

V. CASE MANAGEMENT

Module Outline

1. Standards of Public Health Practice
 2. TB Infection (TBI)
 - a. Responsibilities of the TB Case Manager
 3. TB Disease
 - a. Responsibilities of the TB Case Manager
 4. Delegation of Case Management Responsibilities
 5. Non-Compliance
 6. Incentives and Enablers
 7. Documentation and Maintenance of Appropriate Records
 8. Tools
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1. STANDARDS OF PUBLIC HEALTH PRACTICE

- V-1. A regional/metro TB nurse is assigned case manager for each TBI patient and for each patient with suspected or confirmed TB disease.
- V-2. For each patient with suspected or confirmed TB disease in a congregate setting, the case manager (or designee) makes a visit to the facility at least monthly throughout the course of treatment.
- V-3. For each patient with suspected or confirmed TB disease in a congregate setting, a copy of the medication administration record (MAR) is obtained by the case manager and included in the medical record.
- V-4. For each patient with suspected or confirmed TB disease, appropriate referrals for medical and social services are made and all referrals are documented in the medical record.
- V-5. For each patient with suspected or confirmed TB disease and HIV co-infection, the case manager assesses for current enrollment in HIV health services and makes appropriate referrals as needed.
- V-6. For each patient with suspected or confirmed TB disease, the TB case manager (or designee) conducts the initial interview with the patient according to the timelines established in the TTBEF Manual.
- V-7. For each patient with suspected or confirmed TB disease, the TB case manager (or designee) conducts the initial home visit according to the timelines established in the TTBEF Manual.
- V-8. Each person performing case management activities receives TTBEF Central Office (C.O.) training prior to conducting case management activities.
- V-9. TBI medication resupply follows the process outlined in the TTBEF Manual.

2. TB INFECTION (TBI)

A regional/metro TB nurse is assigned case manager for each TBI patient and for each patient with suspected and confirmed TB disease (**Standard of Public Health Practice V-1**).

Responsibilities of the TB Case Manager

The TB case manager responsibilities for patients with TB infection include:

- Screening:
 - Ensure the completion of the TB Risk Assessment Tool (TB RAT)
 - Provide TB testing (if not already done)
- Assessment:
 - Obtain medical records from providers outside of the health department (if applicable)
 - Obtain patient's medical history including previous treatment history
 - Assess for barriers to adherence
 - Notify the TB physician of any patient with symptoms of TB
 - Record all allergies or previous adverse reactions to medications
 - Assess and document all current medications (including prescriptions, over-the-counter or home remedies); inquire about new medications with each monthly clinic visit
 - Assess and document any history of substance abuse (alcohol and drugs)
 - Ensure patient is scheduled for evaluation in TB clinic
 - Provide laboratory monitoring if indicated by the clinical evaluation or ordered by the TB clinician (refer to current PHN Nursing Protocol)
- Treatment:
 - Ensure only a one (1) month supply of TBI medication is dispensed, excluding Isoniazid/Rifapentine (INH/RPT), as ordered by the TB physician
 - If patient is going out of town for an extended period, consult with TB clinic regarding dispensing more than one-month supply of medication
 - If patient is buying medication, obtain name of pharmacy and monitor monthly pick-up
 - Assess for contraindications and signs/symptoms of adverse reactions while on treatment for TBI
 - Ensure TBI medication is discontinued and the TB clinician is notified for orders if any signs of medication toxicity exist
 - Ensure labs are drawn according to TB clinician orders
 - Ensure incentives and enablers are provided to patient, when indicated, to aid in treatment completion of TBI therapy
- Education:
 - Determine patient's level of education and socioeconomic background for education purposes
 - Determine patient's preferred language
 - Provide written TBI educational materials in patient's preferred language, if available. Review materials with patient
 - Discuss TBI and ensure patient is knowledgeable of the plan of care

- Discuss any concerns of the patient or barriers to treatment initiation and completion
- Provide written information on how and who to contact at the health department after business hours and on holidays
- Documentation:
 - Document TBI education provided to the patient in patient’s preferred language (if available)
 - Enter patient data into the state surveillance system (TB PAM)
 - Provide patient with documentation (**Refer to Appendix T - Completion of Treatment Template**) upon completion of treatment to include:
 - Result of positive test for TB infection (i.e., TST or IGRA)
 - Chest X-ray (CXR) result
 - TBI treatment information:
 - Medication(s) taken (including name of drug, dosage, and frequency)
 - Date of treatment initiation and completion
 - Ensure the treatment completion date for any contact to an infectious TB case is completed on the contact investigation (CI) form
 - Ensure that all documentation for TB related services (i.e., surveillance reporting, patient care, clinic visits, contact investigations, targeted testing, etc.) is completed
- Follow-up:
 - Complete clinical evaluation monthly for contraindications and signs/symptoms of adverse reactions while on treatment for TBI and document on the Drug Screening and Monitoring Record (PH-2040)
 - Establish a “tickler” system or utilize computerized tracking for follow-up of TBI patients
 - Ensure monthly clinic visit for TBI medication re-supply (**Refer to Module III: TB Infection**):
 - TBI medication resupply follows the process outline in this manual (**Standard of Public Health Practice V-9**)
 - Ensure that arrangements are made to provide re-supply medications to patients who work or have transportation issues and cannot arrive to pick up medications during routine health department hours; this must be an arrangement that is acceptable to both patient and staff. Consideration may be given for a HCW to work altered work hours to deliver TBI medications to the patient, if no other options are available
 - If a patient misses a medication resupply appointment, the following will be done sequentially by the case manager, as indicated:
 - Place a phone call to the patient
 - Send a letter requesting the patient to contact the health department (**Refer to Appendix V**)

