Tuberculosis Policy and Procedure Manual

2022

Georgia Department of Public Health
Division of Medical and Clinical Program Services
Tuberculosis Prevention and Control Unit

dph.georgia.gov/tuberculosis-tb-prevention-and-control

GEORGIA DEPARTMENT OF PUBLIC HEALTH

These guidelines were created to assist state, district and local health departments in controlling, monitoring, treating, notifying and testing tuberculosis (TB) disease and infection for the State of Georgia. It is not possible for any guideline to address all situations for individuals; therefore, clinical judgment must always be exercised. Tuberculosis standards have been well established by nationally accepted scientific authorities, such as the American Thoracic Society (ATS), the Infectious Diseases Society of America (IDSA) and the U.S. Centers for Disease Control and Prevention (CDC), as well as generally recognized TB control experts such as the National Tuberculosis Nurse Coalition (NTNC) and National Tuberculosis Controllers Association (NTCA). The standards of care for the medical treatment and control of TB are published jointly by ATS, IDSA and CDC. Georgia follows these national standards and recommendations and in addition, has state-specific standards for TB control and prevention. References to these standards are listed below:

Nurse Protocols for Registered Professional Nurses in Public Health, current edition. Located on the DPH web pages at
https://dph.georgia.gov/sites/dph.georgia.gov/files/TB%20Nurse%20Protocols%2020.pdf

Georgia Tuberculosis Reference Guide, current edition. Located on the TB web pages at
https://dph.georgia.gov/sites/dph.georgia.gov/files/TB-Pub-GATBReferenceGuide2020.pdf

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Table of Contents

F: Clinic Forms
Medical Delegation Signature Form – Form to be signed annually by local TB Program medical practice delegators and nursing staff practicing under the TB Nurse Protocol.
3121-R Tuberculosis Services - Required intake form of all TB clients, whether active TB disease or LTBI. Used to obtain demographic, medical history and TB history. This form can also be forwarded to delegating physician to consult with care of patient.
3126 Contact Investigation Report - Required form to track information of all contacts to a TB case. Information should then be entered into SENDSS. The goal is to document at least 10 contacts for each **infectious** TB case.
3130 DOT Medication Sheet - Required form to document all medication doses administered to a patient receiving Directly Observed Therapy whether active TB disease or LTBI.

3144 Active TB Treatment Plan - Required form completed by the healthcare provider in the TB program as well as signed by the TB patient. Outlines important educational information regarding TB such as infectiousness, medications, appointment adherence and legal action for non-adherence. Available in many languages on the TB website.
3609 LTBI Consent and Treatment Plan/ Consent for DOT - Required form completed by the healthcare provider in the TB program as well as signed by the LTBI patient. Outlines important educational information regarding LTBI such as signs/symptoms of active TB disease, medications, and the health department's contact info. Available in many languages on the TB website.
3609 TB Consent to Treatment - Required form completed by the healthcare provider in the TB program as well as signed by the TB patient. Outlines important educational information regarding TB such as infectiousness, HIV testing consent and link with TB and HIV, appointment adherence and legal action for non-adherence. Available in many languages on the TB website
3610 Video DOT Agreement – Required form completed by the healthcare provider in the TB program as well as TB patient prior to beginning Video DOT. The form discusses the parameters Video DOT can be discontinued, acknowledgement of the lack of security when using the internet and release of liability to the health department.
DOT Instruction Sheet – A tool that can be used by any provider of DOT. Can be especially helpful for new TB staff or non-health department workers administering DOT. Contains pictures of each 1st line TB medication, contact info for patient, DOT worker and TB Nurse Case Manager as well. (not required)
603 DOT Agreement – Required form to be completed by the TB patient, TB nurse and DOT provider. The form outlines the schedule for DOT, contact information and alternate arrangements if routine DOT cannot be completed as usual.
2nd Line Therapy Request – Form to be completed by TB nurse or Physician requesting 2nd line medications to treat a TB patient, whether active TB disease or LTBI. When submitting request please provide all documentation requested.
12 Points of TB Education – Handout that can be given to TB patients as a way to educate regarding TB. Points include differences between LTBI and active TB disease, importance of HIV testing, respiratory isolation, etc.

Case Review Form – Form to be completed by local TB staff in order to conduct yearly case review with State TB staff.
Cohort Review Presentation Form – Form to be completed by local TB staff to conduct yearly cohort review with State TB staff.
Patient Education Review of Systems Aid – Optional tool to use when asking TB patient about any side effects, adverse reactions experienced while taking medications. Can be used daily with each DOT appointment or as clinic visits are scheduled.
Refusal of HIV testing – Required form to document when TB patient chooses to opt out of HIV testing.
TB Flow Sheet – Optional sheet that can be used to summarize patient care while treatment being managed by TB program.
TB Risk Assessment – Form used to assist TB staff in determining a client's risk level for TB and whether an evaluation for TB is necessary. If a client is coming to the health department to obtain testing for school, work, etc the form also helps determine cutoff measurement for positive Tuberculin Skin Tests if a client has a positive reaction.
TB Symptom Screen – Form used by TB staff to document that a client has been evaluated for TB and any actions taken as a result. This completed form can then be forwarded to the client's employer, school or Primary Care Physician if necessary.
TB Symptoms and Risk Assessment Form – Form used by TB clinician to document a client's risk level for TB, evaluation for TB and actions taken as a result. This Form may not be forwarded to the client's employer, school or Primary Care Physician.
G: Georgia Official Code, Chapter 14, Title 31 – Most recent statute outlining Hospitalization for Tuberculosis.
H: Court Order Templates – Samples of Court Orders for TB patients for commitment, consent, emergency commitment, confinement, etc.
I: American Lung Association Alternative Housing Project for Homeless TB Patients in GA – Operational procedures manual (current)
J: GA DPH Laboratory Tests – List of lab tests performed by the GA Public Health Laboratory. Table includes order code, description, specimen requirements, test method, values, turnaround time, contact information and CPT codes.
K: Memo Regarding Notification to Persons Exposed to Tuberculosis – Memo drafted by Legal at GA State Office to address when TB staff may notify a contact that they have been exposed to TB, what TB staff should or should not say, and efforts that should be made to provide notice.

Mission and Responsibilities

Table of Contents

MISSION

The mission of the Georgia Tuberculosis (TB) program is to control transmission, prevent illness and ensure treatment of disease due to TB. This is accomplished by identifying and treating persons who have active TB disease, finding, screening and treating contacts, and screening high-risk populations.

The Georgia TB Program has the legal responsibility for all TB clients in Georgia regardless of who provides the direct services. TB services are available to all who fall within the service criteria without regard to the client's ability to pay. Tuberculosis services in Georgia are provided on a cooperative basis by local county health departments, district health offices, the private medical sector, other public agencies, and the Georgia Tuberculosis Program.

LEGISLATIVE AUTHORITY

Copies of the laws and regulations can be downloaded from these links:
Official Code of Georgia Annotated (O.C.G.A.) http://www.lexisnexis.com/hottopics/gacode/
Title 31-2A, 31-12-2, 31-12-4, and 31-14

Rules and Regulations: Department of Public Health, Tuberculosis Control, Chapter 511-2-3
https://rules.sos.state.ga.us/

REPORTING REQUIREMENTS

In Georgia, all persons with active tuberculosis must be reported immediately to the local county health department.

Physicians, hospitals, laboratories, and other health care providers are also required to report any of the following:

- Any child less than 5 years of age or younger with Latent TB Infection
- Any person diagnosed with TB disease
- Any person suspected to have TB disease
- Any person being treated with or prescribed two or more anti-tuberculosis drugs
- Any positive culture for *Mycobacterium tuberculosis*

HOW TO REPORT

- Report persons with active TB disease electronically through the *State Electronic Notifiable Disease Surveillance System (SendSS)*
- Complete a *Notifiable Disease Report Form* and mail in an envelope marked CONFIDENTIAL
- Call your local County Health Department or District Public Health Office
- If your County Health Department cannot be reached, call the Georgia Department of Public Health at 404-657-2634.

RESPONSIBILITIES OF THE STATE TB PROGRAM

STATE MEDICAL CONSULTANT

The State Medical Consultant responsibilities include:

- Providing medical consultation to district contract physicians, local health departments, and private physicians, other providers and agencies.
- Providing TB treatment recommendations upon request.
- Providing clinical updates to district contract TB physicians and district TB coordinators as needed.
- Reviewing all TB cases and suspects during state case/cohort reviews to ensure quality care and adequate/appropriate treatment regimens are delivered.
  Reviewing and approving all second-line TB medication requests.
- Reviewing, revising and updating *TB Nurse Protocols*, *Georgia TB Reference Guide* and the Tuberculosis *Policy and Procedures Manual* as needed.

EPIDEMIOLOGY

The State Epidemiology staff will:

- Collect, manage, analyze, and interpret TB surveillance and genotyping data to describe tuberculosis morbidity and mortality trends, demographic characteristics and risk factors of TB cases, the incidence of TB among high-risk populations and assist in the development of program policies and procedures.
- Manage state genotype database, notify districts of genotype clusters in their districts, conduct genotype cluster investigations, and recommend measures to control TB transmission.
- Monitor resistance levels to anti-TB drugs.
- Evaluate the implementation of core TB program strategies and attainment of program outcome measures. Some outcome measures include completion of therapy among active TB cases, directly observed therapy, completed contact evaluations, and completion of treatment for latent TB infection among contacts.
- Conduct TB outbreak investigations, other epidemiologic studies and evaluation of special project interventions.
- Review surveillance data for completeness, accuracy and timeliness.
- Review secondary data sources (e.g., hospital discharge summaries, AIDS registries, laboratory reports) in order to detect failure to report TB cases.
- Produce the annual *Georgia TB Report*, annual progress reports, program management reports and other statistical data.

STATE TB PROGRAM STAFF

The State TB Program staff responsibilities include:

- Formulating and distributing state tuberculosis guidelines, procedures and protocols based on best practices.
- Consulting with district health departments, correctional facilities, hospitals, and all other health care providers regarding general concerns relating to tuberculosis management and/or specific tuberculosis cases.
- Providing social service consultation and assessment on TB patients as needed.

- Maintaining lists of current educational materials and information regarding proper management and treatment of tuberculosis and act as a resource to provide these materials and information as requested.
- Maintaining the Georgia Department of Public Health tuberculosis website with current and accurate information.
- Conduct trainings for district and local TB staff and maintain up-to-date training tool kits.
- Provide program evaluation, technical consultation, and support
- Lead state case/cohort reviews.
- Maintain budget and financial data of all state and federal funds.
- Manage grant deliverables.
- Establish, update and maintain charts for all tuberculosis suspects and tuberculosis cases. Maintain medical records on TB cases for at least twenty-one years. Information should include *name, birth date, and county of residence, medications, drug susceptibility results, and record of disposition*.
- Obtain documentation for out-of-state TB cases and/or contacts and provide information to requesting district/county health departments.
- Maintain the TB patient management module of the State Electronic Notifiable Disease Surveillance System (SendSS) and monitor the status of immigrants and refugees in the Electronic Disease Notification System (EDN). Provide consultation and technical support to end users on these systems.
- Monitor accuracy of data, establish files and internal databases, back up files, enter data and maintain tuberculosis documentation.
- Facilitate the process for court-ordered treatment/confinement.
- Recertify covered entities for 340B TB drugs annually or as scheduled by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs.

RESPONSIBILITIES OF THE DISTRICT TB PROGRAM

DISTRICT HEALTH DIRECTOR

The District Health Director:

- Has the ultimate responsibility for ensuring appropriate TB management in their district. This includes implementing TB guidelines, policies, procedures, and protocols in county health departments within the district. Provide supervision and delegate activities to staff and may delegate certain medical acts such as tuberculin skin testing, venipuncture and sputum collection to trained unlicensed public health staff.
- Acts as mediator between health care providers, the local health department, the contract TB physician, and the state office to facilitate best practices for TB programs in the district.
- Produces and delivers health order directives as first legal step to ensure compliance for evaluation and/or treatment of tuberculosis.
- Develops and maintains a working relationship with the county's attorney, the sheriff's office, hospitals, and other community organizations in the district to facilitate access to needed resources, assist with patient adherence issues, and/or court-ordered therapy or confinement.

DISTRICT CONTRACT PHYSICIAN/CONSULTANT

The responsibilities of the District Contract Physician/Consultant include:

- Providing for the overall medical management of clients in the county health department TB programs. The physician/consultant must provide recommendations for clients within the specified time frame after referred; TB suspect/case within 48 hours, close contact to TB cases/suspects and all children within 48 – 72 hours, all other clients within two weeks.
- Conducting and participating in case/cohort reviews regularly.
- Maintain knowledge of current recommendations regarding the clinical management of TB disease and latent TB infection.
- Consult with the State TB Medical Consultant regarding the treatment of multi-drug resistant tuberculosis (TB resistant to at least isoniazid and rifampin) before prescribing second-line drug regimens.
- Monitor the care and treatment of clients with TB disease and latent TB infection being followed by private physicians. Consult as needed with healthcare providers to ensure appropriate medical treatment.
- When contract physician is not available, provide contact information for a back-up physician for consultation.

DISTRICT TB COORDINATORS

The responsibilities of District TB Coordinators include:

- Providing oversight, consultation, and assistance to county health departments.
- Providing consultation and assistance to other health care providers (e.g., hospitals, nursing homes, private physicians, correctional facilities, etc.) as needed.
- Collaborating with physicians, hospitals, substance abuse centers, correctional facilities, and community organizations to promote best practices, foster continuity of care, and provide needed social services for TB clients.
- Facilitating hospitalization and/or discharge planning with social worker and/or infection control nurse. Becoming a state certified TB Trainer and conduct *TB Skin Test (TST) Certification and Update* courses, Contact Investigation/Directly Observed Therapy courses, TB Case Management courses and other educational activities for public health staff, correctional facilities, and private sector providers within the district. Ensure TST certification is maintained by all public health staff who provide direct TB clinical services. Submit all rosters, evaluation summaries and registration forms to the State TB Program within two weeks of each class.
- Provide in-service training on tuberculosis to county health departments, local communities, and other agencies.
- Serve as the point of contact for counties needing emergency and long-term housing services for infectious, people without housing, or non-adherent clients. Identify and establish partnerships with local resources to provide placement as needed.
- Monitor the care and case management of all TB clients to ensure outcomes are achieved according to established state indicators and time frames.
- Develop district policies, procedures, and protocols to include an infection control plan for health departments under direction of the District Health Director.
- Promote and conduct regular case reviews with local staff and contract physician.
- Facilitate court-ordered TB treatment as needed.

- Attend and participate in conference calls, in-person meetings, state sponsored meetings and trainings in order to disseminate the information obtained to the county health department TB staff. Assign a representative to participate in these activities if the coordinator is unable to participate. Promote and conduct program evaluation activities.
- Perform chart audits and send summaries of findings to the State TB Office.
- Promote and attend state case/cohort reviews.
- Maintain a current listing of all Public Health TB facilities that receive TB drugs through the 340B TB Drug Pricing Program. Include the National Provider Identifier (NPI) numbers, the physical address of the facility and information regarding the contact person (e.g., name, title, phone/fax numbers, email address, etc.) who will verify 340B TB status during the State TB Office recertification period, unless a District pharmacist or pharmacy technician is already maintaining this listing. Maintain records and ensure proper documentation of all clients receiving 340B TB drugs.
- Coordinate the submission of patient data to the state office. The state patient records should mirror the district patient records.
- District Coordinators are to submit to the State TB Program the following information on all TB cases and suspects including but not limited to:
    - Consent and treatment
    - Physicians' notes
    - Progress reports
    - Admission and discharge summaries
    - Bacteriology results and laboratory reports
    - Radiology results
    - Any additional supporting documentation
- District coordinators should refer to the case management timeline for a complete list of time-sensitive case management documents to report to the state office.
- Submit Grant-in-Aid information to the State TB Program regularly. Grant-in-Aid quarterly reports are due on the 15th of the month following the end of each quarter. Grant-in-Aid annual report is due by July 15th of every year.

RESPONSIBILITY OF THE COUNTY TB PROGRAM

County Health Departments are responsible for the medical supervision and case management of all known TB cases and suspects in order to prevent the spread of tuberculosis within their county.

TB NURSE

The TB Nurse's responsibilities include:

- Collaborating with local physicians, local hospitals, substance abuse centers, correctional facilities, and community organizations to promote TB education, best practices, foster continuity of care, and provide needed social services for TB clients.

- Facilitating hospitalization and/or discharge planning with social worker and/or infection control nurse.
- Provides tuberculin skin testing as requested.
- Collaborates with community organizations and facilities to perform targeted high risk TB screening and education about TB.
- Ensures submissions of all isolates from local hospitals and laboratories to state laboratory for genotyping.
- Upon notification of a TB case/suspect, performs a home visit within 24 – 48 hours to assess the home environment for home isolation. If the patient is hospitalized, the home visit may be done within 24- 48 hours after discharge. Legal agreements and consents should be signed at this time.
- Provides case management and follow-up of all known TB clients (cases, suspects, contacts, LTBI) to ensure timely and appropriate treatment.
    - Appropriate treatment on the recommended four drug therapy should be initiated and treatment completion obtained be within 12 months, unless medically indicated otherwise.
    - TB clients will be assessed for adverse reactions to medications at every encounter.
    - Clinic visit, clinical status, and adherence shall be monitored and documented monthly.
    - Directly observed therapy (DOT) is the standard of care for all TB cases, children under 4 years of age and younger with active TB disease or LTBI, and for all HIV-infected persons with active TB disease. **DOT is no longer required for all HIV-infected persons on daily INH regimen.**
    - Documentation of the conversion of positive cultures to negative.
    - Drug susceptibilities will be completed on all initial specimens.
- Cooperates with and assists private physicians treating tuberculosis clients. Obtains information from physicians assuring the private provider completes the *Initial Report on Clients with TB* (form 3141) and *Follow-up Report on Clients* (form 3142) monthly.
- Facilitates the enforcement, when necessary, of tuberculosis laws and regulations to protect the health of the public.
- Perform thorough contact investigations to elicit and evaluate identified contacts. Infected contacts should be started on appropriate therapy with completion of treatment within 12 months.
- Provides documentation for and participates in local, district and state case reviews, cohort reviews, chart audits and other program evaluation activities.
- Receive reports of TB suspects/cases from other health care providers and promptly submit these reports (physicians' notes, progress notes, admission and discharge notes and bacteriology and radiology results) to the district TB Coordinator.

COMMUNICABLE DISEASE SPECIALIST (CDS)/OUTREACH WORKER (ORW) (*If the county does not have CDS/ORWs, the TB Nurse is responsible for these duties*)

CDS/ORW is responsible for the following duties:

- Assist with contact investigations for cases and suspects to elicit and evaluate identified contacts.

Provide tuberculin skin testing, venipuncture and sputum collection if properly trained and these acts are delegated by the District Health Director.

- Provide DOT. TB clients will be assessed for adverse reactions to medications at every encounter. In the event of an adverse reaction, medication should be discontinued, and the TB Nurse contacted immediately.
- Follow-up with and locate TB clients who miss appointments.
- Coordinate transportation of TB clients for clinic appointments.
- Educate communities, clients, and families about tuberculosis.
- Provide reports to TB nurse and/or the district TB coordinator as requested.

NATIONAL TB INDICATORS

For tuberculosis (TB) programs, quality of care is measured by means of objectives and standards. Such objectives and standards are used as yardsticks to direct the program and measure its success. Objectives reflect outcomes or results and program desires. Programs require objectives to define expected outcomes and results for case management activities. Standards are an accepted set of conditions or behaviors that define what is expected and acceptable regarding job duties, performance, and provision of services. The TB control program works to achieve objectives through a series of standards. National TB indicators and State targets can be found in *Appendix A*.

Medical Records and Surveillance

Table of Contents

MEDICAL RECORDS AND SURVEILLANCE

All tuberculosis records are confidential. Their release to health and non-health agencies (excluding agencies within DPH) and Quality Service Agreements should be made only with a signed authorization to release information. Health Insurance Portability and Accountability Act (HIPAA) guidelines must be followed. Public Health does have some exceptions. See letter from Commissioner of Public Health on following page. Additional information about HIPAA is available on the **G**DPH website: http://dph.georgia.gov/notice-privacy-policies.

The District TB Coordinators are to coordinate the submission of patient data to the State office. The state patient records should mirror the district patient records.

RETENTION OF MEDICAL RECORDS

The Georgia Archives maintains the record retention timelines and is located at https://www.georgiaarchives.org/records/retention_schedules

Record Title	Description	Retention
Cases/Treatment	All documents relating to health services provided to tuberculosis patients; "cases" includes those clients with active TB infection and/or with latent TB infection (LTBI) and an abnormal chest x-ray	21 years from the date of the last service
Tuberculosis Records (Negative x-rays)		10 years from end of calendar year in which the x-ray was taken
Tuberculosis Records (Positive x-rays)		10 years from end of calendar year in which the x-ray was taken
Tuberculosis Records (Prophylaxis/ Prevention)	All documents relating to health services provided to tuberculosis clients; "prophylaxis" includes those clients with LTBI and a normal chest x-ray	21 years from date of last service

TB SURVEILLANCE

STATE ELECTRONIC NOTIFICATION DISEASE SURVEILLANCE SYSTEM (SendSS)

Approved users of the TB module in the State Electronic Notification Disease Surveillance System (SendSS) can report TB cases, TB suspects, LTBI in children younger than 5 years old, and contacts of TB cases, electronically at https://sendss.state.ga.us

Update the case verification status of all TB suspects in SendSS as a verified TB case or not a TB case within 90 days from the date of report.

REPORTING AND COUNTING CASES OF *M. TUBERCULOSIS*

The District TB Coordinator or designee shall report new suspects/cases of tuberculosis within 24 hours of notification to the State TB Program office using the TB patient management module in SendSS. The State TB Program reviews each TB case to ensure that it meets CDC's surveillance case definition criteria. All cases that meet the surveillance definition of a verified TB case and cases whose TB diagnosis are certified by a licensed health provider are included in Georgia's annual TB morbidity count. Timely reporting of information is imperative to ensure that all verified cases are counted in the year the patient's diagnosis was verified.

Information concerning TB/HIV co-infected patients, MDR cases, airline flight exposures, clusters of TB cases, children suspected of, or diagnosed with TB, or any instance that might precipitate media attention, is to be immediately reported to the District TB Coordinator who will in turn, report it to the State TB Program office.

CRITERIA FOR TB SUSPECT

TB suspects are persons for whom there is a high index of suspicion for active TB (e.g., a known contact to an active TB case or a person with signs or symptoms consistent with TB) who is being evaluated for TB disease. A TB suspect may be referred to as Class V TB. Any pediatric **TB suspect under 5 years of age should be IMMEDIATELY reported to the State Medical Consultant for evaluation by the District TB Coordinator.**

The TB suspect will have a prescription for two or more TB drugs and one or more of the following:

- Signs/symptoms of tuberculosis
- Positive AFB smear
- Abnormal chest x-ray
- History of exposure to tuberculosis

- Initial sputum reports, microbiology reports, prescriptions, chest x-ray reports and other provider notes are reviewed by the State Medical Consultant. If the client meets the above criteria, they will be placed on the State TB Program's active suspect list. TB suspects from districts with contract physicians are placed on the list based on recommendations from clinic notes. State TB Program staff enter refugees and immigrants with a Class B1 or B2 (non-LTBI) status as TB suspects in SendSS and county health departments should complete their evaluation within 90 days of arrival in Georgia to rule out TB.

CASE DEFINITIONS

- **Laboratory confirmed case**: Isolation of *M. tuberculosis* complex from clinical specimen by culture, or demonstration of *M. tuberculosis* from a clinical specimen by nucleic acid amplification test.
- **Clinical case:** In the absence of a laboratory confirmation of *M. tuberculosis*, a person must meet all the following criteria to be considered a clinical case of tuberculosis:
    - Positive tuberculin skin test or IGRA
    - Signs and symptoms compatible with TB (e.g., abnormal chest x-ray, abnormal chest CT scan, or clinical evidence of current disease such as fever, night sweats, cough, weight loss, hemoptysis)

- Receiving treatment with two or more anti-tuberculosis medications.

- **Provider Diagnosis:** If a case does not meet the laboratory or clinical definition, the case may be counted as a verified case of TB by provider diagnosis if clinical evidence of TB is present and a client shows clinical improvement with TB medications.
- **Recurrent TB cases:** New record in SendSS should be created for all recurrent TB cases, whether the recurrent case occurred 12 months before or after treatment completion or closure from supervision by a county health department. However, a case should not be counted twice within a 12-month period. An active TB case diagnosed in a previously verified TB case within 12 months after completion of therapy or after being closed to supervision is not counted as a new case for surveillance purposes. Active TB diagnosed in a previously verified TB case should be counted as a new case if more than 12 months has elapsed since the patient completed treatment or was closed to supervision by the county health department.
- **Non-tuberculous Mycobacterial Disease (NTM): A** person who has disease attributed to or caused by NTM only; should not be counted or reported as a case of tuberculosis. A person who has tuberculosis disease diagnosed with both *M. tuberculosis* and other NTM shall be counted and reported as a case of tuberculosis.
- **Tuberculosis case diagnosed after death**: Tuberculosis cases reported to health departments should be reported and counted as a case if evidence of current disease was present at time of death.

REPORTING LATENT TB INFECTION (LTBI)

Any pediatric suspect for LTBI under **five (5)** years of age should be **IMMEDIATELY** reported to the State Medical Consultant for evaluation as well. The finding of latent TB infection (LTBI) in a child less than **five (5)** years of age is a reportable disease. When LTBI in a child less than five years of age is reported, public health personnel will initiate a contact investigation to identify the source of the infection, recommend treatment for latent TB infection, follow-up with the child to ensure completion of LTBI treatment by directly observed therapy, and monitor for development of active disease. Early identification of TB infection and treatment in children can prevent progression to active disease. The contact investigation of a young child with LTBI may identify a previously undiagnosed and untreated case of active TB.

SendSS REPORTING REQUIREMENTS AND TIMELINES FOR TB CASES AND TB SUSPECTS:

- The patient's basic demographic information (name, birth date, age, sex, race/ethnicity, address, **etc.**) will be entered in the Patient tab of the SendSS within **one business day** after public health (county, district or state level) is notified of a TB suspect/case started on treatment for active TB. Other data in the Patient tab that are not available at time of notification will be updated in SendSS within **one to three business days** after the missing data are received by the end user responsible for data entry in SendSS.
- The Report of Verified case of TB (RVCT) form should be generated (by clicking the Generate button) when data have been entered in SendSS.
- Data for the Assessment tab in SendSS and the patient's initial drug regimen for the Medication tab in SendSS will be entered within **one to two weeks of notification**. Other data in the Assessment or Medication tab that are not available at time of

notification will be updated in SendSS within **one to three business days** after the missing data are received.

- The Report of Verified Case of TB (RVCT) form should be generated (by clicking the Generate button) when data for the Patient, Assessment, and initial drug regimen in the Medication tab have been entered in SendSS.
- Initial TST/IGRA, chest radiographs, chest CT scans **results will be entered in SendsSS within one to two weeks of notification.**
- **Bacteriology results (smears, cultures) will be entered one to three business days after the results are received.**
- **Patients should have a case verification status (positive culture, positive NAA, clinical case, verified by a provider diagnosis, not a verified case) within 12 weeks of notification.**
- The initial drug susceptibility test results will be entered **no later than four weeks after the case has been confirmed.** The end user should click the Generate button in SendSS to generate the RVCT Follow-up 1 form.
- Final disposition information on whether the **completed therapy,** moved while on TB treatment, **was lost to follow up, or died (found in the medication tab)** and DOT information (found in the DOT tab) will be entered in SendSS **no later than one week after the last dose of medication was provided to the patient.**
- **Information on patients who were lost to follow up will be entered as soon as possible, but no later than three months after the last dose of medication was provided.**
- **The Follow –up 2 Form will be completed within one week of determining the final disposition. After entering this information, the end user should click the Generate button in SendSS to generate the RVCT Follow-up 2 form.**

CONTACT INVESTIGATION AND LTBI TREATMENT:

- Any child under 5 years of age being evaluated in a contact investigation **would benefit from presumptive LTBI therapy but do not have to complete the full course of LTBI treatment if the follow-up TST/IGRA is negative. A complete history and review of current medications is required should a child require consultation or referral to the State Medical Consultant.**
- Contact's basic demographic information will be entered in SendSS within **one to three business days** after contacts are identified or within **one to three business days** after the data are received by the end user responsible for data entry of contacts in SendSS.
- **Results of contact evaluations (first TST/IGRA results, follow-up TST/IGRA results, chest radiographic results) will be entered in SendSS no later than one week after the results are received.**
- The start date for LTBI treatment will be entered within **one week** after contacts start LTBI therapy.
- The date LTBI treatment was stopped will be entered within **one week** after contact stops treatment.

OTHER TB PROGRAM REPORTING REQUIREMENTS AND TIMELINES

- District TB Coordinators for Health Districts receiving Grant-in-Aid (GIA) allocations from the Georgia TB Program should submit the GIA Quarterly Report to the state TB Office by the 15th of October, January, April, and July.
- The GIA Annual Report is to be completed and submitted to the state TB Office by July 15 each year.
- GIA District Education Reports are to be submitted quarterly.
- Copies of all current contracts and memorandums of understanding/agreement (e.g., medical consultative, radiology, laboratory, etc.) funded with GIA dollars should be on file at the state TB Office.
- Submit all TB program reports to the State TB program point of contact.

INTERJURISDICTIONAL TRANSFERS

The district office should submit an Interjurisdictional Notification form to the State TB Program's point of contact when a TB patient **(active TB case or suspect, LTBI, or TB contact)** who is still on TB treatment or under current evaluation moves to, **or is in,** another district or state. If the TB patient moves to another country while still on treatment, the district office should submit an International TB Notification form to the state TB Program's point of contact. The State office will send the Interjurisdictional or International TB Notification form to the TB Program of the patient's new state or country of residence, respectively. The State office will also refer patients who move to Mexico to CureTB and refer patients who move to countries other than Mexico to TBNet, for treatment follow-up. The State office is responsible for following up treatment completion data from the State TB Program of the patient's new state of residence and entering the data in SendSS. The State office will inform CDC's Atlanta Quarantine Station of patients who have moved to another country to request their assistance to follow-up treatment abroad and/or request CDC to place the patient on a Do Not Board list.

The Interjurisdictional Notification form *(Appendix C)* can be found on the Georgia TB Program web pages at https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-public-health-clinic-forms. The International TB Notification form *(Appendix D)* can be found on CDC's Division of TB Elimination webpage at https://www.cdc.gov/tb/programs. Referral forms to TBNet *(Appendix E)* can be found at the Migrant Clinician's Network website at https://www.migrantclinician.org.

When patients move to another district, state or country, the District TB Coordinator or their designee should document the move in SendSS by the following procedure.

a. Enter the patient's new address in the Patient Information Tab in SendSS
b. Open the Meds tab and select "Yes" where it asks ""Did the patient move during TB therapy?"
c. Enter the new county, state, or country where the patient has moved.

For **Non- US**-born TB patients who have immigrated to the U.S. in the last five years, District TB Coordinators and county health department nurses are encouraged to identify a patient's family member or point of contact from the patient's country of origin, to avoid the difficulty of locating patients that move back to their country of origin without a forwarding address.

DISTRICT-TO-DISTRICT TRANSFER

When a TB patient plans to move (or has moved) from one District to another, District TB Coordinators or their designee should complete an Interjurisdictional Notification form *(Appendix C)* and fax it to the State Epidemiologist at the State TB program office, inform the District TB Coordinator of the District the patient is moving to about the transfer, and document the transfer in SendSS.

OUT-OF-STATE TRANSFER

When a TB patient plans to move (or has moved) from Georgia to another state, District TB Coordinators or their designee should complete an Interjurisdictional Notification form *(Appendix C)* and fax it to the State Epidemiologist at the State office who will in turn notify the TB control program of the patient's new state of residence. The state office will fax all pertinent medical documents to that state and respond to any additional request for information. District offices or county health departments in Georgia should communicate directly with the county health department in the other state to provide detailed information on TB treatment, laboratory reports and clinical notes, to ensure continuity of care. District TB Coordinators or their designee should document the transfer in SendSS.

OUT-OF-THE-U.S. TRANSFERS

When a TB patient plans to move (or has moved) to another country while still on treatment, or has moved before TB diagnosis was confirmed, or before TB treatment was started, District TB Coordinators should call or email the TB Program Director directly, or in the Director's absence, the TB Medical Records or Epidemiology unit. The patient can travel internationally if they have three consecutively negative sputum AFB smears, have completed at least two weeks of appropriate TB medications, and do not have MDRTB/XDR-TB. If these criteria are not met, the TB Program Director or TB Epidemiologist will contact CDC's Division of Global Migration and Quarantine (DGMQ) to discuss whether the patient should be placed on a Federal Do Not Board list or other means to restrict travel. For patients who move to Mexico, Districts should fill out an International TB notification form *(Appendix D)* and fax it to the State TB program Medical Records who will contact CureTB for follow-up. For countries other than Mexico, Districts should fill out both the International TB notification form *(Appendix D)* and TBNet referral forms *(Appendix E)* and fax them to the State TB program Medical Records who will contact TBNet for follow-up. The Immigration and Customs Enforcement (ICE) agency is responsible for referring undocumented immigrants on TB treatment under ICE custody to CureTB or TBNet on deportation.

REFUGEE OR IMMIGRANT CLASS B1 OR B2

CDC Electronic Disease Notification (EDN) System notifies the Georgia State TB Program of immigrants/refugees arriving in Georgia with a Class B1/B2 TB condition which is assessed during their screening abroad by U.S. Department of State panel physicians. Newly arrived immigrants, refugees, parolees[1] and asylees[2] with a B1/B2 TB classification should receive thorough and timely TB evaluations to ensure prompt detection of TB disease. Appropriate treatment should be completed to prevent future cases.

[1] Parolees: A parolee is a person, appearing to be inadmissible to the inspecting officer, allowed into the United States for urgent humanitarian reasons or when that person's entry is determined to be for significant public benefit. Parole does not constitute a formal admission to the United States and confers temporary status only, requiring parolees to leave when the conditions supporting their parole cease to exist.

[2] Asylee: A person in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the person's race, religion, nationality, membership in a particular social group, or political opinion. For persons with no nationality, the country of nationality is the country in which the person last habitually resided. Asylees are eligible to adjust to lawful permanent resident status after one year of continuous presence in the United States. These immigrants are limited to 10,000 adjustments per fiscal year.

CLASS B CONDITION

A classification based on clinical evaluations performed abroad indicating findings consistent with a specific disease.

Table 1: Tuberculosis Classifications and Descriptions

<table>
<tr><th>Classification</th><th colspan="2">Description</th></tr>
<tr><td>No TB Classification</td><td colspan="2">Applicants with normal tuberculosis screening examinations.</td></tr>
<tr><td>Class A TB with waiver</td><td colspan="2">All applicants who have tuberculosis disease and have been granted a waiver. * Note: This is not a common occurrence.</td></tr>
<tr><td rowspan="2">Class B1 TB, Pulmonary</td><td>No treatment</td><td>Completed treatment</td></tr>
<tr><td>Applicants who have medical history, physical exam, or CXR findings suggestive of pulmonary tuberculosis but have negative AFB sputum smears and cultures and are not diagnosed with tuberculosis or can wait to have tuberculosis treatment started after immigration.</td><td>Applicants who were diagnosed with pulmonary tuberculosis and successfully completed directly observed therapy prior to immigration. The cover sheet should indicate if the initial sputum smears and cultures were positive and if drug susceptibility testing results are available.</td></tr>
<tr><td>Class B1 TB, Extrapulmonary</td><td colspan="2">Applicants with evidence of extrapulmonary tuberculosis. The anatomic site of infection should be documented.</td></tr>
</table>

Class B2 TB, LTBI Evaluation	**Applicants who have a tuberculin skin test ≥10 mm or positive IGRA but otherwise have a negative evaluation for tuberculosis. The size of the TST reaction or IGRA results, the applicant's status with respect to TBI treatment, and medication(s) used should be documented. For applicants who had more than one TST or IGRA, all dates and results and whether the applicant's TST or IGRA converted should be documented. Contacts with TST ≥5 mm or positive IGRA should receive this classification (if they are not already Class B1 TB, Pulmonary).**
Class B3 TB, Contact Evaluation	**Applicants who are a recent contact of a known tuberculosis case. The size of the applicant's TST reaction or IGRA response should be documented. Information about the source case, name, immigrant/refugee number, relationship to contact, and type of tuberculosis should also be documented.**

***In exceptional medical situations, a provision allows applicants undergoing pulmonary tuberculosis treatment to petition for a Class A waiver. Form I-601 or I-602 (for immigrants and refugees, respectively) must be completed. These petitions are reviewed by the Department of Homeland Security (DHS) and also sent to the Division of Global Migration and Quarantine (DGMQ) for review. DGMQ reviews the application and provides an opinion regarding the case to the requesting entity. DHS then has the final authority to adjudicate the waiver request.**

INSTRUCTIONS TO COUNTY HEALTH DEPARTMENTS: CLINICAL EVALUATION OF IMMIGRANTS AND REFUGEES WITH A OR B NOTIFICATIONS

1. Upon receipt of the Class B1/B2 notification from the state TB program, contact the refugee and immigrant immediately and instruct him/her to report to the county health department for a TB skin test/IGRA and clinical evaluation.
2. Assess the immigrant/refugee for TB signs and symptoms.
3. Administer tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA).
4. Read TST after 48-72 hours.
5. Order chest radiograph if TST is greater than or equal to10 mm or the IGRA is positive.
6. After TB evaluation is completed, treat appropriately if diagnosed with LTBI or active TB.
7. Complete TB Follow-Up Worksheet when evaluation is completed and fax the worksheet to District TB Coordinator who will submit the worksheet to the Georgia TB Program Office.
8. If person was started on LTBI treatment, update the section on LTBI treatment on the same TB Follow-Up Worksheet when the person completes or stops LTBI treatment, and submit the worksheet to the District TB Coordinator who will submit the updated worksheet to the Georgia TB Program.

1. **Class A**
   - **Review all paperwork.**
   - **Evaluate for signs and symptoms of active TB.**
   - **Perform a new posterior-anterior (PA) and lateral chest x-ray (CXR) at the initial encounter. The patient may have his/her overseas CXR available for comparison.**
   - **Verify previous TB treatment either as reported by the patient, panel physician or both.**
   - **Collect sputum on three consecutive days for smear, culture, and susceptibility testing. If possible, collect at least the initial sputum by induction.**
   - **Review HIV status. Encourage HIV testing if status is unknown.**
   - **Ensure timely establishment of continuity of care with an appropriate anti-TB regimen and TB case management.**

2. **Class B1 TB, Pulmonary (No Treatment and Completed Treatment)**
   - **Review all paperwork.**
   - **Evaluate for signs and symptoms of TB as these may have developed since the patient's pre-departure exam.**
   - **Administer an IGRA regardless of history of BCG. If a recent IGRA result is documented in the paperwork, there is no need to redraw an IGRA. If a recent TST result is documented (negative or positive) in the paperwork, an IGRA should still be drawn. Overseas TST results may be unreliable; however, overseas IGRA results are considered reliable.**
   - **Perform a new PA and lateral CXR. A new CXR should be done regardless of the TST or IGRA result and should be compared to the patient's overseas CXR (if available).**
   - **Collect sputum on three consecutive days for smear, culture, and susceptibility testing. If possible, collect at least the initial sputum by induction.**
   - **Review HIV status. Encourage HIV testing if status is unknown.**
   - **Verify any previous TB treatment either as reported by the patient, the panel physician, or both.**
   - **Determine final disposition (i.e., LTBI, active TB, or previously treated TB). If active TB is suspected, report patient promptly in SendSS and initiate a contact investigation once case is confirmed.**
   - **Provide adequate treatment based on the final disposition. If there is reliable documentation that the patient has previously been treated for TBI or active TB prior to arriving in the U.S., the provider will determine whether any additional or re-treatment is necessary.**
     - Ensure timely establishment of continuity of care with an appropriate anti-TB regimen and TB case management.

Information on this page was provided by the Tennessee State TB Program Immigrant and Refugee Training Module, March 2019.

3. <u>Class B1 TB, Extrapulmonary</u>

- **Evaluate for signs and symptoms of TB as these may have developed since the patient's pre-departure exam.**
- **Administer an IGRA regardless of history of BCG. If a recent IGRA result is documented in the paperwork, there is no need to redraw an IGRA. If a recent TST result is documented (negative or positive) in the paperwork, an IGRA should still be drawn. Overseas TST results may be unreliable; however, overseas IGRA results are considered reliable.**
- **Perform a new PA and lateral CXR to rule out any pulmonary involvement. A new CXR should be done regardless of the TST or IGRA result and should be compared to the patient's overseas CXR (if available).**
- **Collect sputum on three consecutive days for smear, culture, and susceptibility testing (to rule out any pulmonary involvement). If possible, collect at least the initial sputum by induction.**
- **Review HIV status. Encourage HIV testing if status is unknown.**
- **Verify any previous TB treatment either as reported by the patient, the panel physician or both.**
- **Determine final disposition (i.e., LTBI, active TB, or previously treated TB). If active TB is suspected, report patient promptly in SendSS and initiate a contact investigation once case is confirmed.**
- **Provide adequate treatment based on the final disposition. If there is reliable documentation that the patient has previously been treated for TBI or active TB prior to arriving in the U.S., the provider will determine whether any additional or re-treatment is necessary.**
- **Ensure timely establishment of continuity of care with an appropriate anti-TB regimen and TB case management.**

4. <u>Class B2 TB, TBI Evaluation</u>

- **Review all paperwork.**
- **Evaluate for signs and symptoms of TB as these may have developed since the patient's pre-departure exam.**
- **Administer an IGRA regardless of history of BCG. If a recent IGRA result is documented in the paperwork, there is no need to redraw an IGRA. If a recent TST result is documented (negative or positive) in the paperwork, an IGRA should still be drawn. Overseas TST results may be unreliable; however, overseas IGRA results are considered reliable.**

Information on this page was provided by the Tennessee State TB Program Immigrant and Refugee Training Module, March 2019.

- **Perform a new PA and lateral CXR to rule out any pulmonary involvement. A new CXR should be done regardless of the TST or IGRA result and should be compared to the patient's overseas CXR (if available).**
- **Verify any previous treatment for TB or LTBI either as reported by the patient, the panel physician or both.**
- **Determine final disposition (i.e., LTBI, active TB or no TB/LTBI). If active TB is suspected, promptly report patient in SendSS and initiate a contact investigation once case is confirmed.**
- **Provide adequate treatment based on the final disposition. If there is reliable documentation that the patient has previously been treated for LTBI or active TB prior to arriving in the U.S., the provider will determine whether any additional or re-treatment is necessary.**
- **Ensure timely establishment of continuity of care with an appropriate anti-TB regimen and TB case management.**

5. <u>Class B3 TB, Contact Investigation</u>

- **Review all paperwork.**
- **Evaluate for signs and symptoms of TB as these may have developed since the patient's pre-departure exam.**
- **Administer an IGRA regardless of history of BCG. If a recent IGRA result is documented in the paperwork, there is no need to redraw an IGRA. If a recent TST result is documented (negative or positive) in the paperwork, an IGRA should still be drawn. Overseas TST results may be unreliable; however, overseas IGRA results are considered reliable.**

NOTE: **Despite the overseas use of the Technical Instructions for TB evaluation of immigrants and refugees, county health departments should not presume the adequacy of that evaluation or treatment indicated prior to arrival in the U.S. Prompt identification and evaluation by the county TB clinician should be considered a high priority of all county TB programs, and appropriate incentives and/or enablers should be employed toward that end.**

Information on this page was provided by the Tennessee State TB Program Immigrant and Refugee Training Module, March 2019.

B1/B2 SendSS PROCESSING PROCEDURES FOR DISTRICT TB COORDINATORS

Immigrants/refugees with a B1 or B2 classification should be located, and TB evaluation initiated within 30 days of arrival.

State TB Program staff enter all B1 and B2 (non-LTBI) patients into SendSS as TB suspects.

Some B2 immigrant/refugees are classified as having LTBI (depending on their country of origin) and therefore are not entered in SendSS as TB suspects but should still be evaluated by the county health department.

SendSS DATA ENTRY FOR CLASS B1/B2

The case verification status or TB suspect status of B1/B2 TB suspects should be updated within 90 days of date reported in SendSS when data on their final diagnosis become available. To update the case verification status in SendSS:

- Open the Diagnosis Tab
- Enter correct diagnosis from the Case Verification Status drop down box
- Click on the Add button
- Open the RVCT tab
- Click on the Generate button

TB IMMIGRANT/REFUGEE FOLLOW-UP WORKSHEET COMPLETION

State TB program staff enters the TB Follow-Up Worksheet data in CDC's Electronic Disease Notification (EDN) software. Districts with access program staff enter their own data directly in EDN and which will be reviewed by state staff.

The highlighted fields in the follow-up worksheet are mandatory fields needed to successfully upload the data in EDN. Submit the completed worksheet to state TB Medical Records with attention to Medical Records supervisor. Resubmit the completed worksheet when the immigrant/refugee completes therapy, if applicable.

ELECTRONIC DISEASE NOTIFICATION SYSTEM QUALITY IMPROVEMENT PROCEDURES

A monthly report of un-submitted TB Class B Follow-Up Worksheets and missing worksheet data is distributed by TB Epidemiology staff to District TB Coordinators. The report will include names and identification numbers of immigrants/refugees that have worksheets missing past 90 days. In addition, the report will include a list of Class B patients that have an upcoming deadline for TB worksheet submission. This report will be sent at 60 days; 30 days prior to 90-day deadline.

Overview of Tuberculosis Services

Table of Contents

TUBERCULOSIS SERVICES

Active tuberculosis is a public health threat. Latent TB infection (LTBI) is a reservoir for future active TB cases. TB prevention and control programs need to address both active TB and LTBI to protect the health of the community.

Medicaid and third-party payers may be billed for all TB services according to the county sliding fee scale. Medicaid and third-party payers should not be billed for Oral, Intramuscular TB drugs or the PPD solution as they are purchased from the discounted Federal 340B Drug Pricing Program and are provided to all District TB programs.

It may be possible for contracts or MOUs to be executed with local facilities that frequently send employees or students to the health department for TB screening to generate funds to cover these services.

