Virginia Department of Health
Division of Tuberculosis and Newcomer Health
TB Control and Prevention Program
Guidelines for Tuberculosis Record and Form Use

General

Accurate documentation is an integral part of the treatment and management of all patients served by the Virginia Department of Health (VDH) for a variety of tuberculosis (TB) related diagnoses. Accurate and complete documentation enhances the continuity of care for patients with TB, particularly if different providers are involved in the care over the course of treatment. Appropriate documentation of treatment and its outcome is required for many facets of the TB Control Program including surveillance and monitoring, assurance and legal enforcement with Virginia's TB Control laws.

In general, a record of the encounter should be initiated for all persons served by the TB program. For those seeking TB screening, this could be as little as the completion of a TB Risk Assessment (TB 512) form. All individuals who are reported to the health department as a suspect or confirmed case of active TB disease, regardless of the source of care, should have a permanent VDH case management record. This record should remain open until the case has final disposition and retained according to VDH policies and procedures for record retention and destruction. In addition, a record should be initiated for all individuals referred for chest x-ray and/or recommended for treatment for any TB-related diagnosis.

The following guidelines provide additional information on the use of specific forms that have been designed for use in the VDH TB records.

TB Intake Sheet

- The "TB Intake Sheet" is a guide to facilitate collection of information on new patients. Information contained on this form may be obtained from multiple sources including from the health care providers and the patient.

- A "TB Intake Sheet" should be used for cases, suspects, contacts and LTBI patients for whom a TB record is established. If the information for completion of this form is obtained directly from the patient, the case manager may elect to not complete certain portions and instead complete other TB record forms. When other forms are completed in lieu of certain portion of the "TB Intake Sheet", a notation such as "See [name of form]" should be made on the "TB Intake Sheet."
    a. Examples:
        i. <u>TB Symptoms</u>: instead complete "Signs & Symptoms of TB" section of "Tuberculosis and Health Assessment/History" form
        ii. <u>Initial Bacteriology</u>: instead complete "Bacteriology Flow Sheet"
        iii. <u>Current Treatment Regimen</u>: instead complete "Medication List"

- Definitions
    a. Country of Origin: country of birth
    b. Year of arrival: year patient entered the United States
    c. Provider: private medical provider of patient

Tuberculosis and Health Assessment/History

- Health and history information should be gathered and reviewed by the case manager and clinician for all patients.

- Any item with a "+" should have an additional explanation in the "Comments" column or in the "Additional Comments" section on the backside of the form.

- Information on the Tuberculosis and Health Assessment form should be updated whenever new information about the patient's medical history is obtained or at least annually. When the form is reviewed or updated, the person completing the review should sign and date the form in the "History Review Update" section on the backside of the form. If an interpreter is used, this information should be noted as well in the "Interpreters" section of the form.

Medication List

- List all known medication allergies at the top of the form.

- Complete the "TB Medications" section. List all medications that the patient has received during the current TB treatment course.

- Enter the strength of prescribed TB medications next to the drug name.

- Total dose should be the total amount the client received in a single dose, i.e. 600 mg of rifampin, not the strength of the capsule.

- If frequency is other than pre-printed options, hand write the frequency to the side of the pre-printed options.

- Dosage and frequency changes that occur during the course of treatment should be re-written in the blank boxes of this section (i.e. a change in isoniazid from 300 mg QD to 900 mg BIW). If needed, use an additional copy of the form.

- List all additional medications the patient takes including all prescription drugs, all over-the-counter medications and all herbal supplements.

- Review all medications listed in the "Other Medications" section for potential interactions with anti-TB drugs. All medications should be reviewed for potential interactions with drugs in the TB regimen. If medications are prescribed by the health department, the prescriber should initial completion of this review in the appropriate column. If all medications are prescribed by a community provider, the nurse case manager (NCM) should initial completion of this review in the appropriate column. If the NCM finds potential interactions, the findings should be immediately reviewed with the prescriber and appropriate health department personnel. Also complete the name/initial section at the bottom of the form. Information on such potential interactions can be found in resources such as the PDR, various drug handbooks, the 2003 Treatment of Tuberculosis guidelines, and the Internet.

- The Medication List should be reviewed with the patient and updated at each monthly assessment visit

Bacteriology Flow Sheet

- Whenever sputum is collected, the Bacteriology Flow Sheet should be included in the record.

- Definitions
    a. Date collected: the date the sample was produced by the patient
    b. Specimen type: the source of the sample, i.e. sputum, urine, etc.
    c. Specimen number: the number assigned by DCLS or a private laboratory.
    d. Name of lab: the name of the laboratory where the specimen was sent for processing, i.e. DCLS, LabCorp, Quest, etc.
    e. Culture or isolate #: the isolate or specimen number assigned by DCLS or a private laboratory

- Original lab reports for all bacteriology should be filed together in a separate, labeled section of the patient record. As much as possible, bacteriology reports should be filed chronologically.