- Referrals:
 - Refer the patient to TB clinic if:
 - Patient develops symptoms of adverse reactions or drug toxicity occurs
 - Patient develops symptoms of active TB
 - Abnormal lab results are reported (e.g., liver enzymes exceed upper limits of normal)
 - Treatment is delayed or treatment is stopped for greater than two (2) months
 - Refer the patient to other programs (e.g., HIV/STD, WIC, mental health, family planning, men's health/women's health, alcohol and drug rehabilitation, etc.), as appropriate and available

The county public health nurse (PHN) can assist the TB case manager with these activities:

- Perform symptom screening
- Obtain lab specimens as ordered by the TB clinician
- Assess for adverse effects to TBI medication
- Provide directly observed preventive therapy (DOPT)
- Provide monthly resupply of TBI medication(s)

Reference:

1. Current TB Nursing Protocol

3. TB DISEASE

The regional/metro TB case manager is responsible for providing patient-centered case management for all persons with suspected or confirmed TB disease. This may include patients being treated by a private provider while in a facility where the health department may not provide day-to-day care, such as a:

- Correctional facility
- Long-term care facility
- Alcohol and drug facility
- Hospital

Responsibilities of the TB Case Manager

The TB case manager responsibilities for patients with suspected or confirmed TB disease include:

- Determine patient's preferred language, level of education, and socioeconomic background to ensure appropriate understanding of all aspects of care
- Each patient's management plan must be individualized to incorporate other measures that facilitate adherence to the drug regimen. Such measures may include:
 - Social service support
 - Determine if the patient has insurance upon initial encounter with patient. If patient does not have insurance, a prior authorization (PA)

request form should be submitted to the TTBE Central Office (C.O.), in a timely manner, for TB-related services to be approved (**Refer to Appendix E for Request for Prior Authorization Form and Appendix F for Prior Authorization Instructions**) (**Refer to Tool V-3 Case Managing the TB Patient Receiving Contracted Vendor Services**)

- Treatment incentives and enablers
 - Housing assistance (if approved by the Prior Authorization process) during the infectious period and while the patient is on respiratory isolation may include:
 - Utilities (electric, gas, water)
 - Rent or mortgage payments
 - Motel/hotel
- (Refer to Tool V- 2 Housing Assistance During the Isolation Period)**
- Long-term housing assistance if the patient is homeless or unable to return back to work due to effects of TB disease may include:
 - Rent or mortgage payments
 - Assistance in locating appropriate housing options (e.g. government assistance housing, VA/federal housing for veterans, etc.)
 - Make referrals for medical and social services and document referrals in the medical record (**Standard of Public Health Practice V-4**). Referrals may include services such as:
 - Substance abuse treatment
 - Prenatal care
 - Immunizations
 - HIV clinic
 - For each patient with confirmed TB disease and HIV co-infection, the case manager assesses for current enrollment in HIV health services and makes appropriate referral as needed (**Standard of Public Health Practice V-5**) All referrals are to be documented in the medical record.
 - If patient does not have a primary care provider (PCP) and has other co-morbid conditions, make referral(s) for PCP
 - Make referrals and/or assist with application for financial assistance, which may include:
 - Enrollment in TennCare, Medicaid, Medicare, etc., if patient qualifies
 - Assist in obtaining other resources as needed (e.g., food banks, church outreach programs, donations, etc.)
 - Provide education to patient and family to ensure understanding of the **following (Refer to Tool V-4 TB Teaching Tool Checklist)**:
 - Active disease process, mode of transmission, differences between TB disease and TBI, clinical outcomes of TB disease and TBI if left untreated, and risks/benefits of treatment
 - Purpose for anti-TB medications, medication adverse effects and course of action to follow if adverse effects develop
 - Importance of continuous, uninterrupted treatment and adherence to TB clinic visits for regular medical supervision