MEDICAL CARE

Each health district in Georgia has a District Health Director and a contract with a practicing physician for oversight in providing medical care to TB clients. The district varies widely in how the oversight is implemented. Some districts have the physician see every TB client, while in others; the physicians never see the clients but review the charts on a regular basis and provide consultation to the nurses. If the direct care is provided by a private physician, the county TB nurse is to obtain monthly reports to maintain oversight.

The nurse protocols describe the management of uncomplicated pulmonary, **extra-pulmonary** and LTBI. Anything that falls outside of the protocols is to be managed by the contract or district physician and the nurse will work under those orders and will not be working under protocol. The district or contract physician will write the order and sign off on the chart. The district pharmacy or District physician will dispense the medication**.** If a patient is being co-managed by a private physician in the community, the District contract physician will have to collaborate for care and write the orders for any health department involvement. This is especially important concerning medications. Public health nurses do not work under community physician's orders. They can only work under the Georgia Standard Nursing Protocol or the District contract physician's orders. A registered professional nurse or physician's assistant is only authorized to dispense pursuant to an order issued in conformity with a nurse protocol or job description, **not a prescription or an order written on a chart or phoned in by a physician.** For more information, please see the *Nurse Protocols for Registered Professional Nurses in Public Health, current edition.* Located on the web pages at https://dph.georgia.gov/nurse-protocols or https://gets.sharepoint.com/sites/DPHIntranet/PHIL/Pages/DCR.aspx

Diagnostics, treatment, clinical care, case management and infection control guidelines and standards should be available for reference by each TB staff member. Instead of repeating these guidelines in this document, please refer to the following sources:

Nurse Protocols for Registered Professional Nurses in Public Health, current edition. Located on the TB web page at https://dph.georgia.gov/nurse-protocols or https://gets.sharepoint.com/sites/DPHIntranet/PHIL/Pages/DCR.aspx

Georgia Tuberculosis Reference Guide, current edition. Located on the TB web page: https://dph.georgia.gov/tbpublications-reports-manuals-and-guidelines

NTCA, NTNC. *Tuberculosis Nursing: A Comprehensive Guide to Patient Care, current Edition.2011* Each district health office and county health department was sent a copy in 2012. Currently undergoing revision information at http://tbcontrollers.org/

CDC *Core Curriculum on Tuberculosis: What the Clinician Should Know, Seventh Edition. 2021.* It can also be ordered from CDC or downloaded at http://www.cdc.gov/tb/education/corecurr/

ATS, CDC,IDSA. "Treatment of Tuberculosis" (*MMWR* 2003;52 (NO:RR-11]). Available at: http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf Erratum For: Treatment of TB 2005 Jan 7 53 (NO 51 & 52) CDC, NTCA. "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC" (*MMWR* 2005; 54 [No. RR-15]). Erratum For: Guidelines for Investigations of Contacts 2005 Dec 23, 54 (NO 50) Available at: http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf

CDC NTCA. "Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National TB Controllers Association and CDC 2019"*MMWR 2019; 68*[No.RR-19]).Available at: https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid=mm6819a3_w

CDC. "Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection" (*MMWR* 2000;49[No. RR-6]). Available at: http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf ATS, CDC, IDSA.

"Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America" (*MMWR* 2005; 54[No. RR-12]). Available at: http://www.cdc.gov/MMWR/PDF/rr/rr5412.pdf

ATS, CDC, IDSA. "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" (Am J Respir CritCareMed 2000;161[4Pt1]).Available at: http://www.pubmed.ncbi.nlm.nih.gov/10764337/

OFFICE VISITS

All legal forms are to be completed and signed at the initiation of TB care. These legal forms include consent for treatment, treatment plan, medication information, Directly Observed Therapy (DOT)/Video Directly Observed Therapy (VDOT) agreement and/or refusal of care.

Gather as much locating and contact information from the client as possible. Examples of information to be collected include: emergency contact demographics, email address, cell, home and work phone numbers, aliases, and screen names used on social media such as Facebook, Twitter, or Instagram. Upon evaluation of **Non-US** born, "recent" (past 5 years) immigrants, please identify a family member or another close contact in their home of origin, as an emergency contact. This will assist in locating patients that are "lost" while infectious.

All persons on treatment are expected to have a clinic visit at least once a month. More frequent clinical visits may be needed depending on the complexity of the case. See Section 7: Nursing Evaluation and Monitoring for specific information.

HOME VISITS

All active TB cases are expected to have at least one home visit **within 72 hours. The home visit is used** to: evaluate the living situation of the client, to determine the suitability of home isolation, to **identify the** presence of children and to educate and build rapport with the client and co-habitants.

SCREENING FOR TB

All health departments have the ability to administer and read TSTs. Persons who perform and/or interpret this test should have obtained initial TST certification when newly hired and have it maintained by completing the district annual skill validation review check-off.

Program collaboration with outside facilities/agencies would be encouraged to assure proper placement and reading of tuberculin skin test (TST). A possible MOU might be feasible with an HIV clinic or a correctional facility/other agency for placement and/or reading TSTs.

Interferon Gamma Release Assay (IGRA) is available through contracts with laboratories as well as the GA Public Health Lab. Testing through GA Public Health Lab is prioritized for targeted areas with large numbers of **Non-US-born clients or persons without housing**, and for TB outbreak investigations.

Chest x-rays for follow up of an initial positive skin test or IGRA as a result of routine testing or in conjunction with employment, school, etc. **may be provided through memorandums of agreement (MOA) with private facilities or at the local health department, utilizing sliding fee scale policies.**

A clinical symptom screen is required for all clients who have a lapse in LTBI treatment. A repeat chest x-ray evaluation is required for clients who are symptomatic or who have had a lapse in therapy for two months or more. The forms should be completed and signed to be retained at the facility per district policy. **Please see related forms: TB Symptoms and Risk Assessment Screening Forms, TB Symptom Screen Form and TB Education and Symptom forms are available at**: https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-public-health-clinic-forms.

OTHER IMAGING AND/OR NECESSARY MEDICAL PROCEDURES

The state TB Program is to be notified immediately of any necessary medical procedures that are not in the state nursing protocols. The state medical consultant must approve all procedures. The county will pay for the procedure at the current Medicaid rate.

TUBERCULIN SKIN TESTING BY UNLICENSED PUBLIC HEALTH PERSONNEL

Georgia law permits physicians to delegate the administration of TSTs to unlicensed medical assistants (O.C.G.A. 43-34-44) that they supervise. The law does not always require on-site supervision by the delegating physician. District Health Directors (DHD) may delegate the administration and/or reading of tuberculin skin tests (TST) to unlicensed public health personnel when all the following criteria have been met:

1. The DHD has reviewed and approved the standard training curriculum for the *TB Update and Skin Test Certification* course.
2. The DHD has a written delegation signed by the DHD and the unlicensed public health personnel outlining the specific parameters of the delegation.
3. **The DHD has a system in place in which the skill competency of the individual can be validated on an annual basis. The DHD can set up any system to validate the skill competency of the individual in any way that is feasible for the district. It might be feasible to have a skill competency day at the district health office once a year at which time all unlicensed public health staff could be observed at one time. In other districts, it might be reasonable for an individual in the field to be observed while performing and reading the test. TST-certified nurse trainers can supervise the administration and reading of the TSTs by unlicensed personnel, consistent with usual practice in county health departments, if it is difficult or impractical for DHDs to do so. While unlicensed public health personnel may administer and/or read a TST, they must refer any induration to a licensed medical professional (LPN, RN or other clinician) for interpretation of the induration. The licensed provider must review the paperwork to determine the appropriate follow up for the individual with an induration.**

TB Update and Skin Test Certification Course for Healthcare Personnel

The current standard training curriculum for the TB Update and Skin Test Certification course is available to healthcare workers in both the public and private sectors. The calendar of training dates along with the registration forms can be accessed on the State TB training website: www.dph.georgia.gov/tb-educational-and-trainingopportunities-georgia or by calling 404-657-2634. **All DPH personnel also have access to Exceed, the state training platform; the didactic portion of the certification course resides on this site. For unlicensed public health personnel, the course includes a didactics portion addressing tuberculosis and the screening process, a video demonstrating the correct procedure and a practicum where the participant must provide a return demonstration of the proper procedure. After the class, the participant is required to perform 10 satisfactory administrations and 10 satisfactory readings under supervision in his/her clinic setting. Validation of completion of all steps must be sent to the Georgia Tuberculosis Program prior to an ecertificate being issued. The Georgia Tuberculosis Program issues an ecertificate once all components of the TST certification process are complete. Everyone may be required to submit a copy of**

his/her current certification to the DHD at the time of signing the delegation document. Please see Sample Medical Delegation for licensed and unlicensed public health personnel (Appendix F).

TESTING FOR TUBERCULOSIS INFECTION+++There are two types of tests for TB infections: TB Skin test and TB Blood test. It is not recommended to routinely test an individual with both tests. Either test (TST or IGRA) may be selected based on CDC guidelines.

Selecting a test for TB Infection

- **Tuberculin Skin Test (TST) – this is a preferred test for children under the age of 2 years.**
- **Interferon-gamma release assays or IGRAs – The two blood tests approved by U.S. Food and Drug Administration (FDA) are the QuantiFeron TB Gold In Tube (QFT-GIT) and T-Spot. This is preferred for: People who have received the Bacille Calmette-Guerin (BCG) vaccine, Non-US-born and/or have difficulty returning for a second appointment to read and interpret the reaction to the TST.**
- **Either TST or IGRA – may be used without preference for other groups not included above.**

Please see Testing for TB Infection at CDC's Latent Tuberculosis Infection: A Guide for Primary Health Care Providers: https://cdc.gov/tb/publications/ltbi.

ADMINISTRATION OF MANTOUX TUBERCULIN SKIN TEST (TST)

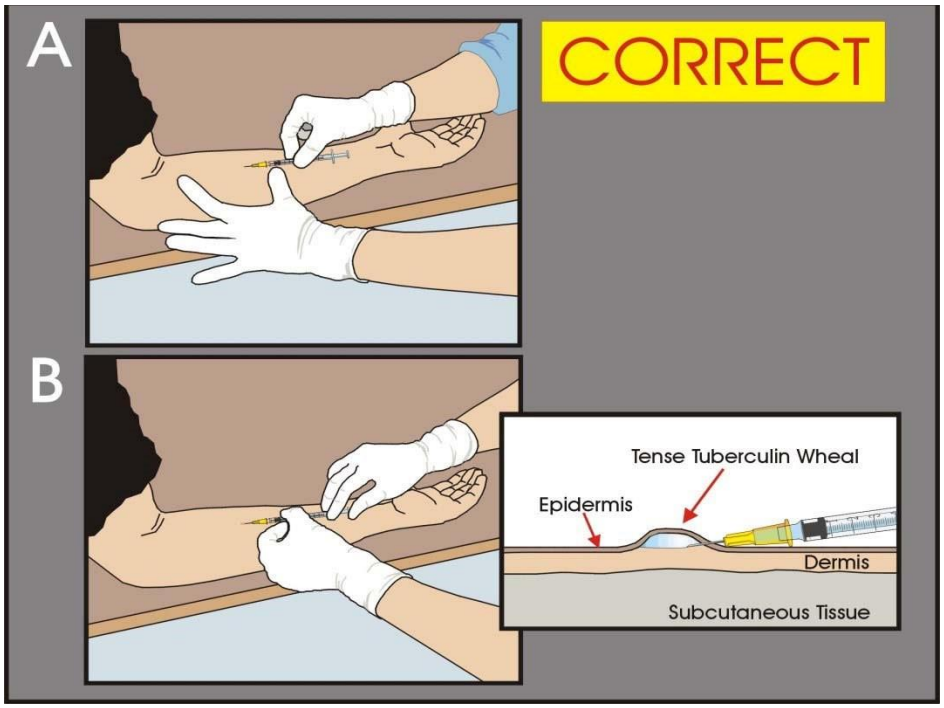
Purpose of test: To determine whether a person has become infected with the TB germ. This test cannot determine whether the person has active TB disease or Latent TB infection.

Supplies: Tuberculin syringe (27 gauge needle, ½" or 3/8" needle length), 5 Tuberculin unit strength PPD solution, alcohol pads, cotton ball, gloves.

Note: gloves may or may not be worn according to facility policy

Procedure:

1. Draw up 0.1 ml of PPD solution into tuberculin syringe
2. Expel excess air bubbles
3. Clean area of forearm (dorsal or volar surface) with alcohol pad. Let dry.
4. With bevel of needle facing upwards, inject the solution intradermally (just under the 1st layer of skin). A tense wheal (bubble) approximately 6 - 10 mm should be visible at the injection site.
5. Withdraw the needle and dispose into SHARPS container.
6. Patient (or nurse if wearing gloves) may "dab" any spot of blood appearing at the site with a cotton ball. Do not place a Band-Aid on the site.
7. Instruct patient to return in 48 – 72 hours for reading.

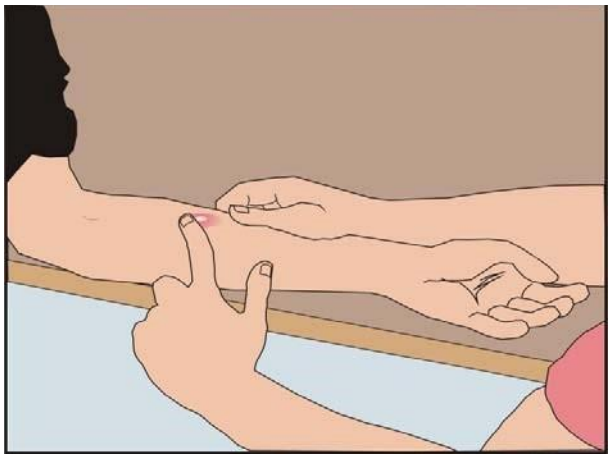


MEASUREMENT OF THE MANTOUX TUBERCULIN SKIN TEST (TST)

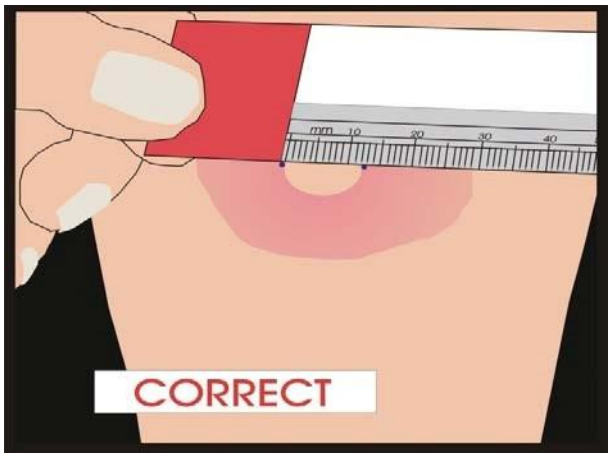
Purpose: To determine a reaction to the tuberculin solution and measure the size of the induration (raised hardened area)

Procedure:

1. Test is read by a trained healthcare worker 48 – 72 hours after the TST Placement. If a patient fails to show up for the scheduled reading, a positive reaction may still be measurable up to 1 week after testing. However, if a patient fails to return within 72 hours and shows no induration, the TST should be repeated.
2. The area of induration (palpable raised hardened area) around the site of injection is the reaction to tuberculin that is to be measured. Erythema (redness) and soft tissue swelling are not to be measured.
3. Palpate the injection site for induration. The borders of the induration can be marked with a ball point pen or with the fingernail.
4. Using either a flexible ruler or caliper ruler with millimeter markings, measure across the forearm (perpendicular to the long axis or transversely). All reactions should be recorded in millimeters (e.g. 12 mm). If no induration is found, “0 mm” should be recorded.



Palpation of the induration



Measurement of the induration

INTERPRETATION OF THE MANTOUX TUBERCULIN SKIN TEST (TST)

Purpose: Skin test interpretation depends on the measurement of the induration and the person's risk of being infected with TB and /or progression to disease if infected. **Procedure:**

1. Match the measurement of the induration with the person's risk factors from the chart below.
2. Record the size of the induration in millimeters (mm)
   - Do not write "negative", but record as 00mm, 7mm.
   - Do not write "positive", but write as a number such as 10mm, 12mm.
3. Give client official documentation of results.

Induration of 5mm or greater is considered positive in:	Induration of 10mm or greater is considered positive in:	Induration of 15mm or greater is considered positive in:[1]
• Human immunodeficiency virus (HIV) positive persons • Recent contacts of TB case patients • Persons with fibrotic changes on chest radiograph consistent with prior TB • Patients with organ transplants and other immunosuppressed patients (Receiving the equivalent of 15 mg/d or greater of prednisone for 1 month or more. Risk of TB in patients with corticosteroids increases with higher dose and longer duration.) • **Candidates being considered for treatment with tumor necrosis factor (TNF) antagonists such as injectable Remicade**.	• **Immigrants from high-prevalence countries.** • Injection drug users • Residents and employees[3] of the following high-risk congregate settings: prisons and jails, nursing homes and other long-term facilities for the elderly, hospitals and other health care facilities, residential facilities for patients with acquired immunodeficiency syndrome (AIDS), and **unhoused** shelters • Mycobacteriology laboratory personnel • Persons with the following clinical conditions that place them at high risk: silicosis, diabetes mellitus, chronic renal failure, some hematologic disorders (e.g., leukemias and lymphomas), other specific malignancies (e.g., carcinoma of the head, neck, or lung),weight loss of ≥10% of ideal body weight, gastrectomy, and jejunoileal bypass • Children less than 5 years of age, or infants, children and adolescents exposed to adults at high-risk	•Persons with no known risk factors for TB

CHEST X-RAYS

Health districts and/or county health departments may have on-site radiology services, or the services may be provided through contracts with local facilities.

Chest x-rays should be performed on the following persons:

- Person with signs and/or symptoms of active TB regardless of TST or IGRA result

[1] For persons who are otherwise at low risk for TB and who are tested at the start of employment, a reaction of >15 mm is considered positive.

- Contacts with a positive reaction to a TST (greater than or equal to 5mm induration) or IGRA
- Contacts to cases that have a previous positive TST
- Contacts with HIV infection
- Contacts for whom window period treatment is being considered
- Persons with documented evidence of converting from a negative TST to a positive TST within the past 2 years
- Persons on LTBI treatment that develop signs and/or symptoms of active TB
- Children under five years of age with a positive TST
- **Persons with an initial positive skin test because of routine testing.**
- **Class B immigrants as indicated in new immigrant evaluation.**

SPUTUM COLLECTION AND SUBMISSION OF SPECIMENS

Sputum is mucous that is coughed up from deep inside the lungs, usually with vigorous cough. It is usually thick, cloudy, may be blood tinged and sticky. For more information about sputum specimens for Tuberculosis testing, please refer to: Association of Public Health Laboratories guidelines for submission of sputum specimens at https://www.aphl.org/aboutAPHL/publications/pages/default.aspx

PURPOSE

To determine if a person is infected with Mycobacterium tuberculosis or any other Mycobacterial infection.

All patients at risk for infectious pulmonary TB are required to produce sputum for AFB smear and culture for identification, diagnosis, susceptibility testing and treatment of MTB.

SPUTUM COLLECTION

Identified patients for sputum collection must be given instructions for collecting sputum. The patient must demonstrate understanding of the procedure to produce good quality specimen.

Sputum specimen must be collected and transported in an approved laboratory container for infectious disease and properly sealed prior to transfer to the testing laboratory. Good quality sputum specimen is critical for the diagnosis of TB and the test performance. **Do not use these guidelines on patients with sustained trauma to their airways. Refer patient to the ordering physician.**

SPONTANEOUSLY PRODUCED (COUGHED) SPUTUM COLLECTION FOR TB

Obtain sputum specimens from persons suspected of having TB that have a productive cough. **In the absence of a sputum collection booth or negative pressure room, place patient outdoors in an open area or space. Provide privacy as needed.**

Materials Required

1. **Sterile specimen container approved by the laboratory for collection and transport of infectious specimen.**
2. **Gloves**
3. **Box of tissues**
4. **N95 Masks or particulate respirator for AFB (To be worn by healthcare worker)**
5. **Surgical mask (To be worn by patient)**
6. **Hand Sanitizing Agent**
7. **ALSO, the following for nebulized sputum induction:**
    a. **A handheld nebulizer with mouthpiece and 15ml vial of 3% saline**

Procedure Preparation:

The health care worker must always observe standard precautions. An N95 masks must be worn by healthcare workers for AFB-cough producing procedures. The patient at risk for Infectious TB must wear a surgical mask until cleared.

1. **Instruct patient to collect sputum early in the morning. Brush teeth and rinse mouth with water as soon as he/she wakes up. Do not use mouthwash, eat,**
2. **or drink anything prior to collection.**
3. **Don't open the sputum container until ready to use it. Verify first name, last name, date of birth or approved patient identification label are on the sample bottles.**
4. **Instruct patient to collect specimen outdoors while at home or in an appropriate negative pressure room or sputum collection booth.**
5. **Healthcare workers must instruct the patient on collections and supervise the first sputum collection. The patient must understand that sputum is coughed up from deep inside the lungs. It is usually thick, cloudy, and sticky. Saliva comes from the mouth, and it is thin, clear, and watery. Do not collect saliva, nasal secretions, or spit for this test.**
6. **Instruct patient to open the sample bottle when ready at the onset of the procedure. Instruct the patient to: take a deep breath, hold the air for a few seconds, breathe slowly, take another deep breath, then cough hard until sputum comes up in the mouth from deep within the lungs. Expectorate the sputum into the specimen container.**
7. **Instruct patient to Repeat this process until there is enough sputum to cover the bottom of the bottle or at least 5 ml (1 teaspoon). Replace the lid on the container and screw the cap on the sample bottle tightly so it does not leak in transit.**
8. **The patient must remain in the negative pressure room, booth or outdoors until they have stopped coughing, has donned a surgical mask (if needed) and has been cleared to leave.**
9. **Label the specimen with time and date of collection and place it in a specimen bag. Attach the requisition form if required and follow local health department procedures.**
10. **Document the attempt in the appropriate flow sheet or medical record as successful or unsuccessful procedures.**

11. **After the procedure, wash hands with soap and water if available or use approved hand sanitizing agent.**

NEBULIZED SPUTUM INDUCTION FOR TB:

This procedure is to obtain sputum specimen for AFB smear and culture from an identified patient who has a dry non-productive cough.

The patient must be placed in an appropriate negative pressure room, sputum collection booth or outdoors. Follow all infection prevention precautions for collecting AFB via cough inducing procedures. In the absence of a negative pressure room or sputum collection booth, place patient outdoors in an open area. Provide privacy as needed. Do not use this guideline on anyone with sustained injury or trauma to their airways.

Material Required:

1. **Box of tissue**
2. **Normal saline 15ml vial of 3% solution**
3. **Handheld Nebulizer**
4. **Disposable tubing with mouthpiece**
5. **N95 Mask, Surgical Mask, and Gloves**
6. **Sterile specimen container approved by the laboratory for sputum collecting and transport**
7. **Hand sanitizing agent**

Procedure preparation:

1. **Instruct patient to brush teeth and mouth and rinse mouth with water. Do not use mouthwash, eat or drink prior to procedure.**
2. **Observe standard precautions – N95 masks must be worn by the healthcare worker for AFB cough-producing procedures. Patient suspected of TB must wear surgical masks.**
3. **Set up the Nebulizer per manufacturer instructions, use long extension cord if outdoors. Prepare the tubing by placing 5ml of 3% saline into the reservoir of the hand-held nebulizer. Set the flow and nebulizer saline for 7-10 minutes or until sputum is expectorated. The maximum nebulizer time is 20 minutes. (More saline may be added to the nebulizer if more than 10 minutes is needed to produce an adequate cough.)**
4. **Ask patient to inhale the nebulized 3% saline deeply 2-5 times followed by a deep vigorous cough. Collect the sputum into a sterile container. It is preferred to collect 5-10ml of raw sputum. Induced sputum may appear thin and watery.**
5. **Patient must remain in the negative pressure room, sputum booth or outdoors till he/she stopped coughing, wear the surgical mask and cleared to leave.**
6. **Label the specimen with time and date of its collection and place it in a specimen bag. Attach a laboratory request form if applicable.**
7. **Document the procedure in the appropriate flow sheet or medical record as successful or unsuccessful procedures.**

8. **Wash hands with soap and water or use approved hand sanitizing agent.**

MYCOBACTERIOLOGY SPECIMEN SHIPPING AND HANDLING

Mycobacteriology specimens sent for culture, PCR and susceptibility testing are classified as Category B – biological substances. Category B specimens are not in a form capable of causing permanent disability, life-threatening or fatal disease in otherwise healthy humans or animals upon exposure.

SUPPLIES

Collection, packaging and shipping materials for TB specimens can be obtained through the Georgia Public Health Laboratory (GPHL) in Decatur. Mycobacteriology (TB) Kits available through the GPHL include biohazard bags, leak-proof 95kPA biohazard bags, mailing cans and lids, and conical collection tubes. Orders may be placed by faxing a completed GPHL Specimen Collection Outfit Order Form (available at http://dph.georgia.gov/lab/) to the Decatur Lab at 404-327-6862. For questions about lab services or supply orders, contact the Decatur Lab Customer Service Phone at 404-327-7928.

PACKAGING

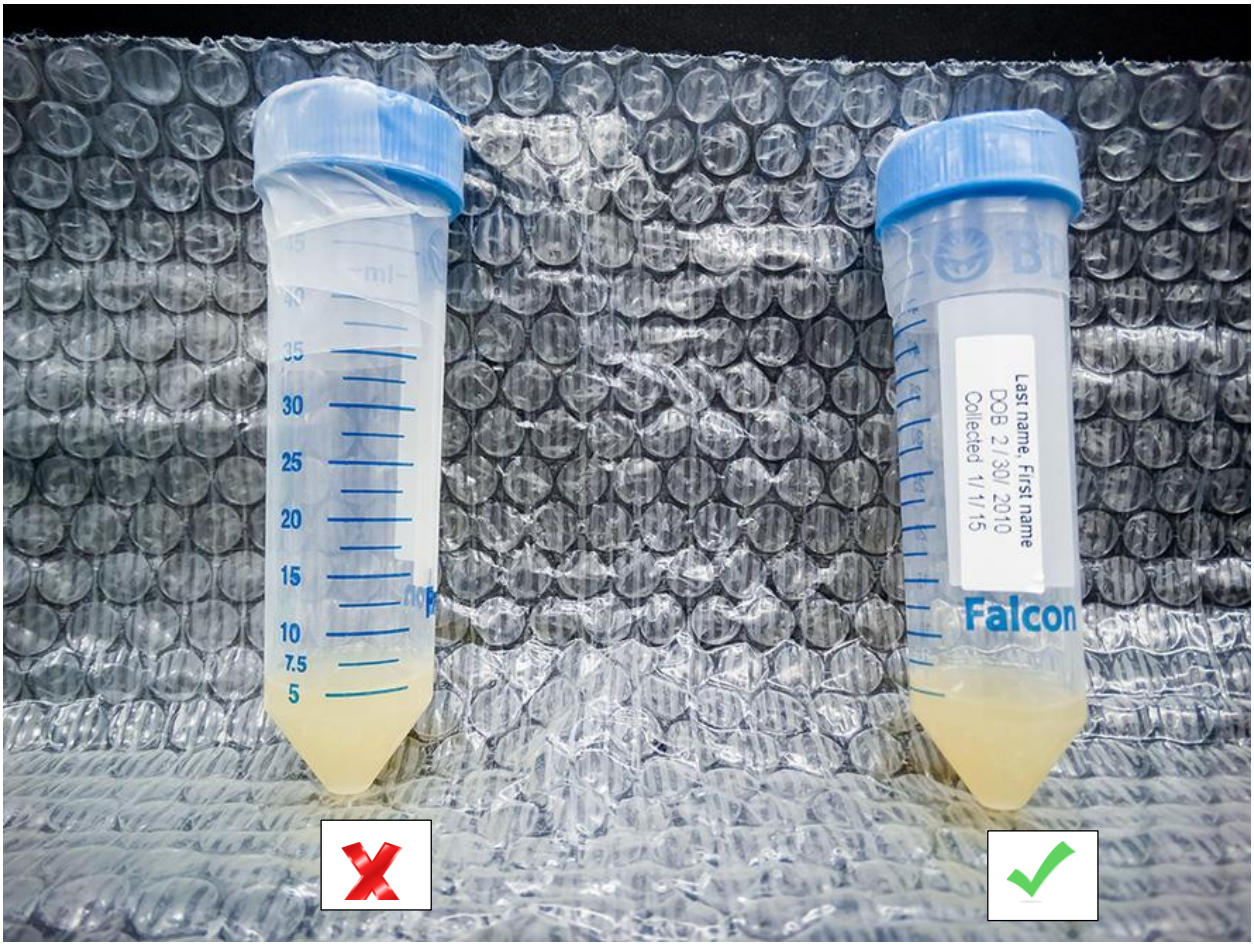
A triple packaging system is required for Category B Substances:

- **A leak proof primary receptacle**
- **A leak proof secondary package to absorb all fluid in case of breakage**
- **A rigid outer packaging of adequate strength for its capacity, mass and intended use**

Mycobacteriology specimens should be collected using the GPHL specimen collection tube for Category B specimens. Instructions for sputum collection can be found in the Policy and Procedure Manual. For sputum, ideally 3-5 ml in volume should be collected; however, a lesser volume with good quality is acceptable. Once samples are collected follow the packaging instructions listed below:

1. **Align the screw cap well on the collection tube to prevent opening in transit.**
2. **Place a single layer of tape on or around the cap to prevent opening/leakage.**
3. **Assure that the collection tube is labeled with at minimum, the patient's name, date of birth, and date and time of collection. Verify that the information on the collection tube matches the information on the laboratory requisition form.**
4. **Place the specimen collection tube in a biohazard bag. Seal the bag from one end of the bag outward to seal and close.**
5. **Place the fully completed requisition/submission form in the receptacle pouch on the outside of the bag, not inside the specimen transport bag.**
6. **Place the sealed and closed biohazard bag inside the leak-proof 96kPA bag. Seal the bag and label the contents appropriately in the box provided.**
7. **Place the leak-proof 95kPA biohazard bag inside the outer rigid container.**

8. **Place a second copy of the laboratory submission form and list of contents in the rigid container between the secondary receptacle and the outer packaging.**
9. **Screw the lid on the rigid container tightly and secure with tape.**
10. **Label outer package with proper shipping name, UN3373 certification mark, shipper and consignee identification (name, address, and phone number).**
11. **Follow LHD shipping and handling of biohazard specimen guidelines.**



UNACCEPTABLE/REJECTION CRITERIA

Following are a list of reasons the laboratory may reject a specimen for testing:

- **Labeling of specimen does not match identifiers on requisition form**
- **Insufficient volume**
- **Broken or leaking specimen containers**
- **Excessive delay between specimen collection and receipt in the laboratory**
- **No specimen in the collection tube**
- **Wrong type of specimen submitted**
- **No patient identifier on specimen tube**

SHIPPING

Specimens should be mailed, shipped or hand delivered to the laboratory as soon as possible after collection or refrigerated to avoid overgrowth of unwanted bacteria. Category B carriers are FedEx, UPS, USPS or any commercial carrier.

Shipping Address

Georgia Public Health Laboratory (Decatur)
Mycobacteriology Laboratory
Mycobacteriology Department
1749 Clairmont Road
Decatur, Georgia 30033-3040

Additional Information/Resources:

Department of Transportation (DOT) Transporting Infectious Substances Safely (PHMSA PHH50-00-79-0706)
https://www.phmsa.dot.gov/sites/phmsa.dot.gov/files/docs/Transporting_Infectious_Substances_brochure.pdf

Georgia Public Health Laboratory Service manual, 2013. Available at: http://dph.georgia.gov/lab/

FedEx Guidance: clinical Samples, biological substances Category B (UN 3373) and Environmental Test Samples

APHL Guidance: http://www.aphl.org/aphlprograms/infectious/tuberculosis/

LABORATORY TESTING

Certain blood and mycobacteriology testing is required to diagnose and monitor TB cases and LTBI. Detailed information about the tests required can be found in the *Standard Nurse Protocols for Public Health Nurses* and in Section 7 of this document. Laboratory results not performed by the State Laboratory are done through a contract with a local laboratory and county and/or district. For more information about the state laboratory, please refer to the current *Laboratory Services Manual* at http://dph.georgia.gov/lab.

HIV test results should be documented on all patients receiving TB care through the health departments. An opt-out approach is recommended. This means the patient is informed of the laboratory tests that will be performed, including an HIV test. The patient can decline the HIV test. Otherwise, the test will be performed. Documentation of a patient's refusal (Appendix F, Refusal of HIV Testing or Opt-Out form) should be in the medical record. During the course of treatment, HIV testing should continue to be offered until results can be obtained. For more information and background on this approach, please refer to CDC's *"Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings"* at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

INCENTIVES AND ENABLERS

Incentives and enablers for TB patients and contacts on LTBI treatment are available from the American Lung Association (ALA) of Georgia through a contract with the Georgia TB Program. Refer to the *Alternative Housing Project for Homeless Tuberculosis Patients in Georgia* brochure *(Appendix J)* or call ALA at 770-434-5864 for current procedures to

request and obtain incentives/enablers. Districts may request approval from the state TB program director or deputy director to use unexpended GIA funds to purchase incentives and enablers. On occasion, there may be incentive/enabler monies available from the state TB Program. Contact the TB program deputy director at 404-657-2634 to request these funds. Ensure is also supplied without charge to supplement the nutritional status of patients. Contact the TB Program to order Ensure.

MEDICAL INTERPRETATION SERVICES

The State of Georgia has a statewide contract with AT&T Language Line to provide medical interpretation services to the clients of Georgia. No person should be turned away because of the inability to speak or understand English. Family members of the client are not to be used to interpret for the client and staff. Language line can be accessed by charge by calling the customer service number 1-800-752-6096.

PROCEDURE FOR USE OF LANGUAGE LINE

- Place the non-English speaker on hold
- Dial **1-800-874-9426 Person Code: TB District #**
- Enter your client **ID [513094**] on the keypad or stay on the line for assistance
- Press 1 for Spanish or
- Press 2 for all other languages
- Speak the name of the language at the prompt
- An interpreter will be connected to the call
- Brief the interpreter. Summarize what you wish to accomplish and give any special instructions.
- Add the non-English speaker to the line
- Conduct your business
- **The Language Line is to be used for TB-client related business only**
- **The Language Line is for TB case management purposes and use must be documented**
- **Users must have a monitoring/accountability system in place for documentation**

HOSPITALIZATION

The state office TB Program is to be notified immediately of any pending hospitalization of a TB suspect/case. If the client has no insurance or Medicaid/Medicare, then the county is expected to negotiate with the local county hospital to use the hospital indigent care funds.

All hospital admissions or deaths of persons with TB disease are to be reported immediately to the District TB Coordinator who will then report to the State TB Program.

ALTERNATIVE HOUSING FOR PERSONS WITHOUT HOUSING OR "UNHOUSED" CLIENTS

Each county and district should maintain a current listing of single occupancy motels in their area. The ALA has a contract to verify suitable housing **for persons without housing**. Refer to the *American Lung Alternative Housing Project for Homeless Tuberculosis Patients in Georgia (Appendix J).*

INTRAVENOUS MEDICATION THROUGH CONTRACTED HOME HEALTH AGENCIES

The TB Program receives oral and intramuscular TB drugs from the State of Georgia. This does not include IV Amikacin or other intravenous medications. Districts are not able to acquire Amikacin IV from the State Pharmacy. If a patient has insurance, it may cover the drug costs for Amikacin including nursing services and IV infusion. If the client has no insurance or Medicaid and/or Medicare, then each district and/or county health department should facilitate a negotiated contract with Home Health Agencies (that have pharmacy services). The MOU/MOA should cover services on related patient education, required IV medication, IV supplies, PICC/IV line and care, routine blood draw/drug monitoring, documentation of services provided, transport of blood draw specimen(s) to the laboratory, reporting adverse effects or side effects to the ordering physician and other necessary clinical procedures. A Memorandum of Agreement (MOA) or (MOU) will need to be in effect between the Home Health Agency and the Health Department or Health District before initiating services. The MOU must be signed by all participating members. The District Coordinator must notify the TB Program Director at 404-463-2643 or the TB Program Deputy Director in the absence of the Director at 404-463-2643 before and through the entire process.

GRANT FUNDED THERAPEUTIC DRUG MONITORING – Southeastern National Tuberculosis Center (SNTC):

When grant funding is available, the SNTC provides free therapeutic drug level/monitoring services to certain qualified patients. Information, instructions, and forms regarding this service is available at the following link: https://idpl.pharmacy.ufl.edu/forms-and-catalog/

1. **The laboratory requisition form can be downloaded from this link: https://cop-idpl.sites.medinfo.ufl.edu/files/2016/02/IDPL-UFHealth-v01.16-writable.pdf**

STATE TB SOCIAL SERVICES

Contact the state TB Program Social Services Provider for assistance with referrals and consultations on complicated clients. The State TB Social Service Provider can provide the following services:

- Provide psychosocial assessments (to determine the problem(s), level of functioning and appropriate services and treatment plans for the patient)
- Provide referral/linkage to appropriate resources
- Provide direct services/counseling to patients and families
- Provide phone consultation to districts on complex cases
- Provide onsite consultation to districts on complex cases
- Provide educational programs to District staff regarding social service issues
- Provide assistance to districts with resource development and coordination by collaborating with local agencies and organizations
- Provide assistance to districts by collaboration with ALA on complex patients

- Provide assistance to districts on special projects

Who can be referred to the State Social Service Provider?

1. Patients referred to ALA for services
2. Patients with complex psychosocial problems (**unhoused**, uninsured, no income, substance abuse, mental health, undocumented, **TANF/Medicaid/Medicare/Disability applications,** complex co-morbid condition etc.)

Items needed for referral to State Social Service Provider:

1. Georgia Department of Public Health Form 3121-R, Tuberculosis Services and Client Referral Form located on the TB web pages at: **https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-public-health-clinic-forms**
2. Social service referral form (completely filled out with relevant information i.e., infectious status, insurance type, family members, family support, next of kin, income, unemployment history, etc.)
3. Any other referrals or social services notes from hospital and/or community agencies. It would also be very helpful to refer complex patients to the state social worker at the same time as they are referred to ALA for services (Appendix J).

PROGRAM EVALUATION

Program evaluation is a core activity of TB control. Self-evaluation is needed in order to identify key intervention points during therapy in which action can be taken to promote optimal patient outcomes. The TB Program encourages participation in the Office of Nursing Quality Assurance/Quality Improvement initiative. During each grant cycle, an evaluation plan is developed and implemented.

CASE REVIEWS

The district and local jurisdictions are expected to perform regular case reviews. The State Medical Consultant and other state office personnel will attend one case review per district per year. The State office will coordinate with each district to conduct these reviews. See ***Case Review Sheet*** **in** ***Appendix F***.

COHORT REVIEWS

The state office will conduct four cohort reviews per year. Usually, these will be in the high morbidity districts. The state office will coordinate with each selected district to conduct these reviews. **See Sample Cohort Review Presentation Form in Appendix F.** For more information on program evaluation expectations, processes, and procedures, please refer to *Tuberculosis Program Evaluation Guidelines* available at **https://dph.georgia.gov/tb-publications-reports-manuals-and-guidelines**

Pharmacy

Table of Contents

MEDICATIONS

The State provides oral, intramuscular TB drugs or PPD solution, free of charge to all TB clients treated through the local health departments. Clients, Medicaid, and insurance companies are not to be charged under any circumstance for oral, intramuscular TB drugs or PPD solution. Any client receiving any oral or injectable drugs through the county health department must be clinically assessed at least monthly by a registered nurse, advance practice registered nurse, physician's assistant or medical doctor for clinical improvement and adverse reactions to the medications. Each patient on TB medications should have a monthly clinical assessment.

For the current list of drugs available from the Department of Public Health's Office of Pharmacy, drug ordering procedures and storage considerations please refer to the current Drug Catalog **and/or current Drug Dispensing Procedure.** Your District Pharmacist or Drug Coordinator can provide you with a copy.

TRANSPORT OF DANGEROUS DRUGS

The DOT agreement signed by the client authorizes the DOT staff person to act as an agent of the client and gives permission for them to transport the client's dispensed medication. This medication is dispensed and labeled with the patient's information. PPD solution is not dispensed but is carried in bulk (multi-dose vials) to perform contact investigations. The Standard Nurse Protocols allows Registered Nurses to transport PPD solution to a non-public health clinic site. **Non-licensed public health staff may be** delegated by the District Health Director (DHD) or delegating physician **to transport PPD solution into the field when all of the following criteria have been met:**

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1. The unlicensed public health personnel job description outlining the specific parameters of the delegation.

2. The individual has obtained TST certification from the Georgia Tuberculosis Program and maintains certification through the district annual skill validation review process.

3. The individual has completed review of Transporting Dangerous Drugs. See standard nurse protocol for transporting dangerous drugs. A licensed medical professional may acknowledge by signing on behalf of the DHD.

340B INFORMATION AND DRUG DISPENSING PROCEDURE

Refer to the Nurse Protocols for Registered Professional Nurses in Public Health, current edition, "Georgia Department of Public Health Drug Dispensing Procedure". Located on the Office of Nursing web page at **https://dph.georgia.gov/clinical-services/office-nursing or** https://gets.sharepoint.com/sites/DPHIntranet/PHIL/Pages/DCR.aspx .

340B LAWS AGAINST SALE, DIVERSION OR TRANSFER OF PUBLIC HEALTH PURCHASED DRUGS

The 340B Drug Program is a program that requires drug manufacturers to provide outpatient drugs to eligible health care agencies and covered entities at a significantly reduced price. There are Federal Laws that prohibit selling and transferring drugs purchased by state and local public health departments. The drugs purchased by the Office of Pharmacy cannot be transferred to a pharmacy, doctor's offices, jails, nursing homes, etc. **Georgia Board of Pharmacy Rule prohibits a Retail Pharmacy from receiving drugs from public health – Rule 480-10-21 Purchase or Receipt of Drugs by a Pharmacy**. Available information at: https://dph.georgia.gov/clinical-services/office-pharmacy.

MEDICATIONS REQUIRING APPROVAL BY STATE MEDICAL CONSULTANT

- Second-line anti-TB medications
- Corticosteroids for patients with TB meningitis or pericarditis
- To receive second-line TB drugs please fax the following information/documentation to (404)463-3460:
    1. Copy of the prescription for ALL TB medications.
    2. List of ALL TB medications in the patient's planned drug regimen (including 2nd line medications) as well as any other prescription medications the patient may be taking.
    3. Progress Note stating the reason for an alternate regimen.

The *Second-Line Therapy Authorization Form* can be found in *Appendix F* as well as on the TB web pages at **https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-public-health-clinic-forms**. The state TB Nurse will verify the documentation and consult with the State Medical Consultant. Additional information may be requested. Once the State Medical Consultant has signed the approval, the State Office TB Nurse will supply a copy of the signed authorization to the State Office of Pharmacy and back to the requestor. The requestor will contact the district drug coordinator or pharmacy to have the order placed into Cardinal Order Express (district drug coordinator or pharmacist sends an e-mail to the State Pharmacy Section verifying the order was placed). Once the State Pharmacy Section receives the signed second-line approval form and the e-mail from the District Drug Coordinator/Pharmacist, the pending order can be approved (if the product is not on hand locally). The pharmacist can dispense the order. ***If there is no district pharmacist, seek Physicians or contracted pharmacy services to dispense since there is no nurse protocol for ordering and dispensing second-line drug or Corticosteroids for patients with TB Meningitis or Pericarditis.*** **All covered entities are responsible for the 340B drugs they purchase and dispense through contracted pharmacy services. All covered entities are required to maintain auditable records and provide oversight of their contract pharmacy arrangements.**

Directly Observed Therapy

Table of Contents

Directly Observed Therapy (DOT)

Tuberculosis (TB) treatment can seem difficult. It requires taking multiple medications for at least 6 months. Most people have trouble remembering to take their medicines, especially after symptoms of the disease improve or have disappeared completely. DOT is an essential element for the prevention of further transmission of infection and disease. The ultimate purpose is to have each patient fully complete his/her first-ever TB treatment. Having every initial treatment fully completed, patients can be cured of TB and relapses are kept to minimum. This is the only effective means to avoid MDR-TB and XDR-TB, which, in developing, high burden countries, is still almost incurable. DOT entails the direct observation, whether face-to-face or via video of the patient's self-administering and swallowing the correct dose of anti-tuberculosis medications at the proper time for the complete period of therapy by a designated, trained, and responsible agent of the patient. However, DOT is not just providing medication. DOT involves front line interaction with the patient. The DOT worker has the opportunity to make a genuine contribution not only to the patient's physical health but also his or her well-being. Frequently, the DOT worker will identify social service or personal needs that could interfere with completion of treatment. Helping the patient resolve these problems not only helps achieve program outcomes but it also helps the patient find the assistance needed with their problems. DOT is the standard of care in Georgia to ensure an individual who has been prescribed medication for the treatment of active TB disease or LTBI completes the recommended course of drug therapy by taking all the medication.

1. DOT is <u>required</u> for:
    - All suspected and/or confirmed active cases disease.
    - All children being treated for LTBI/presumptive LTBI less than 5 years of age.
    - All persons being treated for LTBI/presumptive LTBI on an intermittent dosing regimen
    - **All persons on the combined Isoniazid and Rifapentine regimen (3HP) for LTBI during the first 4 weeks, and all patients who do not meet the criteria for self-administration of 3HP.**
2. If financial resources allow, DOT is <u>strongly</u> recommended for:
    - Persons infected with LTBI/presumptive LTBI that are at risk for active disease (e.g., close contacts, immunocompromised persons, converters, etc.)
    - All children five to fifteen (5–15) years of age being treated for LTBI/presumptive LTBI **thereafter as determine by the district clinical personnel.**
    - Any person being treated for LTBI/presumptive LTBI that has adherence problems
3. Each person (or legal guardian) on DOT should sign and have a copy of a DOT agreement/Form 603 (*Appendix F*). If a patient is participating in VDOT a *Patient Consent and Release of Liability* form (*Appendix F*) should also be signed.

