



Reporting Contact Investigations

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TB/HIV/STD EPIDEMIOLOGY AND SURVEILLANCE GROUP
MANAGER

Objectives

- ▶ Understand reporting requirements for contacts
- ▶ Review Texas and Site Progress toward meeting reporting goals

Texas Reporting Requirements

- ▶ Texas Administrative code requires reporting of TB contact investigations
- ▶ For routine contact investigation reporting, use the TB-340
- ▶ For mass contact investigation reporting, use the mass contact spreadsheet



Texas Administrative Code

- ▶ Title 25, Part 1, Chapter 97, Subchapter A, §97.3
“What and How to Report” Section

(B) for **tuberculosis disease**:

...

- ▶ all information necessary to complete the most recent versions of forms TB 400 A & B (Report of Case and Patient Services), **TB 340** (Report of Contacts) and **TB 341** (Continuation of Report of Contacts);



Texas Administrative Code

- ▶ Title 25, Part 1, Chapter 97, Subchapter A, §97.3
“What and How to Report” Section

(C) for **contacts** to a known case of tuberculosis:

- ▶ complete name;
- ▶ date of birth;
- ▶ physical address;
- ▶ county of residence;
- ▶ and all information necessary to complete the most recent versions of forms TB 400 A & B (Report of Case and Patient Services), **TB 340** (Report of Contacts), and **TB 341** (Continuation of Report of Contacts);

TB-340



TB Program Evaluation Report of Follow-up and Treatment for Contacts to

Page 1 of
Date / /

A. Case/Suspect Information

TB Cases and Suspects

RVCT #: - -

Last Name		First Name		Middle Name	DOB	SSN	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. American <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaskan <input type="checkbox"/> Other <input type="checkbox"/> Hawaiian/Pacific Is.		Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		
Street Address		Apt.	City	County	Zip Code	Census Tract	Home Phone (<u> </u>) <u> </u> - <u> </u> <u> </u>		Work Phone (<u> </u>) <u> </u> - <u> </u> <u> </u>			
Status: <input type="checkbox"/> Suspect Case: <input type="checkbox"/> New <input type="checkbox"/> Recurrent <input type="checkbox"/> Reopen			Predominant Sites: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Other			Is Case Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Daycare Attendee/Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No				
TST Date <u> </u> / <u> </u> / <u> </u>		mm		Positive <input type="checkbox"/> Yes <input type="checkbox"/> No		Bacteriology						
Date Treatment Started: <u> </u> / <u> </u> / <u> </u>		IGRA Date <u> </u> / <u> </u> / <u> </u>		Positive <input type="checkbox"/> Yes <input type="checkbox"/> No		Specimen	Collection Date	Smear	Culture	Culture ID	Resistant to:	
Adherent to Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		CXR Date <u> </u> / <u> </u> / <u> </u>		Reading <input type="checkbox"/> Yes <input type="checkbox"/> No		Cavity		Did patient have contact with livestock or consume unpasteurized dairy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Dates of Infectious Period <u> </u> / <u> </u> / <u> </u> To <u> </u> / <u> </u> / <u> </u>		DOT <input type="checkbox"/> Yes <input type="checkbox"/> No		Source Case: Name: Last, First, Middle <input type="checkbox"/> Unknown		Identified in prior contact investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Comments: <input type="checkbox"/> Pos Sputum Smear <input type="checkbox"/> Laryngeal <input type="checkbox"/> Child (5--15) <input type="checkbox"/> Pos Sputum Culture <input type="checkbox"/> Miliary <input type="checkbox"/> Correctional Facility Inmate <input type="checkbox"/> Cavity X-Ray <input type="checkbox"/> MDR-TB <input type="checkbox"/> Long term Facility Resident <input type="checkbox"/> Pulmonary <input type="checkbox"/> Child (<5) <input type="checkbox"/> Recent Converter				
Fewer than 3 contacts identified due to: <input type="checkbox"/> Patient refused to cooperate <input type="checkbox"/> Patient died <input type="checkbox"/> Patient lost to follow-up <input type="checkbox"/> No contact information available <input type="checkbox"/> Other (Specify)		Social Behavioral Risk <input type="checkbox"/> 900 Positive <input type="checkbox"/> HBV Positive <input type="checkbox"/> Excessive alcohol use <input type="checkbox"/> Other substance use <input type="checkbox"/> Mental illness <input type="checkbox"/> Dementia										
Date assistance requested: <u> </u> / <u> </u> / <u> </u>		Name of assistant: _____										

B. Interview & Exposure Site Information

Interview Date <u> </u> / <u> </u> / <u> </u>		Interviewed by: Last Name _____		First Name: _____		Clinic: _____		Date Home/Other Site Visit 1: <u> </u> / <u> </u> / <u> </u>		Date Home/Other Site Visit 3: <u> </u> / <u> </u> / <u> </u>		
Interview Date (>7 days after) <u> </u> / <u> </u> / <u> </u>								Date Home/Other Site Visit 2: <u> </u> / <u> </u> / <u> </u>		Date Home/Other Site Visit 4: <u> </u> / <u> </u> / <u> </u>		
Site #	Site Name	Location				Site Type						Est. # Exposed
1						<input type="checkbox"/> Airplane/Pub. Transport	<input type="checkbox"/> Daycare	<input type="checkbox"/> Hospital/Medical	<input type="checkbox"/> Office/Workplace			
						<input type="checkbox"/> Colonia	<input type="checkbox"/> Dorm	<input type="checkbox"/> Leisure/Recreation	<input type="checkbox"/> School/College			
						<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Home/Residence	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other (Specify):			
2						<input type="checkbox"/> Airplane/Pub. Transport	<input type="checkbox"/> Daycare	<input type="checkbox"/> Hospital/Medical	<input type="checkbox"/> Office/Workplace			
						<input type="checkbox"/> Colonia	<input type="checkbox"/> Dorm	<input type="checkbox"/> Leisure/Recreation	<input type="checkbox"/> School/College			
						<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Home/Residence	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other (Specify):			
3						<input type="checkbox"/> Airplane/Pub. Transport	<input type="checkbox"/> Daycare	<input type="checkbox"/> Hospital/Medical	<input type="checkbox"/> Office/Workplace			
						<input type="checkbox"/> Colonia	<input type="checkbox"/> Dorm	<input type="checkbox"/> Leisure/Recreation	<input type="checkbox"/> School/College			
						<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Home/Residence	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other (Specify):			
4						<input type="checkbox"/> Airplane/Pub. Transport	<input type="checkbox"/> Daycare	<input type="checkbox"/> Hospital/Medical	<input type="checkbox"/> Office/Workplace			
						<input type="checkbox"/> Colonia	<input type="checkbox"/> Dorm	<input type="checkbox"/> Leisure/Recreation	<input type="checkbox"/> School/College			
						<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Home/Residence	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other (Specify):			
Media Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, media source and contact										