- Importance of initiation of a contact investigation for identification and evaluation of contacts
- Appropriate infection control measures including:
 - Cough etiquette
 - Surgical mask use
 - Instructions for respiratory (isolation) precautions, including household precautions that may include:
 - Provision of adequate ventilation in the home
 - Stay and sleep apart from the rest of the family during the established infectious period
 - Children <5 years old to be removed from the house until patient is deemed non-infectious or the child has been medically evaluated and started on “window therapy”
- For each patient with suspected or confirmed TB disease, the TB case manager (or designee) conducts the initial interview with the patient according to the timelines established in this manual (**Standard of Public Health Practice V-6**).
- If within the case manager’s region, perform the initial hospital or facility visit (if applicable) according to the established timeframes (**Refer to Module VII. Case Finding and Contact Investigation**) (**Refer to Tool V-6 TB Initial Visit Checklist**)
- If within the case manager’s region, perform the initial home visit within the county of residence according to the established timeframes (**Standard of Public Health Practice V-7**) (**Refer to Module VII. Case Finding and Contact Investigation**) (**Refer to Tool V-6 TB Initial Visit Checklist**)
- If the patient is in a congregate setting within the case manager’s region, make at least monthly visits (throughout the course of treatment) to the congregate setting where the patient is currently residing (**Standard of Public Health Practice V-2**) to:
 - Assess the patient for improvement of symptoms
 - Ensure that TB treatment via directly observed therapy (DOT) is being provided according to the standards of public health practice (**Refer to Module VI. Medication Administration** for more information on DOT)
 - Obtain copies of the patient’s medical record for the health department chart and the TB physician to review (**Refer to Tool V-5 Medical Records request checklist**):
 - Medication administration records (MARs) and include in the patient’s medical record (**Standard of Public Health Practice V-3**)
 - Physician progress notes
 - Consult notes
 - Laboratory results (including CBC, CMP, HIV)
 - Microbiology results (including sputum, bronchoscopy, biopsy)
 - Pathology and/or Cytology reports
 - Radiographic reports (i.e., CXR, CT)
 - Any information requested by the TB physician

- Provide education and in-service training to staff at facility(s) as needed or as requested
- Ensure that a thorough contact investigation is performed according to the standards of public health practices (**Refer to Module VII. Case Finding and Contact Investigation**)
 - Coordinate and ensure that all the activities of the contact investigation are performed according to the TTBEF program requirements
 - Ensure that contact investigation forms are utilized including the progress note(s) provided with the CI form
 - Ensure that all documentation related to the contact investigation is recorded on these forms in a timely manner
 - Ensure that weekly TB team discussions/meetings are held to ensure that all contact investigation activities are being performed according to the TTBEF program requirements. The regional/metro TB case manager ensures the contact investigation is completed with all required documentation.
 - Perform the initial interview and a re-interview within the established timeframes (**Refer to Module VII. Case Finding and Contact Investigation**)
 - Interviews should be conducted by a staff member that is fluent in the index patient's preferred language or through the use of an interpreter
 - Following discussion with the TB physician, establish the infectious period (tentative and final)
 - Ensure site visits to all locations where the patient visited during their infectious period are made and document findings on the CI form
 - For metro TB case manager, assess findings of investigator site visits and determine the risk of transmission or if further information is needed. Document on CI forms
 - Provide educational sessions at sites of exposure to employers, employees, volunteers, etc.
 - Ensure the contacts are fully evaluated according to the established timeframes (**Refer to Module VII. Case Finding and Contact Investigation**)
 - Ensure the contact investigation is expanded appropriately, if indicated
 - Ensure that other healthcare facilities are performing the contact investigation according to TTBEF standards. If needed, provide assistance and training to the appropriate facility staff to ensure correct screening and testing is performed on all potential contacts
 - Ensure Aggregate Reports for Program Evaluation (ARPE) are complete and turned into the TTBEF Central Office by the established deadline. If other healthcare facilities perform a contact investigation, obtain outcome numbers to include on the ARPE reports and in the contact investigation record
- Ensure directly observed therapy (DOT) is provided for the entire duration of treatment and is documented correctly on the DOT form(s). Ensure that all clinicians' orders for medications are documented in the chart
- Receive prompt notification of any missed DOT doses or any adverse effects from the medication

- Notify TB clinician of any missed intermittent doses or any adverse effects from the medication
- Follow-up on any lab report that is smear-positive for acid-fast bacilli (AFB) received to include:
 - Discussion with laboratory personnel or the Infection Control Preventionist (ICP) at the reporting facility
 - Discussion with the ordering physician to determine:
 - Reason for testing
 - If symptoms for TB are present
 - Schedule the patient in the next available regional TB clinic if suspicion of TB is high or the patient has a history of signs and symptoms of TB disease
 - Discussion with the TB physician regarding the need for isolation until the initial clinic visit
- Also, the regional/metro case manager will immediately follow-up on a culture report that is positive for *M. tuberculosis* complex to prevent further exposure of airborne disease to others. This includes:
 - Locating the patient
 - Instructing the patient to remain isolated at home until further notice
 - Scheduling the patient at the next available region/metro TB clinic
 - Providing directly observed therapy (DOT) of the initial TB regimen (if next TB clinic visit is prolonged)
 - Initiating case management activities (**Refer to Module V. Case Management**)
- Monitor the expiration dates of all TB medications. Notify the pharmacist a couple of months prior to expiration so appropriate arrangements can be made
- Monitor the expiration dates of the QFT tubes.

Each suspected or confirmed case of TB disease is evaluated in TB clinic by a clinician (physician or nurse practitioner) as soon as practicable, and at least within 10 days of the health department receiving the notification. Following the initial medical evaluation, monthly TB clinic visits allow for timely medical evaluation to determine clinical and radiographic improvement, adverse effects to TB medications and adherence to the treatment regimen.

Patients with suspected TB disease will be seen at least monthly by the TB clinician for a medical evaluation, including a CXR.