4. DOT is given Monday through Friday except in the case of MDR-TB or XDR-TB. Only DOT doses are counted towards completion of treatment.
5. DOT provision sites: DOT can be carried out at any site mutually agreed upon by the patient and DOT provider.
6. The standard DOT Screening Questions regarding TB symptoms, medication side effects and adverse reactions is to be completed at each DOT visit. The results are to be documented on the DOT sheet (*Appendix F*), in the appropriate computer system and communicated to the nurse. *Appendix F* provides a Patient Education *Review of Systems Aid* to assist with questions to ask patients. If at any time the patient displays symptoms of adverse reactions or side effects, please notify the TB Nurse Case Manager immediately.
7. Each dose is to be documented and counted on the DOT sheet, at the time of ingestion. Each dose is to be transferred to the electronic database (SendSS**) by the end of each month or less, as data entry resources allow.**
8. Education **(Review of systems Aid-Appendix F)** should be provided to the patient at each visit. **Use Language Line with Education Tool for non-English Speaking patient.**
9. The DOT worker is expected to be alert for information concerning any identified or unidentified contacts, early warning signs of adherence problems and possible relocation of the patient and to communicate this information to the TB Nurse Case Manager, **TB Coordinator or clinicians** promptly.
10. Any missed DOT appointments will be brought to the attention of the TB Nurse Case Manager or clinician and will be dealt with promptly according to procedures.
11. Who can provide DOT:
    - Supervised and trained licensed or non-licensed employees of local and regional health departments.
    - Any supervised and trained responsible person mutually agreed upon by the patient and the health department including (but not limited to) health care personnel, employers, school staff, clergy, staff of a drug treatment center, fireman or staff of a CBO.
    - Employees of institutions responsible for the TB care of their residents.
    - As a rule, DOT cannot be provided by a family member.
    - For complex regimens including IV/IM medications or twice daily dosing, home care agencies may provide DOT or share responsibilities with the local health department.
12. Personnel without a nursing license are not allowed to pour medications from bottles, pour pills out of packets, crush pills, or mix pills with food or liquids. They are to support the patient in self-preparation and self-administration of his/her own medications.
13. DOT providers are required to complete the orientation and education process outlined in the current Georgia Tuberculosis Program Policy and

Procedure Manual. DOT training must be documented on the DOT Provider Agreement and kept at the clinic level. All DOT workers are to sign a Provider Agreement.

14. Supervisors or TB Nurse case managers will accompany DOT providers on field visits each quarter for quality assurance purposes.
15. All medications must be stored and delivered according to the current Georgia Tuberculosis Program Policy and Procedure Manual.
16. Case conferences between the DOT worker and the TB Nurse Case Manager should be held at least weekly to share information concerning the patient's care.

VIDEO DIRECTLY OBSERVED THERAPY (VDOT)

In order to perform VDOT the outreach worker, RN, or LPN observes a patient taking his/her medication in their homes, workplace, or other location of patient's choice via smartphone, laptop, or desktop.

All patients with suspected or confirmed active TB disease will start TB therapy using traditional DOT. Only after the patient has demonstrated adherence to the treatment plan **over the first four (4) weeks** of therapy will he/she be considered eligible for VDOT as an incentive for continued therapy. All patients with active TB should be evaluated during the **first four (4) weeks of traditional** DOT by the health department to determine if they may be good candidates for switching to VDOT. Patients must achieve at least 80% compliance during this initial phase of therapy in order to be considered eligible for VDOT. Participation in VDOT is voluntary and may be forfeited at any time by the patient or revoked by the health department.

VDOT should be used with carefully selected patients meeting established minimum criteria. Local TB program staff must be trained in appropriate patient selection, use of the VDOT equipment, procedures for observing treatment, as well as the additional VDOT aspects listed in this policy. VDOT staff must be trained on the use of video equipment to include patient confidentiality. VDOT staff must document each patient encounter as directed by the local health department policy. In case of smartphone/laptop/desktop technical failure, the DOT worker will make a home visit to deliver DOT. The DOT worker must provide the patient with written instructions on what to do in an emergency (such as patient becomes hospitalized, equipment for VDOT is not working/accessible, etc.), who to call with questions regarding treatment, and a plan of what to do if the regular staff person providing VDOT is not available.

Once local TB staff select a patient that meets the criteria to receive VDOT, they must submit all required documents to their District TB Coordinator for review and approval. The local/district TB staff must submit a signed copy of the *Patient Consent and Release of Liability* form (*Appendix F*), *Medication Administration Record (MAR)* (*Appendix F*) to reflect patient

was at least 80% adherent during the first (4) weeks of TB treatment, as well as brief explanation why patient is believed to be a good candidate for VDOT. The District TB Coordinator carefully reviews the request and notifies LHD TB case manager that the patient has met/not met all the criteria for VDOT. If a patient does not meet the criteria for VDOT, and the District TB Coordinator believes that the patient should be considered for VDOT, the Nurse Consultant at the State TB Office must be notified for further evaluation of the patient situation. It is the responsibility of the District TB Coordinator to ensure that all the criteria for VDOT detailed in the VDOT Policy are met.

Webex and Pathways accounts, issued by the DPH Telemedicine Office are the only approved platform for VDOT. Staff cannot use personal cell phones/laptops/PCs to administer VDOT. All staff must be trained by the DPH Telemedicine team prior to receiving platform credentials. Staff granted this access will receive a brief online training on how to use the system and will be emailed the proper credentials to access the platforms. Staff at the LHD performing VDOT who do not have a Webex or Pathways account must notify their District TB Coordinator. The District TB Coordinator then contacts the nurse consultant at the State TB Program office to request accounts for those individuals.

TB staff must ensure patient is seen in the clinic by appointment with the TB nurse or physician at least once a month per protocol. This will ensure appropriate clinical and laboratory monitoring, provide the patient with a one-month supply of his/her TB medication, and confirm the date/time of the next clinic appointment.

PATIENT CRITERIA OR ELIGIBILITY FOR TB VDOT:
Patients can qualify for **VDOT FOR TB** after the completion of **4 weeks** of TB treatment if all the following apply:

- Pan-sensitive TB disease
- At least 80% adherent during initial phase
- Converted sputum smear and culture negative in initial phase of treatment
- No adverse reactions during the initial phase of treatment
- Can be served by a health care worker that speaks the same language or can use an interpreter
- No current history of alcohol or drug abuse
- No current history of mental illness e.g. psychiatric/sociopathic or depression
- Patient must not be considered at risk for poor adherence (homeless, prior incomplete or refusal of TB treatment, memory impairment, dementia)
- Patient can prepare his/her TB medications and can accurately identify each medication

- Patient is not a child or adolescent
- Patient can demonstrate how to properly use the equipment
- Patient can provide TB staff with picture identification to keep on file in his/her chart to confirm identity
- Patient owns a smartphone, laptop, or desktop with a data plan

NOTE: If TB Program staff feel strongly about a clients' need or identify a client for VDOT despite he/she not meeting all eligibility requirements outlined in this section, contact the TB State Program to determine patient's ability to begin VDOT.

REASONS TO STOP VDOT ONCE STARTED INCLUDE:

- Patient has an adverse reaction to TB medication
- Patient is no longer in stable housing
- Patient misses one or more health department calls and/or ingests less than 80% of scheduled VDOT medication doses
- Patient defaults on other aspects of adherence (missing medical appointments, not being truthful)
- Patient no longer consents to participating in VDOT and prefers traditional (face-to-face) DOT
- Patient receives American Lung Association (ALA) benefits **due to inadequate or no housing, or other problems or disorders requiring in-person support for successful TB treatment.**
- **Patient is no longer medically stable**

ADMINISTRATIVE REQUIREMENTS FOR VDOT FOR TB PATIENTS

The following administrative requirements must be met prior to placing TB suspects or confirmed cases, on VDOT:

- Signed *Patient Consent and Release of Liability* form
- **Signed *Active TB Treatment Plan*/ Form 3144 (Appendix F)**
- **Signed copy of the Video DOT Agreement – Form 603.VDOT.TB**
- **Medication Administration Record (MAR) – Form 3130 (Appendix F) Patient has completed the required 4 weeks of the initial phase of TB therapy or to reflect patient was at least 80% adherent during initial phase.**
- Paperwork has been submitted to the State TB Office including a brief explanation why patient is believed to be a good candidate for VDOT
- **Signed VDOT District Approver Agreement Form**

PROCEDURE FOR PERFORMING VDOT FOR TB PATIENTS

Prior to performing VDOT, TB program staff must ensure that consents are signed by patient and TB staff and that a mutual time has been established for calls to occur. **Recorded video**

is NOT acceptable, and the procedure must be done "live" face-to-face. VDOT will be performed as follows:

1. TB staff (outreach worker, RN, or LPN) calls the patient at a prearranged time via smartphone, desktop, or laptop using the **DPH Telehealth Webex or Pathways Platform.**
2. Patient displays his/her face on the video screen and confirms identity by stating first and last name as well as password **(agreed code).** (The patient may also wish to have a code word to let the TB staff know he/she is in a situation where confidentiality is compromised and he/she cannot continue with the call. If this occurs, the patient needs to agree on a different time on the same day to complete VDOT with TB staff. The patient and VDOT staff can also wear ear buds to maintain confidentiality).
3. TB staff inquiries about any problems, medications side effects (as outlined in *Policy 5.19 DOT Screening Questions Checklist*), or concerns before the patient takes their medications. Medications are held, if indicated, per existing protocols.
4. Using appropriate lighting, patient clearly displays the medication bottle or blister pack.
5. Patient describes the medication by name, shape, size, and/or other identifying qualities. Patient identifies the number of each type of medication to be taken.
    i. Patient holds medication in front of video camera before placing them in their mouth.
6. Patient swallows' medication in full view of camera.
7. Patient repeats the same procedure for each medication to be taken.
8. **Patient open mouth after ingesting each medication(s) to confirm medication(s) were swallowed**.
9. Prior to disconnecting, TB staff confirms date and time of the next VDOT to be observed.

After completing a VDOT session, the TB staff will document the date/time and medications observed as per standard DOT protocols on the MAR; the letter "V" must be circled after staff's initials on the MAR next to the date for each dose administered using VDOT. A recorded demonstration of VDOT is available on SABA at http://learningdevelopment.dph.ga.gov/Saba/Web/Cloud search for Video Directly Observed Therapy.

LTBI PATIENTS FOR DOT/VDOT OR SELF-ADMINISTERED THERAPY:

All LTBI patients receiving INH/Rifapentine regimen (3HP) should be evaluated for DOT/VDOT or self-administered therapy by the TB nurse.
Enrollment in DOT/VDOT or SA should be applied per the TB Nursing Protocol and thereafter is up to the discretion of the District TB nurse case manager and/or delegating physician.

REASONS TO STOP SELF ADMINISTER THERAPY ON HIGH RISK LTBI PATIENT ONCE STARTED INCLUDE:

- **Patient has an adverse reaction to LTBI medication**
- **Patient is no longer in stable housing**
- **Patient misses one or more health department calls and/or ingests less than 80% of scheduled LTBI medication doses**

- **Patient defaults on other aspects of adherence (missing medical appointments)**
- **Patient prefers traditional (face- to-face) DOT**
- **Patient is no longer medically stable**

CONFIDENTIALITY

Health departments must conform with the provisions regarding protection of personal health information contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Currently, web-based service providers like Skype are not considered secure. This information is included in the *Consent and Release of Liability* Form that the patient and nurse will sign. **The Georgia DPH Telehealth Webex and Pathways Platform, which the state TB program utilizes, is secure, HIPAA compliant and has a telemedicine application for data transfer with end- to- end encryption.**

DIRECTLY OBSERVED THERAPY (DOT) EDUCATION

All training must be verified and documented. These documents are to be kept at the local level and are to be available to the state office upon request.

SECTION A: The public health employee or contractor whose primary duty is to provide DOT

1. Complete the current CDC Self Study Modules on Tuberculosis available online at **https://www.cdc.gov/tb/education/ssmodules/default.htm**. These modules can be completed either online or using hard copies. The Supervisor must verify completion of each module and assess knowledge retained.
    - Introduction to course # SS3035
    - Module 1: Transmission and Pathogenesis of Tuberculosis
    - Module 2: Epidemiology of Tuberculosis
    - Module 3: Targeted Testing and Diagnosis of Latent TB Infection and Tuberculosis Disease
    - Module 4: Treatment of Latent TB Infection and Tuberculosis Disease
    - Module 5: Infectiousness and Infection Control
    - Introduction to course #SS3036
    - Module 6: Contact Investigation for Tuberculosis
    - Module 7: Confidentiality in Tuberculosis Control
    - Module 8: Tuberculosis Surveillance and Case Management in Hospitals and Institutions
    - Module 9: Patient Adherence to Tuberculosis Treatment
2. Complete a DOT class provided by the state office, district or local personnel.
3. Demonstrate skills check to include (but not limited to) the following:
    - Be issued and fit-tested for correct N-95 respirator **by the district or local personnel**. Describe when and how to replace issued masks.
    - Demonstrate the correct procedure for donning an N-95 Respirator.

- Demonstrate correct procedure for a self-check of fit of an N-95 mask.
- Describe when an N-95 respirator must be worn during a visit for DOT.
- Identify an N-95 mask and a surgical mask.
- Correctly name and identify each TB medication after visual inspection.
- Correctly confirm the number of pills needed for the following dosages of each TB medication they will deliver:
    i. Isoniazid **100mg;** 300 mg; 900 mg
    ii. Rifampin **150mg; 300mg;** 600 mg
    iii. Pyrazinamide 1000 mg; 1500 mg; 2000 mg; 3000 mg; 4000 mg
    iv. Ethambutol 800 mg; 1200 mg; 1600 mg; 2000 mg; 2800 mg; 4000 mg
    v. Pyridoxine (B6) 25 mg; 50 mg
    vi. Rifapentine 600mg; 900mg
- Explain the difference between a medication side effect and an adverse reaction.
- Describe side effects of the medications and possible actions to take.
- Describe adverse reactions to the medications and actions to take.
- Identify when to call the TB Nurse Case Manager and how to reach him/her.
- Accurately and legibly complete a DOT sheet (form 3130 or comparable).
- Describe process of turning in DOT sheets and where they are to be kept.
- Be knowledgeable and able to provide basic education on the following
- *12 Points of Tuberculosis (TB) Patient Education (Appendix F)* which includes:
    1. Transmission of TB
    2. Differences between LTBI and Active TB disease
    3. Progression of LTBI to Active TB
    4. Signs and symptoms of disease
    5. Importance of HIV testing and greater risk of progression to active TB if HIV positive
    6. Respiratory isolation and use of masks
    7. Infectious period
    8. Importance of chemotherapy as prescribed
    9. Side effects and adverse medication reactions
    10. Directly Observed Therapy
    11. Importance of regular medical assessments
    12. Importance of contact investigation

4. Complete a minimum of 2 weeks of observation in the field of a qualified DOT worker.

5. Complete a minimum of 2 weeks of performance in the field supervised by the DOT worker's supervisor.
6. Sign a DOT Provider Agreement.

SECTION B: The DOT worker who is not a public health employee or contractor but is a mutually agreed upon person by the patient and the health department OR a public health employee whose regular job does not involve providing DOT, but who is acting as a lay DOT worker. All training must be verified and documented. These documents are to be kept at the local level and are to be available to the state office upon request.

1. Attend a one-on-one educational session with the TB Nurse Case Manager or District TB Coordinator. Review the following:
    a. *12 Points of Tuberculosis (TB) Patient Education*"
    b. Review the specifics of case.
    c. Show the medications and dosages.
    d. Discuss the *DOT Screening Questions Checklist* and actions, side effects and adverse reactions, how to reach the TB Nurse Case Manager and when to seek help.
    e. Review, demonstrate and discuss the applicable skills needed from the following list:
        - Be issued and fit-tested for correct N-95 respirator.
        - Describe when and how to replace issued masks.
        - Demonstrate the correct procedure for donning an N-95 Respirator.
        - Demonstrate correct procedure for self-check of fit of an N-95 mask.
        - Describe when an N-95 respirator must be worn during a visit for DOT.
        - Identify an N-95 mask and a surgical mask.
        - Correctly name and identify each TB medication after visual inspection.
        - Correctly confirm the number of pills needed for the dosages of each TB medication they will deliver. Repeat this each time the medication changes.
        - Explain the difference between a medication side effect and an adverse reaction.
        - Describe side effects of the medications and possible actions to take.
        - Describe adverse reactions to the medications and actions to take.
        - Identify when to call the TB Nurse Case Manager and how to reach him/her.

    f. Show how to document on the DOT sheet. Set up the process to turn in the sheets each month.

2. Arrange to have the DOT worker observe several DOT visits with the patient and then have the DOT worker perform the visits under supervision until all parties feel comfortable.
3. Discuss where and how the medications will be stored.
4. Have the DOT worker sign the DOT Provider Agreement and the DOT consent with the patient.
5. Complete the DOT Instruction Sheet (*Appendix F*) and give to DOT Worker. Update as needed.
6. Allow plenty of time for questions and encourage questions.
7. Make sure the DOT Worker knows how to reach the TB Nurse Case Manager or designated person.

PROCEDURE

1. Obtain the medication bag for each patient from the TB Nurse Case Manager or Medication Nurse. Look at each bottle inside the bag to verify that the name matches the name on the outside of the bag and that there is enough medication to cover the day's dosage. Don't borrow medications from other patient's bottles. Tell the nurse if medications are needed. Make sure DOT sheet, Form #3130-R has the right patient's name on it and is in the right medication bag. Place all labeled medication bags in a carrying container.
2. Obtain information regarding isolation and the need for masks for each patient from the TB Nurse Case Manager. Make sure you have your N95 mask and a supply of surgical masks for the patients, if needed for clinic appointments.
3. Provide the clinic with an itinerary of your DOT visits for the day before leaving the clinic. Observe field safety rules. Follow local procedures for maintaining contact throughout the day.
4. Place the carrying container in your car where the medications are not visible from the windows. Place them in the cooler section of the car out of direct sunlight. During the summer keep the air conditioner on. Never put medication in the trunk. Follow local procedures to insure the proper sanitation, temperature, light, ventilation, moisture control, segregation and security. Lock the car doors whenever you exit the vehicle.
5. When you arrive at the DOT site, greet the person. Verify the identity of the patient and that you have the right medication for that patient.
6. Put on N95 mask, if needed.
7. Ask the patient how he/she is doing. Administer the *DOT Screening Questions Checklist* and take actions as indicated. If you identify any adverse reaction, hold the medication and immediately call the TB Nurse Case Manager. If you are the RN, assess the patient, hold the medication and call your District contract physician. Document on the DOT sheet (form #3130-R).

8. If no adverse reactions are reported, proceed with the DOT visit. Make sure the patient has something to drink and a snack if needed. Give the patient the medication bag with all the medication bottles in them.
9. Observe the patient taking the pills from each bottle and verify he/she has the correct number of pills for each medication. Once the patient has removed the pills from the bottles, maintain visual contact with the pills. Avoid the patient leaving your sight, answering the phone, picking up a child or clothing.
10. Watch the patient take and swallow the medication. Make sure the patient actually swallows the medication and does not "cheek" it or hide the pills in his/her hand, clothing or furniture. Do not leave the pills with the patient to take at a later time. The first line anti-TB medications should be taken together as a single oral dose rather than divided doses. This leads to a higher and potentially more effective peak serum concentration. It is preferable for the medications to be taken on an empty stomach if tolerated. However, if the patient experiences epigastric distress or nausea when taking the medication, dosing with a snack or food is recommended. If the patient (or child) cannot swallow the pills, he/she (or parent) can crush the pills and empty the capsules into one or two teaspoons of non-sugary liquid or food. Follow with the ingestion of non-medicated food or liquid.
11. It is recommended that the DOT Provider remain with the patient at least 5 minutes after the medication has been ingested, to assure that there is no regurgitation of the medication**.** During this time, build rapport and trust with the patient by engaging in interaction. Listen and try to understand the patient's knowledge, beliefs, and feelings about TB disease and treatment. Adopt and reflect a nonjudgmental attitude about behaviors that the patient may participate in that you may not agree with (e.g., drug use).

    Identify potential barriers to adherence and involve the patient in identifying possible solutions. Note any items or ideas that could be used as incentives or enablers for your patient.
12. Reinforce TB education from the *12 Points of Tuberculosis (TB) Patient Education* and answer any questions the patient has regarding the disease or treatment. Prepare the patient for the next step in treatment. The 12 Points of Tuberculosis (TB) Patient Education:
    1. Transmission of TB
    2. Differences Between LTBI and Active TB Disease
    3. Progression of LTBI to Active TB
    4. Signs and Symptoms of Disease
    5. Importance of HIV Testing
    6. Respiratory Isolation and Use of Masks
    7. Infectious Period
    8. Importance of Chemotherapy as Prescribed
    9. Side Effects and Adverse Medication Reactions

10. Directly Observed Therapy
11. Importance of Regular Medical Assessments
12. Importance of Contact Investigation

13. The DOT worker is expected to be alert for information concerning anything out of the ordinary (additional contact identification, social circumstances, and emotional status) and to communicate this information to the TB Nurse Case Manager promptly. For example, in casual conversation the patient may mention participating in a hobby at a previously undisclosed location. The DOT worker could probe a little bit and find out when the last time the patient participated in the hobby and which friends were there. It would be important to relay this information to the TB Nurse Case Manager for follow-up in the contact investigation.
14. After the patient has completed taking all of his/her medication, have the patient initial on the DOT sheet/Form 3130 and place your initials beside them.
15. Have the patient put the medication bottles back into his medication bag and hand it to you. Place the completed DOT sheet in the bag with the patient's medications.
16. Confirm the next DOT appointment, the next clinic appointment and transportation to the clinic. Answer any questions or concerns of the patient.
17. Offer words of support and encouragement to the patient for his/her involvement in treatment and getting better. Offer any incentive or enabler and thank the patient for the visit.
18. Take the medication bag with you (district or local procedure) and leave the DOT site.
19. Return to your vehicle and complete any notes and documentation about the DOT visit and observations made.
20. Place the notes and DOT sheet in the patient's medication bag and place bag into carrying container.
21. When you get back to the clinic**,** return the medications to designated person in designated area. DO NOT KEEP IN CAR. Place DOT sheets in designated place.
22. Communicate with the TB Nurse Case Manager about the patients you observed today. Coordinate any new interventions or strategies with the TB team.
23. Complete any computer documentation or other patient record documentation.

DOSE COUNTING

Dose counting is a method to count and document TB medication doses. It is helpful in determining if a patient is on track to complete treatment within the recommended time frame and it aids in determining when a patient has

completed treatment. Dose counting to determine completion of treatment is only definitive when the patient is on Regimen **allowed under nurse protocol.** These are the only treatment regimens allowed under nurse protocol. All other regimens require the contract physician's clinical judgment to determine when treatment is complete. Dose count for the month and dose count to date should be placed on each DOT sheet as it is completed.

Weekend self-administered medications do not count in the final dose tally. Self-administered doses during short vacations and out of town trips do not count in the final tally.

Weekly and intermittent dosing can be counted together. Five (5) weekly doses equal three (3) thrice weekly doses. Convert weekly and intermittent doses to follow the guidelines below.

The initial phase of treatment is counted first to determine completion of the intensive period of treatment. This count must be complete before moving on to the continuation phase of treatment. Ethambutol doses do not need to be counted and the Ethambutol may be dropped from the regimen as soon as the drug susceptibilities show no resistance.

Regimen 1/Option	Regimen 2 /Option - (Pick one (1) option)
Initial phase • **DOT (INH + RIF + PZA + EMB) 5 days/week** • **40 doses over 8 weeks** • **Should be completed within 3 months. SA doses are not counted towards the total doses.**	**Continuation Phase – 1(a)** • **DOT (INH + RIF) 7 days/week** • **126 doses over 18 weeks** • **SA doses given over weekends are not counted towards the total doses.** **OR**
	Continuation phase – 1(b) • **DOT (INH + RIF) 5 days/week** • **90 doses over 18 weeks** • **SA doses are not counted towards the total doses.** **OR**

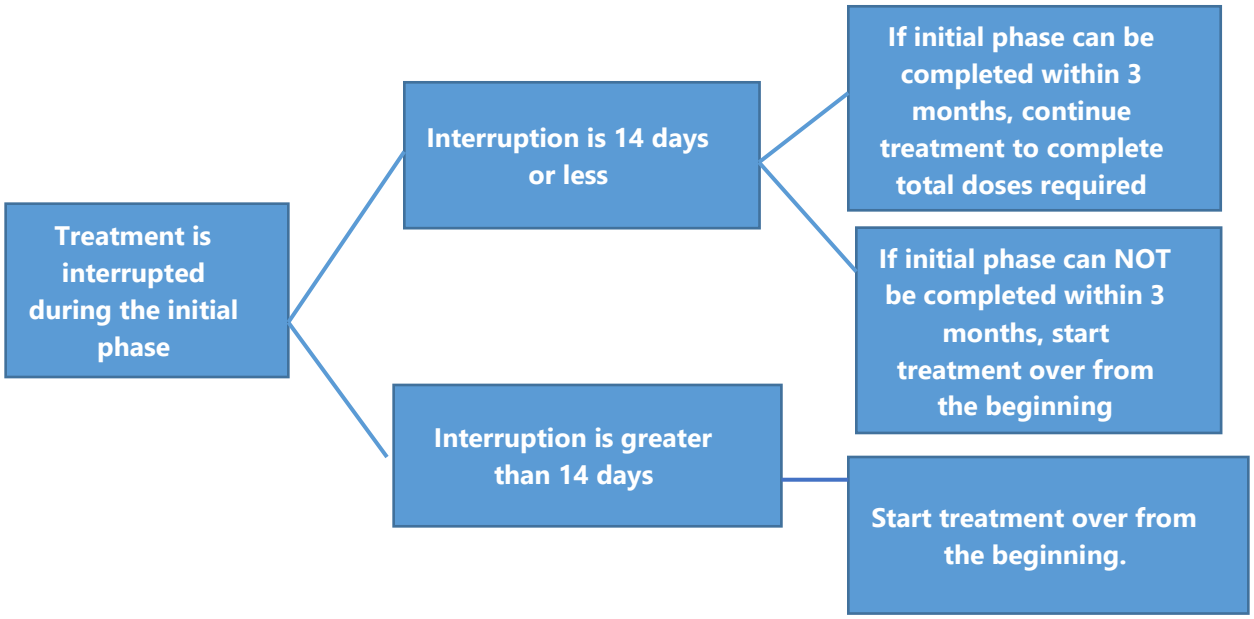
	Continuation phase – 1(c) • **DOT (INH + RIF) 3 days/week** • **54 doses over 18 weeks** • **SA not counted towards total doses. Regimen should be completed within 9 months is preferred treatment.** **OR**

INTERRUPTIONS IN TREATMENT

Interruptions in treatment can lengthen the time of treatment or may cause the patient to have to start treatment over.

INITIAL PHASE

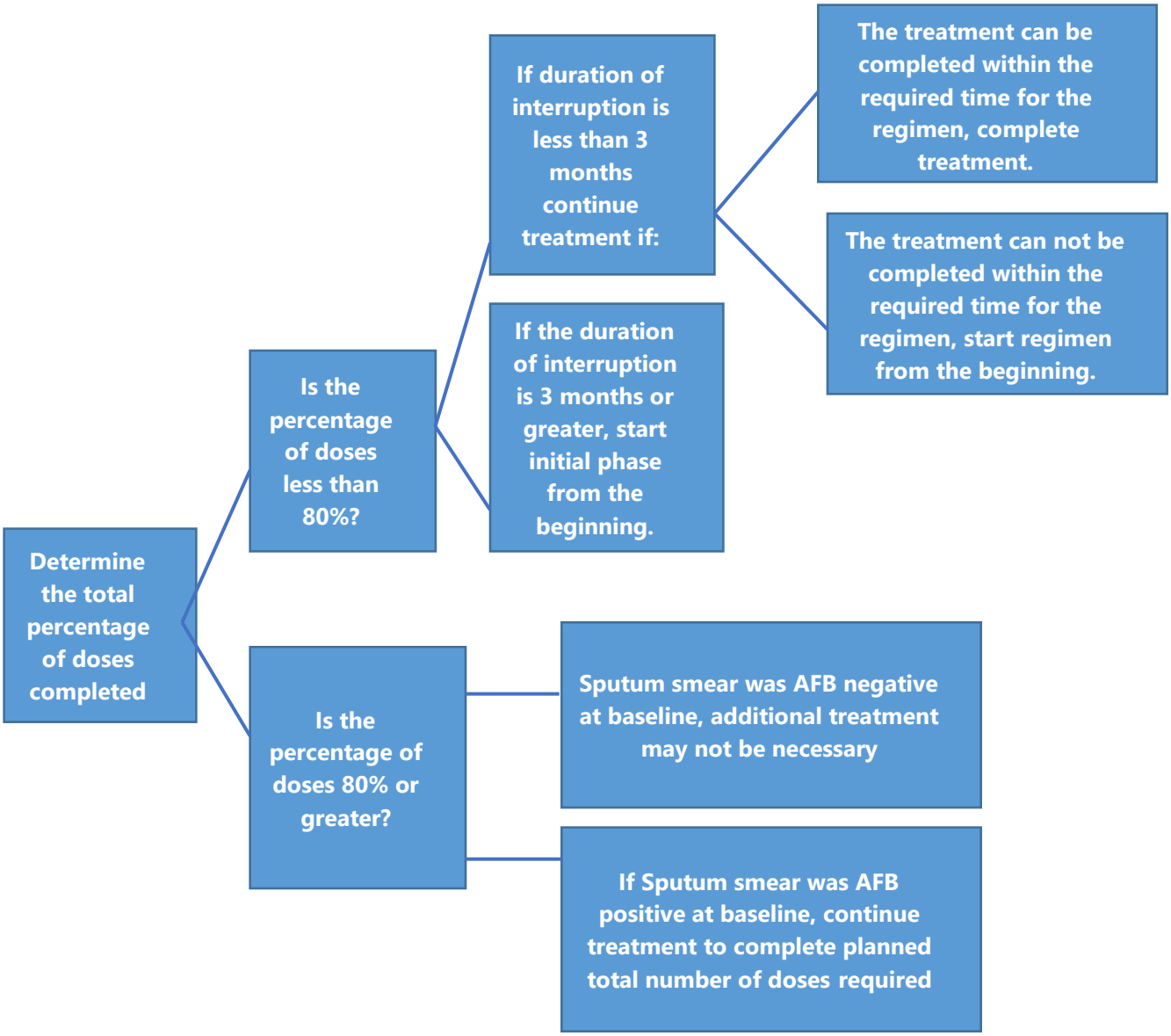
The initial phase of treatment is considered the first two months when the patient is receiving four medications. During this intensive time, if the interruption lasts more than 14 days, the patient must start treatment over. If it is less, then time must be added to the treatment to assure the correct number of doses for the initial phase.



CONTINUATION PHASE

The continuation phase is after the patient completes the intensive portion of treatment and the drug susceptibilities are known. During this time, if the interruption is more than three months, the patient will have to start treatment

INTERRUPTIONS IN THE CONTINUATION PHASE



over. If it is less than three months, then time will have to be added to the treatment to assure the correct numbers of doses are taken to complete treatment.

Contact Investigation

Table of Contents

CONTACT INVESTIGATION

DEFINITIONS AND BACKGROUND

Contact investigations serve as an important means of preventing further TB transmission. The evaluation of contacts of cases of infectious TB is one of the most productive methods of identifying adults and children with LTBI who are at high risk for progression to TB disease and persons already in the early stages of TB disease.

The TB cases we have identified are just the tip of the iceberg. Each infected person is what lies underneath the surface, waiting to emerge and become our next case. Every single TB case began as someone's contact. On average, 10 contacts are identified for each person with infectious TB in the U.S.; 20-30 percent of contacts have latent TB infection and one percent of contacts have active TB disease. Of those contacts who develop disease, approximately one-half will do so within the first two years after exposure.

Below are common terms used during contact investigations:

Suspect: A person believed to have active TB, but has not been confirmed to have TB disease

Case: A person diagnosed with active TB disease

Index patient: The first TB suspect or active TB case reported to the health department around whom a contact investigation is done

Source case: The person who infected another person with *M. tuberculosis*; this may be referenced when a child less than age five is reported to the health department and a source case investigation is done to look for the person who infected the child

Secondary case: Any additional suspects or cases found during the course of a contact investigation

Exposure: The condition of being vulnerable or susceptible to infection due to proximity to an infectious person; not every person who is exposed to TB becomes infected with TB

Infectious period: Time frame when exposure may have occurred. Starts three months prior to TB diagnosis or onset of symptoms

Contact: A person who has been exposed to an infectious case of TB

Elicitation: The naming and identifying of a person who has been exposed

Evaluation: Complete evaluation for a contact consists of a symptom screen, an initial tuberculin skin test (TST)/interferon gamma release assay (IGRA), a follow-up TST/IGRA 8-10 weeks later if initial TST/IGRA is negative, and a chest x-ray after any positive reaction of 5mm or more.

TST/IGRA: Tests to determine if a person is infected with M.tb

NAAT: (Nucleic Acid Ampliication Test) a repid test to determine whether M.tb is present in a specimen sample.

The national and state goals for contact investigation per the Grant-in-Aid annex are below:

- Ensure that 100% of TB patients with positive acid-fast bacillus (AFB) sputum smear have contacts identified.
- Ensure that 93% of contacts to sputum smear AFB positive TB patients be completely evaluated for TB infection and disease.
- Ensure that 88% of contacts to sputum smear AFB positive TB patients with newly diagnosed LTBI start LTBI treatment.
- Ensure that 79% of contacts to sputum smear AFB positive TB patients with newly diagnosed LTBI who started LTBI treatment complete treatment.
- Ensure that 75% of immigrants and refugees have documented complete evaluation within 90 days of arrival.
- Ensure that 80% of immigrants and refugees diagnosed with LTBI start treatment.
- Ensure that 70% of immigrants and refugees who started treatment for LTBI complete treatment.

While there are specific steps in a contact investigation, information is obtained at inconsistent rates which may alter the sequence of events; however, all steps will be covered in a complete investigation. The steps are as follows:

1. Medical record review (Pre-interview preparation)
2. Index patient interviews
3. Field investigation
4. Risk assessment for *M. tuberculosis* transmission
5. Identification of priority contacts
6. Evaluation of contacts
7. Treatment and follow-up of contacts
8. Determining the need to expand the investigation
9. Evaluation of contact investigation activities

For in depth information about each step, refer to the following resources:

CDC's "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis"at
http://www.cdc.gov/tb/publications/guidelines/ContactInvestigations.htm.

NTNC's *Tuberculosis Nursing: A Comprehensive Guide to Patient Care"* located in each health department.

CDC's *Self Study Modules*, "Module 6: Contact Investigation" at
http://www.cdc.gov/tb/education/ssmodules/default.htm

A contact investigation plan is a work in progress and will change as more information is obtained.
Who needs a contact investigation plan?

- Children less than five years old with LTBI
- Clients with extra-pulmonary TB
- Clients with active TB disease

CHILDREN LESS THAN AGE FIVE WITH LTBI

In Georgia, LTBI in children younger than five years old is reportable to public health authorities. Health departments must conduct a source case investigation, which entails looking for the person who may have infected the child. We know that infection had to be fairly recent (within the child's life). Most often, the child is infected by a household member. A contact investigation for these children should be completed within a week in order to prevent further transmission of TB. The investigation consists of inquiring of the parents about any caretaker or family member who has signs and symptoms of TB and to placing and reading one TST/IGRA on each household member. A positive IGRA or a TST result of 5 mm or more is followed with a chest x-ray (CXR). If the CXR is normal or negative, then the initiation and completion of LTBI treatment is encouraged. Any pediatric patient being evaluated for TB under 5 years of age should be IMMEDIATELY reported to the State Medical Consultant for evaluation. Any pediatric suspect for LTBI under 5 years of age should be IMMEDIATELY reported to the State Medical Consultant for evaluation as well.

PATIENTS WITH EXTRAPULMONARY TB

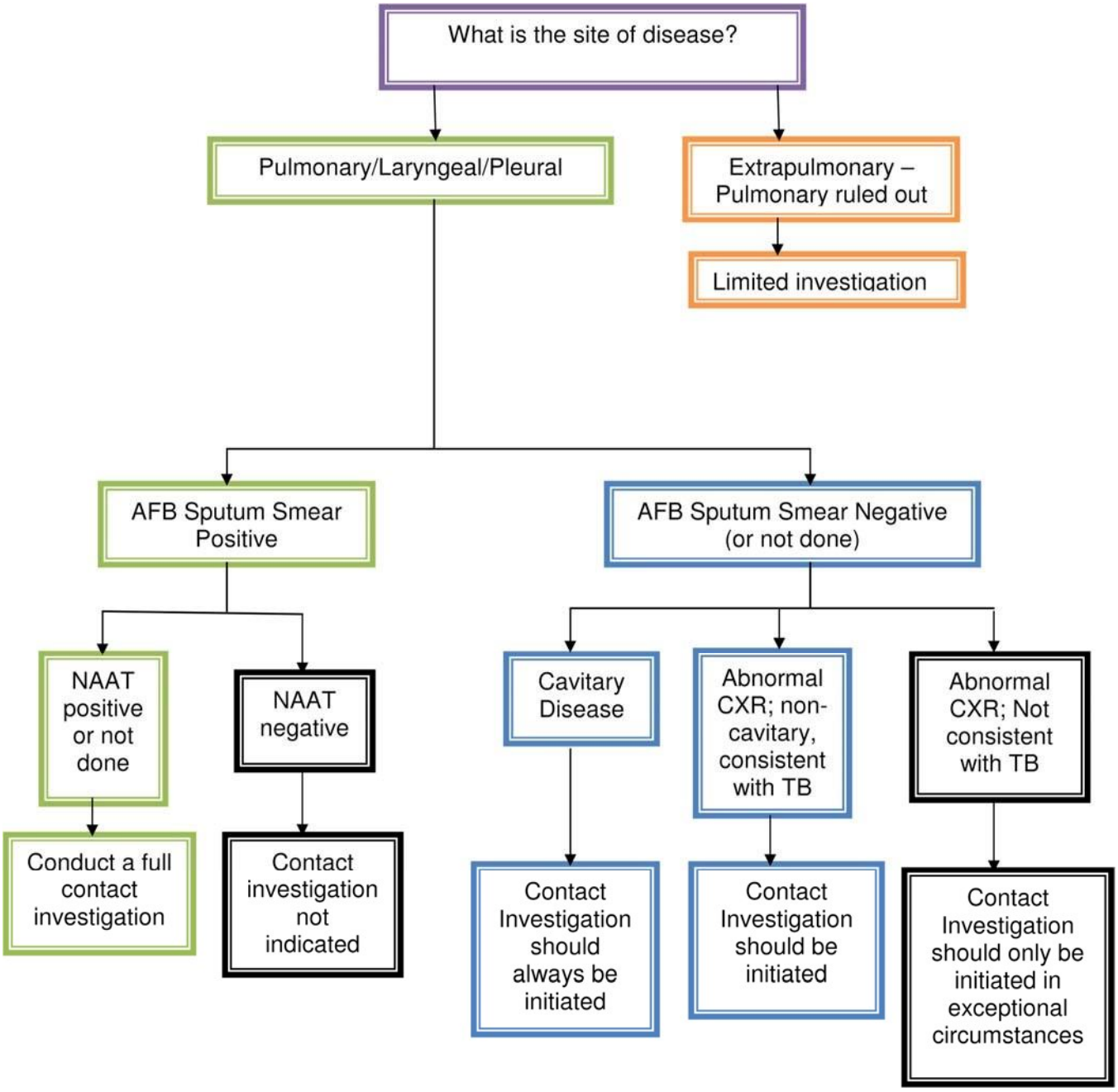
TB patients that do not have pulmonary, laryngeal, or pleural disease are considered to have extra-pulmonary TB and are not infectious. However, sometimes a person will have pulmonary TB along with extra-pulmonary TB. Pulmonary TB must be ruled out by collecting three diagnostic sputum specimens and performing a CXR. A limited contact investigation should be done within 30 days. **This investigation consists of household members only. If a household member is identified with signs and symptoms of TB, that person should be completely evaluated for TB. The household members would then receive one TST/IGRA. A positive IGRA or a TST result of 5mm or more is followed with a CXR. If the CXR is normal or negative, then treatment initiation for LTBI and treatment completion is**

encouraged. If household members initial TST/IGRA is negative, then no further action is required.

NOTE: Nurses can only dispense TB medications for conditions outlined in the TB Nurse Protocols. Please refer to current TB Nurse Protocols for further guidance.

PATIENTS WITH ACTIVE TB DISEASE

Clients with active TB disease will have the most comprehensive contact investigations. The first question to be answered is “what is the site of the disease”?



Indications that a patient is infectious include the following:

- Symptoms of TB (cough that lasts three weeks or longer, fever, weight loss, night sweats, coughing up blood, weakness or fatigue)
- A positive AFB sputum smear
- A positive NAAT
- Cavitary disease
- An abnormal chest x-ray consistent with TB

Once a contact investigation is initiated, certain time frames must be met.

Activity	Suspects with indications of infectiousness	Suspects without indications of infectiousness
First Index Patient: In-person interview	Less than or equal to 1 working day from notification	Less than or equal to 3 working days from notification
Residence Visit: Visit the place of residence of the index patient	Less than or equal to 3 working days after the first interview	3 working days after the first interview
Field Investigation: Visit all potential settings for transmission (school, work, church, leisure, etc.)	5 working days after the start of the investigation	5 working days after the start of the investigation
Index Patient Re-interviews: Re-interview the index patient one or more times for clarification and additional information	1 or 2 weeks after the first interview	1 or 2 weeks after the first interview

Centers for Disease Control and Prevention, National Tuberculosis Controllers Association. Guidelines for the investigation of contacts of persons with infectious tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR 2005:54(No. RR-15):7-8.

For additional information on interviewing the index patient, please see the following resources: T*B Interviewing for Contact Investigation: A Practical Resource for the Healthcare Worker* (New Jersey Medical School Global Tuberculosis Institute Web site at **https://globaltb.njms.rutgers.edu/ntbcweb/downloads/products/tbinterview.pdf**

Effective TB Interviewing for Contact Investigation: Self-Study Modules. CDC **https://www.cdc.gov/tb/education/ssmodules/default.htm**

CONTACT PRIORITY

The following is adapted from NTCA/NTNC *Tuberculosis Nursing: A Comprehensive Guide to Patient Care*, Appendix III, Priority of Exposed Contacts (Washington State):

Contacts are classified into three groups (High, Medium, and Low) according to the priority of their need for follow-up. Priorities may change as you learn more information about the case and/or the contact and/or the environment. Remember: No matter what their category, always prioritize the follow-up of contacts. First address the persons who are considered a medical risk. These are defined as those who are at particularly high risk of developing TB disease once infected with *M. tuberculosis*. These contacts include the following in Georgia:

- Immunosuppressed, e.g., HIV infection, prolonged corticosteroid therapy, organ transplant, TNF blockers
- Less than 5 years of age
- Have diabetes mellitus, silicosis, end stage renal disease, gastrectomy, jejunoileal bypass, leukemia, lymphoma or cancer of the head or neck.

An initial encounter needs to be made with each identified contact in order to assess the person for signs and symptoms of tuberculosis.

Category 1 Time Frames for Contact Evaluation and Treatment Initiation				
Priority	**Working days from listing of a contact to initial encounter**	**Working days from initial encounter to completion of initial medical evaluation**	**Considered for presumptive LTBI treatment during window period**	**Working days from completion of medical evaluation to treatment initiation**
High priority without medical risk	3 working days after being listed as a contact	5 working days	No	10 working days
High priority with a medical risk or age less than 5 years	3 working days after being listed as a contact	5 working days	Yes	Continue treatment for a full course if infected.
Medium priority	3 working days after being listed as a contact	10 working days	No	10 working days
Low priority	10 working days after being listed as a contact	30 calendar days	No	10 working days

EXPOSURE CATEGORY 1

The County Health Department (CHD) should focus on the highest priority contacts:

- Those exposed to persons with acid-fast bacilli (AFB) sputum smear positive or cavitary tuberculosis.

Contacts to these cases are categorized as follows:

- High = Case is sputum smear positive or cavitary chest x-ray and contact is:
    1. A household member
    2. Less than 5 years of age
    3. Has medical risk factors (i.e., HIV)
    4. Was exposed during a medical procedure (i.e., bronchoscopy)
    5. Was exposed in a congregate setting
    6. Exceeds duration environment limits
- Medium = Case is sputum smear positive or cavitary chest x-ray and contact is: 1. 5 - 15 years of age
    2. Exceeds duration environment limits
- Low = Case is sputum smear positive or cavitary chest x-ray and contact is:
    1. All other contacts that do not fall under the preceding categories (e.g. individual visiting outdoors once or twice a week during the infectious period)

EXPOSURE CATEGORY 2

- Those exposed to persons with acid-fast bacilli (AFB) sputum smear negative tuberculosis or,
- Those exposed to persons suspected of having TB disease due to an abnormal chest x-ray that is consistent with TB disease.

Contacts to these cases are categorized as follows:

- High = Case is sputum smear negative, and contact is:
    1. Less than 5 years of age
    2. Has medical risk factors (e.g., HIV)
    3. Was exposed during a medical procedure (e.g., bronchoscopy)

  Medium = Case is sputum smear negative, and contact is:
    1. A household member
    2. Was exposed in a congregate setting
    3. Exceeds duration environment limits □

  Low = Case is sputum smear negative, and contact is:
    1. All other contacts that do not fall under the preceding categories

Category 2 Time Frames for Contact Evaluation and Treatment Initiation				
Priority	**Working days from listing of a contact to initial encounter**	**Working days from initial encounter to completion of initial medical evaluation**	**Considered for presumptive LTBI treatment during window period**	**Working days from completion of medical evaluation to treatment initiation**
High priority without medical risk	3 working days after being listed as a contact	10 working days	No	10 working days
High priority with a medical risk or less than 5 years of age	3 working days after being listed as a contact	10 working days	Yes	Continue treatment for a full course if infected
Medium priority	3 working days after being listed as a contact	10 working days	No	10 Working Days
Low Priority	10 working days after being listed as a contact	May consider waiting until 8 weeks after last exposure to perform TST/IGRA	No	

EXPOSURE CATEGORY 3

The CHD should provide follow up on these contacts according to resource availability (time, staff, etc.):

- Those exposed to persons with suspected TB with abnormal chest x-rays not consistent with TB disease

CONTACT EVALUATION

The evaluation of a contact is much more than simply administering a tuberculin skin test **or IGRA**. The contact must be completely evaluated based on good decision making and best practices. The following format for the evaluation and monitoring of TB patients is used to be consistent within this document. This format can assist the nurse in charting and in determination of correct CPT evaluation and management codes.

