very lonely. She denies any use of drugs but admits to drinking wine on occasion. She has never been in trouble with the law. She states emphatically that she is a mature woman who deserves more respect than she gets.

SECTION IV: CURRENT LIVING SITUATION AND FUNCTIONING

In this section, the worker and client determine the problems which are most immediately affecting him and which might interfere with his TB treatment. The client could admit to injecting heroin and feel that spending his time getting money and seeking a source for the drug is more important than taking TB medication. He may admit to being tired and ask for a referral to a facility for detoxification from drugs or a methadone program. He could admit to being homeless, having no means of economic support, no family or friends, and feeling depressed. The information here will make up the immediate goals in the treatment plan.

Case History: Ms. H

Ms. H says that her most pressing problem is her public assistance case. She says her worker is really out to get her. She states she is afraid of having no food to eat and being evicted from her apartment. She again denies any alcohol or drug use. She says that sometimes she gets sad, but she likes to take walks and that cheers her up. She also says that she has two close girlfriends that she can talk to any time. She claims that she wants to work and would like to work in a store because she likes meeting people. She confides that she has a boyfriend who really loves her, but he is in jail. They write each other at least every week. He will be out of prison about the time she finishes TB treatment, so she wants everything to be right by the time he gets out. She hopes to marry him.

SECTION V: ASSESSMENT

In this section, the worker gives an impression of the client in which specific examples of the client's characteristics are given, as opposed to the worker's subjective feelings. To say a client is not well dressed does not add to the clinical impression. If a client has poor hygiene, one might need to report that the client's clothes were wrinkled and soiled, that his face was dirty, and he had a strong body odor. Thought disorders, memory lapses, statements that the client feels persecuted, a depressed mood, flat or discordant affect, discrepancy in answers to questions, expressions of hostility to worker or people in general are important measures of the client's mental state, ability to get along with others, and motivation for overcoming barriers to treatment completion.

Case History: Ms. H

Ms. H is very verbal and emotional in her expressions. She conveys a sense of immediacy to her problems and is often tearful. When she entered the worker's room her gait was unsteady and there was a strong smell of alcohol on her breath. She occasionally repeated herself and sometimes seemed to forget what she was saying. She continually emphasized that she never did anything wrong but that all her problems were caused by others. She claimed that she likes people but admitted to being lonely. Her explanation of why her children are in foster care is vague, leading one to feel that she is selective and secretive about what she says. She appeared to be in denial of a problem with alcohol use. All these factors call into question her insight into her problems and her ability to cope with what's going on in her life. However, she has come for help, is being cooperative, and has a need to talk — which are positive signs of motivation for change. Ms. H has many potential barriers to completing treatment but many signs that she can be helped. It will just take a lot of effort on the worker's part.

SECTION VI: PLAN

Treatment goals are developed from information the client gives to the questions in the previous sections of the intake and the worker's own assessment of the client's problems and motivation for help. A client who appears to have altered mental status and claims to live on the street, may not be ready for a referral to housing services where he would have to manage his own apartment. The plan is divided into short-term goals (removing the barriers that have an immediate impact on his TB treatment) and long term goals that will need to be worked on over time. The goals should be written as a list, in order of priority:

Short term goals:

- Refer to detoxification from drugs/alcohol
- Refer to public assistance for income support
- Find emergency housing
- Refer to psychiatry for evaluation
- Refer for HIV counseling and testing
- Counsel as needed

Long term goals:

- Refer to long term treatment for people diagnosed with a psychiatric condition and/or chemical dependency
- Find stable housing
- Counsel as needed

This plan will be modified as new circumstances arise or more information is found out about the client.

Case History: Ms. H

Ms. H will need to have her public assistance case reopened and her housing situation put on a firmer footing. She masks many of her problems through rigid denial, magical thinking, and other maladaptive defenses. These mechanisms have allowed her to cope with a difficult life, and the worker needs to be careful in his/her interventions, as there is a risk that upsetting the balance of her defensive behavior may do more harm than good. Her treatment will depend on the ability of the worker to gain her confidence. If this confidence is gained, the issue of her alcohol use may be explored. Her situation with her children in foster care needs to be clarified and, if realistic, an effort to contact the foster parents through child welfare can be made. While there are many ways to help her increase her functioning in her environment, the worker needs always to focus on her completion of TB treatment.