Patients dispositioned with confirmed TB disease (i.e., laboratory-confirmed, clinical, or provider-verified) may be seen by the TB clinician every two (2) months under the following conditions:

- Not infectious, **AND**
- Clinically and radiographically improving, **AND**
- Tolerating TB treatment regimen, **AND**
- Adherent to the TB treatment regimen

For patients with suspected or confirmed TB disease, the regional/metro TB case manager will ensure the following is completed prior to the patient's TB clinic visit:

- Patient has appointments scheduled in TB clinic at appropriate intervals
- Patient medical record(s) from other providers are available for review by the TB physician
- Sputum logs are up-to-date and on the chart
- Lab results and any procedure reports are available for review by the TB physician
- DOT doses are counted, up-to-date, and on the chart; if patient is non-compliant, TB physician can discuss issues with patient during the appointment
- Appropriate follow-up will be made for any patient who misses a scheduled appointment
- Ensure specific clinic functions (i.e., patient assessment, sputum collections, drawing blood, etc.) are completed
- TB case manager will ensure that therapeutic drug levels (if ordered) are obtained and shipped according to TTBEF protocol. A Prior Authorization form will be submitted to the TTBEF Central Office prior to obtaining drug levels (**Refer to Appendix H and Appendix I for Therapeutic Drug Level Monitoring Instructions and Laboratory Requisition**).

4. DELEGATION OF CASE MANAGEMENT RESPONSIBILITIES

If any of the following case management responsibilities are delegated to other health department staff, the TTBEF requires that these staff members must attend a one-time comprehensive TB training course (to be scheduled at a minimum of every six months) provided by TTBEF C.O. public health nurse consultants (PHNCs) prior to performing any of the following delegated duties:

- Initial facility site visit
- Initial home visit (**Refer to Tools V-6 TB Initial Visit Checklist**)
- Initial interview visit
- Re-interview visit
- Contact investigations (all aspects)

Each person performing case management activities receives TTBEF C.O. training prior to conducting case management activities (**Standard of Public Health Practice V-8**), and the regional TB program manager will maintain documentation of regional staff attendance at these comprehensive trainings.

5. NON-COMPLIANCE

- The TB case manager is to notify the TB physician, in a timely manner, of patient non-compliance with DOT, scheduled appointments, sputum/lab collection and isolation precautions so that appropriate measures (i.e., patient education, incentives or

enablers, public health directive or public health measure) can be taken, if needed.

Issues that require interventions and/or legal measures may include:

- Failure to maintain respiratory isolation (critically important)
- Missed doses of anti-TB medication (e.g., during the treatment Initial, two or more daily doses missed in one week; two or more bi-weekly doses missed overall during the continuation phase)
- Failure to routinely be present for DOT at the agreed time and place
- Refusal to take all medicines as prescribed
- Failure to be present for scheduled clinic appointments
- Failure to cooperate with X-ray or laboratory test procedures
- Threatening behavior toward public health staff that jeopardizes ongoing treatment efforts
- Continued substance or alcohol abuse that jeopardizes anti-TB drug absorption, results in drug toxicity, and/or results in missed DOT (**Refer to Module XII. Public Health Law and TB**)

6. INCENTIVES AND ENABLERS

Many variables affect a patient's adherence to the recommended treatment regimen. In order to encourage patients to adhere to and complete treatment, incentives and/or enablers, can be offered. Patients with suspected or confirmed TB disease and persons with TBI at high risk for progression to TB disease are eligible to receive incentives and/or enablers.

Incentives are small rewards that motivate patients to adhere to treatment, take medications, keep clinic appointments, or to cooperate in other ways necessary to complete their treatment.

The TTBEF has approved gift cards, each with a face value of \$10.00, to be used as an incentive to achieve the goal of treatment completion. The TTBEF incentive card program is based solely on available funding and may change annually (**Refer to Appendix G for TDOH TTBEF Protocol for Incentives for Rural TB Patients**).

Enablers help patients overcome barriers to completing treatment, such as bus tokens, food, etc.

The TB case manager will:

- Assess and document the need for an incentive or enabler, and how it is expected to improve or maintain patient adherence to therapy
- Dispense incentives and enablers according to the patient's needs
- Follow the TTBEF Protocol for incentives and document accordingly

7. DOCUMENTATION AND MAINTENANCE OF APPROPRIATE RECORDS

The TB case manager is responsible for ensuring the complete and accurate documentation of all patient information:

- In the patient's chart

- On appropriate or required forms
- In computerized databases (TB PAM, PTBMIS, or locally maintained database)

A patient’s residence at the time of diagnosis determines which region takes “ownership” of the patient. This means reporting the case in TB PAM and providing all aspects of TB case management including the contact investigation. **(Refer to Module VII. Intra-and Interstate Transfers [Interjurisdictionals] for information regarding patients moving in or out of your region/metro).**

It is important to note that homelessness can pose a case management challenge. A homeless shelter cannot be a residential address for a patient, as a stay there is dependent upon bed availability. If a homeless person is in a hospital, the TB case manager in that region must assume responsibility for the patient. This includes all aspects of case management:

- Hospital visit
- Initial home visit **(Refer to Tools V-6 TB Initial Visit Checklist)**
- Site visit
- Re-interview visit
- Contact investigation
- TB PAM entry
- Plan of treatment
- Intrastate or Interjurisdictional movement

The following forms are requirements of the TTBEF and are to be immediately available or located in the patient chart:

