

**TB Program Quality Assurance - Keeping the TB Program Humming in Changing Times**



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**TB Program QA Components**

- Consultation
- Case Review
- Cohort Review
- Program Evaluation
  - District Program Evaluation

Based on Essential components of a Tuberculosis Prevention and Control Program, Sept. 8, 1995, MMWR Vol.44, No. RR-11

- Annual Program Evaluation Project

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**Two approaches with one goal**

• Case Review	• Cohort Review
◦ Concurrent with treatment	◦ Retrospective
◦ Process oriented	◦ Outcome oriented
◦ All facets of care	◦ Selected indicators

Quality Outcomes the Goal!

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**District Program Evaluation –  
Coming Next Year**

- Goal – Evaluation of 12 districts per year
- Essential Components
  - Overall Planning and Policy
    - Overall TB strategy and written policies and procedures
    - Advising local institutions and practitioners
    - Adequate laws and regulations
    - Adequate and appropriate staff
    - Adequate funding
    - Networks with community groups

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**District Program Evaluation –  
Coming Next Year (2)**

- Identifying Persons with Active TB
  - Diagnostic services available for TB Suspects and their Contacts – at no cost per *Code of Virginia § 32.1-50*
    - TST/IGRAs
    - Chest x-ray
    - Sputa collection
    - HIV testing
    - Lab services: smear, culture, DSTs
    - Baseline lab testing
  - Case-finding in High Risk Groups
  - Contact Investigation

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**District Program Evaluation –  
Coming Next Year (3)**

- Managing Persons as TB Suspects or Cases
  - Development of a treatment plan, including
    - Assignment of a case manager
    - Assuring medical evaluation
    - TB treatment
    - Monitoring for response and toxicity
    - Adherence plan - DOT
    - TB Education
    - Social services – needs identified and referrals
    - Follow-up Plan

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**District Program Evaluation –  
Coming Next Year (4)**

- Referral System for other medical problems
  - Clinical consultative service
  - Inpatient care
  - Confinement capability
  - Infection control
  - Coordination with other Health-Care Providers

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**District Program Evaluation –  
Coming Next Year (5)**

- Data Collection and Analysis
  - Case Reporting
  - TB Registry
  - Drug Resistance and Surveillance
  - Data Analysis and Program Evaluation
- Training and Education
  - Staff Training
  - Education for Providers and the Community

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**District Program Evaluation –  
Agenda**

- Meeting with TB Program Staff
- Discussion of Core Elements of TB Control Program at District Level
- Record Review
- Feedback and Recommendations

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### Annual Evaluation Project

- 2010 – Sputa Collection and Conversion
- 2011 – HIV “Not Offered”
- 2012 – Sputum Conversion Revisited
  - To Determine
    - Sputa collected in a timely manner
    - Sputa collected but delayed conversion
    - Baseline to assess impact of early diabetic serum drug level with dose adjustment as indicated

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### HIV “Not Offered” Project - 2011

- 15 occurrences of HIV “not offered” - 5.6%
- HIV status important
  - For optimal treatment including antiviral drugs
  - Treatment restrictions for those with HIV
    - Weekly INH/Rifapentine in continuation phase
    - Twice weekly intermittent therapy
  - Expanded HIV testing in health care settings for adult, adolescents and pregnant women recommended by CDC in September, 2006 with “opt out” approach

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### HIV Project Goals

- Identify practice patterns and factors that influence HIV testing
- Identify strategies to improve levels of testing

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### Project Hypotheses

- Local health department practice
- TB nurse case-manager practice
- Inadvertent impact of data collection procedures
- Delay in reporting to LHD
- Financial barriers to testing
- Bias toward not testing correlated to
  - Care in private sector
  - Age
  - Race

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### Procedure

- Development of data collection tool
- Review of central office database information
- TB nurse case manager interview
- Collation of data
  - Categorization of health department ability to intervene
  - Service provided to clients

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### Findings

- HIV "not offered" not correlated to specific health districts or TB nurse case manager
- Data collection practices without effect
- 6 of 15 cases
  - Never seen by LHD
  - Received care only in facilities
  - Died before TB diagnosis was confirmed or reported

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**Findings (2)**

- In 2 cases, PHN had contact x 1 with client in facility
- In 1 case, released from corrections before diagnosis and lost to follow-up
- In 1 case, private provider documented refusal; public health did not pursue
- Only 1 case medically managed by public health after diagnosis

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**Findings (3)**

- 93.3% managed by private providers
- In 5 cases, public health had opportunity
  - 2 extra-pulmonary
  - 2 cases viewed as "DOT only"
  - In 1 case, facility care only

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**Additional Findings**

- HIV "not offered" strongly correlated to older age
  - Twelve were aged ≥65 yrs.
  - Eight of these died
- No firm conclusion re: financial barriers
  - 50% of those starting treatment had insurance
  - No financial constraint if offered in LHD
- 80% had LHD efforts to obtain medical records
- No conclusion regarding HIV testing and race

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**Practices that Support HIV Testing**

- Local protocols identifying baseline lab testing, including HIV
- Education by PHN as to why HIV testing in TB diagnostic work-up is routine and necessary
- Offer of HIV testing regardless of care provider
- Collaboration with medical community to urge early HIV testing in suspects
- Early outreach to providers when suspects reported

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**The Health Department Role**

- Patients may be managed in the private sector, by public health departments, or jointly, but 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, June 20, 2003, MMWR, Vol. 52, RR-11, pg. 1

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**Quality Assurance –  
Everybody’s Challenge**



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