B. Ongoing counseling and treatment

Ongoing counseling and treatment is the process by which the treatment goals of the intake are achieved. Appendix D is a form that can be used to record referrals, the means used to attain a goal, and the outcome. Appendix E has Fact Sheets on Entitlements and tips on how to refer clients to these agencies. The worker must find out the actual referral process from each specific agency. (The telephone book and phone are good starting points.)

Treatment builds on the therapeutic alliance previously established to help the client remove the barriers to TB treatment and increase his ability to deal with his environment. Besides supportive counseling, the worker must make referrals to the appropriate programs and advocate for the client with these agencies to ensure that their help is obtained, as often clients are poor advocates for themselves or have insufficient frustration tolerance to deal with the bureaucracies involved in applying for services.

Some counseling sessions may consist of referring clients to housing services, drug treatment programs, or legal aid for problems ranging from eviction proceeding to criminal actions. At other times, clients will need to “vent” or share their anger and frustration about relationship problems, self-destructive behavior, past trauma, and depressive feeling of helplessness and hopelessness. While treatment should last until clients finish TB therapy, some patients may be so fragile that after-care treatment is appropriate or a referral to a mental health program may be necessary.

Case History: Ms. H

The worker was able to open Ms. H's public assistance case after writing numerous letters and speaking with several caseworkers and supervisors at the local Human Resources Administration. As Ms. H became more trusting of the worker, she started to reveal more of her personal life and problems. She admitted that her children were taken away at birth because they tested positive for cocaine. While she still expressed a strong desire to raise her children, she had no plans to be reunited with them. She felt the “cards were stacked against her” and therefore just gave up. She claimed that she stopped using drugs years ago. The worker, however, now felt comfortable in bringing up Ms. H's alcohol use. While initially denying this, she later admitted it and promised to think about going into a program. Ms. H's appearance started to improve and she was neater and wore more attractive clothing. She maintained that she was determined to get a job and work and not be dependent on public assistance. Ms. H came often to visit her worker and felt supported. She was 100% adherent with TB treatment after having several treatment interruptions in the past. She said that completing TB treatment was one of her proudest accomplishments. Later, Ms. H became a volunteer at the clinic.

C. Support groups

Support groups can be an important factor in helping clients complete TB treatment, while addressing psychosocial issues. By its very nature, a TB mutual support group has the potential to mitigate the stigma often associated with TB disease. The group can universalize individual problems, reduce isolation, promote socialization, and increase problem-solving abilities. Appendix F is a sample flyer for a TB support group.

TB education is an integral function of group work. Important topics for discussion are the difference between TB disease and infection, how TB is transmitted to others, and concerns family members have about the risk of contracting TB. Sometimes it may be appropriate, if the group as a whole consents, to include family members in educational sessions.

Moreover, in TB support groups certain potentially sensitive issues arise, such as someone's HIV status. While often most group members are supportive, there are individuals who will make judgemental statements. Another potential area of conflict is between members who are drug or alcohol dependent and those who are not. The group leader will need to use his/her skills to focus the group on its supportive nature and safe environment. Appendix G suggests group guidelines, including responsibilities of participants and facilitators, an agenda, and documentation.

STARTING A SUPPORT GROUP

Criteria for membership:

- Diagnosis of TB or suspected TB
- Ability to perform group tasks
- Motivation for change

Exclusion criteria (see below under tasks of group facilitator):

- Behavioral problems incompatible with group norms
- Inability to tolerate group setting
- Friction with one or more group members

Tasks of group facilitator:

- Determine setting and size of group
- Obtain sanction of clinic staff
- Select, if needed, a co-facilitator
- Formulate guidelines and goals
- Select members based upon the above criteria
- Meet with potential group members to prepare them for group work
- Build a group's "culture", i.e., a safe place for members to speak
- Identify common problems and direct problem-solving mechanisms
- Schedule specific activities and guest speakers
- Determine the use of incentives (such as carfare or refreshments) based on clinic resources
- Maintain group confidentiality

IV. CASE MANAGEMENT

Case management is an interdisciplinary team approach to patient care. While case management may vary from agency to agency, depending on its structure and mission, the following model is presented as an effective method for monitoring and helping clients in a TB clinic.

A case management team may consist of representatives from the local health department, physicians and other providers, DOT workers who observe clients ingesting their medications and record adherence rates, nurses, and the workers who help patients with psychosocial problems.