- For patients with positive smear or culture results, circle specimen indicating when smear or culture conversion occurs. Also, enter the date of the smear and/or culture conversion on the appropriate line. For both smear and culture conversion, three (3) negative specimen results – without a subsequent positive result – are required for conversion by either smear or culture.

- Most individuals with positive culture results will only have one susceptibility test result. Repeat susceptibility testing should be considered in cases where the individual remains smear and/or culture positive for a prolonged period of time, or converts back to culture positive after having previously converted to culture negative.

Directly Observed Therapy Log

- Provide the demographic and case manager information at the top of the page.

- Complete section listing the current medications. This list should contain the TB drugs the patient is receiving on the first date that DOT is given in any month.

- Definitions

    a. DOT Month: the current month of the year, (i.e. August)
    b. DOT year: the current year, (i.e. 2005)
    c. Med/Strength: the name of the medication and the strength of the tablets currently in the supply, (i.e. INH 300)
    d. Dosage: the total dosage that the patient receives at each DOT visit, (i.e. 300 mg or 900 mg)
    e. # tablets: the number of tablets of "Med/Strength" that it takes to equal the dosage, (i.e. 1 or 3 tablets)

- The "Dose #" column should provide a cumulative dose count for the patient's TB treatment regimen. The number of each dose should be entered beside the appropriate date. This number should be entered **following** the administration of each dose rather than in advance.

- When the initial phase of treatment is completed, a notation should be made on the form indicating completion of the initial phase in the "Comments" section. Dose count numbering for the continuation phase should be started again at dose number 1.

- If the patient self-administers a dose for any reason, the "Self" box should be checked. In most instances, these doses should not be counted in the "Dose #" column.

- Patients should be queried concerning possible side effects at each DOT visit. Any reported side effect should be checked in the appropriate side effect column, and an explanation of the side effect and any follow-up should be detailed in the progress notes.

Vision and Hearing Monitoring

- The "Vision and Hearing Monitoring" form is intended for use in those patients whose treatment plan includes medications that cause visual or ototoxic side effects.

- Monitoring for changes in patient's visual acuity and hearing should be performed at least monthly while the patient is receiving medications with a potential for visual or ototoxic side effects.

Tuberculosis Service Plan

- The Tuberculosis Service Plan is a template plan that details common problems and needs that frequently occur with individuals undergoing evaluation and treatment in TB programs. Not every patient will have every problem or need listed in the template. Some patients will have additional problems and needs that are not included in these documents. The "Tuberculosis Service Plan" should be individualized for each patient following assessment, not just copied "as is" and placed in charts.

- The "Tuberculosis Service Plan" is also a tool to facilitate documentation of the activities completed by the case manager and others working with the patient.

- The Tuberculosis Service Plan is provided as a Word document to facilitate changes needed to individualize the plan for each patient.

    a. The main body of the document is built as a table in Word.
    b. The template document should be copied or saved as a new document identifying the name of the patient.
    c. Once the document is saved, it can be edited by deleting cells and text within the document.
    d. Additional needs and problems as well as plan action items can be added to the document in order to tailor it for each individual patient.
    e. Once the plan is fully edited, the document should be saved and then printed to include the patient record.
    f. Provide the identifying information at the top of plan. The date the need or problem was identified should be added in the left column in the table for each need selected.

- If additional needs or problems are identified at a later date, those needs and planned actions to address the need or problem can be selected from the master template, printed separately and added to the plan in the chart.

- When planned action items are completed, the date the action is completed should be recorded and signed. Different plan items can have different completion dates.

- Generally, there is space in the signature and date columns to add short additional comments. For the majority of action items, further comments will not be needed. If long comments are needed, they should be placed in a progress notes page. Note on the plan near the action item that additional comments can be found in the progress notes.

Monthly Clinical Assessment

- All patients on treatment with one or more anti-tuberculosis medications should be evaluated at least monthly for response to treatment and onset of potential medication side effects.

- Districts have the option of using a single form for monthly assessment and monitoring or using modified forms for different categories of patients. If the single form is used, the type of patient box should be checked, (i.e. case/suspect, LTBI).

- For any month in which a patient is seen by the clinician in the clinic, the Monthly Clinical Assessment for that month can be noted as "See TB Clinic Record for [date]."

- Complete the assessment and review items appropriate for each patient. Indicate "not applicable" (NA) for items when appropriate. Items necessary for monitoring will depend on whether the patient is on treatment for active disease or LTBI and the type of medication(s) in use.

- A patient's signature or initials is only needed when medications are issued directly to the patient. It is not needed when medications are provided to the patient by directly observed therapy

TB Contact Investigation Form

- **The name of the case should be written on the top of the form only after the follow-up is complete and the contact investigation form is ready to be filed in the patient record.**

- For large contact investigations, electronic record keeping is preferred to use of this form. Results maintained in electronic record keeping systems should not be re-written on the Contact Investigation Form. Instead, a report containing the data requested in the Contact Investigation Form (TB 502) should be filed in the patient record.

