

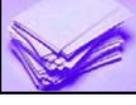
Key Issues in TB Case Management:

So much to do....so little time

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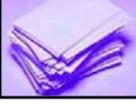



What is TB Case management?

- TB case management includes managing services for the individual diagnosed, or suspected of having TB, from initiation to completion of treatment, or until a change in the diagnosis, or death.

Treatment of Tuberculosis, MMWR, 6.20.03; Vol. 52; No. RR-11; pg. 1



Who does case management?

- WE do!!!
- "Treatment of patients with tuberculosis is most successful within a comprehensive framework that addresses both clinical and social issues of relevance to the patient...."
- "...in all cases the health department is ultimately responsible for ensuring that adequate, appropriate diagnostic and treatment services are available, and for monitoring the results of therapy."

"Treatment of Tuberculosis", pg. 1



TB Program Components

- Health Department TB Program services include a source for:
 - Pharmacy
 - Laboratory services
 - Radiography
 - Medical assessment



Goals of Case-Management

- To cure the individual
- To minimize the transmission of Mycobacterium tuberculosis to others



Session Objectives - 1

Participants will be able to:

- List three principles that guide prioritization of initial investigations
- Utilize the TB discharge plan, and identify 2 other features of TB law in Virginia
- State the importance of documentation for care of the patient and for legal intervention
- Identify strategies to communicate the health department role to private providers



Session Objectives - 2

Participants will be able to:

- Identify four key nursing interventions that contribute to successful TB case management
- State the TB services in Virginia that are provided at no charge
- List four resources available through TB Control to serve patients
- List three “standing orders” needed in each health department to facilitate TB case management



The challenge....

.....how to get it all done

- Multiple programs
- Multiple responsibilities
- Changing guidelines
- Multiple patients with complex situations



Let's start at the very beginning....

- What types of lab results or other reports prompt TB follow-up?
 - Positive M. tb culture
 - Positive DNA probe for M.tb Complex
 - Positive MTD or other NAA for M.tb
 - Positive AFB smears / stains
 - Positive AFB culture
 - Persons with TB-like symptoms



What do each of these mean??

Result	Interpretation
Positive M.tb Culture	TB confirmed in site tested
Positive DNA probe for M.tb Complex	TB or related bacteria confirmed in site tested
Positive MTD or other NAA for M.tb	M.tb very likely (high sensitivity)
Negative MTD or other NAA for M.tb	M.tb NOT ruled out, but less likely if smear neg.
Positive AFB smear	Mycobacteria likely present, TB not confirmed
Positive AFB culture	Mycobacteria present, TB not confirmed
Persons with TB symptoms	Potential TB suspect



What other information is needed to make a decision on follow-up?

- Do you know this person already?
- Why was the testing done?
- What is the specimen source?
- Medical history
- Clinical signs and symptoms
- TST or IGRA results
- Results of other medical tests



Where do you start?

- Look at what you have; what does it mean?
- Using the TB Intake form, collect more patient information
- Obtain copies of all CXRs, CTs, admission H&Ps, HIV, consults, etc.
- Speak with the clinician to get more information (1 day)



What's Next?

- All a suspect until proven otherwise
- Prioritize your reports if you have more than one
- Assign a case manager (1day)
- Begin your documentation on TB intake form, then on progress notes



What would you do with the known MOTT?

- How long has it been since you last spoke to the provider?
- If ≥ 6 months, call clinician
- Follow-up with TB work-up if clinical picture has changed significantly
- Consider if isolation is needed
- Patient may have a record if they are a source of repeated reports



When to Isolate

- In health care settings - when TB is suspected, until 3 negative sputa for AFB
- In community – when patient has positive AFB smear until culture identification



**Case Management Principle –
Prevent Transmission**

- No permission or order is needed to do mandated health department follow-up
- No permission is needed to contact the patient – Negotiate time, but DON'T ASK
- Providers must share health info with the HD
- The HD makes the decision on isolation or return to congregate settings
- Sputa collection does not require an order
 - <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2901.#28>.



**Case Management Principle –
Cure the Patient**

- TB Treatment should be started promptly if there is a high suspicion of TB disease
 - Discuss treatment with the clinician
 - Discuss any regimen that does not include 4 drugs (INH, RIF, PZA, EMB)
 - Evaluate doses of each drug relative to weight
 - If treatment choice is a concern, tactfully refer to the newest TB Tx guidelines
 - For continued resistance enlist the help of your health director or the TB Control Program staff



What if no TB drugs are planned?