The case management team usually meets once a week at a set time. A designated person presents cases for review. The criteria for presenting a case are:

- A newly diagnosed client
- Significant new problems, such as the client's hospitalization, disappearance, or evolving social issues
- A change in client medication
- Client's treatment completion

The presenter will give a summary of the client's case and medical background, and state the issues that need to be addressed. An example would be a client who is non-adherent to treatment. The physician would review the medical record and relate his/her own impression of the client, including his knowledge that the client complains about the burden of taking medication that only makes him feel sicker, that the client is a heavy drinker, and is homeless. The DOT worker would report on the client's adherence rate and divulge that the client is alternately hostile and defensive during their interactions. The nurse would confirm that the client is very impatient during clinic visits and sometimes abusive to staff. The worker would report on repeated attempts to engage the client to counsel him about his problems and offer to find him housing and any other services that were needed—all to no avail.

After this team review, the specific problems would be enumerated with ways to resolve them:

1. Problem: Non-adherence

Action: The health department would use its authority to inform him, either in person or in writing, of the seriousness of his non-adherence and the steps that might legally be taken to ensure treatment completion. (Clients who have documentation of continued nonadherence may be placed in a secured medical facility in some localities.)

2. Problem: Medication side effects

Action: The physician and DOT worker would continue to educate the client about the medications and monitor the client for possible side effects.

3. Problem: Disruptive behavior

Action: The client would be rapidly assessed in the clinic to minimize disturbances to staff and other clients.

4. Problem: Alcohol dependency and homelessness

Action: The worker would attempt to form a therapeutic alliance with the client. While the worker may start out by making himself/herself available as someone the client may talk to, the worker should try to gain the confidence of the client and be able to address the barriers—homelessness and alcohol dependency—and find means of making them less harmful to the client's TB treatment.

Case management is a holistic modality of seeing the client from different perspectives to solve treatment problems. Crucial to this method is the input, knowledge, and problem-solving skills of the worker providing social support services.

EVALUATION

The goal is completion of treatment for TB disease or infection. In any program offering social support services it is difficult to attribute positive outcomes to social support interventions alone. Social support services contribute to achieving the goal, working in concert with TB clinical, X-ray, laboratory and outreach staff. The following process indicators can be used to assess the quality and effectiveness of these services:

- Patient satisfaction with services
- Frequency of attendance at support groups
- Completion of referrals
- Adherence with treatment visits
- Adherence with directly observed therapy/directly observed preventive therapy (if applicable)

VI. SUMMARY

Most of the material covered in this *Guide* deals with the practicalities of establishing social services in a TB clinic. The role of the worker has been described in terms that may sound similar to a job description. However, the success or failure of the program outlined above depends on the intrinsic characteristics of the worker. The worker needs to gain the client's trust, emphasizing the confidential nature of the relationship and the information imparted. This means acceptance of the client as a valued person, worthy of helping. The worker should treat the client with respect, be an empathic listener, reflect concern over the client's condition, and help to find solutions to the client's problems, while promoting the client's own problem-solving abilities. The worker's ability and sincerity are the most significant factors in helping clients and making programs successful.

APPENDIX A

[Name of clinic]
REFERRAL TO SOCIAL WORK

Date _____

Time _____

Medical Record _____

Patient Name _____

Address _____

Phone _____

Diagnosis _____

Social Service Problem _____

Referred by _____

APPENDIX B

OUTLINE OF SOCIAL SERVICES PRESENTATION

A. Introduction: Welcome Clients to Clinic

- Introduce self (name and title)
- Name of clinic

B. Clinic Mission Statement or Statement of Purpose

C. Overview of Services

- Social service and group supportive services (i.e., individual and group counseling, referral for housing, drug treatment, etc.)
- Clinic services including business hours, staffing, TB education, and any features specific to your clinic

D. Questions and Answers

- Solicit questions from clients and answer questions in general terms
- Questions which are specific to any individual's medical or social needs should be addressed in an individual counseling session

E. Closing Statements

- Invite clients to visit the social services department or worker
- Reassure clients that the worker and other clinic staff are on duty to provide supportive and courteous service
- Distribute brochure about program and worker's personal business card

SOCIAL SERVICES INTAKE FORM

DATE: _____

I. PATIENT INFORMATION

Medical Record #: _____ Date of Birth: _____

Name: _____ Telephone: _____

Address: _____

Contact Person: _____ Contact Phone: _____

Relation of contact to patient: _____

Address of contact: _____

HOUSEHOLD COMPOSITION

Name	Gender	Age	Relation to pt.
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Birthplace: _____ Ethnicity: _____

Languages: Primary _____ Others: _____

Years of school: _____ Religion: _____

Social Security # _____ - _____ - _____ Have you ever worked? Yes No

Last time worked: _____ / _____ / _____ For how long? _____ Yrs.