- Complete the top section of the form.
    a. Definitions:
        i. <u>Case ID#</u>: can be one of several identifying numbers, i.e. the assigned state case identification number, the Webvision number or another locally assigned number.
        ii. <u>General investigation</u>: includes family and household contacts, friends, etc.

iii. Special site investigation: includes those situations when a group of contacts are tested at a site such as a school or worksite. A special site could also include a frequented location in a social network investigation.

- Check the "Case Type". Contact investigations are generally not indicated for smear negative pulmonary cases or extrapulmonary cases. Contacts to these cases who are under age 4 or who are HIV+ or otherwise immune compromised should be considered for evaluation. Household contacts to smear negative or extrapulmonary cases may also be considered for evaluation. Source case investigations are generally only conducted in situations where there is a young child (< 4 years of age) identified with TB disease or LTBI or where there are a large number of conversions in a congregate setting with no previously identified source case.

- Determine the "Probable Infectious Period". The case should be questioned extensively to determine the probable onset of symptoms. Information obtained from the case should be reviewed in context with data available from other sources such as the chest x-ray and sputum results for plausibility. The window for the "Probable Infectious Period" should be extended back approximately 2 months prior to the onset of symptoms. Individuals who did not have exposure to the case during the infectious period should not be considered contacts to the case and should not be evaluated.

- Provide requested information for each identified. The contact investigation should remain active until all contacts have either completed all follow-up and recommended treatment or until a disposition of the contact is made.

- Priority of investigation for contacts
    a. Examples of "High" priority contacts include:
        iv. Contacts living in congregate settings
        v. Contacts < 4 yrs of age
        vi. Contacts with medical risk factors
        vii. Contacts exposed during certain medical procedures
        viii. Contacts with frequent, prolonged exposure to the case
    b. Examples of "Medium" priority contacts include:
        i. Contacts who are ≥ 4 years of age and < 15 years of age
        ii. Contacts with significant exposure to the case, but less than the time spent for high priority contacts.
    c. "Low" priority contacts include those without additional risk factors for progression to active TB disease and spent minimal time with the infectious case. In general, lower priority contacts should not be screened unless resources are available to adequately provide screening, evaluation and treatment to higher priority contacts.

- Contacts with a history of treatment for TB disease or LTBI do not need further evaluation unless they have symptoms compatible with active TB disease. Contacts with a history of a positive TST do not need further evaluation or chest x-ray unless they have symptoms compatible with active TB or are a candidate for treatment for LTBI. Before any treatment for LTBI is initiated, active disease must be adequately ruled out.

- Individuals who are symptomatic should be referred immediately for further evaluation including a TST, chest x-ray, sputum examination and clinical assessment. Further evaluation should not be delayed while waiting for the results of the TST.

- All individuals with an abnormal chest x-ray should be referred for medical evaluation. If appropriate, sputum collection should begin immediately and the individual placed on home isolation pending the results from the sputum testing.

- See DDP-tb recommendations and guidelines for the follow-up and evaluation of contacts to cases of active tuberculosis.

http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/Tuberculosis/ContactInvestigations/index.htm

TB Clinic Record

- The TB Clinic Record is to be used by districts that conduct a Chest Clinic.

- Complete the top portion of the form with the patient identifying information. If an interpreter is used during the clinic visit, note the name of the interpreter. If an interpreter is not needed, leave this line blank. Mark whether the individual is being evaluated as a case, suspect, contact or individual with latent TB infection.

- Complete the "Current Symptoms" box for all patients. Check the "none" if the patient is asymptomatic.

- Complete the "Reported Side Effects" box for those patients who are currently receiving treatment with anti-TB medications.

- Check the "See Health History" box to alert the clinician about items of potential significance in the Health Assessment/History. Additional comments about any issue of importance can be made in the "Additional Comments" box.

- Results included in the "Initial Chest X-ray" box should be for the first film or the film used to make the TB diagnosis. The "Current Chest X-ray" box should be used to record the most recent x-ray results.

- The "Initial Bacteriology" section should be used to record the smear, culture and susceptibility results used to make the TB diagnosis. The "Current Bacteriology"

section should be used to record the most current bacteriology results for the patient.

- Information in the "Treatment" section should include not only the patient's current TB drug regimen but also previous drugs the patient took during the course of treatment, (i.e. pyrazinamide and ethambutol dosages and dates for a patient now only on Isoniazid and rifampin).

- The boxes related to bacteriology, x-ray and treatment were designed to provide a diagnostic and treatment summary to the clinician for use during the clinic session. Any district may choose not to complete these sections, but rather refer the clinician to the Bacteriology Flow sheet, Medication List, and other forms for diagnostic and treatment information.

Additional forms that may be used in the TB Record:
http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/Tuberculosis/Forms

1. TB Risk Assessment Form (TB 512)
2. DOT Agreement
3. Patient Isolation Instructions
4. Interjurisdictional Referral Forms
5. TB Case/Suspect Review
6. Forms in the TB Laws Guidebook: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/Tuberculosis/guidebook/index.htm
7. VDH registration, consent, HIPPA and eligibility forms and documentation