- Risk Assessment Tool (PH 3714)
- CDC Report of Verified Case of Tuberculosis (RVCT) **(Refer to Tool V-1: “Building a Case—What Information to Enter and When)**
- TB Contact Investigation form (PH 1631)
- Drug Screening and Monitoring Record (PH 2040)
- Current medication record/DOT forms utilized by region/metro
- Summary of Laboratory Reports (PH 2036) or equivalent sputum summary log

The TB case manager will submit the medical record, in the established timeframe to the TTBEF Central Office for the following persons with suspected or confirmed TB disease:

- Pediatrics—upon notification and monthly updates that include MD progress notes or TB clinic notes
- MDR—upon notification and monthly updates that include MD progress notes or TB clinic notes
- Legal (when health measures are taken)---within one (1) week and monthly updates that include MD progress notes or TB clinic notes
- Death (including the death certificate)---when death certificate is available (this should include the hospital/facility chart if applicable)

- Provider Verified cases (including the Provider Verification consultation form)- at eight (8) weeks for patients with no disposition

Additional medical records may be requested by the TTBEPC.O. as needed, to fulfill medical consultation requests from the TB physician.

When submitting a Prior Authorization (PA) Request to the TTBEPCentral Office (CO), send the

- Completed PA form and
- Supporting documentation, which may include:
 - Last TB clinic visit progress note or
 - Recent TB physician progress note

8. TOOLS

V-1: Building a Case-What Information to Enter and When

V-2: Housing Assistance During the Isolation Period

V-3: Case Managing the TB Patient Receiving Contracted Vendor Services

V-4: TB Teaching Tool Checklist

V-5: Medical Records Request Checklist

V-6: TB Initial Visit Checklist

References:

1. Current TB Nursing Protocol
2. CDC. 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). <http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf>

Tool V-1
Building a Case

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Building a Case

What Information to Enter and When

In most cases this should be no more than 12 months of starting therapy

Submit to Central Office within one week of determining final disposition

Patients that are lost: assign disposition ASAP and finalize ASAP but no later than 3 months after the last dose of medication was provided

No later than 1 week after last dose of medication was provided to the patient

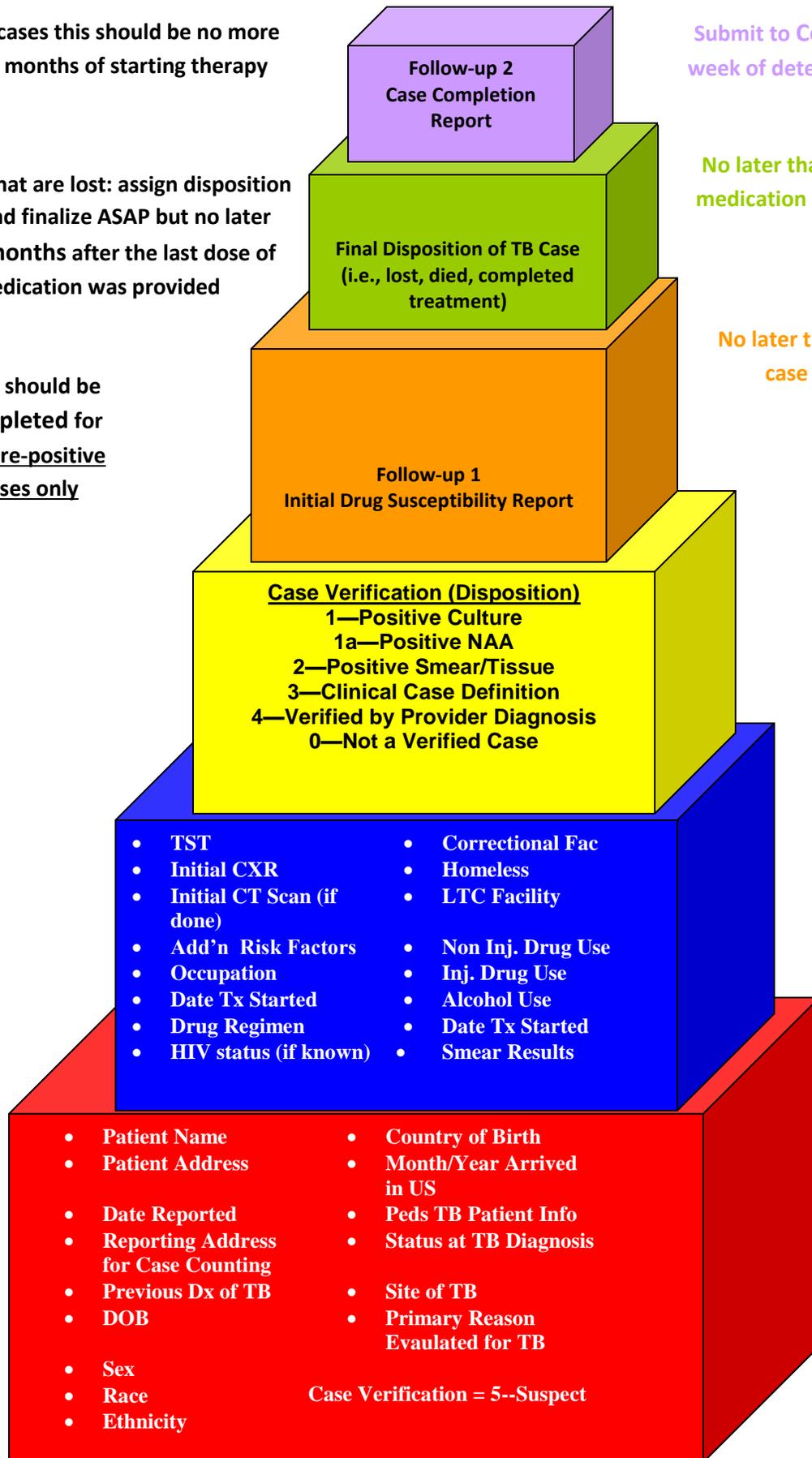
FU 1 should be completed for culture-positive cases only