Usual employment: _____

ENTITLEMENT/PUBLIC ASSISTANCE

PROGRAM	YES/NO	AMOUNT/NUMBER
HOME RELIEF/TANF	Y / N	\$
AIDS SERVICES	Y / N	\$
SSI	Y / N	\$
SSD	Y / N	\$
UNEMPLOYMENT	Y / N	\$
PENSION	Y / N	\$
MEDICAID	Y / N	#
MEDICARE	Y / N	#
(OTHER)	Y / N	

PERTINENT MEDICAL DATA

TB Diagnosis:

Treatment start date: _____ Completion date: _____

Other medical conditions:

Diabetes Hypertension Cardiac HIV infection

ETOH and /or drug use Smoking Cancer

Other: _____

II. REASON FOR SOCIAL SERVICES REFERRAL

(include presenting problem, precipitating factor, referral source)

III. PSYCHOSOCIAL HISTORY

(include if possible: family history, previous medical or mental health problems, history of chemical or alcohol dependency and institutionalization)

IV. CURRENT LIVING SITUATION AND FUNCTIONING

(include problems that interfere with the patient's ability to adhere to medical treatment, e.g., lack of housing, finances, transportation or social support)

V. ASSESSMENT

(include description of patient's appearance and mood, ability to relate to worker, cooperation, coping mechanisms, insight into problems, and motivation)

VI. PLAN

(include immediate goals and long term goals and prognosis)

Worker's Name and Title (Print)

Signature

APPENDIX D

SOCIAL SERVICES OUTCOMES

Patient's Name _____ Worker's Name _____

Date	Issue	Action Taken	Agency Contacted	Outcome

FACT SHEET – ENTITLEMENTS

ENTITLEMENT ACCESS SKILLS

- Knowledge of entitlements and skills in accessing them are an integral part of providing social services
- Entitlements are part of an assessment and treatment plan that reinforces the helping relationship between client and worker
- Develop a file and contacts for locating services
- Learn application procedures and process to prepare client
- Learn the referral process
- Advocate for client by following up referrals by phone call and letters
- Conduct visits to referral agencies and programs to observe their strengths and weaknesses
- Develop contacts at agencies with helpful people and gatekeepers
- Know and, when appropriate, use agency hierarchy and chain of command
- Understand appeals process if clients are denied services

FEDERAL PROGRAMS

While there are many entitlement programs, only those programs for people who are disabled and cannot work are described here. Many clients will have other kinds of entitlements, with which the worker should become familiar. The worker should obtain this information from the local Human Resources Department. The addresses and telephone numbers of agencies are listed in the government pages of the phone book. Medical conditions, that are considered to be disabilities, are defined by federal, state and local laws. To receive disability entitlements, the client must have one of these medical conditions *and* be unable to work. Applications for entitlements include sections to be filled out by the physician, stating the reasons the client cannot work.

Federal disability entitlement programs are very complex in administration, funding, and regulations. The federal government sets certain requirements nationally, but allows the states to administer the programs, set entitlement levels by supplementing the federal contribution, and determine optional services. The worker will need to get specific information from his/her state agencies. Again, the telephone book is a good place to start. The Social Security Administration (SSA) oversees these programs. The SSA can be reached at

1-800-772-1213 between 7:00 a.m. and 7:00 p.m. on business days.
Their web site is <http://www.ssa.gov>

SUPPLEMENTAL SECURITY INCOME (SSI)

- For people of any age who are disabled and cannot work
- Assets and income tested—limits vary from state to state
- Monthly cash grant—amount varies from state to state
- Federal program administered through state Social Security offices
- Disability determined by the state
- Financing through federal revenues with optional state supplementation

SOCIAL SECURITY DISABILITY (SSD)

- For people who have worked and paid into Social Security for a certain number of years
- For people who are disabled and cannot work
- Monthly cash payment—benefit is based on amount of money put into Social Security. If amount is lower than SSI award, recipient may apply to SSI to reach grant cap
- Federal program administered through Social Security offices; disability determined by the state

MEDICAID

- Income and assets tested health care coverage for “financially and medically needy” people of any age who are American citizens
- Clients on SSI receive Medicaid. If clients are not eligible for SSI, they can apply for Medicaid directly
- Federal program administered by state and local agencies; proportionately funded by government agencies on all three levels
- Varies significantly from state to state, locality to locality