TB-341



TB Program Evaluation Report of Follow-up and Treatment for Contacts to TB Cases and Suspects

Page ___ of ___
Date ___/___/___

Case/Suspect Information

Last Name	First Name	Middle Name	DOB	SSN

C. Contact Information

SSN: _____ Last Name: _____ First: _____ Middle: _____ DOB: _____/_____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Site #: _____ Race: _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino Date Identified: _____/_____/_____ Relation to case: _____ BCG: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____		Address: _____ City: _____ County or Country: _____ Phone #: _____ <input type="checkbox"/> Work <input type="checkbox"/> Home Country of Birth (if not US): _____ Exposure Length: <input type="checkbox"/> >6 hrs/wk <input type="checkbox"/> >2 but <=6 hrs/wk <input type="checkbox"/> <2 hrs/wk <input type="checkbox"/> No contact was made Exposure Setting: Indoors: <input type="checkbox"/> Size of car <input type="checkbox"/> Size of bedroom <input type="checkbox"/> Size of house <input type="checkbox"/> Larger than house <input type="checkbox"/> Outdoors Ongoing exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date last exposure: _____/_____/_____		900 Test Results: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Priority (H, M, L): _____ History of positive TST?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____ TST/IGRA Date: _____/_____/_____ mm/% Pos Neg CXR Date: _____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> PA <input type="checkbox"/> Lateral <input type="checkbox"/> Lordotic <input type="checkbox"/> Other		Evaluation Complete? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Reason Not Complete: <input type="checkbox"/> Died <input type="checkbox"/> 2 nd TST not done/read <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> 3 rd TST not done/read <input type="checkbox"/> Refused Evaluation <input type="checkbox"/> 1 st TST not done/read <input type="checkbox"/> No Chest X-Ray Treatment Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason Treatment not started: <input type="checkbox"/> Contraindicated <input type="checkbox"/> Died <input type="checkbox"/> History of noncompliance <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Prior adequate treatment <input type="checkbox"/> Refused treatment # Months Recommended: _____ # Months RX Completed: _____ Clinic: _____		Treatment Outcome (if recommended): <input type="checkbox"/> Completed adequate therapy <input type="checkbox"/> Lost/patient not located <input type="checkbox"/> Refused (patient chose to stop meds) <input type="checkbox"/> Refused (patient chose to stop evaluation) <input type="checkbox"/> Adverse treatment event <input type="checkbox"/> Died <input type="checkbox"/> Moved out of state/country <input type="checkbox"/> Provider decision-pregnant <input type="checkbox"/> Provider decision-other (specify): _____ <input type="checkbox"/> No further evaluation needed <input type="checkbox"/> Active TB developed	
SSN: _____ Last Name: _____ First: _____ Middle: _____ DOB: _____/_____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Site #: _____ Race: _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino Date Identified: _____/_____/_____ Relation to case: _____ BCG: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____		Address: _____ City: _____ County or Country: _____ Phone #: _____ <input type="checkbox"/> Work <input type="checkbox"/> Home Country of Birth (if not US): _____ Exposure Length: <input type="checkbox"/> >6 hrs/wk <input type="checkbox"/> >2 but <=6 hrs/wk <input type="checkbox"/> <2 hrs/wk <input type="checkbox"/> No contact was made Exposure Setting: Indoors: <input type="checkbox"/> Size of car <input type="checkbox"/> Size of bedroom <input type="checkbox"/> Size of house <input type="checkbox"/> Larger than house <input type="checkbox"/> Outdoors Ongoing exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date last exposure: _____/_____/_____		900 Test Results: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Priority (H, M, L): _____ History of positive TST?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____ TST/IGRA Date: _____/_____/_____ mm/% Pos Neg CXR Date: _____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> PA <input type="checkbox"/> Lateral <input type="checkbox"/> Lordotic <input type="checkbox"/> Other		Evaluation Complete? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Reason Not Complete: <input type="checkbox"/> Died <input type="checkbox"/> 2 nd TST not done/read <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> 3 rd TST not done/read <input type="checkbox"/> Refused Evaluation <input type="checkbox"/> 1 st TST not done/read <input type="checkbox"/> No Chest X-Ray Treatment Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason Treatment not started: <input type="checkbox"/> Contraindicated <input type="checkbox"/> Died <input type="checkbox"/> History of noncompliance <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Prior adequate treatment <input type="checkbox"/> Refused treatment # Months Recommended: _____ # Months RX Completed: _____ Clinic: _____		Treatment Outcome (if recommended): <input type="checkbox"/> Completed adequate therapy <input type="checkbox"/> Lost/patient not located <input type="checkbox"/> Refused (patient chose to stop meds) <input type="checkbox"/> Refused (patient chose to stop evaluation) <input type="checkbox"/> Adverse treatment event <input type="checkbox"/> Died <input type="checkbox"/> Moved out of state/country <input type="checkbox"/> Provider decision-pregnant <input type="checkbox"/> Provider decision-other (specify): _____ <input type="checkbox"/> No further evaluation needed <input type="checkbox"/> Active TB developed	
SSN: _____ Last Name: _____ First: _____ Middle: _____ DOB: _____/_____/_____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Site #: _____ Race: _____ <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino Date Identified: _____/_____/_____ Relation to case: _____ BCG: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____		Address: _____ City: _____ County or Country: _____ Phone #: _____ <input type="checkbox"/> Work <input type="checkbox"/> Home Country of Birth (if not US): _____ Exposure Length: <input type="checkbox"/> >6 hrs/wk <input type="checkbox"/> >2 but <=6 hrs/wk <input type="checkbox"/> <2 hrs/wk <input type="checkbox"/> No contact was made Exposure Setting: Indoors: <input type="checkbox"/> Size of car <input type="checkbox"/> Size of bedroom <input type="checkbox"/> Size of house <input type="checkbox"/> Larger than house <input type="checkbox"/> Outdoors Ongoing exposure: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, date last exposure: _____/_____/_____		900 Test Results: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Priority (H, M, L): _____ History of positive TST?: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____/_____/_____ TST/IGRA Date: _____/_____/_____ mm/% Pos Neg CXR Date: _____/_____/_____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> PA <input type="checkbox"/> Lateral <input type="checkbox"/> Lordotic <input type="checkbox"/> Other		Evaluation Complete? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Reason Not Complete: <input type="checkbox"/> Died <input type="checkbox"/> 2 nd TST not done/read <input type="checkbox"/> Lost to Follow-up <input type="checkbox"/> 3 rd TST not done/read <input type="checkbox"/> Refused Evaluation <input type="checkbox"/> 1 st TST not done/read <input type="checkbox"/> No Chest X-Ray Treatment Recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason Treatment not started: <input type="checkbox"/> Contraindicated <input type="checkbox"/> Died <input type="checkbox"/> History of noncompliance <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Prior adequate treatment <input type="checkbox"/> Refused treatment # Months Recommended: _____ # Months RX Completed: _____ Clinic: _____		Treatment Outcome (if recommended): <input type="checkbox"/> Completed adequate therapy <input type="checkbox"/> Lost/patient not located <input type="checkbox"/> Refused (patient chose to stop meds) <input type="checkbox"/> Refused (patient chose to stop evaluation) <input type="checkbox"/> Adverse treatment event <input type="checkbox"/> Died <input type="checkbox"/> Moved out of state/country <input type="checkbox"/> Provider decision-pregnant <input type="checkbox"/> Provider decision-other (specify): _____ <input type="checkbox"/> No further evaluation needed <input type="checkbox"/> Active TB developed	