No later than 4 weeks after the case has been culture confirmed

Within 8 Weeks of Notification

One – Two Weeks Later

Within 1 Business Day of Notification



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Tool V-2

Housing Assistance during the Isolation Period

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Housing Assistance During the Isolation Period

Persons with suspected or confirmed TB disease, who are considered infectious, may not be able to return to their place of residence. This may include persons who:

1. Reside in congregate settings
2. Are homeless
3. Live with persons with an immunosuppressive condition
4. Live with small children

The TB case manager will:

1. Identify a suitable location for isolation (i.e., motel or hospital)
 - a. If a patient has insurance, a hospital room with negative pressure should be used for isolation. The TB case manager can submit a *Prior Authorization Request (PAR)* to assist in paying charges not covered by the primary insurance (i.e., deductibles, patient copays, etc.). The TTBEF will be payor of last resort. **(Refer to Appendix E and Appendix F for the Prior Authorization Request Form and Instructions)**
 - b. If a patient does not have insurance and a hospital room is recommended by the TB physician, the TB case manager will complete the PAR form and submit the form, along with the TB physician's note to the TTBEF C.O. Nurse Consultant. The PAR dates of service should begin with the date the health department was notified of the person with suspected or confirmed TB disease, until the 14 days of TB medication has been completed, unless other housing arrangements have been made. **(Refer to Module IV TB Disease, Discontinuation of Airborne Precautions)**
 - c. If a motel is used, the TB case manager will have to locate a motel that is willing to be a vendor and accept the state's payment procedure. The TB case manager will notify the TTBEF C.O., which will determine the allowable charges so the case manager will have a negotiating price to discuss with the motel manager. The payment is made via a *Prior Authorization Request (PAR)*. The PAR form will be submitted to the TTBEF C.O. Nurse Consultant by the TB case manager, to cover approved charges for the motel. Once the vendor agrees to the payment procedure, the vendor will have to disclose the business W-9 form and sign a Vendor Authorization Form (VAF) form prior to submitting the claim for payment. The TB case manager will also need to ensure the motel room meets the following requirements for respiratory isolation:
 - i. Must have heating and cooling unit that is vented to the outside (must not be re-circulated)
 - ii. Must have a bathroom located in the room
 - iii. Must have a small refrigerator
 - iv. Must have a microwave
 - v. Motel housekeeping is not allowed to enter the room and clean as long as the patient is on respiratory isolation precautions

2. Identify a food source. Note: the TB program will not pay for food and necessities.
Possible sources of food include:
 - a. Second Harvest food bank
 - b. Community food banks through churches or other organizations
 - c. For fresh fruits and vegetables, meats, and dairy items, the regions may utilize the incentive cards provided by the TB program or local county health department line-item budgets
 - d. Hot meals from local restaurants if monetary donations are available
3. Instruct the patient on the conditions of respiratory isolation and the consequences of non-adherence. To ensure compliance with isolation, the TB case manager will ensure:
 - a. Medication is provided by daily DOT for the entire length of respiratory isolation
 - b. Symptoms of active TB disease (if not already confirmed) and adverse effects from the medication are assessed daily
 - c. Visits to the patient are made at different times of the day to ensure compliance with respiratory isolation
 - d. Three (3) sputums are collected on consecutive days, every week, during the entire length of respiratory isolation
4. If there is any indication of non-compliance, the TB case manager is to assess the situation immediately and legal measures may be initiated at this time.

Tool V-3
Case Managing the TB Patient Receiving
Contracted Vendor Services

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Case Managing the TB Patient Receiving Contracted Vendor Services

When a person with suspected or confirmed TB disease is in a medical facility, the TB case manager should take an active role in the discharge planning. If there are anticipated needs for a service to be provided by a home health agency, an infusion supply company, or other contracted vendor upon discharge, the TB case manager will complete the *Prior Approval Request (PAR)* form and submit the form, along with the TB physician's progress notes, to the TTBEPCO for review and approval. Upon receiving the *PAR* and progress notes, the TTBEPCO Central Office (C.O.) Nurse Consultant will negotiate a financial agreement with the vendor(s). Once the financial agreement(s) are in place, the TTBEPCO C.O. Nurse Consultant will update the TB case manager, who is then responsible for case managing the plan of treatment for the patient. After notification by C.O., the TB case manager will then notify the facility that follow-up services are in place and the patient can be discharged from the facility at the appropriate time.