CHIEF COMPLAINT

Patient has been exposed to an active TB case. This person may be a named contact by the index case or may be discovered during the course of the investigation. Not everyone who is exposed to an active case of TB becomes infected or progresses to disease.

HISTORY OF PRESENT COMPLAINT

It is important to gather a pertinent history from contact/patient to perform a thorough evaluation, but it will also aid in conducting a thorough contact investigation.

CONTACT TO A CASE

When eliciting the details about the exposure, document all of the following:

- Location and environment of the exposure – Where did the exposure take place? Was it at school or work? If so, document the name of the workplace or school and describe the exact location of the exposure. Describe the environment.
- Amount of time spent with TB case – How much time is spent with the TB Case?
- Frequency of time spent with TB case – How often do the contact and the TB Case spend time together? Is it every day, once a week?
- Physical space between contact and TB case – What is the physical proximity of the contact and the TB Case? Six inches? 20 feet?

For example, “Ms. Smith and the TB Case share a 45-minute lunch break together in the ABC company break room. The break room is a 12 foot by 14-foot room with one table which seats 10 people. Ms. Smith states she sat at the same table with the TB case approximately 18 inches apart. They would eat lunch together at least 4 days a week.”

PREVIOUS TB HISTORY

It is very important to know if the contact/patient has ever been diagnosed with active TB disease or latent TB infection before because this will impact how he/she is evaluated for this exposure. Document dates of diagnosis or testing, location where the diagnosis or testing took place and what treatment was offered or completed. Also document date, and location of any BCG vaccination given to the patient.

PERTINENT MEDICAL HISTORY

It is necessary to determine if there is any medical history or condition that may indicate the contact would be at a high risk of progression to TB disease if infected with TB. Document the history of any of the following:

- HIV infection*
- Prolonged corticosteroid therapy
- Organ transplant
- Tumor necrosis factor (TNF) blockers
- Diabetes mellitus
- Silicosis
- End stage renal disease
- Gastrectomy
- Jejunoileal bypass
- Leukemia
- Lymphoma
- Cancer of the head or neck
- Less than 5 years of age

*CDC recommends HIV testing **all** contacts, no matter the HIV status of the case. However, if the index TB case is HIV+, then it is vital to have the adult contacts tested for HIV.

Any of the above conditions would make the contact a high priority contact with a medical risk. This means the healthcare provider will need to assess the need to place the contact on presumptive latent TB infection treatment during the window period.

REVIEW OF SYSTEMS
A limited review of systems is done to assess whether the patient has any signs and symptoms of active TB disease and whether there is any contraindication to performing a TST.

CONSTITUTIONAL
Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite?

SKIN
Does the patient have a rash, itching, scaring or tattoos on arm?

RESPIRATORY
Does the patient have any shortness of breath, cough or sputum?

ALLERGIC/IMMUNOLOGIC
Does the patient have asthma? Has he/she had hives or anaphylaxis because of exposure to anything? Does he/she have an allergic response to materials, foods or animals?

PHYSICAL EXAMINATION
A very limited physical examination is made. Observe characteristics of breathing; note any coughing or shortness of
breath. Observe overall skin texture. Examine skin of arm for scarring, tattoos, veins, turgor.

DECISION MAKING
Use all the information obtained during the history, review of systems and physical examination to make your decision on how to handle this patient.

ARE THERE ANY SIGNS OR SYMPTOMS OF POSSIBLE ACTIVE TB?
Does the patient need a complete evaluation for active TB?

Does the patient need a referral for a physician, chest x-ray, etc.?
Does the patient need to be isolated?
Dose the patient need a mask?
Do sputum specimens need to be collected?

WHAT METHOD OF EVALUATION IS BEST?
Is a TST or IGRA needed?
Is there any contraindication to placing a TST, IGRA?
Is the patient able to return to the clinic in 48-72 to have the TST read? Does the patient need a chest x-ray instead of a TST, IGRA?

WHAT IS THE PRIORITY OF THE PATIENT?
Is this patient at high risk of progression to TB disease if infected?
Does the patient need a chest x-ray along with a TST, IGRA?
Will the patient need any follow-up after this test? Does this contact need to be placed on presumptive latent TB infection treatment?

COUNSELING/CARE COORDINATION
GENERAL EDUCATION OF A CONTACT
Regardless of the method of evaluation for the patient, any contact to a case is bound to have questions and the healthcare provider needs to be able to educate the contact on the following:

- The difference between exposure, infection, and disease
- Purpose of an evaluation and the methods (TST, IGRA, Chest X-Ray)
- Limitations of testing
- Discuss follow-up testing in 8 – 10 weeks. Emphasize the significance of the follow-up TST/IGRA. Discuss best way to remind patient of follow-up test. Obtain alternative contact information for the patient.
- Explain the need for HIV status and the relationship between HIV and TB
- Discuss the patient's risk factors and why the test was chosen

TUBERCULIN SKIN TEST

- Do not rub, scratch or pick at injection site
- Do not cover injection site with a Band-Aid
- It is alright to get the injection site wet
- Set appointment for the patient to return in 48-72 hours to have the test read

CHEST X-RAY

- For previous positive patients, explain why a TST is not indicated and why a chest x-ray is being done
- For patients with a medical risk, explain why a chest x-ray is needed regardless of the TST or IGRA result
- Set appointment for chest x-ray
- Complete referral forms
- Give instructions to patient as to where to go, what time and what will occur • Set appointment for follow-up to review the results of the chest x-ray

HIGH PRIORITY CONTACTS WITH A MEDICAL RISK

- Explain how the medical risk can lead to a progression to disease if the contact is infected
- Discuss window period and presumptive latent TB infection treatment

PROCEDURES

Chose the appropriate procedures needed to evaluate the patient. Identify and take credit for everything you do. All procedures need to be coded accurately.

- Administer a TST
- QFT
- T-Spot
- HIV
- Screening for HIV
- Venipuncture
- Handling / Conveyance of specimen
- Chest X-Ray
- Risk Reduction Interventions (15 min.)
- Risk Reduction Interventions (30 min.)

EVALUATION AND MANAGEMENT

The evaluation and management is sometimes referred to as the office visit code. Be sure to select the most appropriate evaluation and management code.
LPN: TST reading; no follow-up
RN: straightforward
RN: arrange for CXR; high risk for progression

This same procedure should be followed in 8 – 10 weeks when the follow-up evaluation is done.

PRESUMPTIVE LATENT TB INFECTION TREATMENT

Presumptive LTBI treatment is the practice of providing window period prophylaxis treatment for presumed *M. tuberculosis* infection to high-risk contacts of infectious TB cases, when the contact has an initial TB skin test reaction of less than 5mm or initial negative IGRA result and the testing was performed less than 8 weeks from the contact's last exposure to the source case.

Contacts at particularly high risk of developing TB disease once infected with *M. tuberculosis* include: children less than 5 years of age and persons with immune systems compromised by HIV infection, immunosuppressive medications (prednisone, cancer chemotherapy, anti-rejection drugs for cancer therapy, tumor necrosis factor alpha agents antagonists) and certain medical conditions (diabetes mellitus, silicosis, end stage renal disease, cancer of the head and neck, reticuloendothelial diseases [e.g., lymphoma, leukemia], gastric or jejunoileal bypass surgery).

Candidates for presumptive LTBI who would benefit from a <u>full course</u> of LTBI treatment are immunosuppressed due to the following conditions:

- HIV infection.
- Prolonged corticosteroid therapy.
- Persons with organ transplants.
- Persons on TNF-alpha inhibitors

Candidates for presumptive LTBI who can stop treatment after the window period if the follow-up TST/IGRA is negative include contacts that are children less than 5 years of age and persons with any of the following conditions:

- Diabetes mellitus.
- Silicosis.
- End stage renal disease
- Gastrectomy
- Jejunoileal bypass
- Leukemia
- Lymphoma
- Cancer of the head or neck

TREATMENT OF INFECTED CONTACTS

All contacts diagnosed with LTBI will be offered treatment unless contraindicated. Contacts will be encouraged to start and complete LTBI treatment. The TB Coordinator should review the contact investigation forms on a regular basis. All contacts will be entered into SENDSS according to the time frames stated in the Medical Records/ Surveillance Section. The following codes are to be used:

CODES		
Reason LTBI treatment stopped	**Reason why contact investigation not completed for contact**	**Reason why no contacts entered**
1. Completed therapy 2. Death 3. Moved 4. Active TB developed 5. Adverse reaction 6. Chose to stop/Lost to follow-up 7. Provider decision	1. Still following up 2. No second TST/IGRA because first TST/IGRA performed 8-10 weeks after exposure 3. No second TST/IGRA because extra-pulmonary source case 4. No second TST/IGRA because sputum/culture negative source case 5. Refused/uncooperative 6. Moved 7. Lost to follow-up 8. Died 9. Other	1. Contact investigation not done 2. Case died or too ill to interview. No surrogate interviewee available. 3. Case uncooperative/refused to identify contacts. No surrogate interviewee available. 4. Case moved/lost to follow-up. No surrogate interviewee available. 5. Contacts identified but cannot be located. 6. Contacts uncooperative/refused 7. Contacts moved/lost to followup 8. Shares same contacts with an index case whose contacts have already been entered 9. Mass screening done. Cannot distinguish between close and casual contacts. 10. Other

INVESTIGATIONS ACROSS JURISDICTIONS

CONTACT INVESTIGATIONS ACROSS HEALTH DISTRICTS

District TB Coordinators should notify other district TB coordinators of cross-district contact investigations and continue to monitor follow-up to ensure all contacts of cases from their district are identified and evaluated. Local health department TB nurses should complete the contact investigation form with full name and location information. This form should be forwarded to the receiving county health department for evaluation who in turn should return the completed form to the originating health department. The district of the source case for the contacts is ultimately responsible for entering the contact investigation results in SENDSS, but may request help from other districts or the state epidemiology unit if the data entry task overwhelms their district's capacity to enter all contact information.

1. Requesting County should send a letter of notification to the identified contact which informs them of the exposure, refers them to their local health department, and lets them know that a health department employee may be contacting them.
2. Requesting County completes Form 3126 with the following information:

- Index Patient Information
- Patient's clinic number
- State registry number
- Patient's county
- Disease site
    - Infectious period
    - Initial sputum results and date collected
- Contact information
- Exposure environment
    - Name, phone number, complete address
    - Race
    - Sex
    - Date of birth and age
    - Relationship to index patient
    - Last exposure date
    - Priority

3. Fax with a copy of the letter sent to the contact to the Receiving County and to the state office
4. Receiving County needs to act within stated time frames for evaluating contacts:

- **HIGH PRIORITY** Initial encounter within 3 or less days after notification with medical evaluation completed within 5 days of initial encounter (10 days if smear negative)
- **MEDIUM PRIORITY** Initial encounter within 3 days after notification with medical evaluation completed within
  10 days of initial encounter
- **LOW-PRIORITY** Initial encounter 10 days after notification with medical evaluation completed within 30 days. 5. Receiving County completes Form 3126 with documentation and faxes back to Requesting County by the timeframes indicated for the priority of the contact so first TST can be entered into SENDSS.

6. Requesting County telephones Receiving County at the time when the 2nd TST is due to give a friendly reminder. Remember, it is the Requesting County who is responsible.
7. Receiving County completes Form 3126 with documentation and faxes back to the Requesting County and to the state office.

CONTACT INVESTIGATIONS ACROSS STATES

Contacts to Georgia cases that move out of state should be referred to that state for follow-up by submitting an interjurisdictional notification form to the State TB Program, which will notify the new state. When the follow-up information is received from the new state, the TB Program will forward the information to the District TB Coordinator. When the Georgia TB Program is notified of contacts entering Georgia from other states, the information is forwarded to the appropriate District TB Coordinator. When follow-up information is returned to the TB Program, it is forwarded to the original state that submitted the contact information.

EXPANDING THE INVESTIGATION

A contact investigation may need to be expanded if there is evidence of recent and/or continuing transmission.

- Unexpectedly large rate of infection in high priority contacts
- Evidence of a secondary case of TB disease
- Infection in any contact less than 5 years of age
- Contacts with change in TST status (converters)

EXAMPLE OF INFECTION RATE

Eleven high priority contacts were identified for a reported TB case. One contact had a documented previous positive skin test. The other 10 contacts did not have documented previous skin tests. These 10 contacts were recently tested in connection with the contact investigation with the following results: 7 had a positive reaction and 3 had a negative reaction.

Summary:

11 contacts were identified
1 contact had a documented previous positive skin test
10 contacts had no documented previous skin test
7 of the 10 contacts had a newly identified previous positive skin test
3 of the 10 contacts had a newly identified negative skin test

1. Determine the number of contacts with a newly identified positive skin test.

Subtract the number of contacts with a documented previous positive skin test from the total number of contacts with positive skin tests (new or previously documented)

8 contacts with positive skin tests (new or previously documented) -1 contact with a documented previous positive skin test

7 contacts with newly identified positive skin tests

2. Next, determine the total number of contacts without a documented previous positive skin test. Subtract the number of contacts with a documented previous positive skin test from the total number of contacts

11 total number of contacts identified -1 contact with a previous positive skin test

10contacts without a documented previous skin test

3. Finally, determine the infection rate.

Divide the number of contacts with a newly identified positive skin test by the total number of contacts without a documented previous positive skin test

Multiply by 100; the resulting percentage is the infection rate for the group of contacts

7 contacts with a new positive skin test

10contacts without a documented previous skin test X 100 = ***70% Infection rate***

4. Decide on expansion of testing.

Yes, you would expand testing since our background infection rate = 2-3%

EXAMPLE OF SECONDARY CASE

During the course of your investigation, 14 contacts are evaluated. One of those contacts has signs and symptoms of active TB. This contact becomes a TB suspect and has a complete evaluation for a TB case. A contact investigation will now begin around this second suspect/case. At this point, it cannot be determined if the index case transmitted the disease to the contact or if the contact is the source case. Either way, recent transmission has taken place and now there is a secondary case of TB. The investigation of the index case should now be expanded.

EXAMPLE OF LATENT TB INFECTION IN PERSON LESS THAN 5 YEARS OF AGE

The contact investigation includes the household members. The index case has a wife, an eight-year-old son and a three-year old toddler. The wife and the son have a 0-millimeter TST (negative), but the three-year old has a 6 mm TST (positive). This indicates recent transmission and calls for an expansion of the investigation.

EXAMPLE OF TST CONVERTER

An index case has exposed 22 co-workers. There is an annual TB screening in the workplace and each of the 22 contacts had a TST within the last year that was 0 mm (negative) at that time. When tested after the exposure, one co-worker had a result that was 12 mm. This co-worker is said to have converted from a negative result to a positive result. The definition of conversion is an increase of 10 mm within a two-year period.

SUMMARY

In the absence of evidence of recent transmission, an investigation should not be expanded to lower priority contacts. When program-evaluation objectives are not being achieved, a contact investigation should be expanded only in exceptional circumstances, generally those involving highly infectious persons with high rates of infection among contacts or evidence for secondary cases and secondary transmission. Expanded investigations must be accompanied by efforts to ensure completion of therapy.

Decisions about expanding contact investigations should be made by clinical and supervisory staff, the TB coordinator, and sometimes the state office.

Evaluation and Monitoring

Table of Contents

Each TB patient with active disease is to have a physical evaluation according to these programmatic guidelines prior to receiving services. Each patient will have to give a medical history, have a review of systems and a physical examination. Whether these components are limited or in-depth depend on why the patient is being evaluated.

The evaluation of a patient needing a TB screening would be limited and focused in scope. A patient who is beginning treatment for active TB disease would need a very detailed and in-depth evaluation. **A patient beginning treatment for LTBI would have review of systems and adverse reactions for monthly monitoring and treatment.**

EVALUATION FOR TB SCREENING

PREVIOUS TB HISTORY

It is very important to know if the patient has ever been diagnosed with active TB disease or latent TB infection before because this will impact how he/she is evaluated. Document dates of diagnosis or testing, location where the diagnosis or testing took place and what treatment was offered or completed. Also document date, and location of any BCG vaccination given to the patient.

PERTINENT MEDICAL HISTORY

It is necessary to determine if there is any medical history or condition that may indicate the patient would be at a high risk of progression to TB disease if infected with TB. Document the history of any of the following:

- HIV infection
- Prolonged corticosteroid therapy
- Organ transplant
- TNF blockers
- Diabetes mellitus
- Silicosis
- End stage renal disease
- Gastrectomy
- Jejunoileal bypass
- Leukemia
- Lymphoma
- Cancer of the head or neck
- Less than 5 years of age

REVIEW OF SYSTEMS

A limited review of systems is done to assess whether the patient has any signs and symptoms of active TB disease and whether there is any contraindication to performing a TST.

CONSTITUTIONAL: Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite?

SKIN: Does the patient have a rash, itching, scaring or tattoos on arm?

RESPIRATORY: Does the patient have any shortness of breath, cough, or sputum?

ALLERGIC/IMMUNOLOGIC: Does the patient have asthma? Has he/she had hives or anaphylaxis as a result of exposure to anything? Does he/she have an allergic response to materials, foods or animals?

PHYSICAL EXAMINATION

A very limited physical examination is made. Observe characteristics of breathing; note any coughing or shortness of breath. Observe overall skin texture. Examine skin of arm for scarring, tattoos, veins, and turgor.

EVALUATION FOR TREATMENT

PERTINENT HISTORY

A thorough and complete medical and social history needs to be taken. The *Tuberculosis Services form* (3121-R) can be used to record much of the information obtained.

DEMOGRAPHICS

Certain demographic information is needed to help direct the focus of the contact investigation and the case management of the patient. Some of the demographic information is for reporting purposes to CDC.

SOCIAL HISTORY

A social history is helpful in determining any special needs that may need to be addressed in order to provide prompt and continuous treatment to completion. Living arrangements, transportation and employment information is needed to provide comprehensive case management. Substance use is a major cause of treatment interruption and needs to be addressed throughout treatment. One way is to perform a Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use:

1. *Screen: How many times in the past year have you had X drinks or more in a day? X= 5 drinks for men, 4 for women. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?*
2. Provide feedback "*What connection (if any) do you see between your drinking and this visit?"*
3. *Provide a brief intervention to enhance motivation, discuss pros and cons, assess patient readiness*
4. *Referral to treatment*

More information can be found here:
SAMSA-HRSA Center for Integrated Health Solutions: Implementing SBIRT in Community health and Community Behavioral Health Centers: https://nned.net/1467/
The patient can be referred to the state Social Worker for an in-depth assessment and intervention if needed.

MEDICAL HISTORY

A thorough medical history is needed to determine if there are any complicated acute or chronic medical conditions including (but not limited to): diabetes, renal insufficiency with estimated

creatinine clearance less than 50 ml/min., end-stage renal disease on hemodialysis that will impact treatment. An alcohol and substance abuse assessment are needed. If HIV status is not documented, a test is indicated. Current prescriptions and over the counter medications need to be listed. Note any allergies and current immunization status.

PREVIOUS TB HISTORY

It is very important to know if the patient has ever been diagnosed with active TB disease or latent TB infection before. Document dates of diagnosis or testing, location where the diagnosis or testing took place and what treatment was offered or completed. Document whether this patient was named as a contact to another TB case. Was he/she a contact to a known drug resistant case? Also document date, and location of any BCG vaccination given to the patient.

REVIEW OF SYSTEMS

A review of systems is indicated when a patient is starting on medication for active TB disease or latent TB infection. A clear picture of the patient's current health status is needed. This is necessary to provide a baseline for later assessment of possible adverse drug reactions. It is important for the patient to be able to describe a change from his/her "normal" baseline. In TB disease, it is also to determine the severity of symptoms and establish how ill the person is as a baseline for documenting clinical improvement with treatment.

CONSTITUTIONAL: Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite? How severe are they?

HEENT: Does the patient have any vision loss, blurred vision, double vision or trouble distinguishing colors? Does he/she wear glasses? Does the patient have any hearing loss or ringing in the ears? Does he/she wear a hearing aid?

SKIN: What is the normal color of skin? Are there any rashes or itching? If so, what is the cause? Is there any bruising? Does the patient bruise easily?

CARDIOVASCULAR: Does the patient have any chest pain, chest pressure/chest discomfort, palpitations, or edema?

RESPIRATORY: Is the patient experiencing any shortness of breath, cough or sputum? Is this something new or is this a chronic condition? Is the patient coughing up blood?

GASTROINTESTINAL: Does the patient have anorexia, heartburn, nausea, vomiting or diarrhea or abdominal pain? Does anything relieve it? Does anything precipitate it? What color are his/her stools? Is there any blood in the stool?

GENITOURINARY: What color is the patient's normal urine? Does he/she have bladder or kidney infections? Have they ever had a problem with kidney function?

NEUROLOGICAL: Does the patient have headaches? What kind and what relieves them? Does he/she have dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities? Is there any problem with memory or cognition?

MUSCULOSKELETAL: Does the patient have muscle and/or back pain? Does he/she have any arthritis, joint pain or stiffness? Is there any weakness in his/her limbs or any problem with gait and movement? Have they ever had signs of gout?

HEMATOLOGIC: Does the patient have anemia, bleeding or bruising? Are they on aspirin therapy?

LYMPHATICS: Has the patient ever had enlarged nodes or a history of splenectomy?

PHYSICAL EXAMINATION

A nursing physical examination will establish how ill the person is as a baseline for documenting clinical improvement with treatment. It also serves as a baseline to assess adverse drug reactions. **A review of systems and adverse reactions would be indicated for LTBI monthly treatment.**

VITAL SIGNS: Temperature, Pulse, Respiration, blood pressure, height, current weight (compared to normal weight), BMI

EYES**:** Check color of sclera. Check pupils for size and reaction to light. Perform a vision test for acuity and color discrimination (especially for patients who will be taking Ethambutol).

SKIN: Observe the overall color of skin. Check trunk and back for bruising or rash. Check turgor and examine extremities for bruising.

GASTROINTESTINAL: Check abdomen for tenderness.

RESPIRATORY**:** Collect sputum specimens. Observe characteristics of cough (if any).

MUSCULOSKELETAL: Observe the patient's movements and gait. Check for joint swelling or redness.

NEUROLOGICAL: Observe for dizziness, syncope, paralysis, ataxia when moving, or getting up and down. Check for any memory difficulty or change in cognition.

MONTHLY TREATMENT MONITORING

Every TB patient receiving treatment through the health department should have a monthly Review of Systems and Physical Examination as outlined above. Patients should also be closely monitored for adverse drug reactions and response to treatment. Is there anything preventing optimal treatment? What can you do to improve treatment? For active TB suspects/cases, review DOT (Section 5) and contact investigation (Section 6). **Every LTBI patient should have review of systems and adverse reactions for monthly treatment evaluation.**

LAB QUICK REFERENCE SHEET

Class 3: TB Disease
Class 4: Old TB Disease
Class 5: Person being evaluated for TB Disease

These patients are usually started on a four-drug regimen of Isoniazid, Pyrazinamide, Ethambutol and Rifampin. When the initial four-drug regimen is used, it is important to perform the following monthly lab assessments for the duration of the four-drug treatment.

Isoniazid - monthly hepatic/liver function test
Pyrazinamide - monthly creatinine
Ethambutol–monthly/vision/color-exam
Rifampin - monthly CBC with differential

In addition to the above labs**,** a baseline **Hemoglobin A1C,** should be **drawn on all adults**. If the results are abnormal, (see TB Nurse Protocol, Baseline Labs, HgbA1C Chart Level) **refer for Diabetes counseling, management and/or PCP for follow up.**

The hepatic/liver function test, the **HgbA1C** and creatinine levels can be ordered as a comprehensive metabolic panel instead of ordering each individual lab to save money**.**
On all known diabetic patients, obtain a Hgb A1C with baseline labs.
The above labs are sent for processing to the lab provider for your county.

HIV testing should be done on all patients. TB patients *may* qualify for **Rapid HIV test, if not, do venipuncture for HIV per district testing policy.**
Hepatitis C lab should be drawn on all adults initially. Hepatitis B profile should be drawn on all adults and anyone less than 18 years old who is non-US-born. The above three labs are sent for processing to the state lab.

During the initial phase of treatment assess the patient monthly for any signs or symptoms of gout or change in kidney function. If any signs or symptoms are present, draw uric acid levels for gout and creatinine for kidney function. If the patient is asymptomatic for gout or kidney issues, then these labs do not have to be drawn.

During the continuation phase of treatment while the patient is on Isoniazid and Rifampin, monthly hepatic/liver function test and CBC with differential will be drawn monthly and sent for processing to the lab provider for your county.

Class 2: Latent TB Infection, no disease

If the patient is on Isoniazid, baseline hepatic/liver function test is done. Then monthly (if indicated by protocol) hepatic/liver function test is done.
If the patient is on Rifampin, baseline hepatic/liver function test and CBC with differential is done. Then monthly CBC differential is done, and monthly (if indicated by protocol) hepatic/liver function test is done. The above labs are sent for processing to the lab provider for your county.

HIV testing should be done on all patients. TB patients *may* qualify for **HIV rapid test**, if not, do venipuncture for HIV and send for processing to the state lab.

TELEPHONE/TELEMEDICINE/TELEHEALTH NURSE MONITORING

Refer to the *Guidelines for Public Health Nurses Practicing in Telehealth/Telenursing/Telemedicine, January 2013*" **https://dph.georgia.gov/sites/dph.georgia.gov/files/GuidelinesTelemedicineTelenursingFINALRevisedMarch 122013.pdf.**

PATIENT EDUCATION

Nurses should provide counseling and education at every encounter. The patient needs to understand the disease process of tuberculosis and their individual treatment plan. The *12 Points of Tuberculosis Patient Education* and the *Tuberculosis Education Record* are excellent tools to use for content and documentation. These are located on the TB website.

It is imperative that the client be thoroughly educated on the potential side effects of TB medications and the symptoms of adverse reactions. It is also vital that the patient know how to describe each symptom and that the nurse understand each description.

Side effects of medications are those things which are anticipated to happen to people taking certain medications. Most of the side effects are manageable and do not require stopping the medication. Adverse reactions of medications are those things which are severe and may indicate harm to the patient. Adverse reactions warrant stopping the medication and consulting the contract physician. Refer to the *Standard Nurse Protocols* and the *12 Points of Tuberculosis Patient Education* for drug specific information and actions. These are available on the TB website.

Use the patient education sheets (located at the end of this section) as you go through the review of systems. Demonstrate how to use the rating scales for each question for assessment during the first three months. This will assist the nurse and the patient understanding each other's vocabulary and what each other mean. This type of communication will carry over to the telephone and assist the nurse in making her assessment if the patient becomes enrolled in the **electronic monitoring or VDOT**.

On the patient education sheets, a scale is used with each symptom. Most of the scales are labeled from 0 to 10 with 0 being "none" of the symptom and 10 being "severe" symptom.

Example 1: Rudy and the nurse go over the patient education sheets about GI disturbances and Rudy denies having any nausea and vomiting. They rate this as 0 and discuss that if he feels nausea, he might rate it as 1, but if he begins to vomit dark, coffee ground material, then he would need to immediately alert the nurse and describe it as 10.

Example 2: When asked what color his urine is, Tom points to the orange urine. The nurse and Tom discuss how the medication rifampin turns secretions orange in color. They compare the normal yellow and the rifampin orange to the dark, maple syrup colors. Together they agree that if Tom's urine begins to look dark like that, he will immediately alert the nurse and describe it as 8 – 10.

Example 3: Jeri states she had some nausea and vomiting. The nurse would discuss the number of events (Jeri states one time); the color of the vomit (Jeri states it looked like her dinner) and when the events took place (Jeri vomited shortly after eating) and when the last dose of medication (she had taken her pill that morning, 6 hours earlier). Together the patient and the nurse would discuss if there were any lingering feelings and how the patient feels at this moment. If Jeri states she felt better after vomiting and did not have any other problems at the time and that she feels great today, then they would discuss that “2 or 3” could describe this event and that it is unlikely to be related to medication. The nurse explains that if Jeri continues to vomit in the next couple of days or if she begins to vomit dark, coffee ground material, then she would need to immediately alert the nurse and describe it as 10.

There are numerous patient education materials available for use in addition to what is covered here. People learn in different ways, so having information presented in writing, by speaking, in pictures, in video and by demonstration all assist in retaining what is learned.

Georgia TB Laws and Court-Ordered Treatment

Table of Contents

ADHERENCE

For in-depth information on adherence, please read Chapter VII in *Tuberculosis Nursing: A Comprehensive Guide to Patient Care* and Module 9 of CDC's *Self Study Modules on Tuberculosis.*

Adherence means "sticking to" or "being faithful to," such as your *adherence* to your diet even when chocolate cake is around, or patients' *adherence* to TB treatment — they continue to take medication even when they are feeling better. TB treatment takes at least six months and could last for up to two years. Most patients begin to feel better early in the treatment. This makes it difficult for them to continue to take medication that may make them feel bad. It can be challenging for the public health staff to help keep the patient on treatment.

Understanding how the patient feels about TB disease and treatment will help the healthcare worker begin to support the patient. Accepting different perceptions while presenting valid health information can be challenging. All education and information must be tailored to the patient's knowledge and readiness to accept new information. The *12 Points of Patient Education* can be presented using videos, pictures, written material or through conversation. The patient education section in this manual contains pictures that can be used as well as the *12 Points of Patient Education*. The county health departments have DVDs and videos. Web presentations and other patient resources can be found online on the DPH TB Program's web site at **https://dph.georgia.gov/health-topics/tuberculosis-tb-prevention-and-control/tb-educational-resources-clinicians-and**

From the first encounter, the patient needs to understand what is expected during the course of TB treatment and the consequences if those expectations are not met. Tell the patient about non-adherence and why it might occur. Explain the consequences of non-adherence are treatment failure and continued TB transmission. Set the expectation that public health is here to support the patient in completing a full course of therapy until treatment completion. The expectations should be reinforced at each encounter with the patient until they are fully understood. This can best be done by the health care worker listening carefully to the patient and quickly identifying any possible barriers to adherence. Once identified, the barriers need to be addressed and mutually resolved.

During the first visit, the consent to treatment form/3609.TB and the treatment plan/3144 should be explained and agreements signed. In addition, a DOT agreement/603 DOT needs to be negotiated and signed. At every patient encounter, adherence should be checked and documented. The TB Case Manager should analyze the patient's adherence rate during monthly evaluation sessions and more frequently as needed. Episodes need to be dealt with promptly and efforts and results of efforts need to be documented as they occur. All forms mentioned above can be found in *Appendix F*

The local clinic staff must assess how the patient is adhering to treatment, quickly recognize when a patient is not on course and make rapid interventions to minimize interruptions in treatment. It is important for the staff to identify the specific reasons a patient is not adherent and address them with the patient. An individualized plan to overcome the barriers to treatment needs to be made and negotiated with the patient. At times, an additional agreement may need to be written and signed by the patient.

The following are some examples of non-adherent episodes:

- Patient on five day per week DOT and misses three DOT appointments in a two-week period.
- Patient on thrice/twice weekly DOT and misses two DOT appointments in a two-week period.
- Patient misses a clinic appointment
- Patient breaks isolation while still infectious
- Failure to disclose adequate information to identify contacts
- Substance abuse during treatment causing interruption in TB treatment

Each episode of non-adherence must be documented in the patient record. All actions taken and the results of those actions must be thoroughly documented in the patient record.

It is important to be as pro-active as possible when dealing with patients. Break down the length of treatment into manageable steps and use individualized incentives for reaching set milestones. Provide positive reinforcement for keeping appointments. Make DOT appointments that fit into the patient's lifestyle and are easy to keep. Send reminders for clinic appointments. Help the patient identify a buddy that can provide additional support during treatment.

Negotiation and assisting the patient to come up with solutions before small incidents become major issues can help to avoid having to take a patient to court. Listening carefully to the patient and acting on clues during conversation can decrease episodes of non-adherence. For instance, during the course of a conversation, the patient may mention leaving town to visit with a family member. The public health staff should act on that information and get details about the possible visit. Answer questions of *who, when, where* and work with the patient to work out a mutually satisfactory way to make sure the patient continues treatment without interruptions while visiting the family.

Adherence should methodically be assessed and documented on a monthly basis at a minimum. Results should be discussed during the regular case reviews with the staff and/or TB Coordinator. Strategies to address issues should be discussed, implemented, evaluated and documented before they become a major problem.

ASSESSMENT TOOL

1. Take the ***actual*** number of events and divide by the ***scheduled*** number of events then multiply by 100 to get percentage of adherence for each of the following:
   - DOT doses in a month
   - Clinic visits to date
   - Referrals made for social services or medical care to date

   Examples:

DOT	65 scheduled DOT visits, showed up for 42 visits 42 divided by 65 = .646 X 100 = 64.6% DOT adherence

Clinic appointments	5 scheduled clinic visits, showed up for 2 visits 2 divided by 5 = .4 X 100 = 40% clinic appointment adherence
Referrals	Referred to HIV clinic for testing, substance abuse counselor & social security disability. Showed up for HIV testing 1 divided by 3 = .33 X 100 = 33% referral adherence

2. Review the number of episodes of non-adherence to date. Have the methods to address those episodes been effective? Are there other steps that need to be taken?

3. Is the patient on track to complete treatment within one year? Do a current dose count and project treatment completion. Minimum amount of time is 26 weeks and maximum time is 52 weeks.

4. Assesses patient's TB knowledge, attitudes, and beliefs concerning drug efficacy and severity of TB disease; reviews patient education progress on the Tuberculosis Education Record.

ESCALATION OF ISSUES

Unfortunately, patient situations can be complex, and timeliness of interventions is needed. Below are guidelines for bringing potential problems to resolution in a prompt manner so that interruptions to treatment are minimized. Remember, documentation is key in these matters.

LOCAL TB NURSE

- Assesses for potential conflicts in approach to TB treatment and naming of exposed persons; identifies nature of differences and addresses patient-centered approach with patient and in written plan
- Outlines, verbally and in writing, patient and provider responsibilities so that each understands important details about how patient's TB will be managed: legal parameters, method of treatment administration, methods of airborne infection control, methods of communication (e.g., phone numbers)
- Assesses for potential treatment barriers; selects, with patient's input, mutually acceptable enablers to overcome barriers;
- Negotiates incentives to reward successful accomplishment of treatment milestones
- Performs initial telephone calls, home visits, and certified letters to gain cooperation and compliance

DISTRICT TB COORDINATOR

- Assists TB nurse with follow up actions, field visits, and location strategies for missing patients
- Supports TB Nurse in negotiation and information sessions with patient to stress patient care plan; adherence; and strategies to overcome barriers
- Discusses with State Office developing situations and possible strategies

DISTRICT TB HEALTH DIRECTOR

- Issues Health Director Orders for compliance

- Notifies county attorney of possible court action; works with attorney through the court process

STATE TB OFFICE

- Support TB Coordinator in strategies to overcome issues
- Support district staff through the court process
- Liaison to **Wellpath Recovery Solutions, Columbia Regional Care Center, Columbia, South Carolina,** if confinement is needed

COURT-ORDERED TREATMENT AND/OR CONFINEMENT OF NON-ADHERENT TB PATIENTS

All court proceedings should be through the District TB Coordinator. The state office TB Program is to be notified immediately of any pending legal issue with a TB case. The county attorney, the client's attorney and all associated court fees are to be paid by the county health department.

The state office TB Program is to be notified immediately of any pending confinement case. Approval must be obtained from the TB Program Director. The health district is expected to pay the confinement facility. Paid invoices can then be submitted to the state office TB Program for reimbursement.

Typical Court-Ordered Treatment Process:

1. District Health Officer or TB Coordinator sends a certified letter to non-adherent patient with specific instructions on TB treatment and isolation, e.g., wear a surgical mask in public.
2. If no letter has been sent, but the County Health Department (CHD) has documentation that they gave specific instructions to the patient, patient agreed and signed a treatment plan, patient did not comply with these instructions and is a public health threat because of potential disease transmission, the District or CHD can proceed to ask for court-ordered compliance with CHD instructions.
3. CHD should contact the county attorney's office for an Emergency Commitment Hearing Order (Form 3 in Court Order Templates). The county attorney will have a judge sign the order.
4. With this order, a court hearing is scheduled within 7 days from the day the order is signed. The county sheriff will pick-up the patient and confines him in a jail or hospital with respiratory isolation facilities until the court hearing. The sheriff's office can contact other counties to confine the patient if their county jail or local hospital does not have an appropriate isolation room.
5. The patient is assigned a lawyer, the county attorney represents the CHD, and CHD health providers appear in court to testify.
6. The judge can order the patient to follow very specific instructions, e.g., wear a mask in public until sputum smear negative 3x and until he has taken 2 weeks of medicines, and comply with DOT. The judge can state that if patient does not comply, he will be in contempt of court and can be detained/committed by court order to a facility approved by the state TB program like a county jail with respiratory isolation units or **WellPath Recovery, Columbia** in South Carolina.
7. If the county attorney does not have a lot of experience with these kinds of orders, s/he can consult with the county attorneys from Fulton, DeKalb, Gwinnett or Cobb, who are experienced with such procedures.

The Georgia Department of Public Health and **WellPath Recovery Solutions** in South Carolina have a memorandum of understanding (MOA) regarding court-ordered non-adherent TB patients referred by county health departments to **WellPath Recovery** for detention. The MOA has the following stipulations:

FUNDING FOR ADMISSION OF GEORGIA TB PATIENTS AT WELLPATH RECOVERY:
Charges incurred by clients involuntarily committed will be invoiced to the client's county health department. The DPH TB Program will provide allocations to the respective district for charges incurred by the client(s) admitted to **Wellpath Recovery**. These allocations will be made within 30 days of receipt of an invoice.

- Services under this MOA will be invoiced to each district at a daily per person rate of $260.00 while in isolation and $189.00 out of isolation (2012 rates).
- After the first year of this MOA, on the anniversary date, the price will adjust for each additional year, in an amount equal to the most recently available annual change in the *Bureau of Labor Statistics Consumer Price Index for the South, Medical Care Component,* which is the most accurate measure of the cost increases CRCC experienced delivering services.
- The DPH TB Program will assist **Wellpath Recovery**, when requested, in collecting past due invoices from respective districts.

RESPONSIBILITIES OF THE DPH TB PROGRAM FOR WELLPATH RECOVERY REFERRALS:

- The DPH TB Program will ensure that all clients referred for admission to **Wellpath Recovery** have a legal commitment order prior to admission.
- The DPH TB Program will ensure that **Wellpath Recovery** receives a completed *Medical Data Summary Sheet* on each pending admission.
- The DPH TB Program will ensure that each client will arrive with a signed *Medical Care Plan*, a copy of his/her current medical record.
- **The DPH TB Program and County HD staff will ensure that the patient will bring the remainder of their dispensed TB medications to Wellpath Recovery Solutions.**
- The DPH TB Program and County HD staff assigned will routinely monitor the care, treatment and clinical status of each TB client committed from Georgia. • The DPH TB Program will provide technical assistance, guidance, educational materials as requested.

RESPONSIBILITIES OF WELLPATH RECOVERY SOLUTIONS REGARDING SERVICES AND DELIVERABLES:

- **Wellpath Recovery** agrees to provide rooms that are secure and ensure safety at all times and that are appropriate for clients involuntarily committed to the facility for failure to adhere to a treatment regimen.
- **Wellpath Recovery** agrees to follow the *Medical Care Plan* which accompanies the client from Georgia.
- **Wellpath Recovery** agrees to consult the DPH TB Program Medical Consultant prior to any change in the prescribed treatment plan.

- **Wellpath Recovery** agrees to obtain prior approval from the DPH TB Program Medical Consultant or a designee before any referral to another facility for services, with the exception of a medical or life-threatening emergency. The DPH TB Program will be notified as soon as possible after the occurrence.
- **Wellpath Recovery** will provide monthly x-rays as ordered.
- **Wellpath Recovery will provide all TB medications when the patient arrives at their facility.**
- **Wellpath Recovery** will provide *Monthly Medical Status Reports* to the DPH TB Program and local county health department.
- **Wellpath Recovery** will provide Airborne Infection Isolation (AII) rooms/special negative pressure rooms for the specific purpose of isolating persons who might have suspected or confirmed infectious TB disease.
- **Wellpath Recovery** will provide three nutritious meals along with snacks daily.
- **Wellpath Recovery** will provide opportunities for recreation in the courtyard.
- **Wellpath Recovery** will provide transportation for external medical appointments, if required.

SPECIAL CIRCUMSTANCES:

- In the event of the death of the TB client committed from Georgia, **Wellpath Recovery** shall notify the state TB Program Manager or designee as soon as possible after the event.
- The DPH TB Program will notify the county health department of the client's death.
- The DPH TB Program will discuss any burial plans with the respective county health department and with family members, if available.
- If the TB client is deemed homeless and after due diligence to identify family none is found, the client will be buried in accordance with the procedures of **Wellpath Recovery**.
- A statement to the effect of the above item will be faxed to the **Wellpath Recovery** General Manager.
- The cost of burial will be included in the client's last invoice.

REPORTING REQUIREMENTS:

- **Wellpath Recovery** will submit monthly invoices for each client's charges to the respective District TB Coordinator by the 15th of each month for the preceding month.
- **Wellpath Recovery** will submit a *Monthly Medical Status Report* to the DPH TB Program's State Office for each TB client in their custody. Reports should be received by the 15th of each month for the preceding month.
- **Wellpath Recovery** will provide the DPH TB Program with a thorough *Discharge Summary* within two weeks after the client's discharge from their facility. The *Discharge Summary* will be inclusive of a synopsis of the hospital course, special procedures performed, consultations performed, abnormal laboratory studies and a complete list of medications prescribed at discharge.
- **Wellpath Recovery** will provide a 7-day supply of TB medications, if the patient is still under treatment at the time of discharge from the facility.

DELINQUENT REPORTS:

- **Wellpath Recovery** will submit reports/client updates as required by the DPH TB Program by the designated due dates as outlined in this MOA.
- DPH TB Program reserves the right to withhold payments for services performed under this MOA, after notice to **Wellpath Recovery** and an opportunity for a meeting with a DPH TB Program representative.

Sample Medical Care Plan for Wellpath Recovery Solutions Referral
(Type the Medical Care Plan on your County Health Department's letterhead/stationery)
Current Date:
Patient's Name:
Patient's Date of Birth:
Patient's Social Security Number:
Diagnosis: Laboratory-confirmed, active pulmonary TB
Medications:
(Provide detailed directions. For PRN medications, add reason for administration)
Initial TB drug regimen (for current weight = xx lbs.)

Isoniazid 300 mg daily for 56 doses by DOT
Rifampin 600 mg daily for 56 doses by DOT
Ethambutol xxxx mg daily for 56 doses by DOT
Pyrazinamide xxxx mg daily for 56 doses by DOT
Pyridoxine 25 mg daily for 56 doses by DOT
Continuation TB drug regimen
Isoniazid 900 mg **thrice** weekly for **54** doses by DOT
Rifampin 600 mg **thrice** weekly for **54** doses by DOT
Pyridoxine 50 mg **thrice** weekly for **54** doses by DOT

Chest x-ray frequency: Only if indicated
Laboratory Testing: (Frequency of sputum examination, liver enzymes, vision tests, etc.)

- Monthly hepatic function panel, or as needed if signs or symptoms of hepatic toxicity
- Sputum AFB smear/culture daily x 3 then weekly until sputum conversion, then monthly

Miscellaneous: (ID consult, negative pressure isolation room, frequency of recording patient's weight, social services referral if substance abuse counseling/drug rehabilitation is indicated, etc.)

- Baseline and monthly visual acuity testing and red/green color discrimination
- Negative pressure room needed until 3 consecutive negative sputum smears collected on different days, 2 weeks of TB medication and signs of clinical improvement
- Biweekly weight checks
- Refer to social services related to substance abuse

Interchange: Please send monthly reports of normal findings re:

- Medical evaluation
- Laboratory results
- General condition and miscellaneous Please notify us as soon as possible re:
- Abnormal laboratory findings
- Adverse reactions to medications
- Any other pertinent abnormal findings

Physician's signature and date signed needed at end of sheet Type physician's name and title underneath signature.

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Appendix A

2025 National TB Program Objectives & Performance Targets

The mission of the Division of Tuberculosis Elimination is to promote health and quality of life by preventing, controlling, and eventually eliminating tuberculosis (TB) from the United States, and by collaborating with other countries and international partners in controlling global tuberculosis.