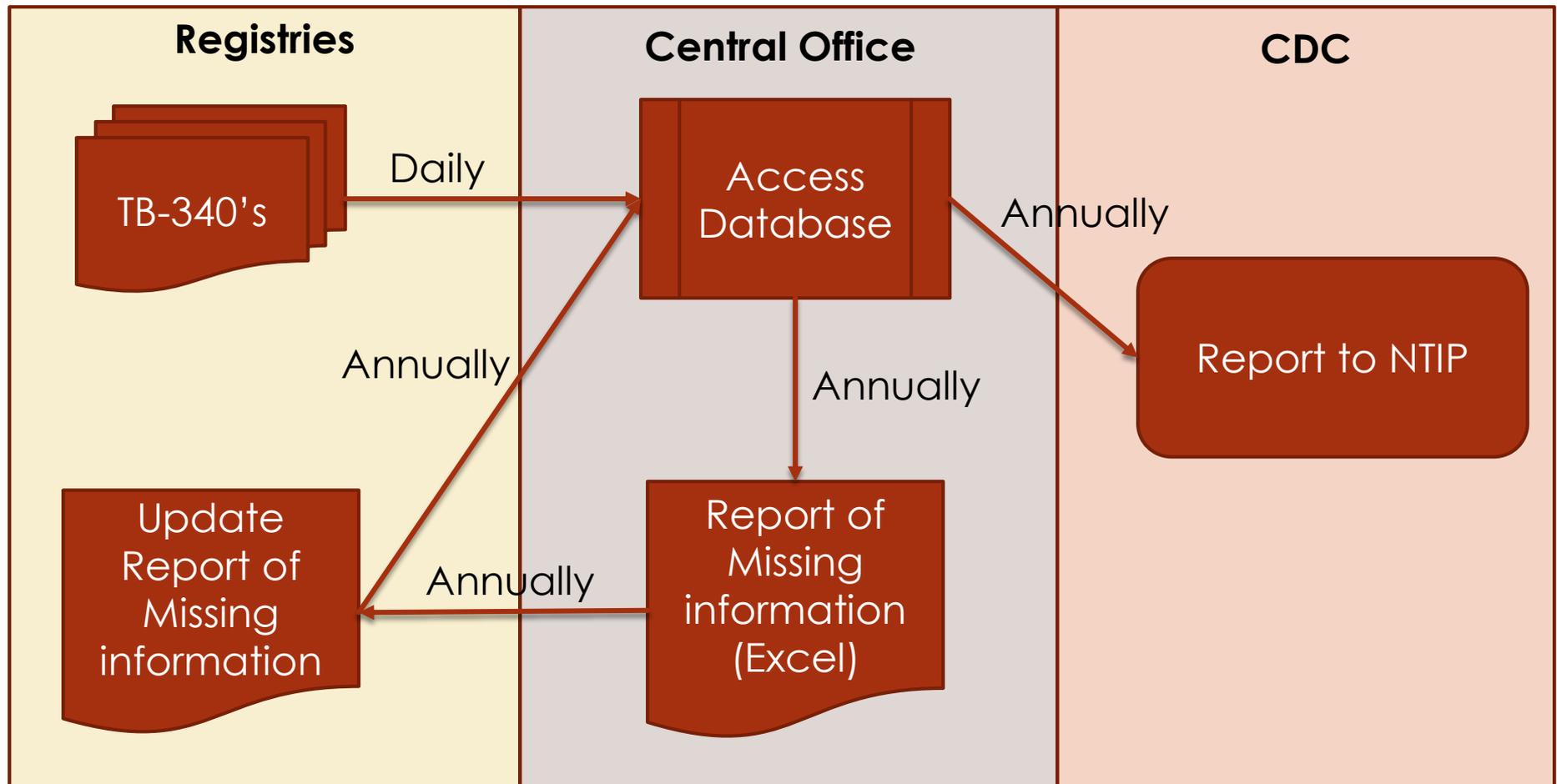
Mass Contact Spreadsheet

Case Year	Case Jurisdiction	Case RVCT	Case SSN	Case ID	Case DOB	Interview Date	Interview Date (>7days after)	Case Last Name	Case First Name	Predominant Sites	Is Case Married?(Y/N)	Dates of Infectious Period	Patient Have Contact with Livestock or	Identified in Prior Contact Investigation?	Priority Criteria	Contact ID	Contact SSN	TB-340 Received	Contact Last Name	Contact First Name	DOB
																C001					
																C002					
																C003					
																C004					
																C005					
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																C031					

Texas Reporting to CDC

- ▶ Report summary level information to the CDC
- ▶ Preliminary: August 15 after year is complete
- ▶ Final: August 15 of following year