Home health services may be ordered for a TB patient upon discharge from a facility. These services will require a *Prior Approval Request* and a *financial agreement* prior to patient's discharge. The home health services may provide skilled care to perform:

- Intravenous (IV) therapy
- Dressing changes to:
 - IV sites (i.e., PICC lines, portacaths)
 - Drain sites
 - Other sites related to TB disease
- Patient education

Infusion supply company services may be ordered for a TB patient upon discharge from a facility. These services would require a *Prior Approval Request* and a *financial agreement* prior to patient's discharge. The infusion supply company may provide:

- Delivery of medication
- Delivery of supplies needed by the home health agency to provide treatment as ordered by the physician (outside provider or the TB physician)

When discharge plans include home health referrals and/or the need for an infusion supply company to provide medication and supplies, the TB case manager will ensure that the TTBEPCO C.O. and vendors (e.g., home health agency, infusion supply company) receive all orders and notifications regarding the plan of treatment. The TB case manager will:

1. Obtain the home health referral orders from the discharge planner/social worker at the discharging facility
2. Notify the TTBEPCO C.O. Nurse Consultant to begin financial arrangements with the appropriate vendor(s) by faxing or emailing the home health referral orders to the C.O.
3. Complete a *PAR* form and submit the form, along with the TB physician's progress notes, to the TTBEPCO C.O. Nurse Consultant

4. Call the home health agency and coordinate plan of care upon discharge. Fax or email the home health referral orders. Ideally, the discharge planner/social worker at the facility will forward the home health referral to the home health company; however, in order to ensure continuity of care, the TB case manager will send the home health referral orders to the vendor's contact person
5. Obtain orders for the medication(s) and supplies that are to be supplied by the infusion company
6. Notify the TTBEPC.O. Nurse Consultant to begin financial arrangements with the appropriate vendor(s) by faxing or emailing the medication orders to the C.O.
7. Complete a *PAR* form and submit the form, along with the TB physician's progress notes, to the TTBEPC.O. Nurse Consultant
8. Call the infusion supply company and coordinate plan of care upon discharge. Fax or email the physician's orders. Ideally, the discharge planner/social worker at the facility will send the physician's orders for the medication to the infusion supply company; however, in order to ensure continuity of care, the TB case manager will send the physician's orders to the vendor's contact person. (The home health agency may not routinely forward the physician's orders to the infusion supply company.)

The TB case manager will ensure that the home health agency, the infusion supply company, any other contracted service, and the TTBEPC.O. is aware of all changes to the plan of treatment, as well as, the patient's status during the time of the contracted service, which may include:

- Date of discharge from facility
- Medication (dosage change, frequency change, hold or discontinue medication)
- Treatment plan (frequency of services, hold or discontinue services)
- Hospitalization(s)
- Patient contact information (new address, new telephone numbers)
- Payor source
- Death

Anytime there is a change in the plan of treatment, a new physician's order must be written (if not obtained from an outside provider) and submitted to each vendor providing a service and to the TTBEPC.O.

For **medication changes** (i.e., increase dose, decrease dose, change in frequency, hold or discontinue medication), the TB case manager will:

1. Obtain from the TB physician or an outside provider, the new written medication order
2. Notify the TTBEPC.O. Nurse Consultant of the medication change(s)
3. Call and report changes to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)
4. Fax or email the order to the vendor(s)'s contact person and to the TTBEPC.O. Nurse Consultant

If the patient is **hospitalized** during the time that vendor services are provided, the TB case manager will:

1. Notify the TTBEPC.O. Nurse Consultant of readmission to a facility
2. Complete a new *PAR*, if readmitted to a facility due to TB disease, and send the *PAR*, along with the TB physician's progress notes, to the TTBEPC.O. Nurse Consultant
3. Obtain from the TB physician or an outside provider, the new written order to hold medication and/or services until further notice
4. Call and report the hospitalization to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)
5. Fax or email the order to the vendor(s)'s contact person

Upon **discharge** from the facility, the TB case manager will:

1. Notify the TTBEPC.O. Nurse Consultant of the patient's discharge date from the facility
2. Obtain from the TB physician or an outside provider, the new written order for the home health referral and/or medication order(s) or to discontinue the vendor(s) service and/or medication supply
3. Call and report the patient's discharge to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)
4. Fax or email the order to the vendor(s)'s contact person

If the patient **moves or has a telephone number change**, the TB case manager will:

1. Notify the TTBEPC.O. of changes in the patient's contact information during the contracted service timeframe. If patient is moving to new region, follow the Intrastate Movement procedure in the TTBEPC Manual, Module VIII
2. Call and report the new contact information for the patient (i.e., new address, telephone number), as soon as possible, to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)

If the patient has a change in the **payor source**, the TB case manager will:

1. Notify the TTBEPC.O. of any changes in the payor source during the contracted service timeframe
2. Call and report the new payor source (i.e., insurance, PAR) to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)

If the patient **expires**, the TB case manager will:

1. Notify the TTBEPC.O. if patient expires.
2. Call and report the patient's expired status, as soon as possible, to the vendor(s) providing a service (i.e., home health company, infusion supply company, other contracted vendor)
3. Obtain death certificate and send a copy, along with the complete medical record to the TTBEPC.O. Nurse Consultant

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Tool V-4
TB Teaching Tool Checklist