Objectives for Reducing TB Incidence[1, 2, 3, 4]

Focus Area	Goal	Targets
TB Incidence	Reduce the incidence of TB disease.	1.3 cases per 100,000
US-Born Persons	Decrease the incidence of TB disease among US-born persons.	0.4 cases per 100,000
Non-US-Born Persons	Decrease the incidence of TB disease among non-US-born persons.	8.8 cases per 100,000
US-Born Non-Hispanic Blacks or African Americans	Decrease the incidence of TB disease among US-born non-Hispanic blacks or African Americans.	1.0 cases per 100,000
Children Younger than 5 Years of Age	Decrease the incidence of TB disease among children younger than 5 years of age.	0.1 cases per 100,000

Objectives on Case Management and Treatment[1,2,3]

Focus Area	Goal	Targets
Known HIV Status	Increase the proportion of TB patients with a positive or negative HIV test result reported.	99%
Treatment Initiation	For TB patients with positive acid-fast bacillus (AFB) sputum-smear results, increase the proportion who initiate treatment within 7 days of specimen collection.	96%
Recommended Initial Therapy	For patients whose diagnosis is likely to be TB disease, increase the proportion who start on the recommended initial 4-drug regimen.	97%
Sputum Culture Result Reported	For TB patients aged 12 years or older with a pleural or respiratory site of disease, increase the proportion with a sputum culture result reported.	99%
Sputum Culture Conversion	For TB patients with positive sputum culture results, increase the proportion with a documented conversion to negative results within 60 days of treatment initiation.	83%
Completion of Treatment	For patients with newly diagnosed TB disease for whom 12 months or less of treatment is indicated, increase the proportion who complete treatment within 12 months.	95%

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS-310290

Objectives on Laboratory Reporting[1, 2, 3]		
Focus Area	**Goal**	**Targets**
Turnaround Time—Culture	For TB patients with cultures of respiratory specimens identified with *M. tuberculosis* complex (MTBC), increase the proportion reported by the laboratory within 25 days from the date the specimen was collected. **NOTE:** *25 days includes 21 days for culture to grow and 4 days for specimen collection and delivery to lab.*	78%
Turnaround Time —Nucleic Acid Amplification test (NAAT)	For TB patients with respiratory specimens positive for MTBC by nucleic acid amplification test (NAAT), increase the proportion reported by the laboratory within 6 days from the date the specimen was collected. **NOTE:** *6 days includes 2 days for detection and 4 days for specimen collection and delivery to lab.*	97%
Drug-Susceptibility Result[5]	For TB patients with positive culture results, increase the proportion who have initial drug-susceptibility results reported.	100%
Universal Genotyping	For TB patients with a positive culture result, increase the proportion who have a MTBC genotyping result reported.	100%
Objectives on Contact Investigations[1, 3, 6]		
Focus Area	**Goal**	**Targets**
Contact Elicitation	For TB patients with positive AFB sputum-smear results, increase the proportion who have contacts elicited.	100%
Examination	For contacts to sputum AFB smear-positive TB cases, increase the proportion who are examined for infection and disease.	94%
Treatment Initiation	For contacts to sputum AFB smear-positive TB cases diagnosed with latent TB infection, increase the proportion who start treatment.	92%
Treatment Completion	For contacts to sputum AFB smear-positive TB cases who have started treatment for latent TB infection, increase the proportion who complete treatment.	93%

Objectives on Examination of Immigrants and Refugees[1, 3, 7]		
Focus Area	**Goal**	**Targets**
Examination Initiation	For immigrants and refugees with abnormal chest radiographs (X-rays) read overseas as consistent with TB, increase the proportion who initiate a medical examination within 30 days of notification.	72%
Examination Completion	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB, increase the proportion who complete a medical examination within 120 days of notification.	78%
Treatment Initiation	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB who are diagnosed with latent TB infection or have radiographic findings consistent with prior pulmonary TB (ATS/CDC Class 4) on the basis of examination in the United States, for whom treatment was recommended, increase the proportion who start treatment.	87%
Treatment Completion	For immigrants and refugees with abnormal chest X-rays read overseas as consistent with TB who are diagnosed with latent TB infection or have radiographic findings consistent with prior pulmonary TB (ATS/CDC Class 4) on the basis of examination in the United States, and who have started on treatment, increase the proportion who complete treatment.	87%
Objectives on Data Reporting		
Focus Area	**Goal**	**Targets**
RVCT[8]	Ensure the completeness of each core Report of Verified Case of Tuberculosis (RVCT) data item reported to CDC.	100%
ARPE[9]	Ensure the completeness of each core Aggregate Reports for Tuberculosis Program Evaluation (ARPE) data item reported to CDC.	100%
EDN[10]	Ensure the completeness of each core TB Follow-Up Worksheet data item reported to CDC via the Electronic Disease Notification (EDN) system.	93%
Objectives on Program Evaluation		
Focus Area	**Goal**	**Targets**
Evaluation Activities	Ensure submission of a program-specific performance-monitoring plan and an annual program evaluation plan to improve program performance.	100%
Evaluation Focal Point	Ensure designation of a TB evaluation focal point.	100%
Objectives on Human Resource Development		
Focus Area	**Goal**	**Targets**
Development Plan	Ensure submission of a program-specific human resource development plan (HRD) and a yearly update of progress.	100%
Training Focal Point	Ensure designation of a TB training focal point.	100%

Footnotes:

1. Indicator calculations for measuring progress are established by the National TB Indicators Project (NTIP).
2. Targets for incidence rates and objectives on case management and laboratory reporting are established on the basis of performance reported in NTIP using 2010–2018 data from the National TB surveillance system. For Sputum Culture Conversion and Completion of Treatment, the latest year with data available is 2017.
3. Targets are based on a statistical model that uses data to find trends from 2010 through 2018 (or the latest year with data available). TB programs with fewer than 150 cases from 2016–2018 were excluded. For each objective, we used a quantile regression model to estimate the 90th percentile for each year, and extrapolated the fitted model to predict the estimated 90th percentile in the year 2025, which served as the target for 2025. The "90th percentile" values reflect the projected performance of the top 10% of TB programs in the United States in 2025. The quantile regression serves to establish a smooth trend over time, which is useful since the actual percentiles in any given year (e.g. the final year of available data) may not be representative of the overall trend.
4. Population data are derived from the American Community Survey. Jurisdictions with a non-US-born population or US-born non-Hispanic black or African American population less than an average of 100,000 persons per year in 2015–2017 are also excluded in the statistical model for TB incidence rates for non-US-born persons and US-born non-Hispanic blacks or African Americans.
5. Drug-susceptibility results from molecular tests will be counted as having met the objective in the indicator calculation starting in 2020.
6. Targets for objectives on contact investigation are established on the basis of performance reported in NTIP using 2010–2016 data from the Aggregate Reports for Tuberculosis Program Evaluation (ARPE) for contacts.
7. Targets for objectives on the examination of immigrants and refugees are established on the basis of performance reported in NTIP using 2010–2018 data from the Electronic Disease Notification (EDN) system. For Treatment Initiation and Treatment Completion, the latest year with data available is 2017.
8. Report of Verified Case of Tuberculosis (RVCT) is the standard surveillance data collection form for reporting tuberculosis cases.
9. Aggregate Reports for Tuberculosis Program Evaluation (ARPE) is the standard form for reporting contact investigation activities.
10. Electronic Disease Notification (EDN) system is a web-based system used to notify health departments of the immigrants and refugees' entry into the United States. The system also includes a module for the TB Follow-Up Worksheet, a data collection form for reporting the outcomes of TB follow-up examinations in the United States.

Appendix B

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Kathleen E. Toomey, M.D., M.P.H., **Commissioner** / Brian Kemp, **Governor**

2 Peachtree Street, NW, 15th Floor
Atlanta, Georgia 30303-3142

dph.ga.gov

Dear Colleague:

One of the traditional missions of public health is disease surveillance – tracking diseases and health conditions in the general population. By learning which diseases are in the community and who is affected, the Georgia Department of Public Health (DPH) can create policies and programs to improve the health of Georgia citizens. From time to time, public health may need health information on specific individuals to fight an outbreak of communicable disease and to link affected persons with testing and treatment.

DPH sometimes receives questions from physicians and other health care providers who are concerned that privacy regulations prevent them from reporting patient information to the Department.

The Department has the legal authority to request your clients' personal health information. Under Georgia law, the Department is authorized to gather information, including personal health information, to protect the health and safety of Georgia citizens.[1]

The Health Insurance Portability and Accountability Act (HIPAA) also allows you to share your clients' personal health information with the Department, a public health authority. HIPAA regulations specifically allow health care providers to disclose health information to public health authorities for the purpose of preventing or controlling disease, and to avert a serious threat to the health or safety of a person or the public.[2] HIPAA regulations also provide that client consent is not required before sharing personal health information with the Department.[3]

If the Department should need to share your clients' personal health information with others, it will be done in strict accordance with HIPAA. The Department has a HIPAA Privacy Officer and an in-house Institutional Review Board to ensure that personal health information in our possession is shared only with persons authorized under HIPAA to receive it, and only in a form that is allowed under HIPAA. In most cases, health data are de-identified in accordance with HIPAA standards to make sure it cannot be traced back to a specific individual.

If you have any questions or concerns about sharing personal health information with the Georgia Department of Public Health, please call 404-657-2700 and ask to speak to the General Counsel or to the Privacy Officer.

Yours truly,

Kathleen E. Toomey, M.D., M.P.H.
Commissioner

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[1] O.C.G.A. §§ 31-2A-4, 31-12-2, and 31-22-7.
[2] 45 C.F.R. § 164.512(b) and (j).
[3] *Id.*

Appendix C

Interjurisdictional TB Notification (IJN) Form

Type of Referral:

- ☐ **Active/Suspect TB** - See Section 1
- ☐ **TB Contact** - See Section 2
- ☐ **Class A/B** - See Section 3
- ☐ **TB Infection** - See Section 4

Date of Expected Arrival ☐

Online directory of state and big city TB programs:
www.tbcontrollers.org/community/statecityterritory /

Referring Jurisdiction Information:

City | County | State

Person Completing Form | Email

Phone | Fax

Form Sent to:

Date IJN Form Sent

Name | Phone | Fax | Location

Name | Phone | Fax | Location

Return Follow-Up Form To:

Follow Up Requested

Name | Jurisdiction | Location

Phone | Fax

Referred Person's Information:

Last Name | First Name | Middle Initial | AKA

DOB | Sex | Hispanic | Race/Ethnicity

Country of Birth | Primary Language | Interpreter Needed?

New Address:

#/St/Apt | City | State | Zip

Phone 1 | Type | Phone 2 | Type

Alternate Contact Name | Phone | Email

National Tuberculosis Nurse Coalition (NTNC)
National Tuberculosis Controllers Association (NTCA)

Revision: May 2015

Referred Person's Name | DOB

SECTION 1: Active/Suspect TB Diseas e

RVCT Number

Site of Disease | Most Recent Respiratory Smear

Treatment Status | Most Recent Respiratory Culture

Results Attached: Please attach all applicable results

RVCT ☐ TST/IGRA ☐ Radiology ☐ Smear(s) ☐ NAAT ☐ Culture(s)/Pathology ☐

DST/Mutation Analysis | Submitted for Genotyping | Gentype

SECTION 2: TB Contact Investigation

Date of Last Exposure | Contact Priority

Initial TB test | Date | Results: attach results | TST mm

8-12 week post exposure | Date | Results: attach results | TST mm

Radiology | Treatment Status

SECTION 3: Immigrants & Refugees - Class A/ B

Classification | Alien # | EDN Transfer Complete

TST/IGRA | US Radiology | Sputa

Treatment Status

SECTION 4: TB Infection - Non-Contact of Class A/ B

Results Attached: TST/IGRA ☐ Radiology ☐ Sputa ☐ Treatment Status

Referred Person's Name | DOB

SECTION 5: TB Treatment Summary

Current Treatment Summary for:

Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	
Drug		Dosage		Therapy Admin		Date Started	

Estimated Date of Completion		Last DOT dose administered on:		# of doses given for travel	
Prescription Given		Side Effects or Adherence Problems		MAR/DOT Log Attached	

Comments:

Note: This form contains confidential patient information. Please comply with HIPAA regulations when sending this form.

Appendix D

Centers for Disease Control and Prevention
Division of Tuberculosis Elimination

INTERNATIONAL TUBERCULOSIS NOTIFICATION FORM

TO: ***Health Officer, Physician, or Tuberculosis Control Personnel of:***

Country	Province	District	City or Village

The individual named below has **active tuberculosis** and was treated in the USA. He or she **has not completed treatment**. This form is to notify you so that treatment can be completed.

Tuberculosis Patient's Name:_____

Date of Birth:_____ Place of Birth:_____ Sex:_____

This patient informed us that he/she was going to the following location:

Patient's Address	
City or village	
District, Province	
Country	
Telephone if available	
e-mail address if available	
Contact person at this location	

If you have any questions, contact the following person who treated this patient in the United States:

Name	
Address	
City, State, Zip Code	
Phone, fax, email	

Date of diagnosis of current illness _____

This illness was a: [ ] New episode of TB

(check one) **[ ] Treated for TB in the past, before the current episode**

If previously treated, describe the patient's prior history of tuberculosis and treatment.

Site(s) of disease: [ ] Pulmonary [ ] Extra-pulmonary (specify)_____

Initial and most recent laboratory and radiographic test results (microscopy, cultures, drug susceptibility test results, radiographs, and other critical lab tests) (use additional pages as needed)

Date	Test	Result

Current Medications (generic name), Dose, Frequency, Route of Administration, Start Date

Drug	**Dose**	**Frequency**	**Route**	**Start Date**

Treatment Plan. Our treatment plan for this patient is specified below. This may differ from TB treatment in your country. ***Please insure this patient completes a full course of treatment***.

Drug	**Dose**	**Frequency**	**Route**	**Start Date**

Any Other Comments

Appendix E

CureTB Binational Notification

Telephone: (619) 542-4013 **Fax: (619) 692-8020**

[1]Referring Jurisdiction: _____ [1]Date sent: _____
City County State

[1]Contact person: _____ [1]Telephone: (___) _____ Ext. ___ Fax (___) _____
Referring Agency: _____ E-Mail Address: _____

At time of referral the patient was at: _____ Telephone: (____) _____

☐ Verified case: ☐ RVCT#: _____ or ☐ Not reported ☐ ICE A# _____ ☐ BOP# _____
☐ Suspect case ☐ Clinical History request (*specify year*): _____ ☐ Immunocompromised (*specify*): _____

Index Case Information for: ☐ Household Contacts (CN-47H) ☐ Moving Contacts (CN-47M) ☐ Source Case Finding

Patient

[1]**Case name**: _____ Sex: ☐ M ☐ F
Paternal Maternal First Middle

Alias: _____ DOB: _____

Info. in Mexico / Central America

_____
Number Street Apt City

_____ Telephone: (___) _____
County State Zip code

Contact person in other country: Name: _____ **Country:** _____

Relationship: _____ Telephone: (____) _____

Info. in U.S.

_____
Number Street Apt City

_____ Telephone: (____) _____
County State Zip code

Contact person in the U.S.: Name: _____ Telephone: (____) _____

Relationship: _____

Clinical Information

Information for: ☐ this referred case ☐ this referred suspect ☐ Index case for contact(s) ☐ Index case for source case investigation

Site (s) of disease: ☐ Pulmonary ☐ Other (s) specify: _____

[2]Date of collection	[2]Specimen type	[2]Smear	Culture	Susceptibility	[2]Chest X-ray	Other tests/results

☐ HIV ☐ Diabetes ☐ No Symptoms ☐ Symptoms specify: _____

Medication

For: ☐ this referred case/suspect ☐ Not started

Drug	Dose	Start date	Stop date

Comments:

Expected move date: _____ to _____

Patient given _____ days of medication.

1. Fields required to initiate the referral process
2. Whenever possible send CXR reports and laboratory reports as attachments to this referral.

County of San Diego
Health and Human Service Agency Public Health Services ▪
TB Control
E-Mail: curetb.hhsa@sdcounty.ca.gov

curetb.org

Migrant Clinicians Network Business Phone: (512) 327-
Austin, Texas 78716 Confidential
2017 PO Box 164285 Confidential Fax: (512) 327-6140
Phone: (800) 825-8205
Migrant Clinicians Network

ENROLLMENT IN THE MCN HEALTH NETWORK

Enrolling Clinic		Clinic phone number(s)	

E-mail address		Clinic fax number(s)	
Contact person at Clinic			
Security Question #1:	Patient's city of birth?		
Security Question #2:	Patient's father's first name?		
Please indicate the health area(s) for which the participant is being enrolled. If the participant's health status changes during enrollment in the Health Network, additional areas may be added with the participant's verbal consent.	⑨ Tuberculosis ⑨ Prenatal Care ⑨ Cancer ⑨ Diabetes	⑨ HIV ⑨ General Health _____	

CONSENT FOR RELEASE OF MEDICAL INFORMATION

First Name		Last Name(s)	
Alias, Nicknames, Etc		Birth Date (Month / Day / Year)	

The Health Network currently helps with continuity of care for people with infectious chronic illnesses or other healthcare concerns. (i) MCN is a non-profit company coordinating my enrollment in the Health Network at no cost to me; (ii) MCN may not be able to obtain health care providers that are available to care for my condition at no cost to me; (iii) the health care providers who will be providing my treatment are independent and not employees of MCN; and (iv) MCN does not provide, and is not responsible for, any health care treatment, or the outcomes of such treatment, in connection with any or all of the Health Network projects.
I agree to participate in the Health Network, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization.

I do NOT authorize MCN or future health care providers to have access to my medical records around issue(s) listed here:

(attach additional page if needed)

I agree to notify my future health care providers of my enrollment in the MCN Health Network to help facilitate the transfer of my medical records. I understand and consent to MCN maintaining records for me containing sensitive health information (examples: HIV status and/or information about mental health issues) if my health care provider believes this information is needed for my treatment. I authorize MCN and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening. Authorized individuals from MCN may contact me by phone, mail or in person regarding follow up and referral for my treatment for these conditions. These individuals will adhere to federally mandated confidentiality, privacy and security procedures. **This consent form will remain in effect for two years (24 months) from the date signed** or until my participation in the Health Network has ended for another reason. I can submit a written request any time to leave the Health Network or to limit the health issues that MCN is authorized to address. I also understand that I have a right to receive a copy of my medical records on file with MCN upon written request.

I HEREBY RELEASE MCN, ITS EMPLOYEES, OFFICERS, DIRECTORS, CONSULTANTS, REPRESENTATIVES, SUCCESSORS, AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, CAUSES OF ACTIONS, DAMAGES, LOSSES, EXPENSES (INCLUDING ATTORNEYS' FEES), AND LIABILITIES OF ANY KIND WHATSOEVER ARISING OUT OF MY ENROLLMENT IN THE HEALTH NETWORK AND MY HEALTH CARE TREATMENT RESULTING FROM MY ENROLLMENT IN THE HEALTH NETWORK.

REQUIRED

***PARTICIPANT SIGNATURE (or Signature of Legal Representative)**		Date	
Relationship of Legal Representative to Patient		Witness Signature	

We recommend that, whenever possible, you provide the participant with a copy of this Consent for Release of Medical Records and MCN Health Network Enrollment form when it is completed. **ENGLISH –THIS CONSENT FORM IS VALID FOR 2 YEARS AFTER DATE OF SIGNATURE** *Please contact us at 512-327-2017 or* www.migrantclinician.org/network *for more information on the MCN Health Network.* 02-07

PARTICIPANT INFORMATION SHEET | MCN HEALTH NETWORK

First Name			Last Name(s)		
Mother's Maiden Name			Birth Date (Month / Day / Year)		
Place of birth:	City		Gender:	⑨ Female	⑨ Male
	State		Marital Status:	⑨ Single ⑨ Divorced	⑨ Other:

	Country			⑨ Married ⑨ Widowed	
Race/Ethnicity:	⑨ White – Non-Hispanic/Latino ⑨ Asian – Non-Hispanic/Latino		⑨ Black – Non-Hispanic/Latino ⑨ Indigenous		⑨ Hispanic/Latino ⑨ Other:
Language(s) Spoken:	⑨ English ⑨ Spanish	⑨ Creole ⑨ Other:		Language you prefer to be contacted in:	
Occupation(s) (from past two years):	⑨ Farmworker ⑨ Homemaker ⑨ Student		⑨ Construction ⑨ Factory ⑨ Child care		⑨ Retired ⑨ Unemployed ⑨ Other:
Current Residence:	⑨ Farmworker Camp Housing ⑨ Home		⑨ Jail ⑨ ICE Detention Center		⑨ Homeless ⑨ Other:

CURRENT CONTACT INFORMATION FOR PARTICIPANT:

	Street / P.O Box	City	State	Zip/Country
***PHYSICAL ADDRESS:**				
***MAILING ADDRESS:**				

***PHONE NUMBER** (with Area Code) HOME / CELL / WORK**:**	Is it ok if we talk to people that answer this phone about your personal health information? *(if you do not check off either box, or you do not initial, your answer will be "No")*	⑨ Yes ⑨ No	***INITIALS:**

OTHER CONTACT INFORMATION FOR PARTICIPANT (Place you normally move to):

	Street / P.O Box	City	State	Zip/Country
Physical Address:				
Mailing Address:				

***PHONE NUMBER** (with Area Code) HOME / CELL / WORK**:**	Is it ok if we talk to people that answer this phone about your personal health information? *(if you do not check off either box, or you do not initial, your answer will be "No")*	⑨ Yes ⑨ No	***INITIALS:**

Additional Contact: Please list someone we can contact if we cannot reach you at either of the locations you provided. In doing this you give MCN permission to contact that family member or friend to assist you in receiving continued health care, which may require discussing your health condition(s) with this individual. You do not have to provide this additional contact information.

First Name		Last Name		Relationship to Participant	
Street / P.O Box		City		State	Zip/Country

***PHONE NUMBER** (with Area Code) HOME / CELL / WORK:	Is it ok if we talk to people that answer this phone about your personal health information? *(if you do not check off either box, or you do not initial, your answer will be "No")*	⑨ Yes ⑨ No	***INITIALS:**

Appendix F

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Tuberculosis Services

#3121-R (Rev. 01/2020)

❑ Suspect ❑ Case ❑ LTBI ❑ Presumptive LTBI ❑ B1/B2 Refugee or Immigrant ❑ MDR ❑Ryan White ❑ Child less than 5 years

Private Physician or Health Department:_____

========== *Refer to Report of Verified Case of Tuberculosis Instructions for Definitions* ==========

DEMOGRAPHICS

Name, Address, City, State, Zip, Phone

Within city limits: ❑Yes ❑No

Date of Birth _____ Age_____
Sex at Birth _____
Race _____
❑Hispanic or Latino ❑Not Hispanic or Latino

Pediatric (less than 15 years old):
Country of Birth for Primary guardian_____
Name _____ Phone _____
Lived outside the U.S. for more than 2 months? ❑Yes ❑No ❑ Unknown
If yes, specify countries:_____

Diagnosed at ❑ Hospital ❑ Physician's Office
❑ Health Dept. ❑Unknown ❑N/A
Date reported to HD_____
Status at Diagnosis: ❑Alive ❑Dead
Date of death _____
Was TB a cause of death? ❑Yes ❑No ❑Unknown

Immigration Status at 1st Entry to U.S.: ❑ N/A (U.S. born) ❑ Immigrant visa ❑Family/Fiancé visa
❑ Student visa ❑Employment visa ❑ Tourist visa ❑ Refugee ❑ Asylee or Parolee
❑Other Immigration status ❑ Unknown

Any travel in the past 6 months? ❑ Yes ❑ No
If yes, what countries (if outside the US) or states (if inside the US) and for how long: _____

U.S. born (born in 1 of 50 states, DC, U.S territories, or to 1 parent of a U.S. citizen) ❑ Yes ❑ No
Country of Birth _____
Foreign-born ❑ Yes ❑ No
If yes, country of birth _____
Date entered U.S._____

Primary Occupation Within the Past Year: ❑Health Care Worker ❑Correctional Facility Employee ❑Migrant/Seasonal Worker
❑Retired ❑Not Seeking Employment (student, homemaker, disabled) ❑Unemployed, but seeking employment ❑Other _____
❑Unknown **Employer** _____ Last date worked _____ Return to work date_____

EVER a resident of a correctional facility? ❑ Yes ❑ No If yes, year_____ ____ Location_____
Currently resident of correctional facility? ❑Yes ❑No ❑ Unknown
❑Federal Prison ❑ State Prison ❑ Local Jail ❑ Juvenile Correction Facility ❑ Other Correctional Facility _____
If yes, under custody of Immigration and Customs Enforcement (ICE)? ❑Yes ❑No

Resident of long term care facility? ❑Yes ❑No ❑ Unknown **EVER a resident of a Homeless Shelter?** Year_____ Location _____
❑Nursing home ❑Hospital based ❑Residential Facility ❑Mental Health Residential ❑Alcohol or Drug Treatment ❑Other Long-term Care Facility_____

Homeless within past year ❑Yes ❑No ❑Unknown	Depression ❑Yes ❑No ❑Unknown	Low literacy ❑Yes ❑No ❑Unknown
Inadequate housing ❑Yes ❑No ❑Unknown	Suicidal/homicidal thoughts ❑Yes ❑No ❑Unknown	Language barrier ❑Yes ❑No ❑Unknown
Inadequate income ❑Yes ❑No ❑Unknown	Paranoia ❑Yes ❑No ❑Unknown	Primary Language _____
Inadequate transportation ❑Yes ❑No ❑Unknown	Defiant ❑Yes ❑No ❑Unknown	Does not follow isolation ❑Yes ❑No❑Unknown
Domestic violence ❑Yes ❑No ❑Unknown	Erratic behavior ❑Yes ❑No ❑Unknown	Misses appointments ❑Yes ❑No❑Unknown
Child abuse ❑Yes ❑No ❑Unknown	Uncooperative ❑Yes ❑No ❑Unknown	Misses DOT appointments ❑Yes ❑No❑Unknown
	Mental Health Referral ❑Yes ❑No ❑Unknown	Reluctant to identify contacts ❑Yes ❑No❑Unknown

MEDICAL HISTORY

HIV status:
Test Offered ❑ Yes ❑ No
Refused Testing ❑ Yes ❑ No
Test done ❑ Yes ❑ No
Results:
❑Indeterminate
❑Unknown
❑Status Negative
❑Status Positive → CD4 _____
On Antiretrovirals ❑ Yes ❑ No
If Yes, List:

PCP Prophylaxis ❑ Yes ❑ No

Females Only:
Last menstrual period _____
Contraceptive Method:
Pregnant? ❑ Yes ❑ No
Pregnancy test done? ❑ Yes ❑ No
Breastfeeding? ❑ Yes ❑ No

Primary Care Physician _____
Ever diagnosed with or treated for:
❑Diabetes Mellitus ❑Cancer (site) _____
❑Leukemia ❑Lymphoma ❑Hodgkins ❑Silicosis ❑Asbestos Exposure
❑Asthma ❑Bronchitis ❑Chest injury ❑Chest surgery ❑COPD
❑End Stage Renal Disease ❑Chronic liver disease
❑Tumor necrosis factor alpha (TNF) antagonists ❑Organ Transplant
❑Corticosteroid Therapy ❑Other immunosuppression (not HIV/AIDS
❑Hypertension ❑Heart disease ❑Bleeding ❑Gastrectomy ❑Intestinal Bypass
❑Malabsorption syndrome ❑ Arthritis ❑Bone/Joint disorder
Hepatitis B : ❑Yes ❑ No Test ordered ❑ Yes ❑ No
Hepatitis C: ❑Yes ❑No Test ordered ❑ Yes ❑No

Ever received BCG vaccine? ❑ Yes ❑ No
❑ Packs of cigarettes smoke daily _____
❑ Ounces of beer drinks daily ____ ❑ Ounces of wine drank daily ____ ❑ Ounces of liquor drank daily ____
❑Injecting drug use _____ ❑Non-injecting drug use_____
❑ Other _____
Recent hospitalization, specify details:_____
_____
Medical Complications:

TB Symptoms present:
❑ Cough ❑ Weight loss
❑Fatigue ❑ Night sweats
❑ Fever ❑ Hemoptysis

Normal weight (lb/kg)_____ Current (initial) weight (lb/kg)_____
Height: _____ BMI: _____
Allergies:_____
_____
Current Medications:_____
_____

TUBERCULOSIS HISTORY

*Expul = Extrapulmonary * IGRA = Interferon-gamma release assay tests

Primary reason for TB evaluation: ❑TB Symptoms (❑ cough ❑ fever ❑ weight loss ❑ fatigue ❑ night sweats ❑ hemoptysis) ❑Abnormal Chest Radiograph (consistent with TB) ❑ Contact Investigation ❑ Targeted testing ❑ Health Care Worker ❑Employment/Administrative ❑ Immigration medical ❑ Incidental lab result ❑ Unknown

❑ Contact of MDR-TB Patient ❑ S+ ❑ S- ❑Expul*
❑ Contact of TB Patient ❑S+ ❑ S- ❑ Expul*
❑ Missed Contact ❑ No Known exposure

Contact to _____

Relationship_____

Environment _____

Priority: ❑High (❑Medical Risk) ❑Medium ❑Low

Last exposure date _____

❑ **Previous Diagnosis of TB Disease**
Date start treatment _____

Date stop treatment _____

Site of infection_____

Medications_____
_____
_____
_____

❑ Inadequate or incomplete TB treatment

❑ **Previous TST & Chest X-Rays**

Date _____

Result_____

Location_____

Date start treatment _____
Date stop treatment _____
Medication(s)_____
_____
❑ Incomplete LTBI Treatment
❑ Chest X-Ray (date) _____
Location _____

Initial TST
Date _____

Result _____

Follow-Up TST
Date _____

Result _____

IGRA* (type)_____

Result _____

INITIAL BACTERIOLOGY SUMMARY

*(+) = Positive **(-) = Negative

INITIAL SPECIMEN:

Date _____ Site_____ code _____

❑ Sputum Smear ❑ Smear/Pathology/Cytology of Tissue & other body fluids
❑ **Public Health Laboratory** ❑ **Commercial Laboratory** ❑ **Other**

INITIAL RESULTS:
Smear
❑(+)* ❑ (-)** ❑ Pending
❑ Not done ❑ Unknown

Culture
❑(+)* ❑ (-)** ❑ Pending
❑ Not done ❑ Unknown

Nucleic Acid Amplification test:
❑(+)* ❑ (-)**
❑Indeterminate ❑ Pending
❑ Not done
❑ Unknown

INITIAL DRUG REGIMEN ORDERED BY NURSE PROTOCOL

Case/suspect Initial treatment: 4 Drug Regimen - Option 1 4 Drug Regimen Option 2

LTBI/presumptive Initial Treatment: Isoniazid 9 months Rifampin 4 months Rifampin 6 months Isoniazid/Rifapentine 12 weeks

Isoniazid_____ mg ____tab PO ____x wk X____ mo #_____ (# doses____)
Rifampin_____ mg ____caps PO _____x wk X____ mo #____ (# doses____)
Pyrazinamide_____ mg ____tab PO ____x wk X____ mo #____ (# doses____)
Ethambutol_____ mg ____tab PO ____x wk X_____ mo #____ (# doses____)
Rifipentine_____ mg ___tab PO ___x wk X_____ mo #_____ (# doses____)
Pyridoxine_____ mg ___tab PO ____x wk X___ mo #_____ (# doses____)

Medication Start Date_____ ❑ DOT ❑ Non- DOT ❑ VDOT ❑ Self Administer

Comments:

Date Completed _____ **SIGNATURE**_____

Reason for Review: ❑Continuation/review ❑Follow up/Adverse Event ❑Window Period Prophylaxis ❑Treatment Completion ❑Other

Health Department: _____ **Phone:**_____

CURRENT DRUG REGIMEN

Date RX Started:_____ ❑ DOT ❑Non-DOT ❑ VDOT
❑Daily ❑Twice Weekly ❑Thrice Weekly ❑Other _____

❑ Isoniazid _____ ❑ Rifampin _____
❑ Pyrazinamide _____ _____ ❑ Ethambutol _____
❑ Rifapentine_____
❑ Other _____

TREATMENT COURSE

 # Months on Therapy _____ **# Doses to date** _____
Anticipated length of treatment _____
Anticipated completion date _____
❑Treatment interruptions: Date stopped _____
Date re-started _____ # Doses missed _____
Reason therapy stopped:
❑ Medical adverse reactions ❑ Liver Enzymes elevated
❑ Patient non-adherence ❑ Provider reasons
❑ Other_____

Comments:

Date Completed _____ **SIGNATURE** _____

CHEST RADIOGRAPHY & IMAGING STUDY

INITIAL
❑ Not done ❑ Unknown
Date _____
❑Chest views_____
❑CT scan/imaging_____
Remarks:

Interpretation
❑Normal ❑Not done❑Unknown
❑Abnormal :
- ❑ Pleural Effusion
- ❑ Evidence of Miliary TB
- ❑ Cavitary
- ❑ Non-cavitary:
  - ❑Consistent with TB
  - ❑ Inconsistent with TB

FOLLOW-UP
Date _____
❑Chest views_____
❑CT scan_____
❑ MRI _____
Status ❑ Stable ❑ Improving ❑Worsening ❑Unknown

Treatment:
❑Do not treat
❑Treatment complete
❑Refer to private Physician for diagnosis and/or treatment
❑ Start or continue window period prophylaxis
❑Discontinue window period prophylaxis
❑Start or continue treatment for LTBI
❑Discontinue treatment for LTBI
❑ Start or continue treatment for active TB disease
❑Discontinue treatment for active TB disease
❑Other_____

Site of TB Disease (select all that apply):
❑Pulmonary ❑Pleural ❑Laryngeal
❑Lymphatic:Cervical
❑Lymphatic: Intrathoracic
❑Lymphatic: Axillary
❑Lymphatic: Other
❑Lymphatic: Unknown
❑Bone and/or Joint
❑Genitourinary ❑Meningeal
❑Peritoneal
❑Site not stated
❑Other _____

Diagnosis:
❑ Latent TB Infection
❑Laboratory confirmed TB case
❑Clinical TB case
❑Recurrent TB case within 12 months after completion of therapy
❑Nontuberculous Mycobacterial Disease
❑Other _____

Classification:
❑ 0 No exposure, not infected
❑ I Exposure, no infection
❑ II TB Infection, no disease
❑ III Current TB disease
❑ IV Previous TB disease
❑ V TB suspected

PHYSICIAN RECOMMENDATIONS

Medication: ❑Initial ❑Continuation ❑ Change of medications / ❑ Daily ❑ Twice weekly ❑ Thrice weekly ❑ Other _____❑ DOT ❑ Self administer

❑ Isoniazid 300 mg ____ tab(s) (_____ mg) PO _____days/wk X _____ doses
❑ Rifampin 300 mg _____ cap(s) (_____mg) PO ___days/wk X ____doses
❑ Pyrazinamide 500 mg _____ tab(s) (_____mg) PO ____days/wk X ___ doses
❑ Ethambutol 400 mg ____ tab(s) (_____mg) PO ___days/wk X ____ doses
❑ Pyridoxine 25 mg 1 tablet PO _____days/wk X ___ ___ doses
❑ Pyridoxine 50 mg 1 tablet PO BIW X _____ doses
❑ Other _____

❑ Isoniazid 300 mg _____tab(s) (_____mg) PO BIW X _____ doses
❑ Rifampin 300 mg _____ cap(s) (_____ mg) PO BIW X _____ doses
❑ Pyrazinamide 500 mg _____ tab(s) PO (_____ mg) BIW X _____ doses
❑ Ethambutol 400 mg _____tab(s) (_____mg) PO BIW X _____ doses
❑ Pyridoxine 50 mg 1 tablet PO _____days/wk X _____ doses

Recommendations:❑ None ❑ Hospitalization ❑ Send old X-rays ❑ Send medical records
❑ Repeat TST (mo./yr._____) ❑ Repeat Chest-X-ray (mo./yr._____) ❑ Re X-ray as clinically indicated
❑ Sputum AFB Smear/Culture daily X3 then weekly until sputum conversion, then monthly ❑ Sputum culture sensitivity ❑ 2 month sputum conversion
Perform baseline labs: ❑ AST ❑ ALT ❑ Liver profile ❑ Bilirubin ❑ Alkaline phosphatase ❑ CBC with platelet count
❑ Serum creatinine ❑ Hepatitis B & C profile ❑ HIV counseling & testing ❑ CD4+count
Perform monthly labs: ❑ AST ❑ ALT ❑ Liver profile ❑ Bilirubin ❑ Alkaline phosphatase ❑ CBC with platelet count
❑ Serum creatinine
❑ Baseline and monthly visual acuity testing and red/green color discrimination while on Ethambutol ❑ Other _____
Comments:

Date Review Completed _____ **SIGNATURE**_____

TUBERCULOSIS FLOW SHEET

Name:	**Date of Birth:**	Gender at birth: Male Female				
Person w TB/Evaluate for TB	Initial Treatment: 4 Drug Regimen - Option 1	4 Drug Regimen - Option 2	Other			
LTBI/Presumptive LTBI	Initial Treatment: Isoniazid 9 mo.	Rifampin 4 mo.	Rifampin 6 mo.	Isoniazid/Rifapentine 12 wk.		
Med Start Date: ❑ DOT ❑ Non- DOT	Exposed person	MDR	Ryan White	Child less 5 years age		
Isolation Ordered □ YES □ NO Isolation Stop Date:	Last Date Worked:	Date Returned to Work:				
Telephone Nurse Monitoring Program Start Date:						
KEY: YES = √ NO = Ø NORMAL = N ABNORMAL = ABN (Make note) NOT ASSESSED = NA POSITIVE = POS NEGATIVE = NEG						
Date						
Adheres to treatment plan /Number of doses completed to date						
# missed doses/# missed appointments (make note)						
Last menstrual period						
Alcohol Use/Substance Use (make note)						
Any travel since last visit? Plans to travel within the next month?						
Review of Systems (Questions on back of flow sheet)						
CONSTITUTIONAL						
HEENT						
SKIN						
CARDIOVASCULAR						
RESPIRATORY						
GASTROINTESTINAL/GENITOURINARY						
NEUROLOGICAL						
MUSCULOSKELETAL						
Physical Evaluation						
VITAL SIGNS: Temperature/Pulse/Respirations						
Blood Pressure						
Current weight (Initial weight at diagnosis _____)						
HEENT						
Vision acuity test/Vision color discrimination						
SKIN						
Rash (trunk = t, back = b, extremities = e)						
Bruises (trunk = t, back = b, extremities = e)						
RESPIRATORY						
Shortness of Breath						
Cough (note characteristics)						
GASTROINTESTINAL						
Abdominal tenderness						
NEUROLOGICAL						
Memory loss/poor cognition/dizziness						
MUSCULOSKELETAL						
Pain, swelling of joints/abnormal gait						
Laboratory Tests Ordered						
Baseline Hepatitis B/Hepatitis C/HIV						
Glucose/Hbg A1C						
Uric Acid/Serum Creatinine/Bilirubin						
AST/ALT/Liver Profile						
CBC with differential						
Pregnancy test (if applicable)						
Most recent date of sputum specimen						
Most recent sputum status (Positive, Negative, NA)						
Medications Ordered and Dispensed						
Isoniazid_____ mg ____tab(s) PO ___x wk X___ mo #____ (# doses____)						
Rifampin_____ mg ___cap(s) PO ___x wk X___ mo #____ (# doses____)						
Pyrazinamide_____ mg __tab(s) PO __x wk X___ mo #____ (# doses____)						
Ethambutol_____ mg ___tab(s) PO ___x wk X___ mo #____ (# doses____)						
Pyridoxine_____ mg ____tab(s) PO ___x wk X___ mo #____ (# doses____)						
Rifapentine _____mg ___tab(s) PO ____x wk X ___mo #___ (#doses____)						
Next appointment date						
Nurse's Signature						

TUBERCULOSIS FLOW SHEET

REFERENCE: Review of Systems questions:

CONSTITUTIONAL: Does the patient have any unexplained weight loss, fever, chills, weakness or fatigue, night sweats, and/or loss of appetite? How severe are they?

HEENT: Does the patient have any vision loss, blurred vision, double vision or trouble distinguishing colors? Does he/she wear glasses?
Does the patient have any hearing loss or ringing in the ears? Does he/she wear a hearing aid?

SKIN: What is the normal color of skin? Are there any rashes or itching? If so, what is the cause? Is there any bruising? Does the patient bruise easily?

CARDIOVASCULAR: Does the patient have any chest pain, chest pressure/chest discomfort, palpitations or edema?

RESPIRATORY: Is the patient experiencing any shortness of breath, cough or sputum? Is this something new or is this a chronic condition? Is the patient coughing up blood?

GASTROINTESTINAL/GENITOURINARY: Does the patient have anorexia, heartburn, nausea, vomiting or diarrhea or abdominal pain? Does anything relieve it? Does anything precipitate it? What color are his/her stools? Is there any blood in the stool? What color is the patient's normal urine? Does he/she have bladder or kidney infections? Have they ever had a problem with kidney function?

NEUROLOGICAL: Does the patient have headaches? What kind and what relieves them? Does he/she have dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities? Is there any problem with memory or cognition?

MUSCULOSKELETAL: Does the patient have muscle and/or back pain? Does he/she have any arthritis, joint pain or stiffness? Is there any weakness in his/her limbs or any problem with gait and movement? Have they ever had signs of gout?

SAMPLE MEDICAL DELEGATION FORM FOR UNLICENSED P.H. PERSONNEL

The signatures below indicate a mutual agreement between the delegating physician(s) and the unlicensed public health (PH) personnel who are authorized to perform administration of tuberculin skin test (TST) and reading (measurement) of tuberculin test for the purpose of screening for active TB and latent TB infection.

All public health personnel whose signatures appear on this page:

1. Have been adequately trained to perform the delegated act of administering and/or reading tuberculin skin tests

2. Have obtained certification in TST reading and administration from a certified instructor for the Tuberculosis Program, Georgia Department of Public Health AND maintain and renew their TST administration and reading certification every two years, AND , and such training is documented by a state certification form in each person's training file.
3. Have immediate access to a licensed medical professional for consultation and for referral of any induration read for interpretation.

4. Participate in an annual skill competency event that is observed by the delegating physician.

5. Have been given an opportunity to have questions answered.

_____ _____
Signature of Delegating Physician Date

_____ _____
Signature of PH Personnel Date

_____ _____
Signature of PH Personnel Date

_____ _____
Signature of PH Personnel Date

_____ _____
Signature of PH Personnel Date

GEORGIA DEPARTMENT OF PUBLIC HEALTH

INSTRUCTIONS FOR COMPLETELY EVALUATED PERSONS EXPOSED TO TB

The ideal initial encounter with an exposed person is made within 3 days. Gather background information, make a face-to-face assessment of the person's health and assign the appropriate priority.

Persons with Pulmonary/Laryngeal/Pleural TB Disease:

1. **High Priority** - Initial encounter 3 - 7 days from notification with medical evaluation completed within 5 days of initial encounter (10 days if smear negative)
   - Medical history, exposure history and a physical assessment
   - Initial IGRA/TST within 7 days or less if not done during initial encounter
   - Any positive IGRA/TST with induration 5mm or greater followed up with a chest x-ray
   - HIV Counseling, Testing and Referral
   - Follow-up IGRA/TST 8-10 weeks later
   - Place on LTBI treatment if indicated
   - ***Those exposed persons who are considered a medical risk* should have the following regardless of initial TST/IGRA status:***
     1. Chest x-ray
     2. Place on INH if their chest x-ray is negative for active TB disease
     3. See list below to determine if window period treatment or a full course of treatment is recommended
2. **Medium Priority** – Initial encounter 14 days or less with medical evaluation completed within 10 days of initial encounter
   - Medical history, exposure history and a physical assessment
   - Initial IGRA/TST 14 days or less if not done during initial encounter
   - Any positive IGRA/TST with induration 5mm or greater followed up with a chest x-ray
   - HIV Counseling, Testing and Referral
   - Follow-up IGRA/TST 8 -10 weeks later
   - Place on LTBI treatment if indicated
3. **Low-Priority** – Initial encounter 30 calendar days or less after notification
   - Medical history, exposure history and a physical assessment
   - IGRA/TST 8 - 10 weeks later
   - Any positive IGRA/TST result should be followed up with a chest x-ray
   - Place on LTBI treatment if indicated

Persons with Pulmonary/Laryngeal TB Disease that is sputum smear AND culture Negative; Source Person identification for children less than 5 Years of age with active TB disease; persons with Extra-Pulmonary TB:

1. Initial encounter 30 days or less after notification (**household exposed persons only**)
2. Medical history, exposure history and a physical assessment
3. Initial IGRA/TST, if negative then no further action is needed
4. Initial IGRA/TST, if positive then follow-up with a chest X-ray
5. Place on LTBI treatment if indicated

Any symptomatic exposed person needs to have a chest x-ray and sputum specimens obtained as part of the evaluation – regardless of assigned priority or IGRA/TST result. Some exposed persons may have a false negative reaction to IGRA/TST due to HIV/AIDS, treatment with steroids or immunosuppressive drugs, old age, or tuberculosis disease. If such is suspected, the exposed person should have a chest x-ray.

CODES:

Reason LTBI therapy stopped	Reason contact identification not completed	Reason no exposed persons entered into SENDSS
1. Completed therapy	1. Still following up	1. Contact identification not performed
2. Death	2. No 2nd IGRA/TST because 1st test done 8-10 weeks after exposure	2. Person with TB disease died or too ill to interview. No surrogate interviewee available.
3. Moved	3. No 2nd IGRA/TST done because source person has extra-pulmonary TB	3. Person with TB disease declined/uncooperative to identify exposed persons. No surrogate interviewee available.
4. Active TB disease	4. No 2nd IGRA/TST since sputum/culture of source person with TB was neg	4. Person with TB disease moved/lost to follow up. No surrogate interviewee available.
5. Adverse reaction	5. Declined/uncooperative	5. Exposed persons identified but not located.
6. Chose to stop treatment	6. Moved	6. Exposed person declined/uncooperative.
7. Lost to follow-up	7. Lost to follow up	7. Exposed person moved/lost to follow up
8. Provider decision	8. Death	8. Shares same exposed person with an index source of TB whose exposed persons have already been entered.
	9. Other	9. Mass screening performed. Cannot distinguish between close and causal exposed persons.
		10. Other

*** Exposed persons who are considered a medical risk** are those who are at a particularly high risk of developing TB disease once infected with *M. tuberculosis*. These contacts include the following:

- Immunosuppressed, e.g., HIV infection, prolonged corticosteroid therapy, organ transplant, TNF blockers (full course of preventive treatment beyond window period)
- Less than 5 years of age (Window period treatment)
- Have diabetes mellitus, silicosis, end stage renal disease, gastrectomy, jejunoileal bypass, leukemia, lymphoma or cancer of the head or neck (Window period treatment)

This contact identification form should be forwarded to the district TB coordinator after the initial phase, but no later than 30 days. Update the district TB coordinator as determined by local policy. Initial information is to be entered into SENDSS within 30 days. Complete information is to be entered within 90 days. Do not send this form to the state office.