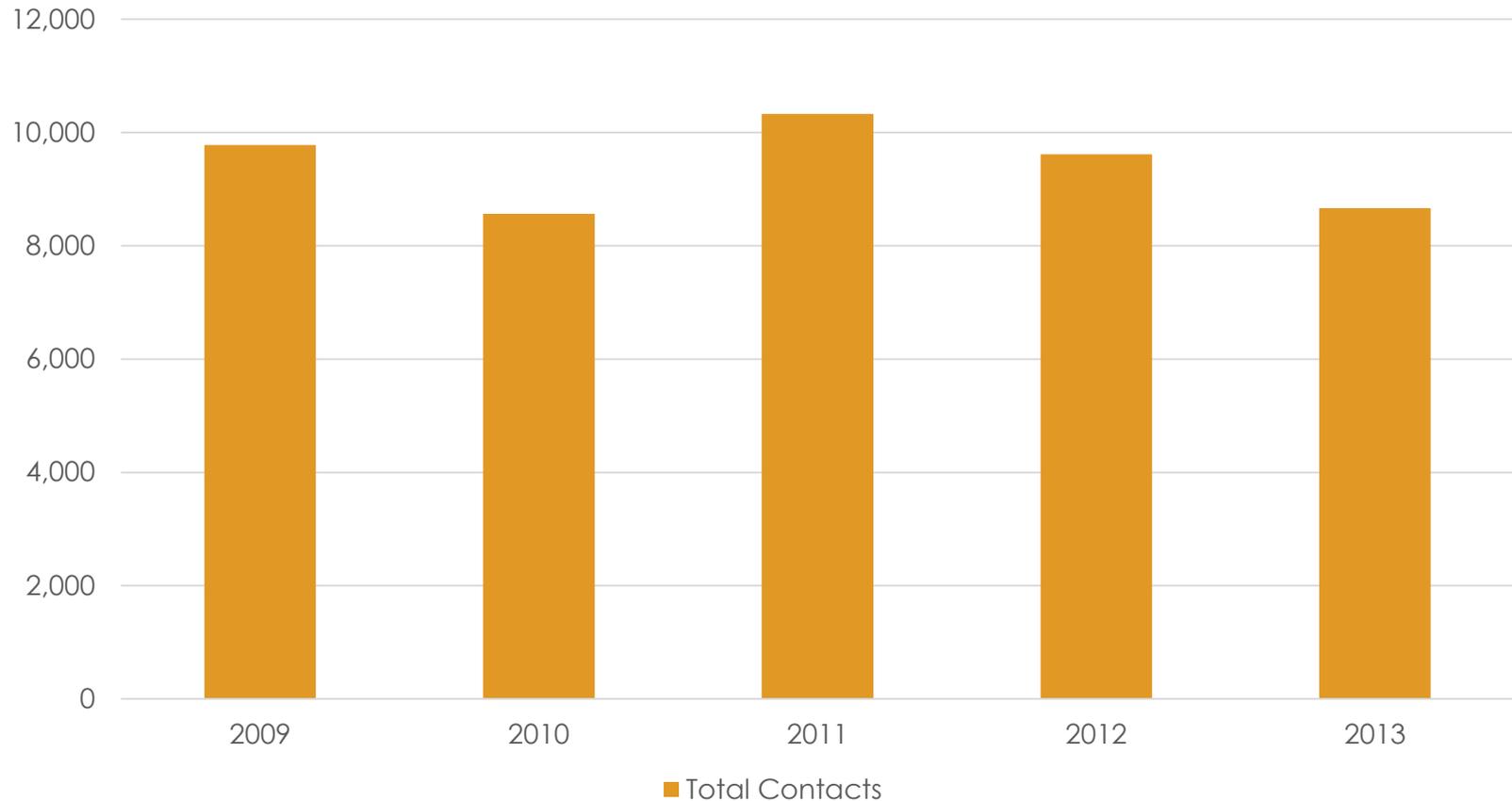
Overview of Contact Reporting Process



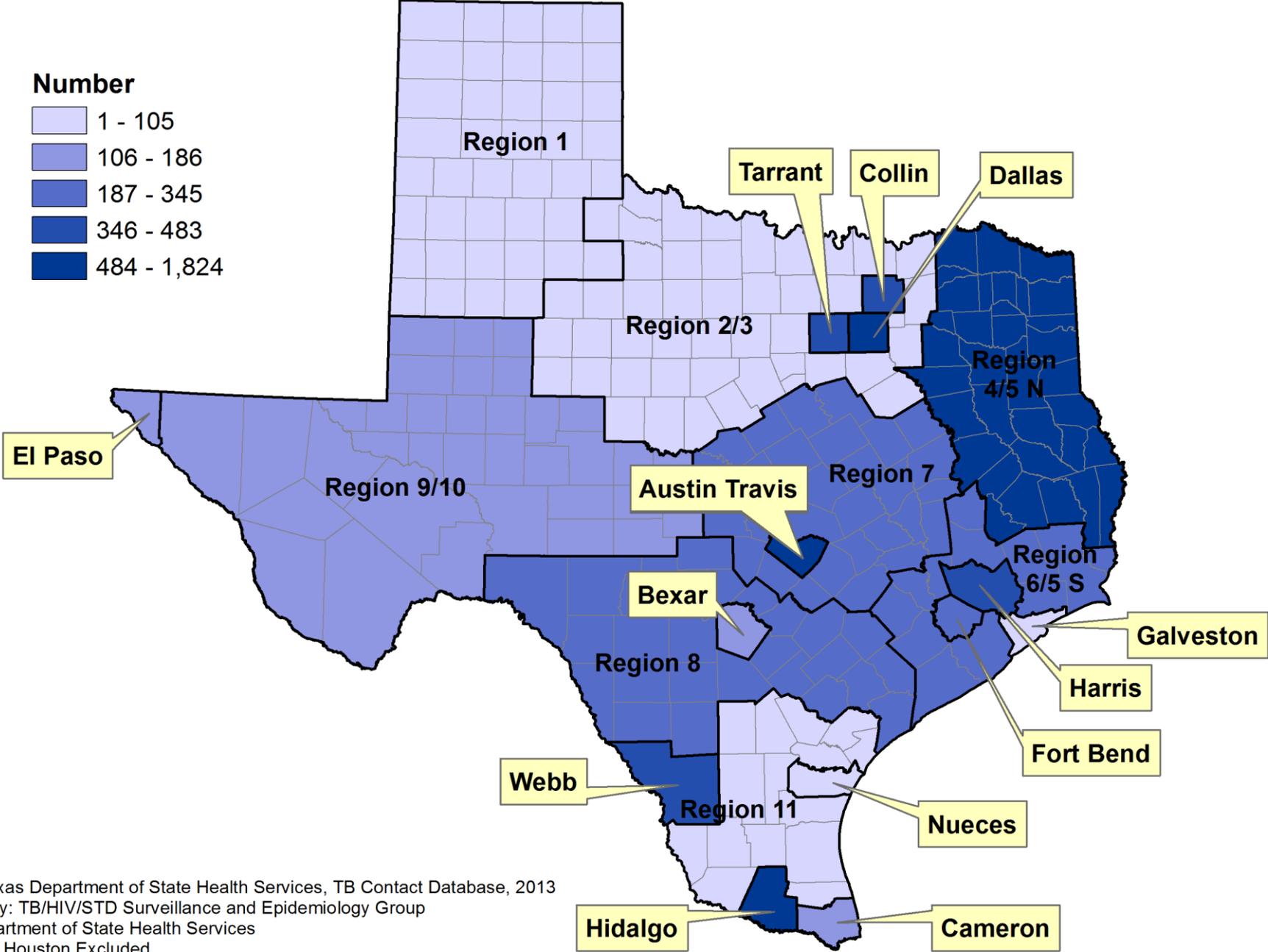
Contact Reporting Progress



Total Contacts Reported to Smear + cases, 2009-2013



Number of Contacts Investigated by TB Service Area, 2013



Source: Texas Department of State Health Services, TB Contact Database, 2013
 Prepared by: TB/HIV/STD Surveillance and Epidemiology Group