- May wait for MTD if suspicion is low
- When MAC is strongly suspected
- When TB drug side effects are a concern and the patient with positive AFB smear is willing to stay in isolation until culture identification
- If a patient is a hospice patient for another terminal condition
- Discuss all of these on a case-by-case basis



Next Steps

- Start your TB record
 - Use the TB Care Plan
 - Consider typed or spoken notes
 - Typed pharmacy orders
- Do things in order
 - Take care of the patient first
 - Determine clinical provider
 - Call the patient
 - Begin education and collecting contact information
 - See the patient within 3 days
 - Determine if isolation is needed / PPE



Patient Interview – within 3 days

- Establish rapport
- Patient education
- HD required forms
- General and TB History
- Explain diagnostic process
- Determine plan for TB meds
- DOT agreement
- Isolation agreement
- Contact investigation information
- TB discharge plan



TB Record

- Standard TB chart forms
- Chart order
- Standard abbreviations
- Signature and title
- Making corrections
- Documenting with a view to legal action
- Contact records
- Contact investigation documentation



Clinical Assessment

- Baseline Labs
 - CBC without diff, with platelets
 - Uric acid
 - Creatinine
 - ALT, AST, T. Bili, Alk. Phos.
 - HIV – within 6 months
- Vision
- Hearing, if necessary
- Weight
- Current nutrition / dietary intake



Overcoming Barriers to Care

- HIP program
 - Rent / hotels
 - Food money
- Drug Assistance Program
 - Case-by-case consideration of drug co-pays for use of private insurance
 - HD patient portion reimbursement
- Second Line Drug Program
- Social Services applications
- Substance abuse services
- Mental health referrals



VA Eligibility and TB Services Non-chargeable Services

- Evaluation of TB suspects
- Evaluation of contacts of TB cases (1st and 2nd eval.)
- Any services, labs or x-rays paid for by TB Control
- DOT and DOPT



Next Steps

- Obtaining prior medical records
- Report to TB Control (7 days)
- Regular sputum collection
- Drug levels
- Continued patient education
- Further TB legal intervention, if needed
 - Counseling Order
 - Out-patient Treatment Order
- If drug resistance suspected



Standing Orders

- PPD administration
- Standard baseline labs
- Follow-up labs for Sx of hepatotoxicity
- Monthly labs to monitor therapy



TB Medication Orders

- Clinician can write in d/c of EMB and PZA with original order
 - EMB after sensitivities are known
 - PZA after 8 weeks of DOT doses
- Count doses and document
- Whether to include hospital doses
- Need signed MD order for initial drug order, regimen changes and final d/c



Sputum Collection

- 3 consecutive days in a row to diagnose a TB suspect
- Weekly or every 2 weeks to monitor response to therapy
- 2 more consecutive sputa when 1st negative smear received (series of 3)
- 3 consecutive monthly until culture negative
- Special attention at 60 days to document culture conversion in 2 months



Ongoing Case Management

- Assess for changes in plan needed:
 - After culture ID is received
 - After sensitivities are available
- PHN visit with patient monthly, regardless of who manages care
- Necessary monthly labs
- Monitor response to therapy
 - ↓ cough and other Sx
 - ↑ weight
- Intervention if patient Sx don't improve



When to Call TB Program for Consult on TB Cases

- RIF or PZA resistance suspected
- If multiple drugs are resistant, unless 2nd drug is strep or not in Tx plan
- No improvement in smear after 1 month
- Newly smear + after 3 consecutive negative smears
- Access medical consultation
- Drug serum level approval
- Need for specialized susceptibility testing



Sputa Collection

- In series of 3 sputa, one HCW observed
- Rinse mouth first
- Refrigerate after collection until sending to lab
- Induction with nebulizer if patient unable to cough



Interruptions in Treatment

- In initiation phase (1st 8 weeks)
 - If > 2 weeks, start Rx over
 - If < 2 weeks, resume; count doses
 - Must complete 1st 8 weeks within 3 months
- In continuation phase
 - If < 80% complete, resume; count doses; collect sputa
 - If > 80% complete, may need nothing more
 - Check overall completion timeframes for regimen



Contact Investigation

- Pursue throughout treatment
- Emphasize the patient's role in preventing TB for others
- Discuss confidentiality
- Document actions and decision points in contact investigation in patient's record
 - Reason for expansion
 - Reason for not expanding



Final Steps

- Provide a record of treatment to the patient
- End of treatment chest x-ray
- Patient education
 - What to do if symptoms recur
 - No TST in future
- File DOT record, if separate, in case record
- Continue to complete TB 502 as contacts complete Rx for LTBI
- Interjurisdictional or international notifications
- Cohort Review
- Data collected for 2 years after Dx



Nursing Directives re: TB

- Tuberculosis case management
- Guidelines for TB record and form use
- TB contact investigation
- Management of individuals with LTBI
- Directly observed therapy
- Delegation of nursing tasks to unlicensed personnel



Nursing Directives - General

- Documentation in the medical record
- Telephone and fax orders
- VDH abbreviations and symbols



Questions??