CONTACT IDENTIFICATION REPORT PLEASE REPORT ALL EXPOSED PERSON TO PERSONS DIAGNOSED WITH OR BEING EVALUATED FOR TUBERCULOSIS TO THE _____ of ______

Chart #_________ **TUBERCULOSIS PROGRAM 2 PEACHTREE STREET, NW, 12TH FLOOR, ATLANTA, GEORGIA 30303-3142**

Patient's Name (Nicknames – Alias)	Patient's Registry No. & Date Counted	County	Home Telephone Pager Cell	Race / Sex	Date of Birth

Address (Street) City/State/Zip	**DISEASE SITE:** 1. Pulmonary ☐ 2. Pleural ☐ 3. Lymphatic ☐ 4. Bone/Joint ☐ 5. Genito-Urinary ☐ 6. Miliary ☐ 7. Meningeal ☐ 8. Peritoneal ☐ 9. Other__________________ ☐ **INFECTIOUS PERIOD:**___________________________	**INITIAL SPUTUM:** 1. S+, C+ ☐ 2. S-,C+ ☐ 3. S+,C- ☐ 4. S-,C- ☐ 5. S Unk.,C+ ☐ 6. S+, C Unk ☐ 7. S unk., C Unk ☐ 8. S-, C Unk ☐ DATE COLLECTED ______________________

Employer	Employer Telephone	Next of Kin	Next of Kin's Telephone

Site of Initial Interview: Home ________ Work ________ Community ________ Site Name: ________________________________ Date__________________	Site of 2nd Interview: Home ________ Work ________ Community________ Site Name: ____________________________ Date__________________

Exposed Person's Environment	EXPOSED PERSON'S NAME (Last Name, First) Nicknames-alias & Phone Number	Street Address or RFD City, State, Zip Code	RACE	SEX	Date of Birth & Age	Relation To Person with TB Disease	Last Exposure Date	Priority	Initial IGRA/ TST Date Results	F/U IGRA/TST or single IGRA/TST done after window period Date Results	Chest X-ray Date Results	a) LTBI Therapy Recommended b) DOPT if less than 15 years of age Date Started	DATE & CODES: a) LTBI RX stopped b) CI not completed
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	____________________ ____________________ Phone:_______________ Date of Interview: ____________________			F M				☐ High ☐ Medium ☐ Low	______	______	______	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)______ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	____________________ ____________________ Phone:_______________ Date of Interview: ____________________			F M				☐ High ☐ Medium ☐ Low	______	______	______	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)______ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	____________________ ____________________ Phone:_______________ Date of Interview: ____________________			F M				☐ High ☐ Medium ☐ Low	______	______	______	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)______ b)

* If person with TB disease is a child less than 5 years, name source person with TB disease: ___________________________ Code for Reason NO Contacts Entered ___________Reviewed By: __________________ Date: ______________ Signature of Person Completing 1st Interview: ________________________ Date: ____________ Telephone _________

Comments: Signature of Person Completing 2nd Interview: ________________________ Date: ____________ Telephone _________

Chart # _____ Patient's Name _____ Date of Birth _____ Page _____ of _____

Exposed Person's Environment	EXPOSED PERSON'S NAME (Last Name, First) Nicknames-alias & Phone Number	Address Street or RFD City, State, Zip Code	RACE	SEX	Date of Birth & Age	Relation To Person with TB Disease	Last Exposure Date	Priority	Initial IGRA/ TST Date Results	F/U IGRA/TST or single IGRA/TST done after window period Date Results	Chest X-ray Date Results	a) LTBI Therapy Recommended _____ b) DOPT if 15 years of age or less _____ Date Started	DATE & CODES: a) LTBI RX stopped b) CI not completed
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ _____ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ _____ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)_____ b)
☐ Work ☐ Home ☐ Leisure ☐ Medical Risk	_____ _____ Phone:_____ Date of Interview: _____			F M				☐ High ☐ Medium ☐ Low	_____	_____	_____	a) Yes☐ No☐ b) Yes☐ No☐ Date:	Date: a)_____ b)

GEORGIA DEPARTMENT OF PUBLIC HEALTH

SCREENING DONE IN CONNECTION WITH PERSON WITH TB DISEASE

Location of Screening ____ Date ______________________

Exposed Person ______________________________ Title ______________________ Telephone ____________________

Case Cross-Reference Identifier______________________________

Environment	Name / Telephone	Address, City, State, Zip	RACE	SEX	Date of Birth	Relation to Person with TB disease	Known Exposure to Person with TB disease	IGRA/ TST Date Result	IGRA/ TST Date Result	Document/Comments: - Referrals - Recommendations - Follow-Up
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			
☐ Work ☐ Home ☐ Leisure							☐ Casual ☐ Minimal ☐ None			

Comments:

CONTACT IDENTIFICATION SUMMARY

	Total exposed persons screened	Total number of previous positive IGRA/TST	Initial IGRA/TST Results		Chest x-ray		Number of exposed persons with medical risks	Number of exposed persons started on window period treatment	F/U IGRA/TST Results		Number of exposed persons who started LTBI treatment	Number of exposed persons who stopped LTBI treatment? Why?	Number of exposed persons who completed treatment	Number of secondary people with active TB disease found	Number of exposed persons lost to follow-up or declined to complete evaluation
			+ P	- N	Abnormal	Normal			+ P	- N					
Household															
School / Work															
Social															
Additional persons screened															

Additional contact identification information:

Date Summary Completed _____ Signature _____

DOT MEDICATION SHEET PAGE _____of _____

Name: _____ DOB: _____ Race: _____ Sex: M / F Date medication started: _____ Address: _____ Telephone: (home/cell) _____ (work) _____

Month/Year _____

Medication	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Isoniazid_____mg PO __x wk																															
Rifampin _____mg PO__ x wk																															
Pyrazinamide____mg PO__x wk																															
Ethambutol_____mg PO__ x wk																															
Pyridoxine_____mg PO__x wk																															
Rifamate_____mg PO___x wk																															
Rifapentine_____mg PO 1x wk																															
Code (SEE BELOW)																															
Dose Number																															
Time of DOT																															
# of doses this month															# weeks of treatment this month _____															
Side effects: If present write √ and write F/U under comments. If absent, write Ø																															
Nausea/vomiting/abdominal																															
Jaundice/dark urine/yellow eyes																															
Headache/skin rash/weakness																															
Fatigue/flu-like symptoms																															
Unsteady gait/behavioral																															
Visual problems/change in hearing																															
Tingling in extremities/ bleeding problems/ joint pain																															
Loss of appetite/weight loss																															
Coughing/coughing up blood																															
Fever/chills/night sweats																															
Total doses to date _____																															

Initials	Signature of Person Observing Medication	Initials	Signature of Person Observing Medication

Sputum Date: _____ Sputum Date: _____

Sputum Date: _____ Sputum Date: _____

CODES USED ABOVE: H = Holiday F = Failed/Missed Appointment W = Withheld (note reason below and in progress notes) V = Video DOT SA = Self-Administered

Special Instructions/Comments:

GA DPH TB Unit
Form 3130 (Revised 01/2020)

GEORGIA DEPARTMENT OF PUBLIC HEALTH

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Active Tuberculosis Treatment Plan

Form 3144 (revised 01/2020)

Health care provider will check the appropriate instructions. The patient will initial checked instructions.

I understand I may have/have active tuberculosis (TB) disease and I need to take TB medications for an extended period of time. I may need to take medications longer than initially told if my clinical condition changes. _____

- ❑ I agree to take my medication as prescribed. I will call the health department if I am unable to take my medication for any reason. Directly Observed Therapy (DOT) has been explained to me and I have signed a DOT agreement. _____
- ❑ The side effects of my medication have been explained to me and I agree to call the health department immediately at _____ if I develop any of the side effects. _____
- ❑ I agree to keep all clinic appointments. If I am unable to keep an appointment, I will call the health department and reschedule another appointment within 7 days. _____
- ❑ I agree to provide sputum, urine or blood specimens as requested. _____
- ❑ I agree to tell the health department of any changes in my health. _____
- ❑ I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone. _____

I am contagious and can spread the disease to others. _____

- ❑ I will remain at home on isolation. As much as possible, I will stay away from other people in my house by staying in my room or wearing a surgical mask when I leave the room. I understand separate bedrooms or beds are highly recommended. _____
- ❑ I will cover my mouth and nose with a tissue when I cough or sneeze. These tissues should be flushed, burned or placed in a sealed leak proof bag before disposal. _____
- ❑ I understand that my activities are limited. I will not travel, go to work, go to school, go shopping or participate in any other activity where I will be in contact with other people. _____
- ❑ I agree not to leave my home except to keep medical appointments. I agree to wear a surgical mask to the clinic and doctor's offices. _____
- ❑ I will not allow anyone, other than those living with me or those individuals providing care to me, into my home and I will stay away from young children. _____
- ❑ I understand these isolation instructions remain in effect until I am told by the health department that I no longer have to stay in isolation. _____
- ❑ I understand these isolation instructions may become effective again after I have been told I am no longer infectious should my clinical situation change. _____
- ❑ I agree to help with identifying persons exposed to my TB disease by sharing the places I have been and names of the people I have been around to prevent my family, friends or co-workers from developing this disease. _____

I understand the reasons I need to complete my treatment and that legal action can be taken against me if I fail to follow my treatment plan. _____

I have received a copy of this treatment plan. It has been explained to me and all my questions have been answered. I agree to follow this treatment plan.

Patient's Signature _____ Date _____

Public Health Representative's Signature _____ Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Consent to and Treatment Plan for Latent Tuberculosis Infection

Form 3609.LTBI (revised 01/2020)

I, _____, have been advised and counseled by _____
(patient's name) (Public Health Representative/Title)

that based on available information, I may have/have latent tuberculosis infection (LTBI). The following has been explained to me:

- ❑ LTBI means I have been infected by the TB germ *M. tuberculosis.* My immune system has walled off the germs to keep them dormant (sleeping). I have no symptoms and can not spread the germ to others.
- ❑ I know that without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department at _____ immediately.
- ❑ I understand the link between TB and HIV and therefore, I agree to be tested for HIV.
- ❑ I agree to follow this treatment plan. I agree to come to the health department for medical evaluations and medication refills as prescribed. I agree to cooperate during my treatment. If I am unable to keep a scheduled appointment, I will call the health department at once and reschedule another appointment within 7 days.
- ❑ I agree to take my TB medication as ordered for the entire length of treatment. I will notify the health department if I am unable to take my medication for any reason.
- ❑ The side effects of the medication I am taking have been explained to me. I agree to call the health department at _____ immediately if I develop any of these side effects.
- ❑ I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone.
- ❑ My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

Patient signature _____ Date _____

Public Health Representative Signature _____ Date _____
Public Health Representative Title _____

Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete: Patient Name _____
Patient Address _____
City, State, Zip _____
Patient Telephone _____
Patient ID# _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Consent to and Treatment Plan for Latent Tuberculosis Infection with Directly Observed Therapy Form 603.LTBI (revised 01/2020)

I, _____, have been advised and counseled by _____.
(Client's Name) (Public Health Representative/Title)

Based on available information, I have/may have latent tuberculosis infection (LTBI). The following has been explained to me:

- ❑ LTBI means I have been infected by the TB germ M. tuberculosis. My immune system has walled off the germs to keep them dormant (sleeping). I have no symptoms and cannot spread the germ to others.
- ❑ Without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department at _____ immediately.
- ❑ I understand the link between TB and HIV and therefore I agree to be tested for HIV.
- ❑ I agree to take my TB medication, as ordered via DOT for the entire length of treatment. I agree to cooperate with the supervised DOT program to help remind me to take my medicine and to make sure I complete my treatment. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of my medication and to be present when I take my TB medicine.
- ❑ I will be at: ___ home ___work ___ clinic/HD ___ other (specify) _____ between the hours of _____ and _____ for my DOT visit. If I cannot meet at the agreed place/time, I will call _____ at _____ to change the visit. If I do not call in time to change the visit, I know that I may have to go to _____ between _____ for my DOT visit.
- ❑ I will notify the health department if I am unable to take my medication for any reason.
- ❑ The side effects of the medication I am taking have been explained to me. I agree to call the health department at _____ immediately if I develop any of these side effects.
- ❑ I agree to tell the health department if I move or change my phone number. I agree to tell the health department how to reach me in person and by telephone.
- ❑ My treatment plan has been explained to me and all my questions have been answered. I have a copy of this plan.

Patient Signature _____ Date _____

Public Health Representative/Title Signature _____ Date _____
Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete:

Patient Name _____
Patient Address _____
City, State, Zip _____
Patient Telephone _____
Patient ID# _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Video Observed Therapy Agreement for Latent TB Infection Treatment Form 603.VDOT.LTBI (created 01/2020)

Patient Name _____ **Date of Birth** _____ **Home phone** _____
Patient Address _____ Work phone _____
City _____ ZIP _____ Cell phone _____
Emergency Contact Person Name _____ Telephone _____
Health Department _____ Date _____

I _____ **understand and agree that:**
(patient name)

Based on available information, I have/may have latent tuberculosis infection (LTBI). The following has been explained to me:

- ❑ LTBI means I have been infected by the TB germ M. tuberculosis. My immune system has walled off the germs to keep them dormant (sleeping). I have no symptoms and cannot spread the germ to others.
- ❑ Without treatment, I can get sick with active TB disease and have symptoms such as cough, fever, night sweats, weight loss or extreme tiredness. If any of these symptoms appear, I agree to call the health department at _____ immediately.
- ❑ I understand the link between TB and HIV and therefore I agree to be tested for HIV.
- ❑ I will be taking medications for a long time (4 months or more) in order to kill the TB germs.
- ❑ I agree to cooperate with the Video Directly Observed Therapy (VDOT) program using Telehealth Webex application to make sure I complete my treatment. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of/transport my medication (if/when necessary) and to be present (electronically) in order to view me when I take my TB medicine.
- ❑ I understand that Webex is HIPAA compliant so my personal information is private and secure. End-to-end encryption is used to ensure that my information is kept private and no information or video is recorded and stored. This technology is free to me but I must use my own cell phone, computer (or other electronic device) and internet in order to participate in the program.
- ❑ I will be available for my VDOT appointment between _____ and _____.
- ❑ If I cannot make my VDOT appointment at the agreed time, I will call _____ at _____ to change the time of the appointment.
- ❑ If I do not call in time to change the VDOT appointment, I know that I may have to go to _____ between _____ and _____ for my DOT visit.
- ❑ I will tell my DOT worker if I have any problems. I may be asked to go to _____ to meet with a doctor or nurse and/or to have tests during my treatment.
- ❑ VDOT is voluntary and I can choose to use traditional face-to-face Directly Observed Therapy at any time.
- ❑ VDOT may be stopped if I miss more than one scheduled VDOT appointment in a week, miss a scheduled clinic appointment, have any reaction(s) during my treatment and require physician evaluation, have any adverse reactions to my medications, my equipment (cell phone, computer, etc) is lost, stolen, or damaged, my condition worsens or I am physically unable to participate in VDOT.

I, _____ **understand and agree that:**
(Name of Public Health Representative/Title)

- ❑ If I cannot call in for the VDOT appointment at the agreed time, I will call _____ at _____ to change the appointment time.
- ❑ I will keep the patient's health data private.
- ❑ I will answer questions and concerns of the patient. I will help link the patient to other services as needed.
- ❑ I will promptly tell the doctor and/or nurse of anything out of the ordinary. I will give reports as needed.

Patient Signature _____ Date _____
Public Health Nurse Signature _____ Date _____
DOT Provider/Interpreter Signature _____ Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Consent to Treatment for Active Tuberculosis Disease

Form 3609.TB (revised 01/2020)

I, _____, have been told by _____
(patient's name) (Public Health Representative/Title)

that based on available information, I may have/have active tuberculosis (TB) disease. The following has been explained to me:

- ❑ TB is an infectious disease that can be spread to others. I know that I need to be away from other people until I can not spread the disease to them. I know that untreated TB can lead to drug resistant disease or may be fatal. I need to take TB medicines for many months to get well.
- ❑ I agree to be treated for TB and to help with identifying any persons that could have been exposed to TB by me in order to prevent my family, friends or co-workers from getting sick.
- ❑ I understand the link between TB and HIV and therefore, I agree to be tested for HIV.
- ❑ I agree to follow the treatment plan given to me by my health care provider and the health department.
- ❑ If I do not follow my treatment plan, legal action can be taken against me.
- ❑ I have a copy of my treatment plan and all my questions have been answered.

Patient's signature _____ Date _____

Public Health Representative Signature _____ Date _____
Public Health Representative Title _____

Witness/Interpreter Signature _____ Date _____

Affix Patient label or complete:
Patient Name _____
Patient Address _____
City, State, Zip _____
Patient Telephone _____
Patient ID# _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Directly Observed Therapy Agreement for Tuberculosis Treatment

Form 603 (revised 01/2020)

Patient Name _____ Date of Birth _____ Home phone _____
Patient Address _____ Work phone _____
City _____ ZIP _____ Cell phone _____
Emergency Contact Person Name _____ Telephone _____
Health Department _____ Date _____

I _____ **understand and agree that:**
(patient's name)

- ❑ The only way to get well is by taking my tuberculosis (TB) medicine exactly as my nurse or doctor tells me. If I do not follow these directions, my illness could come back worse than before. Then it could be harder to treat, take longer to treat and/or could spread the disease to others.
- ❑ I will be taking several medications for a long time (6 months or more) in order to kill the TB germs.
- ❑ I agree to cooperate with the supervised Directly Observed Therapy (DOT) program to help remind me to take my medicine and to make sure I complete my treatment and get well. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of my medication and to be present when I take my TB medicine.
- ❑ I will be at: ____Home ____Work ____Clinic/Health Department ____ Other_____ between the hours of _____ and _____ for my DOT visit.
- ❑ If I cannot be at the agreed place and time, I will call _____ at _____ to change the visit.
- ❑ If I do not call in time to change the visit, I know that I may have to go to _____ between _____ for my DOT visit.
- ❑ I will tell my DOT worker if I have any problems. I may be asked to go to _____ to meet with a doctor or nurse and/or to have tests during my treatment.
- ❑ I know that if I miss my visits and do not take my treatment as scheduled, legal action may be taken.

I, _____ **understand and agree that:**
(Name of Public Health Representative/Title)

- ❑ If I cannot be at the agreed place and time, I will call _____ at _____ to change the visit.
- ❑ I will keep the patient's health data private.
- ❑ I will answer questions and concerns of the patient. I will help link the patient to other services as needed.
- ❑ I will promptly tell the doctor and/or nurse of anything out of the ordinary. I will give reports as needed.

Patient Signature _____ Date _____

Public Health Nurse Signature _____ Date _____

DOT Provider Signature _____ Date _____

Witness/Interpreter Signature/ID# _____ Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Video Observed Therapy Agreement for Active Tuberculosis Disease Treatment

Form 603.VDOT.TB (created 01/2020)

Patient Name _____ **Date of Birth** _____ **Home phone** _____
Patient Address _____ Work phone _____
City _____ ZIP _____ Cell phone _____
Emergency Contact Person Name _____ Telephone _____
Health Department _____ Date _____

I _____ **understand and agree that:**
(patient name)

- ❑ The only way to get well is by taking my tuberculosis (TB) medicine exactly as my nurse or doctor tells me. If I do not follow these directions, my illness could come back worse than before. Then it could be harder to treat, take longer to treat and/or could spread the disease to others.
- ❑ I will be taking several medications for a long time (6 months or more) in order to kill the TB germs.
- ❑ I understand the link between TB and HIV and therefore I agree to be tested for HIV.
- ❑ I agree to cooperate with the Video Directly Observed Therapy (VDOT) program using Telehealth Webex application to make sure I complete my treatment and get well. In this program, a designated public health employee or a trained DOT worker is authorized as my agent to maintain possession of/transport my medication (if/when necessary) and to be present (electronically) in order to view me when I take my TB medicine.
- ❑ I understand that Webex is HIPAA compliant so my personal information is private and secure. End-to-end encryption is used to ensure that my information is kept private and no information or video is recorded and stored. This technology is free to me but I must use my own cell phone, computer (or other electronic device) and internet in order to participate in the program.
- ❑ I will be available for my VDOT appointment between _____ and _____.
- ❑ If I cannot make my VDOT appointment at the agreed time, I will call _____ at _____ to change the time of the appointment.
- ❑ If I do not call in time to change the VDOT appointment, I know that I may have to go to _____ between _____ and _____ for my DOT visit.
- ❑ I will tell my DOT worker if I have any problems. I may be asked to go to _____ to meet with a doctor or nurse and/or to have tests during my treatment.
- ❑ VDOT is voluntary and I can choose to use traditional face-to-face Directly Observed Therapy at any time.
- ❑ VDOT may be stopped if I miss more than one scheduled VDOT appointment in a week, miss a scheduled clinic appointment, have any reaction(s) during my treatment and require physician evaluation, have any adverse reactions to my medications, my equipment (cell phone, computer, etc) is lost, stolen, or damaged, my condition worsens or I am physically unable to perform VDOT.
- ❑ I know that if I miss my VDOT appointments, clinic visits/appointments and do not take my treatment as scheduled, legal action may be taken.

I, _____ **understand and agree that:**
(Name of Public Health Representative/Title)

- ❑ If I cannot call in for the VDOT appointment at the agreed time, I will call _____ at _____ to change the appointment time.
- ❑ I will keep the patient's health data private.
- ❑ I will answer questions and concerns of the patient. I will help link the patient to other services as needed.
- ❑ I will promptly tell the doctor and/or nurse of anything out of the ordinary. I will give reports as needed.

Patient Signature _____ Date _____
Public Health Nurse Signature _____ Date _____
DOT Provider/Interpreter Signature _____ Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Refusal of HIV Testing

Revised (01/2020)

Name: _____ Date of Birth: _____

- ○ I have been exposed to a person with active TB disease
- ○ I have been diagnosed with latent TB infection (LTBI)
- ○ I have been diagnosed with active TB disease or I am being evaluated for TB disease

CDC recommends HIV screening for all TB clients. This includes persons who have been exposed to a person with active case of TB disease, persons diagnosed with latent TB infection (LTBI) and those persons either diagnosed with active TB disease or being evaluated for TB disease.

TB is particularly serious for people with HIV. TB disease can accelerate the progression of HIV in persons living with HIV. Having HIV when diagnosed with LTBI can also increase the progression of the latent form of TB to active TB disease.

After having the recommendations and risks explained to me, I **do not want** a test for HIV. I have been told the signs and symptoms of active TB disease, which are cough lasting more than 3 weeks, fever, night sweats, coughing up blood, chest pain, fatigue and unexplained weight loss. I understand that if I develop any signs and symptoms of active TB disease, I need to seek medical care immediately. I understand that TB disease is an infectious disease that can be passed to others. I also understand that legal steps can be taken if I develop active TB disease and I do not seek medical care, but expose others to becoming infected and/or sick.

Patient's signature/Date _____

Public Health Representative Signature/Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Second Line Therapy Authorization Form

The items listed on this page are for people with complicated Tuberculosis (TB) disease only and require consultation with the TB Program Medical Consultant, Dr. Susan Ray. Please fax to (404)463-3460 the following documentation:

1. **Copy of the prescription for ALL TB medications**
2. **List of ALL TB medications in patient's drug regimen (including 2nd line medications) as well as any other prescription medications the patient may be taking**
3. **Progress Note stating why the need for alternate regimen**
4. **This completed form**

To contact Dr. Ray call 404-657-2634 or email sray02@emory.edu

Name of patient: _____

District: _____ **Date of original request:** _____

Requestor Name (print): _____ **Signature:** _____

Approved: _____ **Date of Approval:** _____

Approval good until: _____ **Fax signed form to:** _____

Medication requested for: ❑ New Patient ❑ Continued drug treatment

❑ Levofloxacin (tablets) 500mg, 50 in bottle

❑ Levofloxacin (tablets) 750mg, 50 in bottle

❑ Moxifloxacin (tablets) 400mg, 30 in bottle

❑ Streptomycin 1gram, vial (**refrigerate)**

❑ Kanamycin (vial) 1gram, 3mL vial

❑ Capreomycin (vial) 1gram, 10mL vial

❑ Amikacin (vial) 500mg, 2mL vial

❑ Amikacin (vial) 1gram, 4mL vial

❑ Ethionamide (tablets) 250mg, 100 in bottle

❑ Cycloserine (capsules) 250mg, 40 in bottle

❑ Clofazimine (capsules) 50mg, 100 in bottle

❑ Para-aminosalicylic acid (packets) 4grams, 30 packs in carton (**refrigerate**)

❑ Rifampin (vial) 600mg, 10mL vial

❑ Prednisone 5mg ❑ Prednisone 10mg

❑ Dexamethasone 4mg

❑ Other: _____ ❑ Other: _____

❑ Other: _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Medical Case Review

revised 01/2020

Patient Name _____ Date of Birth _____ Age _____ Race _____ Sex ___ HIV status _____ ☐ US born

☐ Foreign-born If foreign-born from what country? And date came to United States? _____

Exposed to a person with TB disease? _____ If person with TB disease is less than 18, source identified? _____

Physician or Health Department _____ Occupation _____ Last date worked _____

DIAGNOSTIC INFORMATION

Diagnosed at ☐ Hospital ☐ Physician's Office ☐ Health Dept.
Status at Diagnosis: ☐Alive ☐Dead (date) _____

Major site of disease:

Additional site:

Skin/IGRA Test
Date _____
Results _____
Reason _____

Fluid specimens	Date(s) Collected	Smear	Culture	Biopsy specimens for pathology & culture
		Pos / Neg / Pend/Not done	Pos / Neg / Pend / Not done	Date Collected / AFB / Necrotizing granuloma / Culture
Initial Sputum	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Lymph node _____ _____ _____ _____
	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Pleura _____ _____ _____ _____
	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Bone _____ _____ _____ _____
Bronchial Wash	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Other _____ _____ _____ _____
Gastric Aspirate	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Pleural Fluid	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Not performed ❑
CSF	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	
Urine	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	Not applicable ❑
Other _____	_____	☐ ___ ☐ ☐ ☐	☐ ☐ ☐ ☐	

DRUG SUSCEPTIBILITY RESULTS: ❑ No resistance ❑ INH resistance ❑ RIF resistance ❑ Other _____
SPUTUM CULTURE CONVERSION: Date _____ Occurred within 2 months of treatment? ❑ Yes ❑ No
BACTERIOLOGY SUMMARY: Smear: Last Positive _____ 1st Negative _____ Culture: Last Positive _____ 1st Negative _____

CHEST RADIOGRAPHY

INITIAL

Date _____
Remarks:

Interpretation
❑ Normal ❑ Not done ❑ Unknown
❑ Abnormal → ❑ Cavitary
❑ Non-cavitary → ❑ Consistent with TB
❑ Inconsistent with TB
❑ Pleural Effusion

FOLLOW-UP

Date _____
Status
❑ Stable
❑ Worsening
❑ Improving
❑ Unknown

CO-MORBID MEDICAL

HIV Test Offered ❑ Yes ❑ No
Refused Testing ❑ Yes ❑ No
Test done, results unknown ❑

❑Status Negative
❑Status Positive → CD4 _____
On Antiretrovirals ❑ Yes ❑ No
If Yes, List:

PCP Prophylaxis ❑ Yes ❑ No

❑ Diabetes Mellitus ❑ Cancer (site) _____
❑ Silicosis ❑ Chronic Liver disease
❑ End Stage Renal Disease ❑ Hepatitis B ❑ Hepatitis C
❑ Tumor necrosis factor alpha (TNF) antagonists ❑ No Medical History
❑ Other _____
Recent hospitalization, specify details:

Medical Complications:

Initial weight _____
Current weight _____

ALLERGIES:

INITIAL DRUG REGIMEN

Date RX Started:_____ ☐5x/week ☐ 3x/week Other _____ ☐ DOT ☐ Video DOT ☐Non-DOT
☐ Isoniazid _____ ☐ Rifampin _____ ☐ Pyrazinamide _____ ☐ Ethambutol _____
☐ Other_____ ☐ Other _____ ☐ Other _____

CURRENT DRUG REGIMEN

Date RX Started:_____ ☐5x/week ☐ 3x/week Other _____ ☐ DOT ☐ Video DOT ☐Non-DOT ☐ Isoniazid
_____ ☐ Rifampin _____ ☐ Pyrazinamide _____ ☐ Ethambutol _____
☐ Other_____ ☐ Other _____ ☐ Other _____
 # Months on Therapy _____ **# Doses to Date** _____ **Est. length of treatment** _____ **Anticipated completion date** _____

Describe clinical improvement _____

RISK FACTORS

Within last 12 months:

- ❑ Homeless
- ❑ IV Drug Use
- ❑ Non-IV Drug Use
- ❑ Excessive Alcohol
- ❑ Unknown

At time of Diagnosis:

- ❑ Previous LTBI history ❑Did not complete therapy ❑ Completed therapy (date) _____
- ❑ Resident of correctional facility, if yes: ❑Federal Prison ❑ State Prison ❑ Local Jail ❑ Juvenile Correction Facility
- ❑ Other Correctional Facility _____
- ❑ Unknown
- ❑ Resident of long term care facility, if yes: ❑ Nursing home ❑ Hospital based facility ❑ Alcohol or drug treatment facility
- ❑ Mental health facility ❑ Other _____

BARRIERS TO ADHERENCE

- ❑ Homelessness
- ❑ Inadequate housing
- ❑ Inadequate nutrition
- ❑ Inadequate income
- ❑ Inadequate transportation
- ❑ Inadequate healthcare/insurance
- ❑ Unemployment
- ❑ Domestic violence/abuse
- ❑ Low literacy
- ❑ Language barrier
- ❑ Alcohol use
- ❑ Drug use

Specify _____

- ❑ Depression
- ❑ Suicidal/homicidal thoughts
- ❑ Paranoia / Defiant / Erratic behavior
- ❑ Uncooperative
- ❑ Erratic behavior
- ❑ Does not follow isolation
- ❑ Misses Clinical appointments
- ❑ Misses DOT appointments
- ❑ Reluctant to identify contacts

TREATMENT ISSUES

Treatment interruptions? ❑ Yes ❑ No Date stopped _____

Medical/adverse reactions ❑ Yes ❑ No
Specify _____

Liver Enzymes elevated ❑ Yes ❑ No Specify _____

Patient nonadherence ❑ Yes ❑ No
Specify _____

Provider reasons ❑ Yes ❑ No
Specify _____

Date re-started _____

REFERRALS & ADHERENCE STRATEGIES (specify):

ADDITIONAL COMMENTS:

Date Report Completed _____ **SIGNATURE**_____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

MEDICAL CASE REVIEW

ATTENDEES: TB Medical Consultant, State TB Program, District TB Program Staff/Other

State Case Number: _____ **Date:** Click here to enter a date.

Patient Last name: _____ **First Name:** _____

DOB: _____ **Health District Reporting:** _____

Health Department: _____ **Private Physician:** _____

DOT: ❑ Traditional DOT ❑ VDOT ❑ Non-DOT Pansensitive: ❑ Yes ❑ No ❑ NA

Reason(s) for Review: ❑ Annual Case Review ❑ Case Consultation

TB Diagnosis: ❑ Pulm. TB ❑ Extra-Pulm. TB ❑ TB/Extra-Pulm TB ❑ Pleural TB

❑ TB Meningitis ❑ MDR TB ❑ MDDR TB ❑ XDR-TB ❑ TB/HIV ❑Other _____

Resistance/Special Circumstances (Check all that Applies):

❑ Pregnant ❑ Non-Adherent ❑ Pediatric ❑ IV Meds ❑ IV Access ❑ Other diagnosis (sarcoidosis, lung disease) ❑ Culture positive beyond 2 months of diagnosis ❑ Hepatic Toxicity ❑ Therapeutic Drug Monitoring (TDM) ❑ Mental Health/Dx ❑ Substance Abuse ❑ Treatment Completion ❑ Co-Morbid Medical ❑ Relapse ❑ Lost to Follow Up ❑ Renal Impairment ❑ Hospitalization ❑ Death _____

Question/Comment:

_____

_____

Recommendation(s):- Case Review Note/ Special Consultation (Circle)

_____

_____

_____

_____

_____

_____ **Referral:** _____

Preparer's Name/Title _____ Date: Click here to enter a date.

For: Dr. Susan Ray/State TB Program Medical Consultant

C: TB Program Coordinator's Name/Health District: _____

Cohort Review Presentation Form

Patient Information:

- State Case Number: _____
- First Name: _____ Last Name: _____
- Date case reported: _____
- Age: _____ Gender:_____ Country of birth_____ Year entered US: _____
- Race/Ethnicity _____

TB Information:

- TST _____ mm, Date read: _____
- IGRA result: Pos / Neg Date of results: _____
- Sputum smear results: (+ / –) if + 1 2 3 4 plus Other: _____
- Culture Result _____ Date of first + culture: _____
  Extrapulmonary site: _____ Clinical Case: Yes / No
- Drug-Susceptibility Results _____
- Chest X-ray Cavitary Yes / No, or abnormal (noncavitary) Yes / No, or normal CXR: Yes / No
- Culture conversion less than 60 days? Yes / No Date: _____
- HIV status (+ / - / refused / not offered / unknown) **Explanation** of not known or not offered:
  _____

Treatment Information:

- Completed therapy date: _____
- Current TB medications: _____
  Number of months completed: _____ Projected month/year to complete therapy: _____
- Check (X) other disposition below:
  ___Uncooperative/Refused ____Lost ____Died ____Moved ____Reported at death
- DOT/VDOT: Yes / No If no, why not? _____
- If patient is a child 18 years old or younger:
  Source identified? Y/N Name/State Case Number: _____
  Relationship to Index case: _____

Contacts:

#		#	
	Identified		Started treatment for LTBI
	Evaluated		Completed treatment for LTBI
	Infected (TST/QFT+) without disease (confirmed by chest x-ray)		Currently on treatment
	Infected, with disease		Discontinued Treatment for LTBI (died/moved/active TB developed/chose to stop/lost to follow-up/provider decision)
%	Percentage evaluated	%	Percentage completed LTBI therapy
#	Number of house-hold contacts	#	Number of Work Contacts
#	Number of Social Contact	#	Number associated with a mass screening

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Declination of Care

Form 3575 (revised 01/2020)

Patient Name _____ Date of Birth _____

I have been educated about latent tuberculosis infection (LTBI) and tuberculosis (TB) disease. I understand why I should:

- ❑ Be evaluated for TB
- ❑ Take medicine for LTBI
- ❑ Other _____

I have decided I do not wish to follow the medical recommendations offered. I have been educated about the signs and symptoms of active TB disease, which are fever, night sweats, cough lasting more than 3 weeks, coughing up blood, chest pain, fatigue and unexplained weight loss. I understand that if I develop any signs and symptoms of active TB disease, I need to seek medical care right away. I understand that TB is an infectious disease that can be passed to others and that legal steps can be taken if I do not seek medical care and put others at risk of getting sick or infected.

I, take personal responsibility regarding the **possible future development of tuberculosis** that may have been **prevented** if I had followed the medical recommendations.

Patient Signature _____ **Date** _____

Public Health Representative Signature/Title _____ **Date** _____

Witness/Interpreter Signature _____ **Date** _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Initial Report on Patient with Tuberculosis

Form 3141 (revised 01/2020)

Physician _____ Date _____
Physician Address _____ Patient Name _____
_____ Patient Address _____
Physician Telephone _____ _____
Patient DOB _____ Telephone _____

The above identified patient has been evaluated for/diagnosed with tuberculosis (TB) and has given your name as his/her physician. Since TB is a communicable disease, the County Public Health Department is required by law to assure that every patient with TB receives proper treatment and contact identification. In order to adhere with Georgia Statutes and to assure quality care for this patient, your cooperation in completing, signing and returning this form is necessary. Please return to _____ County Public Health Department at _____ _____ by _____.

Patient newly diagnosed with TB? ❑ YES ❑ NO Patient previously diagnosed with TB, reactivated? ❑ YES ❑NO

TUBERCULOSIS EVALUATION

TB SKIN TEST/IGRA RESULTS
Date performed _____ ❑TB skin test _____mm ❑T-spot/Quantiferon Plus _____

RADIOGRAPH FINDINGS
Date performed _____ Results (please check): ❑ Normal ❑Abnormal ❑ Cavitary ❑Non-Cavitary
Additional Info/Other _____

LOCATION OF DISEASE (CHECK ALL THAT APPLY)
❑Pulmonary ❑Pleural ❑Lymphatic ❑Bone/Joint ❑Genitourinary ❑Miliary ❑Meningeal ❑Peritoneal
❑Other (please specify) _____

BACTERIOLOGICAL STATUS
Date Performed _____ Type of Specimen _____
Smear: Positive Negative Pending Not Performed
Culture: Positive Negative Pending Not Performed
If culture positive, Mycobacterium Tuberculosis or other (please specify) _____

CLINICAL/LAB RESULTS
Liver function tests/date: _____ Visual acuity _____ Color Discrimination _____ Hearing _____

MEDICATIONS **If not receiving TB medications explain why,** _____

Date started: _____	Isoniazid _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Rifampin _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Ethambutol _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyrazinamide _____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyroxidine _____mg PO ____times/week	Doses received to date: ____
Date started: _____	_____mg PO ____times/week	Doses received to date: ____

CONTACT IDENTIFICATION
_____ I have already evaluated the persons exposed to TB by the above named patient and will complete and return the enclosed contact form.
_____ I prefer that the County Public Health Department provide contact identification and evaluation.

MEDICAL CARE Circle who will provide the following **PMD** = Private Medical Provider **HD** = Health Department

Patient Care	PMD	HD	Chest x-ray	PMD	HD	Hearing screen	PMD	HD
TB Medication[1]	PMD	HD	Liver function test	PMD	HD	Visual acuity/color	PMD	HD
Sputum collection	PMD	HD	Blood/Other labs	PMD	HD	Directly observed therapy[2]	PMD	HD

In the event you prefer to provide the above services yourself, a follow-up form will be sent to you every month to obtain patient status and persons exposed to TB data. The County Public Health Department will fulfill its obligation in assuring this patient and his/her contacts are receiving adequate care. Be assured that all information provided will be held in confidence and used for official purposes only.

Physician's signature _____ Date _____

[1]If the HD provides the patient's TB medications, a monthly assessment MUST be performed by the HD provider.

[2]Directly Observed Therapy is the **standard of care** for all patients being evaluated for/diagnosed with TB in Georgia.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Follow-up Report on Patient with Tuberculosis

Form 3142 (revised 01/2020)

Physician _____ Date _____
Physician Address _____ Patient Name _____
_____ Patient Address _____
Physician Telephone _____ _____
Patient DOB _____ Telephone _____

Since tuberculosis (TB) is a communicable disease, the County Public Health Department is required by law to assure that every patient with Tuberculosis receives proper treatment and follow-up. In order to adhere with Georgia Statutes and to assure quality care for this patient, your cooperation in completing, signing and returning this form is necessary. Please return to _____ County Public Health Department at _____ by _____ _____.

RADIOGRAPH FINDINGS

Date performed _____ Results (please circle) Normal Abnormal Cavitary Disease Stable
Additional Info/Other _____

BACTERIOLOGICAL STATUS

Date Performed _____ Type of Specimen _____

Smear: Positive Negative Pending Not Performed
Culture: Positive Negative Pending Not Performed
If culture positive, Mycobacterium Tuberculosis or other (please specify) _____
Date of last culture positive specimen (if applicable): _____
Date of last culture negative specimen (if applicable): _____
Were drug susceptibility tests ordered on a positive culture? Yes No If no, please explain _____
_____

CLINICAL/LAB RESULTS

Liver function tests/date: _____ Visual acuity _____ Color Discrimination _____ Hearing _____

MEDICATIONS **If not receiving TB medications explain why,** _____

Date started: _____	Isoniazid ____mg PO ____times/week	Doses received to date: ____
Date started: _____	Rifampin ____mg PO ____times/week	Doses received to date: ____
Date started: _____	Ethambutol ____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyrazinamide ____mg PO ____times/week	Doses received to date: ____
Date started: _____	Pyroxidine ____mg PO ____times/week	Doses received to date: ____
Date started: _____	_____mg PO ____times/week	Doses received to date: ____

Name of Person performing Directly Observed Therapy: _____ **(please attach completed DOT sheet)**
Directly Observed Therapy is the **standard of care** for all patients being evaluated for/diagnosed with TB in Georgia.

Comments: _____
_____
_____
_____
_____
_____
_____
_____

Physician's signature _____ **Date** _____

Enter County Board of Health
Information/Letterhead Here
(Enter Region, Address, City, State, Zip)

_____

(Date)

_____

Patient Name

_____

Patient Address, City, State, Zip Code

I _____, consent to use a personal smartphone with video capability ____ (initial) or internet web camera ____ (initial) technology to ensure compliance with Video Directly Observed Therapy (VDOT) for the treatment of Tuberculosis (TB).

I understand that if I choose to use a webcam for VDOT that a secure connection over the Internet cannot be guaranteed. I understand that the webcam is to be used only for observation of taking the prescribed TB medications. I will immediately contact the (insert Local Health Department name here) or the Department of Public Health for other concerns and/or questions regarding my treatment.

I understand that the video transmission will occur over the internet, that the transmission is not secure or encrypted, and that (enter County Board of Health name here) cannot guarantee that third parties will not gain access to the transmission. I release the (enter County Board of Health name here) of liability for the access to the transmission by third parties. I understand that use of this video technology is voluntary and may be stopped at any time should I choose to use face-to-face Directly Observed Therapy. VDOT can also be stopped if:

- I miss more than one scheduled VDOT in one week
- I miss a scheduled clinic appointment
- I have any reaction(s) during my treatment and require a physician evaluation
- I have any adverse reactions to my medication
- My equipment (smartphone/desktop/laptop) is lost, stolen, or damaged
- My condition worsens
- I am physically unable to perform VDOT

GEORGIA DEPARTMENT OF PUBLIC HEALTH

DOT INSTRUCTION SHEET

Date medication started _____

	Name	Address	Main phone	Cell phone
Patient				
DOT Worker				
TB Nurse Case Manager				

Medications

Medication name and dosage	Picture of medication	Number of Pills to take	Number of Days / week
Isoniazid _____ mg			
Rifampin _____ mg			
Pyrazinamide _____ mg			
Ethambutol _____ mg			
Pyridoxine (B6) _____ mg			

12 Points of Tuberculosis (TB) Patient Education

Transmission of TB

- TB is a disease caused by the TB germ. The disease is mainly in the lungs (pulmonary TB), but the germ can travel to other parts of the body (extrapulmonary TB) and sometimes can be in multiple parts of the body (miliary or disseminated TB).
- TB is spread when someone who is sick with TB in his/her lungs coughs, sneezes, talks or sings and sprays the TB germ into the air. When someone spends time with that person, he/she can breathe in the TB germ and become infected. Usually have to be around an infectious person for a long time and share the same airspace.
- Infectiousness decreases after the person has been on treatment for a while Can NOT get TB by sharing drinks, toys or personal items.
- When a person is exposed to the TB germ and becomes infected, the person's own immune system will usually build a wall around the TB germs, keeping them from growing and multiplying. This is called latent TB infection or LTBI. The germs can remain dormant in a person's body throughout his/her lifetime.
- A TB skin test (Mantoux) can be given to see if someone has been infected with the TB germ. If the skin test is positive, a chest X-ray and sputum test will be done to make sure the person does not have TB disease. The skin test only determines TB infection. A positive result does not necessarily mean the person has TB disease.
- Once TB disease is ruled out, the doctor may prescribe a preventive medicine called Isoniazid (INH). INH can prevent TB by killing the TB germs.

Differences between LTBI & Active TB disease

- Both can have a positive skin test.
- LTBI has no symptoms & the person feels fine, but in active TB disease, the person usually feels sick and has symptoms of TB.
- LTBI the chest x-ray is normal, in active TB disease, it is usually abnormal.
- LTBI can NOT transmit the germs to others, in active TB disease; the germs can be transmitted to other people.
- Both can be treated.

Progression of LTBI to Active TB

- A person who is exposed and becomes infected with TB has a 10% chance of developing active TB disease. The most critical time period is the first 2 years after becoming infected.
- When the body's immune system is weak, the wall around the TB germs begins to break down. The TB germs wake up and start multiplying; growing and attacking the body, making the person feel sick and develop symptoms.
- Anyone can get TB, but some people are at greater risk than others. These include:
- ○ Persons living with someone who has active TB of the lungs

- Persons who had TB disease in the past but didn't receive or complete their treatment
- Persons who are elderly
- Persons with weakened immune systems

Signs & symptoms of disease

- The early signs and symptoms of TB develop slowly and may go unnoticed for a long time. These include:
  - Cough
  - Chest pain
  - Loss of appetite
  - Weight loss
  - Tiredness
  - Fever/chills/ night sweats
- The symptoms should get better after the person is on medication for a couple of weeks. If they don't or if they come back after getting better, the nurse or physician needs to be notified.

Importance of HIV testing

- All patients in TB clinics should be tested for HIV. This includes TB suspects, patients, and contacts.
- People infected with HIV (the virus that causes AIDS) are more likely than uninfected people to get sick with other infections and diseases. Tuberculosis (TB) is one of these diseases.
- HIV infection weakens the immune system. If a person's immune system gets weak, TB infection can activate and become TB disease. Someone with TB infection and HIV infection has a **very high risk** of developing TB disease. Without treatment, these two infections can work together to shorten the life of the person infected with both.
- HIV infection is the most important known risk factor for progression from latent TB infection to TB disease. Progression to TB disease is often rapid among HIV-infected persons and can be deadly. In addition, TB outbreaks can rapidly expand in HIV-infected patient groups.

Respiratory isolation & use of masks

- It is important for the patient to remain at home on isolation. As much as possible, he/she should stay away from other people in the house by staying in a separate room or wearing a surgical mask when leaving the room. Separate bedrooms or beds are highly recommended, if possible. The patient cannot travel, go to work, go to school, go shopping or participate in any other activity where there is contact with other people.
- The patient needs to cover his/her mouth and nose with a tissue when coughing or sneezing. These tissues should be flushed, burned or placed in a sealed leak proof bag before disposal.
- The patient cannot leave home except to keep medical appointments. He/she must wear a surgical mask to the clinic and doctor's offices.
- The patient should not allow anyone, other than those living with him/her or those individuals providing care to him/her, into the home and should stay away from young children.
- These isolation instructions remain in effect until the patient is told by the health department that he/she no longer has to stay in isolation.

- These isolation instructions may become effective again after the patient has been told that he/she is no longer infectious should the clinical situation change.
- Keep doors and windows open as much as possible.
- DOT visits will be conducted outdoors, beside open windows and as efficiently as possible in order to reduce exposure time.
- The DOT worker will wear an N95 mask during the time the patient is considered infectious.
- Go outside to collect sputum specimens. The DOT worker should wear an N95 mask anytime sputum is being collected.

Infectious period

- The infectious period is the time when a patient sick with active TB can pass the germs to other people.
- The infectious period begins 3 months prior to the onset of symptoms or clinical sign of TB.
- The infectious period continues until all of the following criteria is met:
  - 3 consecutive smear negative specimens
  - The patient is on appropriate medications
  - The patient is getting better.
- The infectious period is important to determine in order to focus the contact investigation.