 Texas Department of State Health Services
 *TDCJ and Houston Excluded

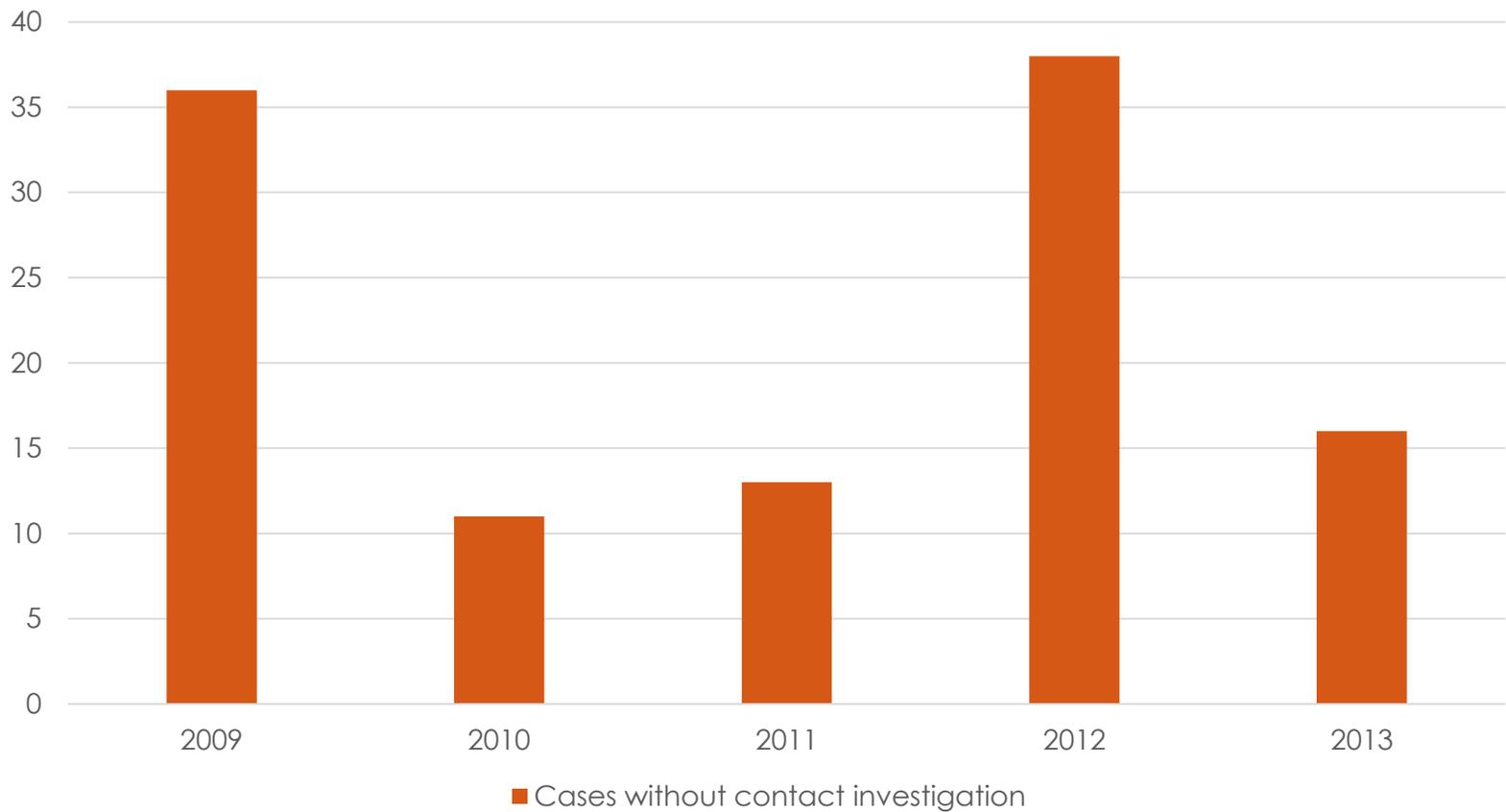
Evaluation Indices Smear + Cases

Evaluation Indices	CDC Goal
No-Contacts Rate	0%
Evaluation Rate	93%
LTBI Treatment Rate	88%
LTBI Completion Rate	79%

Evaluation Indices Smear + Cases

Evaluation Indices	CDC Goal
No-Contacts Rate	0%
Evaluation Rate	93%
LTBI Treatment Rate	88%
LTBI Completion Rate	79%