MEDICARE

- Health care coverage for disabled people on SSD
- Benefit begins after 24 months on SSD
- Does not pay for prescribed medications

LOCAL ENTITLEMENTS**HOME RELIEF OR GENERAL ASSISTANCE**

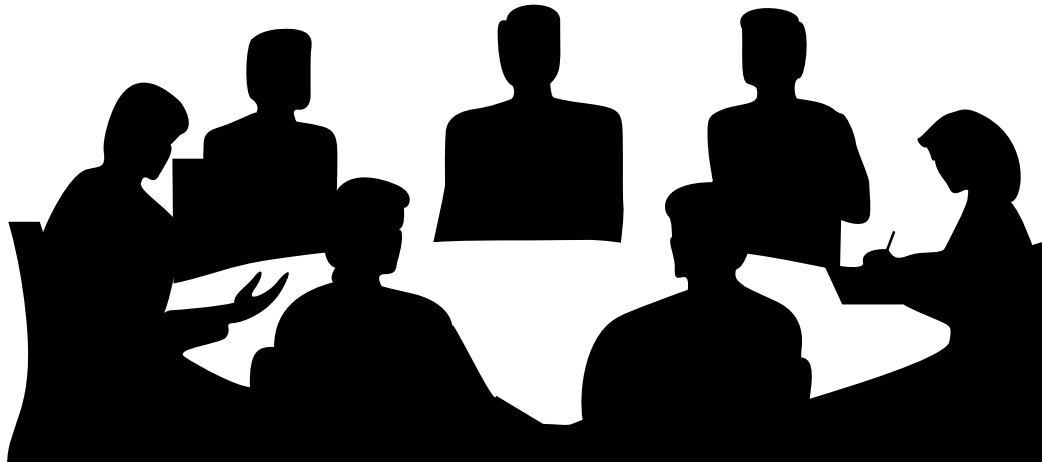
- Means tested state or local programs providing cash benefits to needy individuals who are disabled
- Most of these programs have job training and workfare components, except for people who are unable to work because of disability as defined by the agency

AIDS SERVICES

- Some cities have special services for people with AIDS that are separate from General Assistance. Since HIV infection in conjunction with TB diagnosis fulfills CDC AIDS criteria, these agencies are important resources

APPENDIX F

NEW SUPPORT GROUP FOR ALL PATIENTS ON DOT



LEARN ABOUT
TB disease, TB medications, staying healthy

GET SUPPORT
from other patients

GUEST SPEAKERS INCLUDE
doctors, pharmacists, public health advisors, etc.

REFRESHMENTS AND CARFARE AVAILABLE!!

WHEN: (date and time)

WHERE: (address of meeting place)

GROUP LEADERS: (names and telephone numbers of group facilitators)

NAME OF SPONSORING CLINIC

APPENDIX G

GROUP GUIDELINES

I. FACILITATORS' AND SPEAKERS' RESPONSIBILITIES

1. Be on time: lateness on the part of staff shows a lack of interest in the group and may lower group morale.
2. Maintain confidentiality: participants' issues should not be discussed in hallways, elevators or public spaces.
3. Facilitate meetings in a supportive, impartial and non-judgmental manner.
4. The facilitators and speakers should encourage group participation and feedback.

II. PARTICIPANTS' RESPONSIBILITIES

1. Keep confidentiality – "Whatever is said in this room, stays in this room."
2. Show respect for others by not interrupting someone who is speaking or by monopolizing the group's time.
3. Participants should arrive on time. However, a grace period can be given which is consistent for all participants.
4. Participants should not come to the group if they are high or intoxicated unless the issue is open for discussion.

III. GROUP AGENDA

1. Introduction of facilitators and speakers (participants should also introduce themselves).
2. Statement of purpose of the group: To provide TB and related health information and to develop problem solving and coping skills in a supportive environment.
3. Review of facilitator and participant responsibilities.
4. Summary of group topic and process which will vary weekly but may consist of group discussion, educational presentations, guest speakers, and any other activity for which the group feels a need.
5. Involve participants in planning for future activities and topics for discussion.
6. Involve participants in setting up and cleaning up the meeting room.

IV. GROUP DOCUMENTATION

1. Attendance sheet.
2. After the group is adjourned the facilitator should write a summary of the group's activities and responses from participants.

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