

## Q&A Summary

### ***Global Is Local! How Does Global Health Impact Us?***

June 12, 2019

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**Available On-Demand:** [optumhealtheducation.com/global-health-2019](https://optumhealtheducation.com/global-health-2019)

Answers provided by Dr. William Stauffer:

1. We treat our horses/donkeys routinely for prevention of strongyloides. Would these be the same that infect humans?

*Interesting question, I work with a lot of Vets on One Health issues (which I love because I am always learning something new...and this is a new one to me). As far as I know, S. stercoralis, the human species, is sometimes found in dogs, although not considered a reservoir generally (although some debate). I had to look up horses and donkeys but it looks like there are several species, most predominant S westeri. It doesn't look like it infects humans (although I don't think speciation is routinely done in humans, so it's possible, I suppose). Looks like it causes similar pathogenesis in horses as S stercoralis does in humans. Here is a good review of Strongyloides in different hosts: <https://www.cambridge.org/core/journals/parasitology/article/strongyloides-spp-infections-of-veterinary-importance/0E052A0C75B34441289883C1A4DDBC51/core-reader>.*

2. I have gone through the Hep B series three times and I am a non-responder. What are my options for protection?

*I would check with your provider; it depends on several factors. If you don't have an increased risk of infection, you wouldn't need to do anything. However, assuming you are a health care worker and are at increased risk and need to try to demonstrate protection, there are various approaches to try to get a person to convert. Most commonly, the series is repeated (although sometimes just trying a 4<sup>th</sup> dose works). If you are still negative, the CDC provides the below guidance. There are some "tricks" that can be tried as well (e.g. double dosing or using Twinrix) but for any approach, would consult your local ID expert.*

"If the test is still negative after a second vaccine series, the person should be tested for HBsAg and total anti-HBc to determine their HBV infection status. People who test negative for HBsAg and total anti-HBc should be considered vaccine non-responders and susceptible to HBV infection. They should be counseled about precautions to prevent HBV infection and the need to obtain hepatitis B immune globulin (HBIG) prophylaxis for any known or likely exposure to HBsAg-positive blood. Those found to be HBsAg negative but total anti-HBc positive were infected in the past and require no vaccination or treatment. If the HBsAg and total anti-HBc tests are positive, the person should receive appropriate counseling for preventing transmission to others as well as referral for ongoing care to a specialist experienced in the medical management of chronic HBV infection. They should not be excluded from work." (source: [http://www.immunize.org/askexperts/experts\\_hepb.asp](http://www.immunize.org/askexperts/experts_hepb.asp))

3. Please address the impact of the "anti" vaccine movements around the world. What are the results?

*I think this was in context of increased human mobility. This is fairly straight forward in the sense that the more susceptible people, and the greater the susceptibility of a population (less "heard immunity"), combined with the increased human travel/inter-mixing, the greater the probability of cases and outbreaks--ultimately leading to more morbidity and mortality that would otherwise be preventable as well as increase cost and burden to the health care and private sectors.*

4. What education techniques have you seen as most successful when working with diverse immigrant populations?

*This is a long answer and I can't cover the specifics in a short answer. However, we have created learning resources that are online that we use for residents, fellows and practicing health professionals. Here are a few:*

*--Open Access (<https://www.dom.umn.edu/global-medicine/education-training/free-educational-offerings>). This includes a course on palliative care across cultures that has approaches when working with patients who are making difficult medical conditions.*

*--We also created a documentary film that actually won a regional academy award for best documentary on refugee health (American Heart). Using footage from this we created several short films/learning exercises that address working in a more globally connected world, including this question: <http://www.medicinoboxproject.org>. The one I would highly recommend is the Crossing Cultures—LEARN. This is a 13 minute video with techniques for taking a history and negotiating a care plan with someone from another culture. It comes with exercises and can be used with groups (e.g. we use in our medical school and with residents).*

5. It's hard to find facilities for Travel Medicine, especially in NC. Why is that?

*I can't speak for every state/setting, but generally, it is difficult to make a travel clinic financially feasible. In many places (I believe in New York), insurance does not reimburse for travel medicine, so most of the cost is born directly by the patient. This is unfortunate, as travel medicine decreases morbidity and mortality related to travel, and likely would save insurers money in the end. I tell most people that providers who do travel medicine, do it because they enjoy it. In our model we have highly trained (ASTMH Certified providers) and do a high volume and our goal is generally to break even providing pre- and post- travel services (although Minnesota is a bit unique as most insurers reimburse for travel services in Minnesota). Our system has recognized the value it brings both in preventing disease but also in getting appropriate diagnosis and treatment for persons with travel associated infections/conditions.*

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