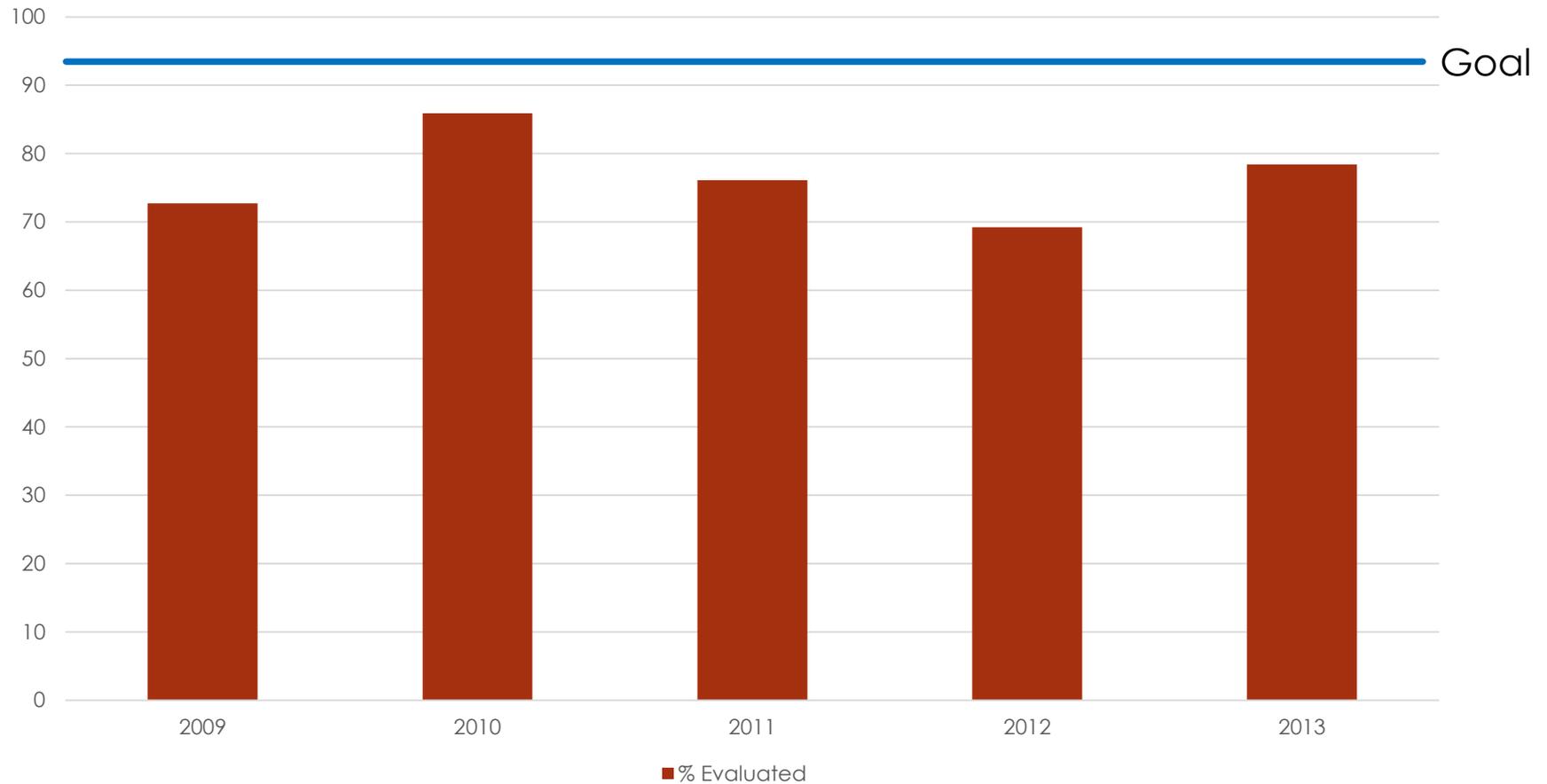
Cases without Contact Investigations- Smear + Cases



Evaluation Indices Smear + Cases

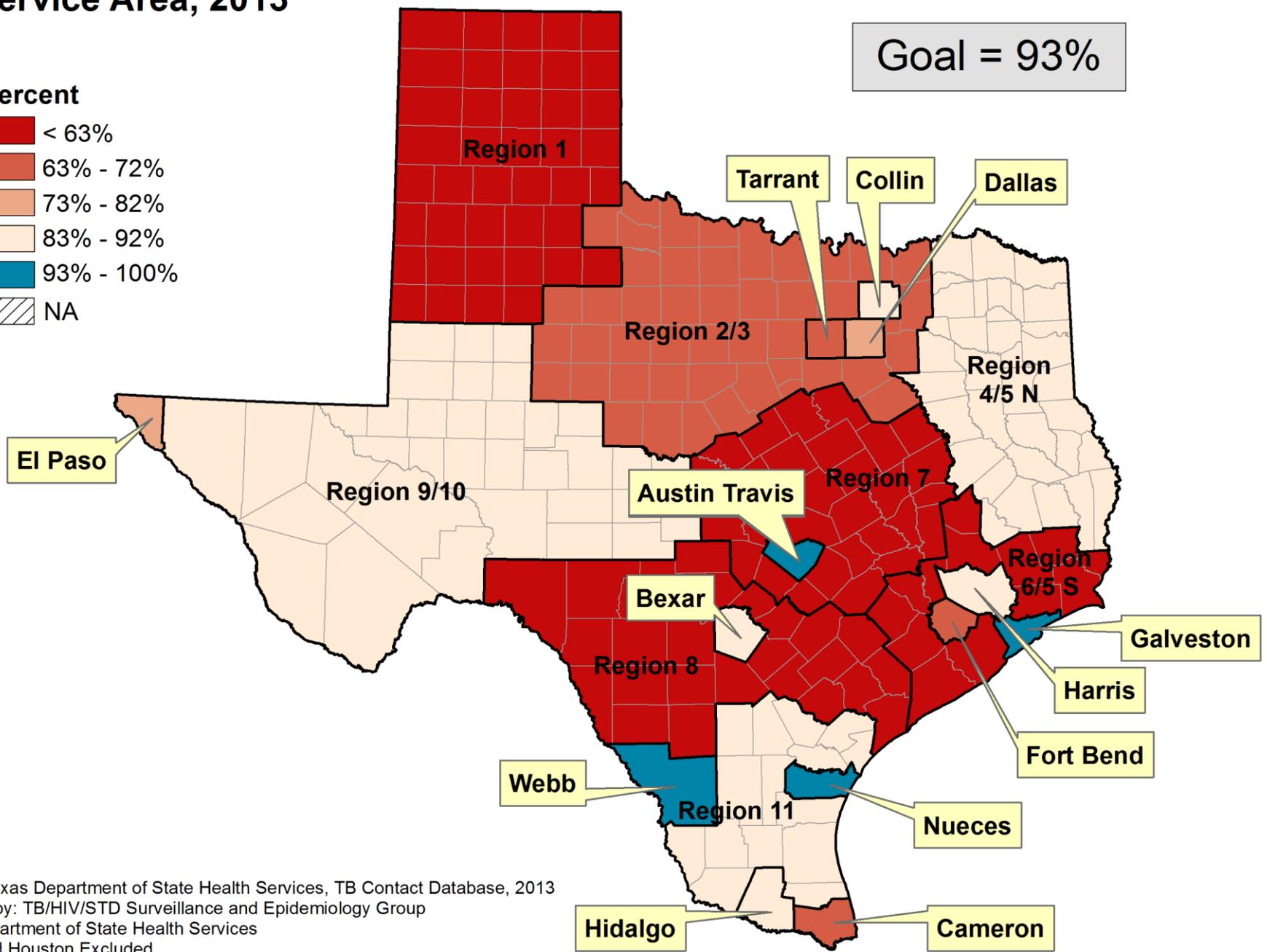
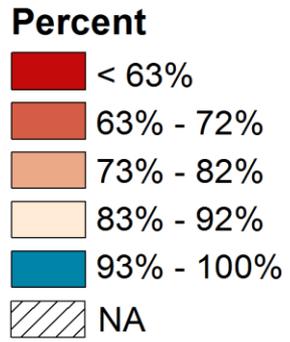
Evaluation Indices	CDC Goal
No-Contacts Rate	0%
Evaluation Rate	93%
LTBI Treatment Rate	88%
LTBI Completion Rate	79%