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TB Teaching Tool Checklist

<input type="checkbox"/>	Maintaining confidentiality
<input type="checkbox"/>	Disease transmission and infection
<input type="checkbox"/>	TB infection (TBI) vs. active TB disease
<input type="checkbox"/>	Assuring that TB can be cured with treatment
<input type="checkbox"/>	Isolation procedures (no visitors, no shopping, etc.) and proper use of a mask
<input type="checkbox"/>	Cover mouth and nose when sneezing and coughing; proper disposal of tissues
<input type="checkbox"/>	Importance of identifying contacts and the need for evaluation of contacts
<input type="checkbox"/>	Contacts to pulmonary will need QFT or TST placed initially and repeated in 8-10 weeks (if initial test is negative)
<input type="checkbox"/>	Children <5 years of age that are high risk will have a TST, PA and lateral chest X-ray, evaluation by clinician and will be placed on "window" treatment until the 2 nd TST is read
<input type="checkbox"/>	Reason for medication treatment and directly observed therapy (DOT)
<input type="checkbox"/>	Medication dosage, frequency and possible side effects
<input type="checkbox"/>	Importance of continuous, uninterrupted treatment until treatment is complete
<input type="checkbox"/>	How to contact nurse and/or health department during normal working hours, after hours, weekends and holidays
<input type="checkbox"/>	Purpose of collecting sputum specimens, frequency, how to collect and that health department will pick-up specimens collected at home
<input type="checkbox"/>	Importance of medical evaluation and clinic visits as ordered by clinician
<input type="checkbox"/>	Purpose of blood work and reasons it might be drawn
<input type="checkbox"/>	HIV and its relationship to TB and treatment
<input type="checkbox"/>	Written TB literature given in appropriate language to patient/family

Patient and/or family verbalize and/or demonstrate understanding of TB information

Nurse _____ Date _____

Interpreter _____ Date _____

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Tennessee TB Elimination Program

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Tool V-5

**Medical Records Request
Checklist**

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Medical Records Information to Request Checklist

<u>Outside Providers (e.g., clinics)</u>	
<input type="checkbox"/>	Clinic visit progress notes (may need to request previous 6 months)
<input type="checkbox"/>	Radiographic reports (e.g., chest X-ray, CT, MRI)
<input type="checkbox"/>	All AFB reports (sputum, bronchial lavage, tissue, urine, stool, etc.)
<input type="checkbox"/>	Most current lab results <ul style="list-style-type: none"> • CBC • CMP • HgA1c (if diabetic) • HIV (if HIV+ obtain most recent viral load)
<input type="checkbox"/>	TST or IGRA result
<input type="checkbox"/>	Pathology and/or cytology reports
<u>Hospital</u>	
<input type="checkbox"/>	Admission note
<input type="checkbox"/>	Emergency Department (ED) note
<input type="checkbox"/>	History and physical
<input type="checkbox"/>	Consultation notes
<input type="checkbox"/>	Radiographic reports (chest X-ray, CT, MRI)
<input type="checkbox"/>	All AFB reports (sputum, bronchial lavage, tissue, urine, stool, etc.)
<input type="checkbox"/>	Most current lab results <ul style="list-style-type: none"> • CBC • CMP • HgA1c (if diabetic) • HIV (if HIV+ obtain most recent viral load)
<input type="checkbox"/>	TST or IGRA result
<input type="checkbox"/>	Pathology and/or cytology reports
<input type="checkbox"/>	Medication administration records (MARs), if started on treatment
<input type="checkbox"/>	Discharge summary (when available)
<input type="checkbox"/>	

If the patient is a confirmed TB case and expires, request the complete hospital record to send to the TTBEF central office for review.

Additional records may be requested as needed by the TB physician.

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Tool V-6
TB Initial Visit Checklist

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TB Initial Visit Checklist

<input type="checkbox"/>	HIPAA confidentiality explained and signed
<input type="checkbox"/>	Medical records requested
<input type="checkbox"/>	Release of Information signed
<input type="checkbox"/>	Medical history completed
<input type="checkbox"/>	Instruction sheet for patient is reviewed and p
<input type="checkbox"/>	TB Risk Assessment Tool (TB RAT) completed
<input type="checkbox"/>	Document initial visit on progress note
<input type="checkbox"/>	Complete Initial Report Worksheet
<input type="checkbox"/>	Provide patient with mask and explain isolation procedure
<input type="checkbox"/>	Obtain QFT for children >5 years and adults or place TST for children <5 years
<input type="checkbox"/>	If TST was placed, read in 48-72 hours
<input type="checkbox"/>	Provide DOT for the patient and document medications
<input type="checkbox"/>	Draw labs, if ordered (CMP, CBS, HIV) and send to lab
<input type="checkbox"/>	Collect one sputum specimen and leave two sputum containers to be picked up by health department staff
<input type="checkbox"/>	Weigh the patient
<input type="checkbox"/>	If on EMB, check vision and color discrimination and document in patient chart
<input type="checkbox"/>	Identify contacts and record on PH-1631 TB Contact Record
<input type="checkbox"/>	Provide TB teaching and literature as per TB Teaching Tool Checklist
<input type="checkbox"/>	Obtain and record directions to the patient's home
<input type="checkbox"/>	Give patient business card and contact information
<input type="checkbox"/>	Enter the encounter in PTBMIS
<input type="checkbox"/>	Schedule TB clinic appointment within 10 days