Importance of chemotherapy as prescribed

- Having TB should not keep someone from leading a normal life. When TB patients are no longer infectious or feeling sick, they can do the same things they did before they had TB. The medicine does not affect strength, sexual function or the ability to work. If the TB medicine is taken as directed, the medicine will kill all the TB germs and prevent the patient from becoming sick with TB again.
- It is necessary to take several different TB medications because there are many TB germs to be killed. Taking three to four different TB medications will stop the TB germs from becoming resistant to the medication.
- The most common medications are Isoniazid; Rifampin; Pyrazinamide & Ethambutol.
- The patient will usually take several tablets of 4 different medications every day (M-F) for the first 2 months. Then the patient may be able to take several tablets of just 2 medications twice a week until treatment is completed (another 4-7 months).
- TB is almost always curable if the patient adheres to the treatment regimen of taking several special medications for six to nine months. The medication must be taken continuously and uninterrupted for the duration of treatment.
- The treatment takes this long because the TB germs grow very slowly and are slow to die. The combination of these medications delivered by DOT can cure the disease in less than a year.
- Prolonged illness, disability or possible death is avoided.
- Risk of developing MDR-TB or XDR-TB is decreased.

Side effects and adverse medication reactions

Side effects of medications are those things which are anticipated to happen in people taking certain medications.

Most of the side effects are manageable and do not require stopping the medication.

Medication	Side Effect	Action
Isoniazid	Dizziness, tingling/numbness around the mouth or in the extremities GI distress; nausea when taking the pills but feels better later in the day	Proactively B6 is usually given; report any mild signs or symptoms to the nurse or physician Alter time of day pills are given; try giving pills with a small snack or food; report to nurse or physician
Rifampin	Discoloration of bodily fluids; urine, sweat or tears may be orange or reddish Drug interactions; can interfere with birth control pills or implants; can alter effectiveness of methadone	Prepare the patient to see this; have him/her switch to hard contact lenses or glasses because staining can occur of soft contact lenses Counsel patient to use an alternative or back-up method of birth control (e.g., copper-bearing IUD such as ParaGard, condoms, diaphragm) when rifampin is prescribed, it reduces effectiveness (degree depending on method) of combined oral contraceptives, progestinonly oral contraceptives, levonorgestrel implants, Depo-Provera, patch and ring.Advise condom back- up. Make

		sure nurse & physician are aware of all medications the patient is taking.
	Sun sensitivity; frequent sunburn	Counsel patient to avoid prolonged exposure to sun & to wear adequate sunblock
	Easy bruising; slow blood clotting	Avoid bruising; do not take aspirin unless ordered by a physician; tell healthcare provider about medications prior to any procedure that might cause bleeding
	GI distress; nausea when taking the pills but feels better later in the day	Alter time of day pills are given; try giving pills with a small snack or food; report to nurse or physician
Pyrazinamide	GI distress; nausea when taking the pills but feels better later in the day	Alter time of day pills are given; try giving pills with a small snack or food; report to nurse or physician
	Joint aches	Cold packs or heat packs; report to nurse or physician
Ethambutol	Can cause blurred or changes vision; changes in color vision	Monitor & test eyes monthly

Adverse reactions to medications are unexpected reactions to medications that may be severe and warrant stopping the medications to avoid harm or damage to the patient.

Medication	Adverse Reaction	Action
Isoniazid	Dizziness; tingling/numbness around the mouth or in the extremities Hepatitis: nausea; vomiting; yellowish skin or eyes; abdominal pain; dark, maple syrup or coffee colored urine; abnormal liver function tests; fatigue; fever >3 days; flu-like symptoms; lack of appetite	Stop medication if severe or seems to be worsening; notify nurse or physician Stop medication and notify nurse or physician
Rifampin	Easy bruising; slow blood clotting Hepatitis: nausea; vomiting; yellowish skin or eyes; abdominal pain; dark, maple syrup or coffee	Stop medication and notify nurse or physician Stop medication and notify nurse or physician
	colored urine; abnormal liver function tests; fatigue; fever >3 days; flu-like symptoms; lack of appetite	
Pyrazinamide	Severe stomach upset; vomiting; lack of appetite Hepatitis: nausea; vomiting; yellowish skin or eyes; abdominal pain; dark, maple syrup or coffee colored urine; abnormal liver function tests; fatigue; fever >3 days; flu-like symptoms; lack of appetite	Stop medication and notify nurse or physician Stop medication and notify nurse or physician
Ethambutol	Any changes in visions noted	Stop medication and notify nurse or physician

Other warnings to tell clients taking TB medications

- Limit alcohol use when taking TB medication. Combining alcohol and TB medicine can cause liver damage.
- Tell the nurse if other medications are being taken. TB medication can interfere with certain prescription drugs.
- Report any concerns to the nurse.

Directly Observed Therapy (DOT)

- Most TB patients start feeling well after only a few weeks of treatment but the TB germs are still alive in the body.
- It is very dangerous for a TB patient to stop taking medicine early or not to take it regularly. The TB germs begin to grow again and patients may become infectious and remain sick much longer.
- Stopping treatment too early or taking treatment irregularly could cause the TB germs to become resistant to
  the TB medicine. If this happens, new and different medicines will be needed to kill the TB germs. These new medicines have to be taken for a longer time and usually have more serious side effects.
- DOT helps prevent these problems by making sure that treatment is complete.

Importance of regular medical assessments

- It is very important to have regular checkups at the clinic at least monthly.
- Blood tests can be done to make sure the medications are not harming the liver.
- Chest x-rays may be done to see if there is improvement.
- Sputum tests will be done to ensure medications are working. The sputum results also help decide when a
  patient is no longer infectious and can return to his/her
  normal life.

Importance of contact investigation

- When a patient has TB disease, they are doing the right thing by sharing the names of people they spent
  time with when they were able to pass TB germs to others (infectious period). By helping the healthcare worker do a contact investigation, they are helping their family and friends stay well. And they are helping to make sure their community stays healthy.
- The healthcare worker will ask for the names of contacts, people the patient spent time with before getting
  treatment—when the TB germs could be passed on to others.
- The healthcare worker will call or visit people to let them know they should be tested for TB. Together the
  healthcare worker and patient make a list of all contacts. Contacts are family members, friends, neighbors, co-workers, and others who spent time with the patient when they were sick.
- Give the names of the contacts to your healthcare worker. Don’t let being embarrassed keep you from listing
  people you may have given TB germs. Think of how you are helping those around you stay well. Protect your family and friends.
- Questions the healthcare worker may ask the patient:
  - “How long have you been coughing? When did you first feel sick?”
  - “Where did you spend time when you were feeling sick and coughing? Where did you live? Did you go to school? Where did you hang out when you were not at home or working?”
  - “Who are the family members, friends, neighbors, and co-workers you spent time with while coughing?”
- The healthcare worker will decide which people need to be contacted based on the information given. It is important for the healthcare worker to be in touch with people who may have been given TB germs. These friends, family members, co-workers, or classmates may have TB infection. This means they have dormant (sleeping) TB germs in their body, so they may not feel sick. If they get treatment for TB infection, they won’t

get sick with TB disease. If they already have TB disease, they will need treatment right away.

- Some people with TB disease are afraid they will lose their job if others learn they passed TB germs to people at work. Others may be worried their friends and family will reject them. What you need to know is that the information you share with the healthcare worker is kept private and personal.
- The healthcare worker will call or visit the people named. He/she may talk to a group of people at the patient's work, school, or place of worship. The healthcare worker will suggest the contact get a TB skin test and will provide information on where to get tested.

CONSTITUTIONAL

Unexplained elevated temperature for three or more days

0__I__I__I__I__I__I__I__I__I__10

98° **101°**

Unexplained weight loss

0__I__I__I__I__I__I__I__I__I__10

None **Severe**

Tired, don't feel well, malaise, weakness

0__I__I__I__I__I__I__I__I__I__10

None **Severe**

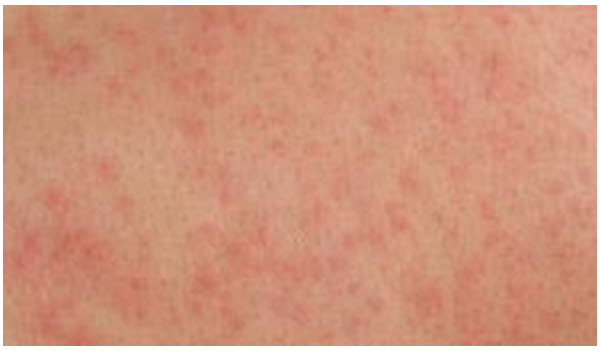
		**Chills and/or night sweats** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

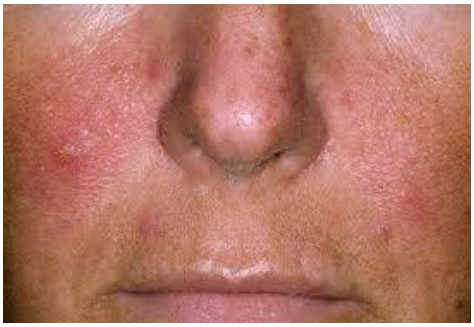
HEAD, EYES, EARS, NOSE, THROAT (HEENT)

	**Vision changes** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Color of sclera** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

	**Hearing loss, ringing in ears** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

SKIN

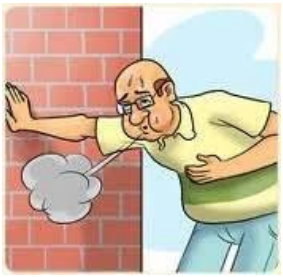
	**Yellowish skin** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Rash or itching** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

	**Bruising** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Flushing** Avoid eating cheeses and meats, soy sauce, soy beans. Miso soup, fava beans, snow peas, sauerkraut, yeast, wine or beer **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

CARDIOVASCULAR

	**Chest Pain** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

RESPIRATORY

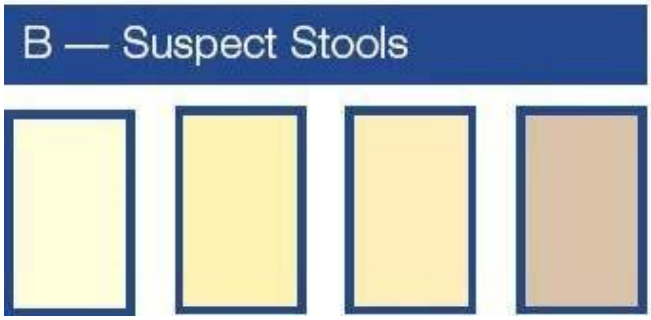
	**Shortness of Breath** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Coughing** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Coughing up blood** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

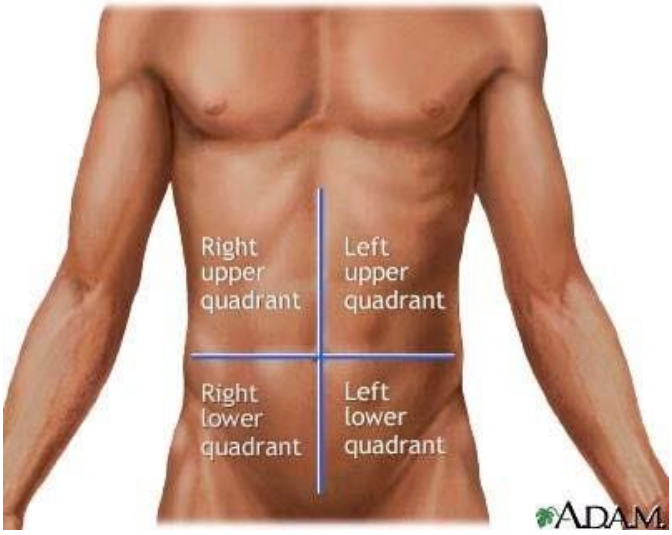
GASTROINTESTINAL, 1

	**Loss of appetite** **0__I__I__I__I__I__I__I__I__I__10** **None** **Severe**
	**Nausea** Small snack with pill or suck on hard candy **0__I__I__I__I__I__I__I__I__I__10** **None** **Severe**
 	**Nausea and Vomiting** Dark brown, coffee grounds material **0__I__I__I__I__I__I__I__I__I__10** **None** **Severe**

	**Heartburn** Do not take antacids 1 hour before or 1 hour after your pill **0__I__I__I__I__I__I__I__I__I__10** **None** **Severe**
	**Diarrhea** **0__I__I__I__I__I__I__I__I__I__10** **None** **Severe**

GASTROINTESTINAL, 2

	**Pale or clay-colored stools** **0__I__I__I__I__I__I__I__I__I__1** **0** **Dark Brown** **White**

	**Abdominal Pain** Cramping, belly pain **0__I__I__I__I__I__I__I__I__I__1** **0** **None** **Severe**
	**Right upper quadrant tenderness** **0__I__I__I__I__I__I__I__I__I__1** **0** **None** **Severe**

GENITOURINARY

	**Normal** Urine is light yellow to a deep yellow in color **0__I__I__I__I__I__I__I__I__I__10** **Light, clear deeper, cloudy**
	**Normal** Urine is light to deep orange with Rifampin **0__I__I__I__I__I__I__I__I__I__10**
	**Abnormal** **Persistently dark urine** **Urine the color of maple syrup or coca cola** **0__I__I__I__I__I__I__I__I__I__10** **Yellow Maple syrup**

Change in kidney function Lethargy, feeling of being unwell, flu-like feelings but no fever, weakness, shortness of breath, appetite loss, nausea, weight loss, itching, dry skin and generalized swelling may occur	**Kidney function** **0__I__I__I__I__I__I__I__I__I__10** **No symptoms Symptoms**

NEUROLOGICAL

 	Peripheral Neuropathy • A burning or prickling sensation • Tingling or numbness, skin crawling, or itching • A feeling of "pins and needles" Taking Vitamin B6 will help decrease **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Headache** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

	**Dizziness** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Cognitive and memory problems** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

MUSCULOSKELETAL

	**Joint pain, Stiffness, Gout** **0__I__I__I__I__I__I__I__I__I__10**

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	**Sore Muscles** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**
	**Weakness in legs or difference in walking** **0__I__I__I__I__I__I__I__I__I__10** **None Severe**

Client Name:_____

Tuberculosis Education Record

Communication methods should be adapted to client's cultural and linguistic background. Provide education to the client and his/her family (when possible) regarding the following topics. Education is a on-going process that can be considered complete when the client is able to verbalize the concepts or demonstrate the behavior back to the provider. Utilize the *12 Points of Tuberculosis (TB) Patient Education* with this form.

Educational Point	**Date began / comments on patient understanding**	**Date continued / comments on patient understanding**	**Date completed / comments on patient understanding**
Transmission of tuberculosis			
Differences between LTBI & Active TB Disease			
Progression of LTBI to Active Disease			
Signs and symptoms of disease			
Importance of HIV testing			
Respiratory isolation & use of masks			
Infectious period			
Importance of chemotherapy as prescribed			
Side effects and adverse medication reactions			
Directly Observed Therapy (DOT)			
Importance of regular medical assessments			
Importance of contact investigation			

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Refusal of HIV Testing

Name_____ Date of Birth _____

□ I have been exposed to an active TB case
□ I have been diagnosed with latent TB infection (LTBI)
□ I have been diagnosed with an active case of TB or suspected case of active TB

CDC recommends HIV screening for all TB clients. This includes persons who have been exposed to an active case of TB (contacts), persons diagnosed with latent TB infection (LTBI) and those persons either suspected to have active TB or those persons confirmed to have active TB.

TB is particularly dangerous for people with HIV infection. Active TB can accelerate the progression of HIV in persons living with HIV. Having HIV infection when exposed or diagnosed with LTBI can increase the progression of the latent form of TB to an active case of TB.

After having the recommendations and risks explained to me, I have decided to refuse a test for HIV. I have been told the signs and symptoms of active TB are cough lasting more than 3 weeks, fever, night sweats, coughing up blood, chest pain, fatigue and unexplained weight loss. I understand that if I develop any signs and symptoms of active TB, I need to seek medical care immediately. I understand that TB is an infectious disease that can be passed to others. I also understand that legal steps can be taken if I develop active TB and I do not seek medical care, but expose others to becoming infected and/or sick.

_____ _____

Client's signature Date

_____ _____

Public Health Representative Signature Date

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Tuberculosis (TB) Risk Assessment

revised 01/2020

Name: _____ Date of Birth: _____

Please circle **YES** or **NO.**

1. Have you been around a person sick with active TB disease? Yes No
   If yes who/when? _____

2. Have you had an organ transplant? Yes No

3. Have you ever injected drugs? Yes No

4. Have you been in jail, prison, nursing home or homeless housing facility? Yes No

5. Have you ever worked in a lab that processed TB samples? Yes No

6. Do you have/have had?
   a. Diabetes Yes No
   b. Kidney failure with dialysis Yes No
   c. Cancer Yes No
   e. Stomach surgery Yes No
   g. Immune problems (HIV, taking steroids longer than 1 month) Yes No

7. Are you starting/taking a treatment for arthritis? Yes No

8. Have you ever been told you have an abnormal chest x-ray? Yes No

9. Do you have any of the following?
   a. A cough and/or hoarseness lasting more than 3 weeks Yes No
   b. Coughing up mucous or blood Yes No
   c. Fever or night sweats for more than one week Yes No
   d. Weight loss without trying Yes No
   e. Tiredness or weakness Yes No

10. Have you ever had a positive TB skin or blood test? Yes No

11. Have you ever received the BCG vaccine? Yes No

12. Have you lived in, traveled to or had a visitor from outside of the United States in the past few years? Yes No If yes, where? _____

Patient Signature/Date _____

Signature of Person Assessing the Patient/Date _____

Title of Person Assessing the Patient _____

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Pediatric Tuberculosis (TB) Risk Assessment

revised 01/2020

Name _____ **Date of birth** _____

Please answer **Yes** or **No**

1. Does the child have any of the symptoms of TB below:
   - Cough or hoarseness of more than 3 weeks? Yes No
   - Fever or night sweats more than a week? Yes No
   - Loss of appetite, weight loss or fatigue? Yes No
   - Been told he/she has an abnormal chest x-ray? Yes No

2. Has the child been around someone who is/was sick with active TB disease or someone with a positive skin/blood test? Yes No

3. Was the child born outside the United States or has the child traveled outside the United States? Yes No
   If yes, where and when? _____
   _____

4. Does the child have a household member who was born outside the United States or who has traveled outside the United States? If yes, where and when? Yes No
   _____

5. Has the child been around a person who:
   - Is currently in jail or has been in jail in the past 5 years? Yes No
   - Has HIV? Yes No
   - Is homeless? Yes No
   - Lives in a group home? Yes No
   - Uses illegal drugs? Yes No
   - Is a migrant farm worker? Yes No

6. Does the child have HIV or at risk to get HIV? Yes No

7. Does the child take steroids for more than a month or have any other health problems that lower the immune system? If yes, please explain. _____
   _____

8. Is the child/teen currently in a jail/detention center or ever been in jail/detention center? Yes No
   If yes, when and where? _____
   _____

9. Has the child ever had a positive skin test/blood test for TB in the past? Yes No
   If yes, please explain. _____
   _____

10. Has the child ever received BCG (Bacillus Calmette–Guérin) vaccine? Yes No
    If yes, when and where? _____

Healthcare Provider, please refer to **Instructions Page** for any **Yes** answers

Instructions Page for Pediatric TB Risk Assessment

revised 01/2020

The Pediatric Tuberculosis (TB) Risk Assessment should be performed at first contact with a child, then at 6 months, 1 year of age and every year thereafter. In the private healthcare sector a child should have a TB Risk Assessment performed at every well-child visit. A Tuberculin Skin Test (TST) should be performed by a trained healthcare provider and read 48-72 hours later by a trained healthcare provider. There is also an option to perform an Interferon Gamma Release Assay (IGRA) blood test to be performed by a trained healthcare provider. This test is useful because it can be more specific than the TST when used to test persons who have received BCG vaccination. **Any positive TST/IGRA in a child younger than 5 years of age must be reported to the local county Health Department.** Any child with latent TB infection (LTBI) should be treated with daily Isoniazid for 9 months in conjunction with the local county health department. Children younger than 15 years of age need Directly Observed Preventive Therapy (DOPT). Please call your local Health Department or Georgia's TB Program at 404-657-2634 with any questions/concerns or assistance.

A "Yes" answer to question #1 or #2 indicates the child should have an immediate TST/IGRA regardless of age. *NOTE: If the TB skin test result is negative for a child younger than six (6) months of age, please retest the child at six (6) months of age.*

1. If the child is experiencing cough or hoarseness of more than 3 weeks, fever or night sweats more than a week, loss of appetite, weight loss or fatigue or been told he/she has an abnormal chest x-ray, please:
   - Notify local county health department **immediately**
   - Medical evaluation for active TB disease and chest x-ray is needed

2. If the child has been around someone who is/was sick with active TB disease or someone with a positive skin/blood test, please:
   - Notify local county health department **immediately**
   - Medical evaluation for active TB disease and chest x-ray is needed
   - For children younger than 5 years of age, after active TB disease has been ruled out by medical evaluation and chest x-ray, Isoniazid therapy should be initiated during the window period under DOPT until the follow-up TST is done in 8–10 weeks.

Questions #3, #4 If the child has been born/traveled outside of the United States and stayed more than 1 week with family and friends, please refer to http://www.stoptb.org/countries/tbdata.asp in order to determine if the country is that of high TB incidence. If the country is of high incidence, a TST/IGRA should be performed immediately and then 8-10 weeks later.

Question #9 If the child has had a positive TST/IGRA in the past, LTBI treatment should be offered if not taken in the past. Always refer to a Pediatrician for further evaluation, especially if the child has signs/symptoms of TB.

Question #10 If the child has received the BCG vaccine and has 1 or more Yes answers, please test for TB using an IGRA (blood) test such as Quantiferon Gold or T-Spot. Using a traditional TST could produce a false positive result.

A Yes answer to the remaining questions indicates the child should have an initial TST/IGRA. Additional TB testing should only be done if a new risk factor/exposure occurs. *NOTE: If the TB skin test result is negative for a child younger than six (6) months, please retest the child at six (6) months of age.*

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Tuberculosis Symptom and Risk Assessment Screening Form

Revised 01/2020

Name: _____ Sex: M / F Date of Birth: _____

Race / Ethnicity:_____ Country of Birth _____ Year of US Arrival _____

History of TB Vaccination, Testing and Treatment

History of Prior BCG? _____ No _____ Yes → _____Year

Prior TST or IGRAs? _____No _____Yes (If yes, provide details below)

Date:_____ Test: TST / IGRA Result: _____mm or Positive, Negative, Indeterminate

Date:_____ Test: TST / IGRA Result: _____mm or Positive, Negative, Indeterminate

Chest Radiography: CXR / CT Scan Location:_____ Date:_____

Result: Normal / Abnormal → If abnormal: Consistent with TB / Not Consistent with TB

Prior TB Treatment: _____ No _____Yes → _____LTBI _____ Active TB Disease

Year of Treatment:_____ Location:_____ Duration:_____

TB Medications Taken:_____

TB Symptom Screen: Have you had any of the following in the past 3 months?

____ **None** (Skip to next Section)

____ Cough for >3 weeks → Productive? ____Yes _____No Hemoptysis? ____Yes ____No

____ Fever, unexplained _____Unexplained Weight Loss ____ Loss of Appetite _____ Night Sweats

____ Fatigue ____ Weakness _____ Chest Pain ____ Shortness of Breath _____ Chills

Duration and comments regarding symptoms:

TB Risk Assessment: Check all risks regarding the patient named above

____ Is a close contact of a person known or suspected to have TB Disease? Source Name:_____

____ Has lived in or recently traveled to a country where TB is common

____ Is an employee or resident of a high TB risk congregate setting (Ex: jail, rehab, nursing home, shelter)

____ Is a health care worker in a high risk setting (Ex: pulmonology, TB Clinic, ID)

____ Has been homeless in the last two years

____ Is in a medically under served, low-income population

____ Uses or has a history of illicit drug use

____ Is HIV positive or is a high risk for HIV infection

____ Has clinical condition that places them at high risk of disease if infected (Ex: persons on long term steroids or TNF medications, diabetic, low body weight, organ transplant, kidney disease, head or neck cancer)

____ Has a history of inadequately treated TB

Explain TB risks that were checked:_____

_____

Action taken (check all that apply)

_____ No sign of active TB at this time, patient is clear to work, got to school, or resume usual activities

_____ TST placed / IGRA drawn (see medical record)

_____ Chest X-Ray not needed at this time

_____ Discussed signs and symptoms of TB with client

_____ Instructed client to seek health care if begin having TB symptoms

_____ Patient chose to decline LTBI medication at this time

_____ Patient chose to begin LTBI medication at this time

Additional measures needed at this time:

_____ Isolation

_____ Given surgical mask

_____ Chest x-ray needed at this time

_____ Sputum samples collected

_____ Referred to physician/clinic (specify):

Other:_____

Signature of person conducting the assessment _____

Signature of patient _____ Date _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Tuberculosis (TB) Symptom Screen

GA DPH TB Unit (Revised 01/2020)

Name: _____ Sex: M / F Date of Birth: _____

Last TB skin/blood test: _____

(Location Name, address, city, state, zip, and phone number of place where test was given)

TST Test date: _____ Results: ___mm **IGRA Test Date:** _____ **Results: Positive/Negative Other:** _____

Chest x-ray Test Date _____ Normal Abnormal **Comment**: _____

Were you treated for: **Latent TB Infection (LTBI)** Yes/No If yes, # of months treated: _____

TB Disease Yes/No If yes, # of months treated: _____

When/Where _____ _____

Medications used _____

Have you ever received the BCG vaccine? Yes No; if yes, when? _____

Today's Date _____

Do you currently have or have had any of the following in the past few months?

Cough:	Yes / No	If yes, for how long? _____
	Are you coughing up blood? Yes / No	If you produce mucus, what color _____
Night sweats:	Yes / No	
Fever:	Yes / No	
Weight loss:	Yes / No	If yes, how many pounds? _____
Weakness:	Yes / No	If yes, how long? _____
Chest pain:	Yes / No	If yes, how long? _____
Short of breath:	Yes / No	If yes, how long? _____

Do you know anyone who has these symptoms? Yes / No

If yes, what is his/her name, address, and phone number? _____

Action taken (check all that apply)

No sign of active TB at this time	
Chest X-Ray not needed at this time	
Discussed signs and symptoms of TB with client	
Instructed client to seek health care if begin having TB symptoms	
Patient chose to decline LTBI medication at this time	
Patient chose to begin LTBI medication at this time	
Additional measures needed at this time:	
Isolation	
Given surgical mask	
Chest x-ray needed at this time	
Sputum samples collected	
Referred to physician/clinic (specify):	
Other:	

Signature of person conducting the assessment _____

Signature of patient _____ Date _____

Case Management Time Line

rev. 6/2020

FIRST NOTIFICATION

Reporting and Notification	Date HD	Date State	Comments
Local Health Department (immediate) and State HD (w/i 24 HRS) Notification			
Interjurisdictional TB Notification (NTCA 3-2002) if from other State/Country			
Initial Report (form 3140 or 3141) and/or discharge summary from hospital			
Discuss with hospital Case Manager, if hospitalized			
Estimate potential Infectiousness			
Arrange to visit client while hospitalized (ideal). Call client in hospital if cannot visit			
Initial Interview to verify info – DISCUSS BARRIERS, infection control, arrange for accommodations			

First Visit to Home: Within 24 – 48 hours of notification of TB Suspect

Legal	Date HD	Date State	Comments
Signed Consent (form 3609)			
Signed Treatment Plan (form 3144)			
Signed DOT agreement (form DPH06/060W)			
Signed Release of Information (form 5459)			
Documentation of Patient receiving Medication Information Sheet (DPH04/328HW)			
Case Management	**Date HD**	**Date State**	**Comments**
TB Services (form 3121R) Initial completion			
Physical Assessment in chart (hospital, physician or HD)			
SENDSS entry: demographics w/i 24 hrs of notification, assessment w/i 24 hrs of receipt			
Check weight/Recalculate TB med doses			
Initial chest x-ray report in chart			
HIV status and post test counseling documented			
Baseline labs: Adults: AST, ALT, bilirubin, alkaline phosphatase, CBC with platelet count, serum creatinine, Hemoglobin A1C, Hep B profile and Hep C Antibody. All ages FB: Hep B profile			
Other labs ordered per history and protocol			
Pregnancy test, if indicated			
Baseline visual acuity testing and red/green color discrimination for clients on Ethambutol			
Baseline hearing if on a "mycin" medication (injectable)			
Appropriate client education documented: Utilizing Client Education Guidelines in P&P			
3 Consecutive sputum specimens collected (Check: smear, culture, & sensitivity and NAAT x2)			
3 Consecutive sputum smears date documented			
Refer for CXR if not already done			
Started on appropriate medications with at least 4 Drugs			
Medication start date documented			
Medical Case Review form started			
Make arrangements for DOT			
Discuss infection control measures (isolation in room in home and surgical mask when out)			
Assess Barriers to adherence. Consider incentives/enablers			
Referrals and f/u for:co-morbidities, tobacco cessation, drug &/or alcohol addiction treatment			
Contacts identified at 1st patient visit (and with each visit thereafter)			

Within First Month 1

Reporting and Notification	Date HD	Date State	Comments
Initial RVCT form completed in SENDSS within 30 days			
Case Management	**Date HD**	**Date State**	**Comments**
Initial chest x-ray report in chart			
HIV status and post test counseling documented			
Follow-up labs, as indicated. Refer where needed, e.g. primary MD for elevated A1C			
Weekly sputa x3 until 3 consecutive AFB smear neg. Then 1/week for AFB, C&S 'til Culture neg			
Monthly visual acuity testing and red/green color discrimination for clients on Ethambutol			
Appropriate client education documented: Utilizing Client Education Guidelines in P&P			
High Priority Contacts initial encounter w/i 3-7 days w/medical eval w/i 5 days			
Medium Priority Contacts initial encounter w/i 14 days w/medical eval w/i 10 days			
Low Priority Contacts Initial encounter w/i 30 days			
Ensure that the case management plan is shared with the TB team			
Count Medication Doses to ensure Patient is on-target			
Monthly hearing and balance assessment if on "mycin" injectable			

Within 3 Months

Reporting and Notification	Date HD	Date State	Comments
TB Classification within 90 days			
Follow Up RVCT form completed in SENDSS within 2 months of RVCT (Follow Up Report – 1)			
Monthly Follow up Reports from PMD (form 3142) if co-managed			
Case Management	**Date HD**	**Date State**	**Comments**
2 month sputum status documented			
Initial TB Drug Susceptibility			
Monthly Flow Sheets Completed			
Calculate number of doses taken within initial phase before starting Continuation Phase			
Initiation Phase Completed and Medications changed for Continuation Phase			
If no clinical improvement by 2 months, discuss w/MD – may need serum drug levels			
Appropriate client education documented: Utilizing Client Education Guidelines in P&P			
F/U on referrals, re-assess readiness to quit tobacco, alcohol, illicit drugs			
Medical Case Review form started			
TB Services (form 3121R) Updated			
Weeks 8 -12 Follow-up TSTs/IGRAs for Close Contacts			

Monthly / On-Going

Case Management	Date HD	Date State	Comments
Follow up Chest x-ray reports in chart			
Monthly sputum specimen obtained for AFB/C&S			
Sputum conversion documented			
Follow up TB Drug Susceptibility, if needed			
Appropriate number of doses within time frame			
DOT form complete and current (form 3130)			
Appropriate action documented for side effects, adverse reactions and other identified problems			
Complete & current TB Flow Sheet (form 3135)			
Monthly labs: AST, ALT, bilirubin, alkaline phosphatase & CBC with platelets			
Monthly visual acuity and red/green color discrimination, if on Ethambutol			
Monthly hearing checks if on injectable			
Adherence assessed and documented with appropriate action taken documented			
Documented referrals and follow up as indicated			
Documented f/u for Mental Health, as needed			
Documented f/u for Tobacco, Drugs &/or Alcohol Treatment referrals			
Continue follow-up with Contacts: Complete Contact Investigation Sheet, make sure all needed CXRs are done, f/u with patients on LTBI treatment			
Medication stop date documented			
Appropriate client education documented: Utilizing Client Education Guidelines in P&P			
Medical Case Review form started			
TB Services (form 3121R) Updated			

Close-out

Reporting and Notification	Date HD	Date State	Comments
Follow Up RVCT form completed in SENDSS when case is closed (Follow Up Report – 2)			
Appropriate number of doses of each recommended medication verified			
Appropriate completion of treatment within 12 months			
Cohort form completed			
All information regarding case is entered into SENDSS			

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SAMPLE MEDICAL DELEGATION

The signatures below indicate a mutual agreement between the delegating physician(s) and the unlicensed public health (PH) personnel who are authorized to perform administration of tuberculin skin test (TST) and reading (measurement) of tuberculin test for the purpose of screening for active TB and latent TB infection.

All public health personnel whose signatures appear on this page:

1. Have been adequately trained to perform the delegated act of administering and/or reading tuberculin skin tests

2. Have obtained certification in TST reading and administration from a certified instructor for the Tuberculosis Program, Georgia Department of Public Health AND maintain and renew their TST administration and reading certification every two years, AND , and such training is documented by a state certification form in each person's training file.

3. Have immediate access to a licensed medical professional for consultation and for referral of any induration read for interpretation.

4.Participate in an annual skill competency event that is observed by the delegating physician.

5. Have been given an opportunity to have questions answered.

_____	_____
Signature of Delegating Physician	Date
_____	_____
Signature of PH Personnel	Date
_____	_____
Signature of PH Personnel	Date
_____	_____
Signature of PH Personnel	Date
_____	_____
Signature of PH Personnel	Date

Appendix G

Hospitalization for Tuberculosis

[Georgia Statutes current through 2016]

O.C.G.A. § 31-14-1. Active tuberculosis; definition; declaration of policy

(a) As used in this chapter, the term “active tuberculosis” means a diagnosis demonstrated by clinical, bacteriologic, or diagnostic imaging evidence, or a combination thereof. Persons who have been diagnosed as having active tuberculosis and have not completed a course of antituberculosis treatment are still considered to have active tuberculosis and may be infectious.

(b) Active tuberculosis is declared to be dangerous to the public health.

O.C.G.A. § 31-14-2. Conduct of diseased person likely to expose others; petition for commitment

When the county board of health or the Department of Public Health has evidence that any person has active tuberculosis and is violating the rules and regulations promulgated by the department or the orders issued by the county board of health and thereby presents a substantial risk of exposing other persons to an imminent danger of infection, after having been directed by the county board of health or the department to comply with such rules, regulations, or orders, the county board of health or the department shall institute proceedings by petition for commitment, returnable to the superior court of the county wherein such person resides or, if such person is a nonresident or has no fixed place of abode, in the county wherein such person may be found. The petition executed under oath shall state the specific evidence supporting the allegations, that the evidence has existed within the preceding 30 days, that the person named therein has active tuberculosis and is violating the rules and regulations of the department or the orders of the county board of health and presents a substantial risk of exposing other persons to an imminent danger of infection, after having been directed by the county board of health or department to comply with such rules, regulations, or orders, and that the public health requires commitment of the person named therein. The petition must be accompanied by a certificate of a physician stating that the physician knows or suspects that the person named therein may have active tuberculosis, the evidence which forms the basis of this opinion, and whether a full evaluation of the person is necessary.

O.C.G.A. § 31-14-3. Hearing on petition; notice of hearing; physical examination; court costs; conduct of hearing

(a) Immediately upon the filing of a petition pursuant to Code Section 31-14-2, the judge of the superior court shall set the matter for a full and fair hearing on the petition. Such hearing shall be held no sooner than seven days and no later than 12 days, excluding Saturdays, Sundays, and holidays, subsequent to the time of filing of the petition. The court shall serve personal notice of the hearing upon the person named in the petition and upon the petitioner. The notice required by this Code section shall include the time and place of the hearing; notice of the person's right to counsel, that the person may apply for court appointed counsel if the person cannot afford counsel, and that the court will appoint counsel unless the person indicates in writing that he or she does not wish to be represented by counsel; and notice that the person may waive his or her rights to a hearing under this Code section. A copy of the petition and physician's certificate filed under Code Section 31-14-2 shall be attached to the notice. The judge shall, where prayed for in the petition, provide for the examination of the person named therein by a physician licensed under Chapter 34 of Title 43,

which examination shall include sputum examinations by a laboratory approved by the department and a recent chest X-ray of good diagnostic quality interpreted by a physician licensed to practice under Chapter 34 of Title 43, as a part of the order setting the matter for hearing; the order shall require the person or persons named therein to make such examination. Any X-ray and accompanying report or any written report as to a sputum examination shall be admissible as evidence without the necessity of the personal testimony of the person or persons making such examination and report. A physician may rely upon this evidence as the basis for the diagnosis of active tuberculosis and the defendant may offer opposing evidence on this issue by testimony or otherwise. All court costs incurred in proceedings under this chapter, including costs of examinations required by order of court but excluding any examinations procured by the person named in the petition, shall be borne by the county wherein the proceedings are brought. The fee to be paid to an attorney appointed under this Code section to represent a person who cannot afford counsel shall be paid by the county board of health instituting proceedings for commitment.

(b) A full and fair hearing shall mean a proceeding before a hearing examiner under Code Section 31-14-8.1 or before the superior court in a proceeding under subsection (a) of this Code section. The hearing may be held in a regular court room or in an informal setting, in the discretion of the hearing examiner or the court, but the hearing shall be recorded electronically or by a qualified court reporter. The person named as defendant shall be provided with the opportunity for the assistance of counsel. If the defendant cannot afford counsel, the court shall appoint counsel for the defendant or the hearing examiner shall request that the court appoint such counsel; provided, however, that the defendant shall have the right to refuse in writing appointment of counsel. Both parties shall have the right to confront and cross-examine witnesses, to offer evidence, and to subpoena witnesses. Both parties shall have the right to require testimony before the hearing examiner or in court in person or by deposition from any physician upon whose evaluation the decision of the hearing examiner or the court may rest. The hearing examiner and the court shall apply the rules of evidence applicable in civil cases, except as otherwise provided for in this chapter. The burden of proof shall be upon the party seeking commitment of the defendant. The standard of proof shall be by clear and convincing evidence. At the request of the defendant, the public may be excluded from the hearing. The defendant may waive his or her right to be present at the hearing. The reason for the action of the court or the hearing examiner in excluding the public or permitting the hearing to proceed in the defendant's absence shall be reflected in the record.

O.C.G.A. § 31-14-4. Service of copy of petition and order; contempt for failure to comply

A copy of the petition and order shall be served on the person named in the petition. Any failure of such person to comply with the order or with the notice by the persons appointed therein to make examination shall be enforceable by attachment for contempt.

O.C.G.A. § 31-14-5. Procedure where there is danger of diseased person absconding

Where a danger exists that the person named in the petition may abscond or conceal himself or herself or where the person is conducting himself or herself so as to present a substantial risk of exposing other persons to an imminent danger of infection, the court may, as a part of the order made pursuant to Code Section 31-14-3, direct the sheriff or

the sheriff's deputies to take such person into custody pending hearing and impose such confinement as will not endanger other persons. An affidavit shall be attached to the petition containing the specific facts supporting the need for custody pending hearing.

O.C.G.A. § 31-14-6. Report of person making examination; service of copies

The person or persons appointed by the order to make the examination shall file a report thereof, in triplicate, in the court wherein the proceeding is pending. The clerk of the superior court shall forthwith make service of one copy on the agency instituting the proceeding and one copy on the party named as defendant therein and the defendant's attorney, which service shall be personal or by certified mail or statutory overnight delivery.

O.C.G.A. § 31-14-7. Order based upon hearing; commitment of patient to hospital; costs of transportation; dismissal of petition and release of defendant where standards not met; review of commitment order

(a) Upon the hearing set in the order, if the court finds that the person has active tuberculosis, is violating the rules and regulations promulgated by the department or the orders issued by the county board of health after having been directed by the county board of health or the department to comply with such rules, regulations, or orders, presents a substantial risk of exposing other persons to an imminent danger of infection, and there is no less restrictive available alternative to involuntary treatment at a hospital or facility approved by the department for the care of tubercular patients, then the court shall issue an order committing the defendant to the custody of the sheriff of the county or the sheriff's deputies to be delivered to the designated hospital or facility, where the defendant shall be admitted for care and treatment not to exceed two years. If the court does not find that the above standards are met, then the court shall dismiss the petition and the defendant shall be released from custody if taken into custody pursuant to Code Section 31-14-5. The costs of transporting such person to the hospital or facility shall be paid out of county funds.

(b) An order for commitment shall be subject to review at the instance of either party by appeal.

O.C.G.A. § 31-14-7. Order based upon hearing; commitment of patient to hospital; costs of transportation; dismissal of petition and release of defendant where standards not met; review of commitment order

(a) Upon the hearing set in the order, if the court finds that the person has active tuberculosis, is violating the rules and regulations promulgated by the department or the orders issued by the county board of health after having been directed by the county board of health or the department to comply with such rules, regulations, or orders, presents a substantial risk of exposing other persons to an imminent danger of infection, and there is no less restrictive available alternative to involuntary treatment at a hospital or facility approved by the department for the care of tubercular patients, then the court shall issue an order committing the defendant to the custody of the sheriff of the county or the sheriff's deputies to be delivered to the designated hospital or facility, where the defendant shall be admitted for care and treatment not to exceed two years. If the court does not find that the above standards are met, then the court shall dismiss the petition and the defendant shall be released from custody if taken into custody

pursuant to Code Section 31-14-5. The costs of transporting such person to the hospital or facility shall be paid out of county funds.

(b) An order for commitment shall be subject to review at the instance of either party by appeal.

O.C.G.A. § 31-14-8.1. Continued confinement; report of necessity; hearing

(a) If it is necessary to continue confinement of a committed patient beyond a period of two years ordered by a court or hearing examiner or authorized under subsection (d) of this Code section, the designated responsible physician of the tuberculosis inpatient unit shall review and update the patient's treatment plan and shall prepare a report giving evidence of the necessity of such continued confinement. The report shall be prepared so as to allow sufficient time for the hearing authorized by this Code section to be conducted before the expiration of the two-year period of confinement. The report shall specify that, based upon clinical or X-ray evidence:

(1) The patient is a person having active tuberculosis requiring continued commitment; or

(2) The patient is a person having active tuberculosis with a substantial likelihood of future noncompliance with a proposed treatment plan which will predictably lead to the development of infectious drug-resistant tuberculosis. The likelihood of noncompliance must be based upon a history of noncompliance with treatment.

(b) Such report shall be filed in the patient's medical record. A copy of the report shall be personally served on the patient along with a statement that the patient may, within 15 days after service of the report, file a request for a hearing to be conducted in accordance with the procedure for contested cases under Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," except as otherwise provided in this chapter, that the patient has a right to counsel at the hearing, that the patient may apply immediately to the superior court in the county where the committed patient is confined to have counsel appointed if the patient cannot afford counsel, and that the court will appoint counsel for the patient unless the patient indicates in writing that he or she does not desire to be represented by counsel or has made his or her own arrangements for counsel. Payment for such court appointed representation shall be made by the department. The hearing may be continued as necessary to allow the appointment of counsel.

(c) If a hearing is requested within 15 days of service of the report on the patient, the hearing examiner shall set a time and place for the hearing to be held within 15 days of the time the hearing examiner receives the request. The hearing examiner may set a hearing if a request is made later than 15 days after service of the report if good cause is shown for the delay in making the request. Notice of the hearing shall be personally served on the patient, the hospital or facility, and, when appropriate, on counsel for the patient. Such hearing shall be a full and fair hearing, as described in Code Section 31-14-3, before a hearing examiner. After such hearing, the hearing examiner may issue any order which the court is authorized to issue under Code Section 31-14-7.

(d) If a hearing is not requested within 15 days of service of the report on the patient, the department shall be authorized to continue confinement of the patient for an additional period not to exceed six months.

O.C.G.A. § 31-14-8.2. Appeal of order of superior court or hearing officer

[*Text of section effective until Jan. 1, 2017.*]

Either party may appeal any order of the superior court or hearing examiner in a proceeding under this chapter. An order of the superior court may be appealed to the Court of Appeals and the Supreme Court as provided by law but shall be

heard as expeditiously as possible. The appeal of an order of a hearing examiner shall be to the superior court of the county in which the proceeding was held. The review shall be conducted by the superior court without a jury and shall be confined to the record. The court, upon request, may hear oral argument and receive written briefs. The patient must pay his or her costs upon filing any appeal authorized under this Code section or must make an affidavit that he or she is unable to pay costs. The parties shall retain all rights of review of any order of the superior court, the Court of Appeals, and the Supreme Court, as provided by law. The patient shall have a right to counsel on appeal or, if unable to afford counsel, shall have counsel appointed for the patient by the court. The appeal rights provided in this Code section are in addition to any other appeal rights which the parties may have.

O.C.G.A. § 31-14-8.2. Appeal of order of superior court or hearing officer

[*This text becomes effective Jan. 1, 2017*.]

Either party may appeal any order of the superior court or hearing examiner in a proceeding under this chapter. An order of the superior court may be appealed to the Court of Appeals or the Supreme Court as provided by law but shall be heard as expeditiously as possible. The appeal of an order of a hearing examiner shall be to the superior court of the county in which the proceeding was held. The review shall be conducted by the superior court without a jury and shall be confined to the record. The court, upon request, may hear oral argument and receive written briefs. The patient must pay his or her costs upon filing any appeal authorized under this Code section or must make an affidavit that he or she is unable to pay costs. The parties shall retain all rights of review of any order of the superior court, the Court of Appeals, and the Supreme Court, as provided by law. The patient shall have a right to counsel on appeal or, if unable to afford counsel, shall have counsel appointed for the patient by the court. The appeal rights provided in this Code section are in addition to any other appeal rights which the parties may have.

O.C.G.A. § 31-14-9. Procedure to secure discharge; examination; hearing; limitation on frequency of applications; petition for writ of habeas corpus

(a) At any time after commitment and not more often than once every six months, the patient or any friend or relative having reason to believe that the patient no longer has active tuberculosis or that the patient's discharge will not endanger the public health may institute proceedings by petition in the superior court of the county wherein the confinement exists, whereupon the judge shall set the matter for a hearing to occur within 15 days requiring the person or persons to whose care the patient was committed, or their duly authorized agents, to show cause on a day certain why the patient should not be discharged. The judge shall also require that the patient be allowed the right to be examined prior to the hearing by a licensed physician of the patient's own choice and at the patient's own personal expense. Thereafter all proceedings shall be conducted in the same manner as are proceedings for commitment.