Contacts Reported to Smear + cases, 2009-2013



Percent of Contacts to Smear Positive Cases with a Completed Evaluation by TB Service Area, 2013

Goal = 93%

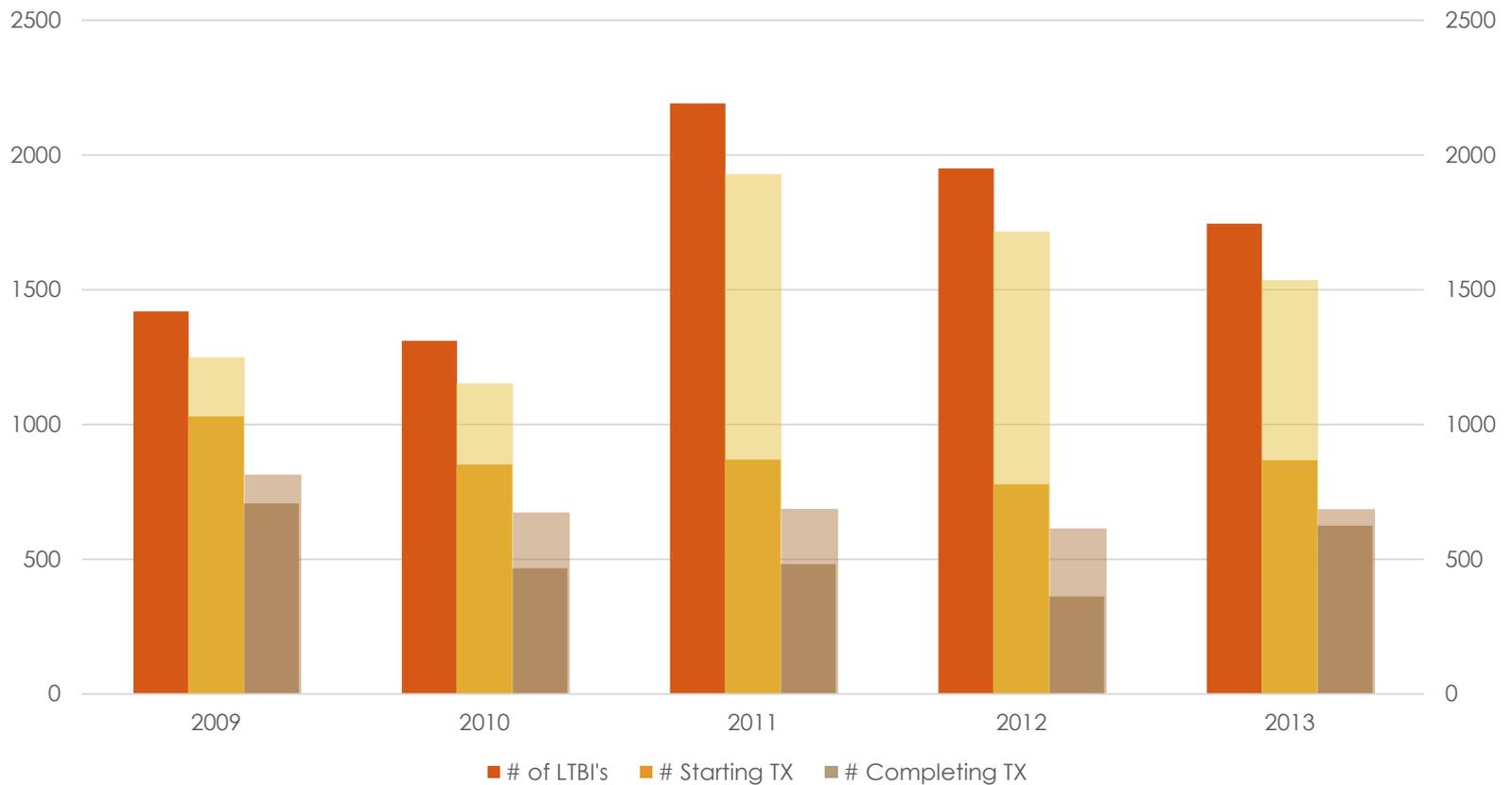


Source: Texas Department of State Health Services, TB Contact Database, 2013
 Prepared by: TB/HIV/STD Surveillance and Epidemiology Group
 Texas Department of State Health Services
 *TDCJ and Houston Excluded