(b) In addition to the above procedure for securing discharge, the patient or a friend or relative on behalf of such person may petition, as provided by law, for a writ of habeas corpus to question the cause and legality of detention and to request a court of competent jurisdiction to issue a writ for release, provided that a copy of the petition along with the proper certificate of service shall also be served upon the presiding judge of the court ordering such detention and upon the county board of health or the Department of Public Health which initiated the petition for commitment pursuant to Code Section 31-14-2, which service shall be made by certified mail or statutory overnight delivery.

O.C.G.A. § 31-14-10. Enforcement of rules and regulations by county boards of health

The county boards of health or their duly authorized agents shall, within their respective limits, enforce rules and regulations adopted by the department for the protection of the public against active tuberculosis.

O.C.G.A. § 31-14-11. Taking into custody and return of committed person leaving hospital without authority

Any person who leaves a hospital or facility approved by the department for the treatment of tuberculosis to which he or she has been committed by court order, without having been discharged by the medical staff of the tuberculosis inpatient unit or the community tuberculosis control unit, shall be taken into custody and returned thereto by the sheriff of any county where such person may be found, upon affidavit being filed with the sheriff by the designated responsible official of the hospital or facility to which such person has been committed.

O.C.G.A. § 31-14-12. No commitment for person having active tuberculosis who obeys rules and regulations

No person having active tuberculosis who, in his or her home or other place, obeys the rules and regulations of the department and county boards of health for the control of active tuberculosis or who voluntarily accepts care in a hospital or facility operated for the care of tuberculosis, in his or her home, or in another place and who obeys the rules and regulations of the department and completes the prescribed course of therapy for the control of active tuberculosis shall be committed as prescribed in this chapter.

Appendix H

COMMITMENT TEMPLATES

COMMITMENT FOR TUBERCULOSIS TREATMENT

IN THE SUPERIOR COURT OF _____ COUNTY

STATE OF GEORGIA

_____ COUNTY BOARD OF HEALTH	*	
Plaintiff,	*	
_____,	*	**CIVIL ACTION**
v.	*	**FILE NO.**
_____,	*	
Defendant,	*	

COMMITMENT ORDER

The Plaintiff having filed a Petition for Commitment to a hospital of a client with active tuberculosis on _____, 202__, the Court having appointed a hearing officer to hear the Plaintiff's Petition and counsel to represent the Defendant, the Plaintiff and the Defendant having agreed to the following Consent Order for Confinement and the hearing officer having agreed to this Consent Order; the hearing officer finds the following:

The Defendant, _____, is a _____-year old male/female who has active tuberculosis as defined by O.C.G.A. 31-14-1. From 202__, the Defendant was under the supervision of the _____Board of Health's Tuberculosis Clinic for treatment of his/her active tuberculosis. During this time, the Defendant did not comply with Board of Health orders to consistently take his/her medication and remain confined so that he/she would not spread the disease. The inconsistent treatment of tuberculosis poses the risk to_____ and the general public of creating a resistant tuberculosis strain that would not be treatable for the Defendant or for any person who might contract this resistant strain. Since the Defendant's involuntary confinement on _____, 202__, at _____, the Defendant's tuberculosis has responded to treatment and the level of bacteria in his/her sputum has reduced dramatically. Although he/she shortly will

become non-infectious for active tuberculosis, he/she would subject himself/herself to a relapse if the tuberculosis treatment were not confined for the length of time as prescribed by his/her physician, which could result in a resistant or multi-resistant tuberculosis strain.

Based upon the above-described facts, the hearing officer hereby finds that the Defendant should remain confined to a facility that will ensure he/she consistently takes his/her medication for active tuberculosis. The period of confinement shall be for six (6) months unless an extension of the confinement is granted pursuant to O.C.G.A 31-14-8.1. The place of confinement shall be _____, a facility that has been approved by the Department of Human Resources for the care of tubercular clients. The Defendant's confinement at _____ shall begin only after the Defendant no longer has active tuberculosis as determined by his/her physician. While the client still has active tuberculosis, he/she shall remain confined at _____ under the _____ County Sheriff's supervision. When it is determined that he/she no longer has active tuberculosis, the Sheriff of _____ County or his/her deputies will transport the client to _____ in _____, _____, and release him/her into the custody of and care of _____.

SO FOUND this _____day of _____, 202_____.

_____

Hearing Officer appointed by

Superior Court Judge

Consented to and approved by:

_____

Attorney for Defendant

_____

Attorney for Plaintiff

_____

Defendant

IN THE SUPERIOR COURT OF _____ COUNTY

STATE OF GEORGIA

_____ COUNTY BOARD OF HEALTH	*	
Plaintiff	*	**CIVIL ACTION**
v.	*	**FILE NO.**
_____,	*	
Defendant,	*	

CONSENT COMMITMENT ORDER

The hearing officer that was appointed by this Court having approved a Consent Commitment Order for the confinement of the Defendant, this Court hereby approves the Commitment Oder that was entered into by the hearing officer on the _____ day of _____, 202___.

THEREFORE, the Defendant is ORDERED to be confined pursuant to **O.C.G.A 31-14-1, et seq.,** and to _____ for a period of _____(_____) months to ensure that he/she regularly takes his/her tuberculosis treatment. While at _____, the Defendant will comply with all the orders of _____ for the treatment of tuberculosis, Board of Health orders regarding his/her treatment for tuberculosis, and the orders of medical professional whose care he/she is under. The Defendant's confinement for the treatment and care for his/her disease shall not exceed _____ (___) months, unless that time period is extended by hearing as provided in **O.C.G.A. 31-14-8.1.**

The Defendant's confinement at _____ shall begin only after he/she is negative for active tuberculosis. Until the Defendant is negative for active tuberculosis, he/she shall remain in the custody of the _____County Sheriff or his/her lawful deputies at _____ Hospital.

SO ORDERED this _____ day of _____, 202___.

_____

Judge

Superior Court _____ County

Prepared and presented by:

_____

Attorney for _____

Approved by:

_____

Attorney for _____

_____

Defendant

IN THE SUPERIOR COURT OF _____ COUNTY

STATE OF GEORGIA

_____ COUNTY

BOARD OF HEALTH
Plaintiff, * **CIVIL ACTION**

v. * **FILE NO. _____**
_____ *

Defendant, *

EMERGENCY COMMITMENT HEARING ORDER

The plaintiffs' Emergency Petition for Confinement of Tuberculosis Client having come before this Court, and after hearing ex parte evidence presented by the Plaintiff, the Court finds the following:

1.

The Defendant, _____, has active tuberculosis

2.

The Defendant has violated the _____ County Board of Health orders to remain confined in the Defendant's residence and has further defied the Board of Health orders to consistently take his/her medicine.

3.

The Defendant poses a flight risk because (state documented basis for allegation – he/she does not have a stable address, has a drug problem, is used to living on the streets).

4.

Based upon the above listed conclusions, the evidence presented to the Court and the Physicians Certificate attached to the Plaintiff's Petition, and the verified Petition, the Court holds the following:

a. Because the Defendant may abscond or conceal himself/herself and because his/her violation of Board of Health orders makes him/her a substantial risk of exposing other person to an imminent danger of infection, the Court directs the Sheriff or his/her deputies to take the Defendant into custody pending the hearing that is required pursuant to **O.C.G.A. 31-14-3.** This shall be under the supervision of Board of Health personnel or other medical personnel to ensure the safety of the Sheriff's deputies.

b. The Defendant shall remain in custody until he/she has a full and fair hearing on the Plaintiff's Petition for Confinement. This initial confinement shall be at a facility appropriate for TB treatment.

c. The Court hereby sets a hearing date on the Plaintiff's Petition for the _____day of _____, 202_ at _____ ___. The hearing shall be conducted at _____.

d. _____ is entitled to appointed counsel. The Court will appoint counsel unless _____ indicates in writing he/she does not want counsel. The Court will appoint counsel unless _____ indicates in writing he/she does not want counsel. The Court hereby appoints _____ as Counsel for the Defendant to represent him/her in this matter.

e. During the Defendant's initial confinement pursuant to this Order, the Defendant shall remain confined so that he/she does not infect the general public with tuberculosis and he/she shall take his/her medications as directed by the Board of Health and any health professional whose care he/she is under.

f. The Defendant shall further submit himself/herself to appropriate medical examinations to determine whether and when the tuberculosis is no longer active.

SO ORDERED this _____ day of _____, 202_. _____
_____, Judge

Superior Court of

County

Prepared and Presented by:

_____ Attorney for Plaintiff Ga. Bar No. _____

IN THE SUPERIOR COURT OF _____ COUNTY

STATE OF GEORGIA

_____ COUNTY	*	
BOARD OF HEALTH	*	
Plaintiff,	*	**CIVIL ACTION**
v.	*	**FILE NO._____**
_____	*	
Defendant,	*	

EMERGENCY PETITION FOR CONFINEMENT OF TUBERCULOSIS CLIENT

COMES NOW, the _____ **COUNTY BOARD OF HEALTH** to file this Petition for Commitment of a Person with Active Tuberculosis pursuant to **O.C.G.A. 31-14-1, et seq.,** and shows the Court as follows;

1.

The Defendant, _____, resides at _____in _____ County, and is therefore subject to the jurisdiction of this Court.

2.

The Defendant has active tuberculosis as defined in **O.C.G.A. 31-14-1 (a).**

3.

The Defendant is violating orders of the Department regarding treatment of his/her active tuberculosis having missed _____ (_____) out of his/her last _____ (_____) scheduled doses. The Defendant has also violated specific Board of Health orders by not confining himself/herself to his/her residence, thus exposing himself/herself to the general public. The Defendant, by violating these orders of the Board of Health presents a substantial risk of exposing

other persons to an imminent danger of infection. The Defendant was released from _____ Hospital on _____, 202_, with active tuberculosis and was referred to the _____County Board of Health Tuberculosis Clinic for follow-up treatment.

5.

The Defendant's chest x-ray and medical examinations and sputum examination confirm that the Defendant has active tuberculosis. The state medical lab has confirmed the sputum test.

6.

The general public's health requires commitment of this person to prevent exposing the general public to tuberculosis.

7.

The Defendant was formerly a homeless person, but since his/her release from _____ Hospital, has resided with _____at _____. This person may be unaware of their risk for TB infection due to continued contact with the Defendant therefore screening may be necessary. Because he/she has no stable address, the Defendant presents a risk of concealing himself/herself from the _____ County Board of Health. He/She has also conducted himself/herself in a manner to expose the general public by disregarding the Board of Health orders to remain confined in_____'s house and to regularly take his/her medication.

8.

Because the Defendant is a flight risk and is conducting himself/herself in a manner to expose others to imminent danger of infection, emergency commitment is necessary to protect the general public.

WHEREFORE, the Plaintiff respectfully requests that this Court:

a. Direct the Sheriff or Sheriff's Deputies to take the Defendant into Custody pending a hearing on the Petition for Confinement so he/she will not endanger other persons pursuant to **O.C.G.A 31-14-5.**

b. That the Court schedules a hearing no sooner than _____ (__) days and no later than

_____ (__) days to determine whether the Defendant should be confined.

c. That the Court appoints the Defendant counsels to represent him/her at this hearing.

d. That the Court give the Plaintiff such further relief as the Court deems necessary.

Respectfully submitted,

_____

_____

Attorney for Plaintiff

Ga.Bar No._____

Address

Phone Number

IN THE SUPERIOR COURT OF _____ COUNTY

STATE OF GEORGIA

_____ COUNTY BOARD OF HEALTH,	*	**CIVIL ACTION**
Petitioner	*	
v.	*	**FILE NO. _____**
_____,	*	
Respondent.	*	

MODIFICATION OF CONSENT COMMITMENT ORDER

The Plaintiff and the Defendant having come before this Court with a Consent Modification of this Court's Consent Commitment Order dated _____, 202_, the Court hereby amends its Order of _____, 202__, as follows:

1.

The _____ County Sheriff is relieved of his/her responsibility of maintaining the Defendant in his/her custody at _____ Hospital until further order of this Court. The _____ County Sheriff or his/her lawful deputies are still responsible for transporting the Defendant to _____ in _____, _____. No other terms of the Consent Commitment Order or the Commitment Order of the hearing officer is altered or amended or superseded by this amendment.

_____

Judge,____ County Superior Court

(Signatures continued on following page.)

Consented to by: _____
Attorney for Plaintiff

Ga. Bar No._____

_____
Attorney for Defendant
Ga. Bar No._____ **IN THE SUPERIOR COURT OF _____ COUNTY**

STATE OF GEORGIA

_____ COUNTY	*	
BOARD OF HEALTH	*	
Plaintiff,	*	**CIVIL ACTION**
	*	
	*	**FILE NO. _____**
_____	*	
Defendant,	*	

PHYSICIAN'S CERTIFICATTION FOR TUBERCULOSIS CONFINEMENT

COMES NOW, _____, **M.D.,** who after being duly sworn states the following:

1.

Affiant is a Physician licensed to practice medicine in the State of Georgia and is the Primary Physician for the Defendant.

2.

The Defendant is a _____ year old man/woman with presumptive active Tuberculosis (TB). This diagnosis is based upon a physical examination of the client and reviewing _____'s medical records, including his/her chest x-ray, which shows an anomaly, and positive AFB sputum smears.

3.

The client should be strictly monitored to ensure that he/she takes his/her medication for the TB as prescribed to ensure his/her infection is not infectious and that he/she does not develop drug-resistant TB.

4.

Since _____'s TB is contagious, he/she should be confined so he/she does not come into contact with the general public.

FURTHER AFFIANT SAYETH NOT.

_____

Print Physician Name

Sworn to and subscribed before me this _____ day of _____, 202_.

_____
NOTARY PUBLIC

[seal]

STATE OF _____

COUNTY OF

VERIFICATION

_____, DIRECTOR, TB CLINIC, _____ COUNTY BOARD OF HEALTH being first duly sworn on oath, deposes and say that he/she is the **Coordinator of the TB Clinic for the _____ County Board of Health,** that he/she has read the foregoing **Emergency Petition for Confinement of Tuberculosis Client** and knows the contents thereof, and that the contents of the Petition are true and correct to the best of his/her knowledge.

_____

DIRECTOR OF _____ COUNTY BOARD OF HEALTH

Sworn to and subscribed before me this _____ day of _____, 202 ___.

_____

NOTARY PUBLIC

[SEAL]

Appendix I

AMERICAN LUNG ASSOCIATION®
IN GEORGIA

Alternative Housing Program-HOPWA AID Atlanta for Homeless Tuberculosis Patients

OPERATIONAL PROCEDURES

2452 Spring Road
Smyrna, Georgia 30080
(770) 434-5864

Revised
July 2015

TABLE OF CONTENTS

Alternative Housing For Homeless Tuberculosis Patients In Georgia

Overview

The closure of the TB Unit at Northwest Georgia Regional Hospital (NWGRH) required public health to identify alternative housing for homeless patients discharged from acute care hospitals within the State of Georgia. These patients, some of whom are infectious, need stable housing in which to receive Directly Observed Therapy (DOT), meals and referrals for social services. Working in collaboration with Metro TB Task Force, the American Lung Association in Georgia (ALAG), Grady Health System and the Atlanta TB Prevention Coalition (ATPC), this plan addresses these public health needs for the statewide TB Program.

The Division of Public Health, TB Unit, Office of Infectious Disease, contracts with the ALAG to provide alternative housing (including meals, personal supplies, transportation [non TB clinic appointments are coordinated through sub-contracted vendors and MARTA tokens for non-infectious patients] and referrals for social services for the homeless TB patients). Through the contract with ALAG, the VP of Public Policy & Health Promotions, two Health Promotions Managers and a Patient Services Coordinator, manage this Program.

Hundreds of tuberculosis patients have utilized the Alternative Housing Program since 1996. The Program utilizes inexpensive motels, trailers, duplexes, apartments and houses. The Health Departments provide DOT and transportation to TB and Ryan White clinic appointments. July 1, 2005, American Lung Association in Georgia began to extend its services to provide housing services for non-infectious clients.

The plan to place homeless patients in area housing requires frequent communication among ALAG area hospitals, and county TB Clinics. In addition to the formal agreements between ALAG and rental establishments, letters of agreements are on file from all participating districts. These letters demonstrate a commitment to the Alternative Housing Program by each District TB Program. Monthly patient care reviews are mandatory to ensure that continuity of care is maintained and other needed services are being provided. A designated Outreach Worker (ORW) provide DOT and patient follow-up.

Procedures for Alternative Housing Program

Purpose:

Funds are provided by the Georgia Department of Public Health, TB Unit, to the American Lung Association in Georgia (ALAG) to provide assistance for temporary housing and to facilitate Directly Observed Therapy (DOT) to ensure completion of therapy among homeless TB patients.

Organizational Roles:

ALA in Georgia	Health District	Georgia DPH – TB Control Program
Provide technical assistance in locating appropriate housing for 18 health districts and contracts with housing vendors	Identify housing possibilities and work with ALAG to secure contracts, assess tuberculosis patients for housing placement and financial assistance	Consultation
Maintain weekly communication & conduct monthly case review with Health Districts	Maintain weekly communication & participate in monthly case review with ALAG	Technical Assistance
Participate/facilitate multidisciplinary team conferences to maintain patient continuity of care after hospital discharge	Provide directly observed therapy and TB medical management	Administrative Support
Establish goals that can be used to measure progress	Provide transportation to the TB, Ryan White and Infectious Disease clinics	Disburse Funds
Preserve and ensure lines of communications	Preserve and ensure lines of communications	Preserve and ensure lines of communications

Program:

I. The Program will enable homeless TB patients to complete TB therapy by assisting with housing, meals, non-TB clinic transportation substance abuse/mental health referrals and DOT.

II. Negotiations with potential housing providers must be initiated prior to the identification of homeless patients. District TB coordinators will identify temporary housing options. ALAG will validate selections and negotiate with housing vendors for appropriate individuals based on medical status and housing needs.

III. ALAG coordinates and approves housing services for the state of Georgia. Funds will be disbursed for housing by check or credit card

to the leasing agent only. No funds will be issued to the client or family members. The maximum amount allowable at one time is one month's rent. ALAG will not be responsible for paying rent and/or utilities prior to client entering Program. Clients should be evaluated monthly and monthly assessments should be reported to ALAG to determine the continued need for housing services or referrals to other housing programs.

Process:

I. **Identify Housing Resources**

Temporary housing may be a motel, hotel, efficiency, apartment, trailer, personal care home or rooming house. Reasonable utilities additionally will be paid, if not included in the rental agreement.

Housing Options *

Options include home for patients who can return to a stable home and three levels of facilities for those without a stable home.

Levels of Housing

Level 1: Acute care hospitals
Alternative Housing Program - smear positive, medically stable and clinical improving

Level 2: Shelters – ones that require negative smears; trained staffs provide DOT.
Alternative Housing Program - smear positive, medically stable and clinical improving

Level 3: Shelters that require negative cultures (extra-pulmonary cases); trained staff for DOT
Alternative Housing Program – negative cultures (pulmonary cases)

* Georgia Tuberculosis Reference Guide, 2014. Emory University School of Medicine, Department of Medicine, Division of Infectious Diseases, and Georgia Department of Public Health,TB Program, 2014.

II. **Patient Assessment**

It is the responsibility of the Health Department to assess all possibilities for housing before requesting assistance through the Program.

A. Eligibility

Patient should be a suspect or an active case of tuberculosis and must demonstrate that he/she has an unstable home environment.

Financial Assistance

If a patient is unable to work because of infectiousness, ALAG will assist with monthly financial obligations; this is based on the availability of funds and patient's financial status. Funds will immediately cease once the patient has three negative smears unless a medical statement is provided. If a patient is living with a family member, all funds will be distributed to the leasing agent and utility company. ALAG will only pay the patient's portion of rent and/or utilities.

Financial Assistance Awards

Financial Assistance Awards are based on four factors:

1. Income (see chart on Federal Poverty Level) 2. Patient should have been working prior to being diagnosed with tuberculosis and he or she can return to the job.
3. Patient should be smear positive and/or provide a medical statement.
4. Financial Assistance is based on the availability of funds.

Annual Income Federal Poverty Guidelines

Size of Family Unit	48 Contiguous States & D.C.	Alaska	Hawaii
1	$11,770	$14,720	$13,550
2	15,930	19,920	18,330
3	20,090	25,120	23,110
4	24,250	30,320	27,890
5	28,410	35,520	32,670
6	32,570	40,720	37,450
7	36,730	45,920	42,230
8	40,890	51,120	47,010
For each additional person, add	$4,780		

List of Essential Living Expenses/Maximum Monthly Amounts Allowed:

1. Rent – $500.00
2. Water - $100.00
3. Electric- $200.00
4. Gas - $200.00
5. Food - $200.00

The American Lung Association in Georgia (ALAG) will only pay current amounts for utility bills. No late fees and/or deposits will be paid. ALAG has the right to make determinations of maximum amounts allowed outside the above guidelines.

Housing Placement - without income

Type of Placements	Infectious or Status Unknown	Non-Infectious	Extra Pulmonary	Latent TB Infection
Hotel	No	Yes	Yes (based on funding availability)	No Services
Motel	Yes	No	Yes (infectious status unknown)	No Services
Personal Care Homes	No	Yes (based on medical condition)	Yes (based on medical condition)	No Services
Rooming House	No	Yes	Yes (based of funding availability)	No Services
*Food	Yes	Yes	Yes	No Services

*Once a client converts to smear/culture negative. He/she will have 30 days to apply for the Food Stamp Program. Client MUST provide ALAG written documentation at that time.

Housing Placement-with income (including food stamps) not to exceed $500.00

Type of Placements	Infectious or Status Unknown	Non-Infectious	Extra Pulmonary	Latent TB Infection
Hotel	No	Yes	Yes (based of funding availability)	No Services
Motel	Yes	No	Yes (infectious status unknown)	No Services
Personal Care Homes	No	Yes (based on medical condition and income amount)	Yes (based on medical condition and income amount)	No Services
Rooming House	No	Yes	Yes (based of funding availability)	No Services

Food	No	No	No	No
	(ALAG will provide transportation to store with mask)	(ALAG will provide transportation to store)	(ALAG will provide transportation to store)	Services

ALAG has the right to make determinations of eligibility outside the above guidelines.

B. Administrative Procedures

1. The District Health TB Coordinators notifies ALAG, via fax, e-mail or in person, with the following completed forms:

A. Alternative Housing/Social Service Referral;
B. Patient Health Department Agreement for Temporary Housing;
C. Temporary Housing Fund Application; and
D. Patient-Provider Therapeutic Contract; or **Patient-Provider Therapeutic Contract for Financial Assistance.**

All forms must be completed and signed by the appropriate individuals.

2. Once the forms have been submitted, ALAG will respond in writing with the approval time and date within 48 hours. Once the time and date have been set, it is the responsibility of the Health District to inform ALAG of any change. If both parties have not confirmed a time and date, ALAG will not be responsible for groceries, supplies and/or rent for that day.

Friday/Weekend Placements:
Generally, there are no placements on Fridays as available weekend patient care and follow up are limited. If/when a homeless TB case or TB suspect comes into the Health Department on Fridays and it is determined that he/she cannot return to a shelter, the patient will be placed in housing. For situations that require housing placement on weekends ALAG, the hospital, Health Department and State TB Control will conduct a multidisciplinary conference to plan and provide continuity of care for the TB patient.

3. During the first week, **supervised** sputums must be collected by the designated health professional three times, thereafter, once a week until three consecutive negative

smears are obtained. Sputum containers should never be left with the patient nor should the patient receive sputum mailers.

4. For additional funding of current patients, the Health Districts MUST submit a new **Temporary Housing Fund Application** along with a **Monthly Assessment** by the **first business day of each month**. It is not the responsibility of ALAG to request additional funding for existing patients. **If the necessary paperwork is not submitted, no funds will be disbursed**.

5. If the patient misses any DOTs, specimen collections, and/or TB clinic appointments, please complete the **Alert Form** and submit it to ALAG within 48 hours. Please also submit an Alert Form for any change in the patient's status.

6. Once the patient is ready for other housing, it is the responsibility of the Health District to transport patient. Any patient completing treatment or violating the contract is responsible for his/her own transportation. A Health District representative must be present at the time of the move.

   In the Metro-Atlanta area, ALAG will meet the Health District representative at the designated site. All parties must be there at the agreed time. Keys will be collected by ALAG at that time.

District Health TB Coordinators MUST adhere to the above protocols to ensure funding in a timely manner to secure patient's retention in this Program.

Housing Facility Guidelines for Infectious Patients

1. The housing establishment must have prompt availability of housing, a willingness to provide housing and to receive payment on a bi-weekly and monthly basis.

2. The American Lung Association in Georgia will provide TB education and the Health Districts will provide skin testing for housing facility staff.

3. The rental unit (motel) will have at minimum, a bed, table, chair, clothing chest, rack for hangers, refrigerator, stove/microwave and television. The room will be clean and without noticeable pest or odors.

4. The room will have a linen change at least once a week. To minimize the risk of exposure to the hotel staff, the linen should be left for the patient to change.

5. The room will be accessible only from a door leading to the outside, not to a public hallway or another room.

6. The entrance door will have a lock on the inside that the client can set manually and a peephole for safety.

7. The room will have its own toilet, bath or shower with hot running water.

8. The room will have its own independent air conditioner that vents to the outside.

9. The selected motel will have a clean appearance on the outside, excluding areas that are under renovation.

Housing Facility Guidelines for Non-Infectious Patients

1. The housing establishment must have prompt availability of housing, a willingness to provide housing and to receive payment on a biweekly and monthly basis.

2. The rental unit (hotel, motel, personal care home or a rooming house) must have at a minimum, a bed, a clothing chest, and a rack for hangers. The room will be clean and without noticeable pest or odors.

3. The housing site must be at least within walking distance of a laundry mat or on the bus route.

4. The entrance will have a lock on the inside that the client can set manually and a peephole for safety.

5. The room will be accessible to a toilet, bathroom with hot running water.

6. The selected housing facility will have a clean appearance on the outside, excluding areas that are under renovation.

TB Enablers/Incentives Program
OPERATIONAL GUIDELINES

POLICY STATEMENT:
Enablers and incentives are used in the Alternative Housing Program to increase compliance with the treatment regimen for infectious and non-infectious TB disease to assure the completion of diagnostic and other procedures.

STANDARD:
Enablers and incentives encourage patients to take medications to completion of treatment, to keep clinic, home or other medical appointments and directly observed therapy (DOT) appointments. The use of patient enablers and incentives in the Alternative Housing Program has proven to be a valuable intervention.

RULES:
1. An incentive is defined as an item needed or desired by the tuberculosis patient that will reward the patient and act as positive reinforcement when the patient complies with the prescribed treatment regimen.
2. An enabler is defined as anything given to the patient that will assist them in keeping appointments.
3. As part of the American Lung Association in Georgia (ALAG) continuing commitment to tuberculosis control, funding for the enablers and incentives program will be provided by ALAG and managed and distributed by the District TB Coordinators to the county health departments.
4. Each District TB Coordinator must submit a formal request to participate in the Enablers/Incentive Program.
5. Request forms may not exceed $500.00 each month.
6. Incentives and/or enablers must be used to ensure compliance with the completion of DOT for treatment of infectious and non-infectious TB disease.
7. ALAG reserves the right to discontinue the program and or individual participation in the program.

PROCEDURE:
1. TB Coordinators who wish to participate in the Enablers/Incentives Program will complete the "Incentives Request Form" and fax it to ALAG.
2. ALAG will disburse the incentives to the health district who will then disburse incentives to the local health departments.
3. TB Incentives may be requested on a monthly basis based on the need and availability of funds.
4. For additional incentive requests, the health districts MUST submit a TB Patient Incentive Report and Enrollment Forms.

Forms

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IN GEORGIA

Alternative Housing Program / HOPWA AID ATLANTA

SOCIAL SERVICES REFERRAL

Patient's Name:_____County/District:_____
Date of Birth:_____ Race:_____ Gender: Female Male
Previous/Current Address:_____
Address Was: Street Shelter* Abandoned Building Family/Friends Home
*Name of Shelter_____
Reason for services:_____ **Lab Status: (Must have lab work to process referral)**

	Smear				Culture		
Case	1+	2+	3+	4+	No Growth	MTB	Atypical
					Type of specimen:_____		
Suspect		1+	2+	3+	4+	Pending at _____weeks	

Expected TB Completion Date:____/____/___ Site of TB_____
Chest x-ray Status:
Abnormal Normal Date:____/___/____
HIV STATUS **VETERAN** **CLIENT ID#**

Confirmed Positive Confirmed Negative ☐ Yes or ☐ No _____
Physical Health Status Healthy Diabetes Hypertension Other _____ **Mental Health Status**
Past Psychiatric History Yes No
Diagnosis (where, when, name of Doctor/Therapist) _____
_____
Income Status:
Employment (Where)_____ $_____ Can Patient return to work Yes No
Food Assistance $_____ General Assistant $_____ SSI Disability $_____
TANF $_____
Veterans Benefits $_____
TOTAL MONTHLY INCOME **$_____**
Substance Abuse:
Alcohol Amphetamine Cocaine Crack IV Drug
Marijuana Denied **Services**
Requested:
Housing Food Funds for Rent/Utilities Social Services
Anticipated move-in date:_____ TB Representative:_____
Date_____
****
For ALAG Use Only
Approved Denied _____ Signature and Date
Move in Date:_____
All sections must be completed in its entirety to be processed.
It is the American Lung Association of the Southeast's (ALASE's) policy to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by establishing sanctions for breaches of confidentiality.All employees are required to be aware of their responsibilities under ALASE privacy policies.

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Alternative Housing Program
PATIENT AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Georgia and Federal law concerning the privacy of such information. **Failure to provide *all* information requested may invalidate this Authorization.**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Member Name: _____

Persons/Organizations authorized to *use or disclose* the information: American Lung Association in Georgia _____

Persons/Organizations authorized to *receive* the information: _____
_____(list vendors)

Purpose of requested use or disclosure: ii _____
_____

This Authorization applies to the following information (select ***only one*** of the following):iii All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] **Except:**_____

Only the following records or types of health information (including any dates). This may consist of psychotherapy notes, if specifically authorized:

_____
_____

This Authorization expires [insert date or event]: iv _____
_____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may refuse to sign this Authorization.
I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____

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IN GEORGIA

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

I have a right to receive a copy of this authorization.

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.vi

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA).

Signature of Member or Authorized Representative / Date

If Signed by Representative, State Relationship or Basis of Authority

********** [i] If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
[ii] The statement "at the request of the individual" is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose. [iii] This form may not be used to release both psychotherapy notes and other types of health information *(see 45 CFR § 164.508(b)(3)(ii**)). **If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.**
[iv] If authorization is for use or disclosure of PHI for research, including the creation and maintenance of a research database or repository, the statement "end of research study," "none" or similar language is sufficient.
[v] Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a covered entity for its own uses and disclosures *(see 45 CFR § 164.508(d)(1), (e)(2)).* [vi] If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condition treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as follows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations, or (iii) to create health information to provide to a third party or for disclosure of the health information to such third party. **Under no circumstances, however, may an individual be required to authorize the disclosure of psychotherapy notes.**

7-15

AMERICAN LUNG ASSOCIATION.
IN GEORGIA

Alternative Housing Program

PATIENT-HEALTH DEPARTMENT AGREEMENT FOR TEMPORARY HOUSING

I, _____certify that I have no fixed, regular, and/or adequate residence at this time and I am unable to provide shelter for myself. I understand that I have (confirmed or suspected) active TB disease and treatment is necessary. I understand that, at this time, I am (infectious or not infectious) to others. I understand that District Public Health and the _____ will provide temporary housing during treatment and I must:

1. Be at _____ on _____ at _____ am/pm to take my medicine.
2. Keep clinic appointments and have laboratory tests as necessary.
3. Notify the TB nurse of any problems with TB medicine or other emergencies.
4. Avoid alcohol and/or other drug use.
5. Not to participate in any illegal activity at the residential facility.
6. Not visit with other people in the housing area or other indoor areas until the TB nurse tells me I am not infectious to others.
7. Follow lease conditions by not having anyone else stay overnight, unless pre-approved in the lease.
8. Not to make any charges to the housing; and not make any long distance phone calls charged to the housing.
9. Remove all personal items from housing at termination of lease.Neither the American Lung Association in Georgia, District Public Health, nor the residential facility will be responsible for personal items left after termination of lease.
10. Allow the Health Department to identify me by name to the housing agent if needed.
11. Will hold the _____ District Public Health, the American Lung Association in Georgia,and its agents, from **any and all liability.**

I understand that if I violate any of the above, I may lose the housing and I may be confined to another appropriate facility to complete my TB disease treatment.

Client: _____ TB Representative: _____
Date: _____

****

The housing agent hereby agrees to comply with the following and thereby, will hold harmless the American Lung Association in Georgia and its agents from **any and all liability**. **Infectious Patients:**

1. Provide housing that meets infection control guidelines.
2. Provide housing with an exit that leads directly to the outside or to a hallway that leads directly outside.
3. Provide single occupancy housing and will report TB patient violations to the TB representative and ALAG.
4. Allow no housing employee to enter the client's room until 24 hours after the client is determined to be noninfectious by the TB nurse. Housekeeping and linen supply arrangements are as follows:

_____ **Non-Infectious Patients:**

1. Provide single occupancy housing and will report TB patient violations to the TB representative and ALAG.
2. Provide TB patient with clean linen at least once a week if patient is residing at a hotel, motel or a personal care home. Clients residing at a rooming house will be responsible for their own linen.

Housing Agent: _____ TB Representative:_____
Date: _____

It is the American Lung Association of the Southeast's (ALASE's) policy to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by establishing sanctions for breaches of confidentiality. All employees are required to be aware of their responsibilities under ALASE privacy policies.

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IN GEORGIA

Alternative Housing Program
TEMPORARY HOUSING FUND APPLICATION

Patient's Name:_____

Address:_____

****

TB Coordinator Name:_____

District:_____ Health Department:_____

Address:_____

County:_____ Telephone #:_____
E-Mail:_____ Fax #: _____

****

Housing Vendor:_____

Federal ID Number:_____

Contact Person:_____

Address:_____

County:_____ Telephone #:_____
E-Mail:_____ Fax #: _____

Charges for Housing $ _____ Monthly from _____to_____
$ _____ Bi-weekly from _____to_____
$ _____ Weekly from _____to_____

****

Signature of TB Representative: _____ Date: _____

Signature of Housing Vendor: _____Date: _____

*If there is not a vendor signature, Coordinator must provide official documentation of the amount and address.

All Sections must be completed in its entirety to be processed.

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IN GEORGIA

Alternative Housing Program
PATIENT-PROVIDER THERAPEUTIC CONTRACT

The following is a statement of what is expected of each patient who agrees to accept temporary housing paid for by the American Lung Association in Georgia. Please read guidelines carefully and if you agree to abide by the conditions listed, please sign at the bottom.

1. Lodging will be temporarily provided for you during your treatment for TB. The length of time the room will be made available to you will depend on your medical needs, your cooperation and continued participation with follow-up provided by District Public Health.
2. During your stay, you are expected to keep your room clean and undamaged. At the end of your stay, you must remove all personal items and the room must be left in good condition. Neither the American Lung Association in Georgia, District Public Health, nor the residential facility will be responsible for personal items left after termination of lease.
3. You should have **no** visitors at any time.
4. If it is determined that you need food assistance, food vouchers/certificates may be made available to you so that your family or friends may purchase food for you.
5. You must remain in your room until District Public Health informs you otherwise. 6. Your outreach worker or nurse will visit with you once a day, usually in the morning. Other unannounced visits will be made.

7. Participation in Directly Observed Therapy (DOT) is required in order to stay at the residential facility. DOT will be provided to you by a designated health care professional. Failure to participate in a scheduled DOT session, may lead to the immediate termination of your room rental. As a part of your treatment, you may be transported from time to time to the Health Department for test, or to see physicians.

8. Use of illegal drug or other illegal activities by you and/or any guest(s) in your room will result in the immediate termination of your room rental.

9. Any behavior deemed detrimental and or inappropriate (determined by ALAG, the District Public Health and/or the vendor) to your health, the health of others or the property will result in the immediate termination of your room rental.

10. If your room rental is terminated due to inappropriate behavior by you or your guest(s) or by your inability to comply with DOT, you must return the room key immediately to the outreach worker, TB nurse or designated staff and vacate the premises.

11. If you are diagnosed as **not** having TB, you will be released from the Program within 48 hours.

12. ALAG will seek, when possible, to involve and educate family and friends in your aftercare so that they will have a better understanding of how to assist you while you are in the motel and later when you are able to find alternate housing.

Signature: _____ Date: _____

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IN GEORGIA

Alternative Housing Program
PATIENT-PROVIDER THERAPEUTIC CONTRACT
For Financial Assistance

The following is a statement of what is expected of each patient who agrees to accept financial assistance for (name services) _____ paid for by the American Lung Association in Georgia. Please read guidelines carefully and if you agree to abide by the conditions listed, please sign at the bottom.

1. The length of time that ALAG will provide financial assistance will be determined by any financial changes, your medical needs, your cooperation and continued participation with follow-up provided by District Public Health.
2. You should not have visitors until Public Health informs you that you are no longer infectious to others.
3. Your TB representative will visit with you weekly. Other unannounced visits will be made.
4. Participation in Directly Observed Therapy (DOT) is required in order to receive financial assistance. DOT will be provided to you by a designated health care professional. Failure to participate in a scheduled DOT session may lead to the immediate dismissal from the Program. As a part of your treatment, you may be transported from time to time to the Health Department or another site for tests or to see physicians.
5. Any behavior deemed detrimental to your health or the health of others will result in the immediate termination of the agreement.
6. ALAG will immediately cease to provide financial assistance if you fail to comply with DOT due to inappropriate behavior.
7. When you have completed the program and/or have **three negative smears**, ALAG will **immediately cease** from financial assistance.
8. If you are diagnosed as <u>not</u> having TB, ALAG will immediately cease financial assistance.
9. We will seek, when possible, to involve and educate family and friends in your aftercare so that they will have a better understanding of how to assist you while you are enrolled in the Program.

Signature: _____ Date: _____

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AMERICAN LUNG ASSOCIATION®
IN GEORGIA

Alternative Housing Program
ALERT FORM

Date: _____

Patient's Name: _____

Location:_____

Date of field visit: _____ Time: _____

Name of person conducting field visit:_____
Title/Health District: _____

Reason for field visit:

Collect Sputum
DOT
Transportation to TB Clinic
Routine visit
Other

****

Reason for Alert:

Patient not at designated site
Patient was hospitalized
Patient refused DOT
Patient has unauthorized visitors
Patient left Program
Patient incapable of living alone

Concerns: _____
_____

Plan of Actions: _____
_____

Submitted by: _____Date:_____

Note: Form must be sent to American Lung Association in Georgia's Alternative Housing Program within 48 hours of the event.
Fax: (770) 319-0349, Office Phone: (770) 434-5864,
Scan/E-Mail: luvette.baldwin@lungse.org/stephanie.quinn@lungse.org

It is the American Lung Association of the Southeast's (ALASE's) policy to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by establishing sanctions for breaches of confidentiality. All employees are required to be aware of their responsibilities under ALASE privacy policies

AMERICAN LUNG ASSOCIATION® IN GEORGIA

Alternative Housing Program

MONTHLY ASSESSMENT

MONTH: _____

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

COUNTY OF RESIDENCE:_____ DISTRICT: _____

LAST CLINIC EVALUATION:_____ ANTICIPATED CLOSURE DATE:_____

****

LAB STATUS:

DATE	SMEAR (Please check box)				CULTURE (Please check box)		
1. _____ -	1+	2+	3+	4+	No Growth	MTB	Pending
2. _____ -	1+	2+	3+	4+	No Growth	MTB	Pending
3. _____ -	1+	2+	3+	4+	No Growth	MTB	Pending
4. _____ -	1+	2+	3+	4+	No Growth	MTB	Pending
5. _____ -	1+	2+	3+	4+	No Growth	MTB	Pending

How Results Obtained: Sputum Culture Induced Other _____

(Please Check Appropriate Boxes)

****

CURRENT TREATMENT REGIMEN - DOT:

Daily Biweekly 3x weekly Total Number of DOT's _____
(for the entire month)

If DOT's missed, please give explanation: _____
_____

Number Delivered: _____ Number Taken/Observed _____

****

PATIENT IS PHYSICALLY ABLE TO WORK: Full time Part time Not able to work

SUMMARY/RECOMMENDATIONS: _____
_____

Submitted by: _____ Date: _____

All sections must be completed before submitting Monthly Assessment Form.

It is the American Lung Association of the Southeast's (ALASE's) policy to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by establishing sanctions for breaches of confidentiality. All employees are required to be aware of their responsibilities under ALASE privacy policies

AMERICAN LUNG ASSOCIATION. IN GEORGIA

Alternative Housing Program
ENABLERS/INCENTIVES REQUEST

Date:_____

Total Amounts

☐ **Fast Food Coupons**

Burger King $_____ Kentucky Fried $_____ Wendy's $_____ McDonalds $ _____ $_____

($5.00 increments) ($5.00 increments) ($10.00 increments) ($5.00 increments)

☐ **Grocery/Merchandise Coupons**

Kroger $_____ Wal-Mart $_____ $_____

($5.00 increments) ($10.00 increments)

☐ **Transportation**

BP Gas $_____ QuickTrip $_____ Chevron $ _____ $_____

($20.00 increments)

TOTAL AMOUNT OF REQUEST **$_____**

The maximum amount per request per district per month (30 days) is $400.00.
Please attach TB Patient Incentives Report and Enrollment Forms

****

MAIL TO:

_____ _____
District Attention

_____ _____ _____
Address (NO PO BOX) City Zip

_____ _____
Phone Number Fax Number

_____ _____
TB Coordinator's Signature E-Mail

Please fax/mail request to:
2452 Spring Road
Smyrna, Georgia 30080
Fax (770) 319-0349
Scan/e-mail to luvette.baldwin@lungse.org/stephanie.quinn@lungse.org

AMERICAN LUNG ASSOCIATION®
IN GEORGIA

Alternative Housing Program
ENABLERS/INCENTIVES LOG

month/year_____

Patient Identifier (DO NOT USE NAME)	Type of Incentive	Type of Enabler	Amount	What type of service	Adherence rate	Case, suspect,
EXAMPLE: #123456	***McDonalds food voucher***		***$5.00***	***Monthly clinical evaluation***	***83%***	

TB Enablers/Incentives Program
PATIENT ENROLLMENT FORM

Name:_____

Address:_____

Date:_____

City:_____ State:_____ Zip:_____

Age:_____ Race:_____ Gender: Female Male

County/District:_____

Patient Status:

Case Suspect LTBI

****

Substance Abuse:

Alcohol Amphetamine Cocaine Crack IV Drug
Marijuana Denied

****

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Appendix J

Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor
Atlanta, Georgia 30303-3142
dph.ga.gov

MEMORANDUM

From: Sidney R. Barrett, Jr., General Counsel SRB
Date: 30 December 2015

Re: **Notification to Persons Exposed to Tuberculosis**

This memorandum will address when you may notify someone that they have been exposed to tuberculosis, what you should and should not say, and what efforts should be made to provide notice.

What is the authority of Public Health to notify third parties of possible exposure to TB?

Public Health has broad legal powers to track and fight communicable diseases, including the general power to isolate and treat persons with TB.[1] Public Health has the authority to require that health care providers and others notify Public Health when someone is or may be infected with TB.[2]

One of Public Health's traditional tactics in fighting communicable disease is to contact persons who are or may have been infected, and encourage them to seek testing and treatment. This often can be done only by disclosing personal health information of the person who may have passed the infection on to them. HIPAA expressly permits the disclosure of personal health information, without the patient's consent, if disclosure is necessary "to prevent or lessen a serious and imminent threat to the health or safety of a person or the public," and if the disclosure is made to someone who is "reasonably able to prevent or lessen the threat."[3]

Is there a duty to notify? What does "best efforts" mean?

Public Health is authorized to share health information with persons who might be exposed to TB, but the law does not specifically say that we *must* do so. Notification is a matter within the discretion of Public Health. How and when to notify is a judgment call, based on all the circumstances and what is best for the patients and the community. Of course, since it is our mission to prevent the spread of disease, it is expected that we will always make a good faith attempt to notify persons who have been exposed to disease and encourage them to seek testing and treatment.

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[1] Code Sections 31-2A-4(2, 4), 31-12-2, 31-14-1 *et seq*.
[2] Code Sections 31-12-2, 31-17-3, 31-22-7.
[3] 45 C.F.R. 164.512(j)(1)(i).

There is no specific legal definition of what constitutes "good faith efforts" – that is, there is no specific list of actions you must take, or a particular number of letters you must send or phone calls you must make. "Good faith efforts" will vary from one situation to the next, depending on the circumstances. Most judges will candidly tell you "I know it when I see it." At the end of the day, the question is whether you took reasonable action in light of the information available to you, and in light of the serious consequences of untreated TB.

Who may be notified of a possible exposure?

HIPAA permits Public Health to protect against a threat to the health of a person or the public by disclosing personal health information to anyone who is "reasonably able to prevent or lessen the threat."[4] In most cases, that will be the person who was exposed to the infectious agent. In other cases, the person who may be "reasonably able to prevent or lessen the threat" may be a parent or legal guardian, or the manager of a jail or homeless shelter. In general, it is left to the discretion of Public Health to decide which persons should be notified.

Who may provide the notice?

The law does not dictate who may provide notice. Any properly trained member of the Public Health workforce may notify a person who may have been exposed to TB. It does not have to be a licensed medical professional, such as a physician or registered nurse.

What information should be provided?

In general, when disclosing someone's personal health information, HIPAA requires that you disclose only the "minimum necessary" to accomplish your objective.[5] How much information should be disclosed, and what type, will depend on the individual circumstances of the case. For example, it may or may not be necessary to disclose the name of the contact who may have exposed the person to disease.

What information to disclose in a particular situation is a judgment call. If it is not necessary to disclose the name of the index patient, then don't. If you believe the possibly infected person will not take the threat of disease seriously unless they are confronted with names and details, then you may disclose that information.

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[4] 45 C.F.R. 164.512(j)(1)(i).

[5] 45 C.F.R. 164.514(d).