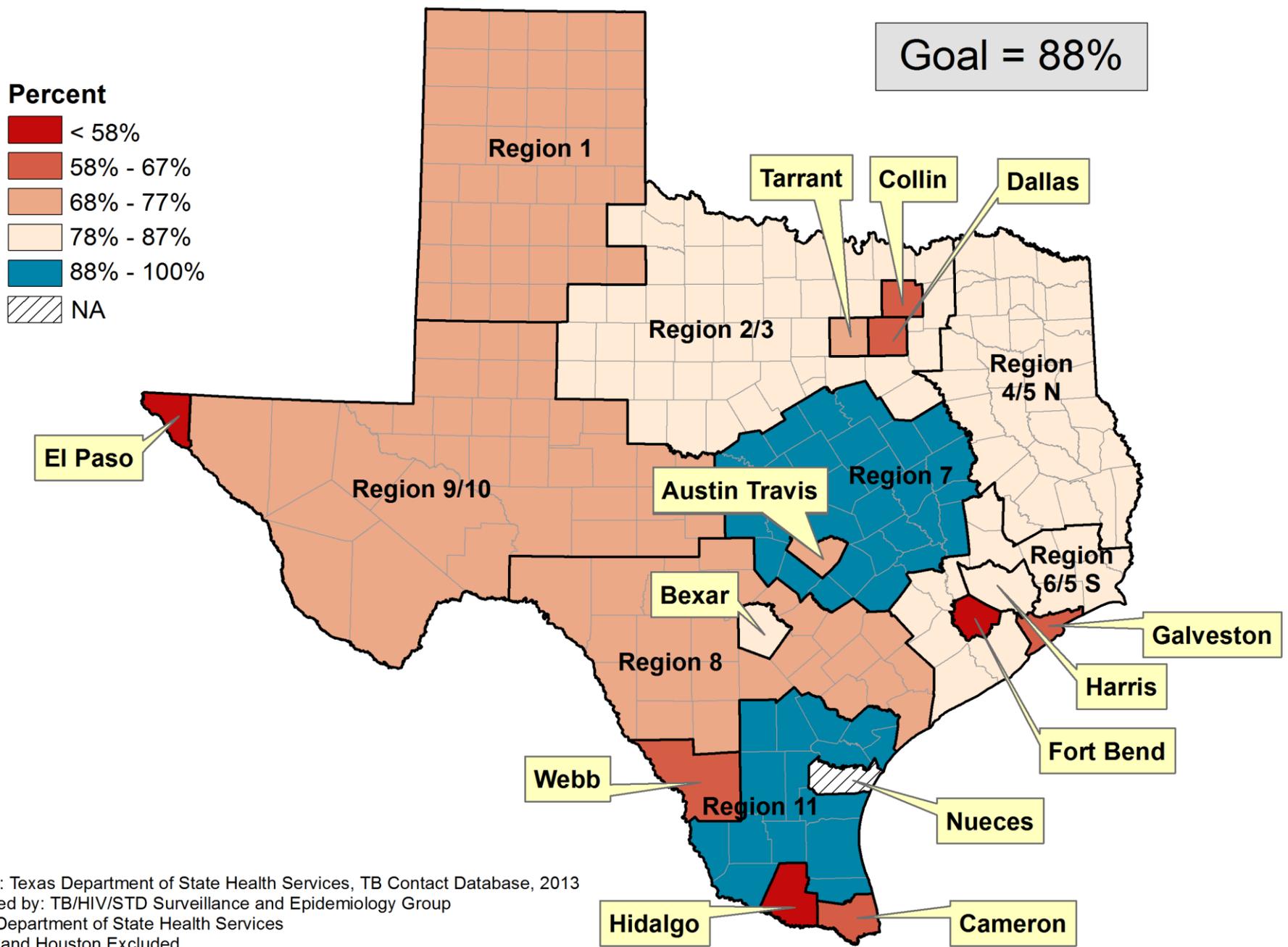
Evaluation Indices Smear + Cases

Evaluation Indices	CDC Goal
No-Contacts Rate	0%
Evaluation Rate	93%
LTBI Treatment Rate	88%
LTBI Completion Rate	79%

Contacts Reported to Smear + cases, 2009-2013



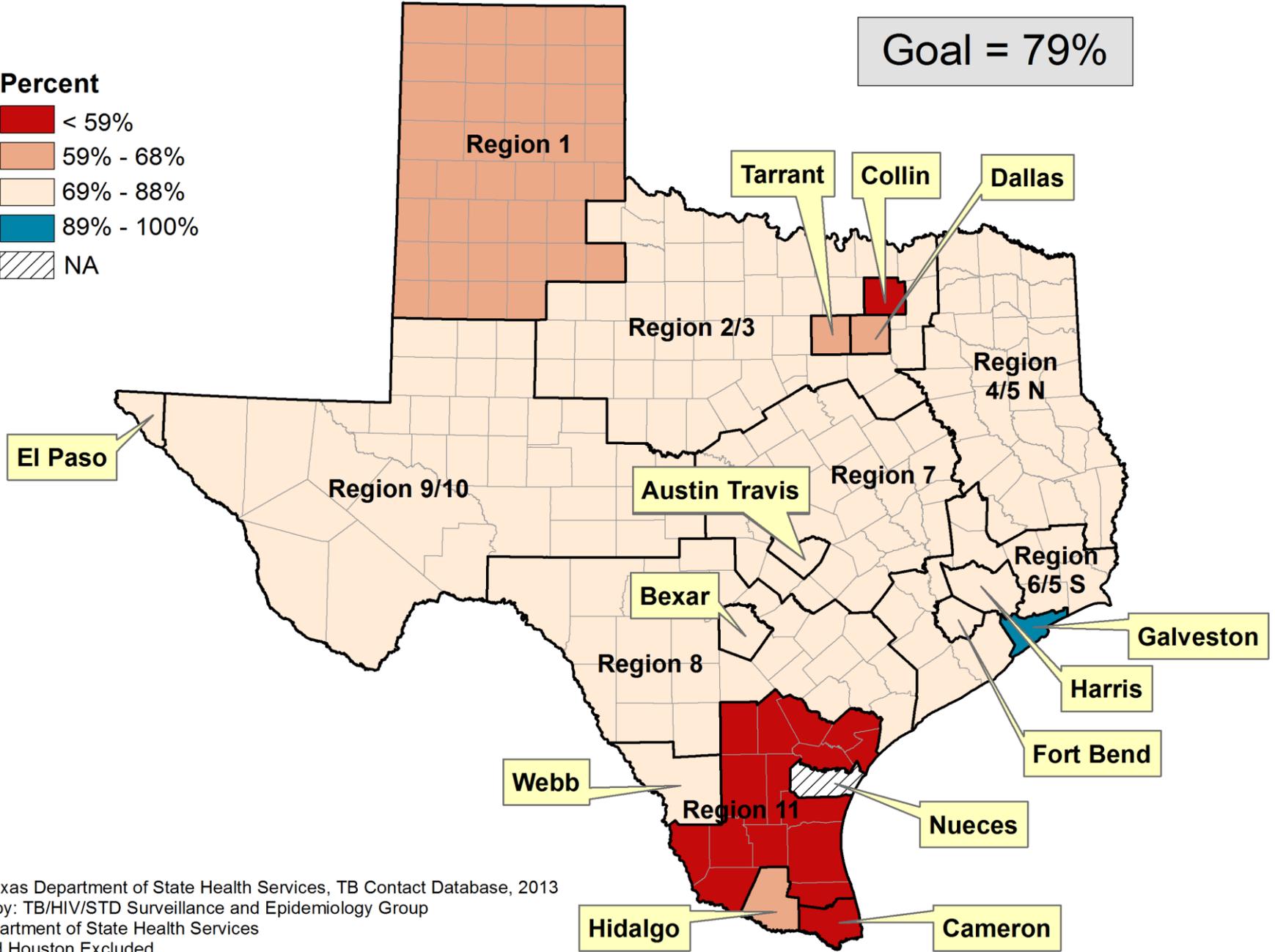
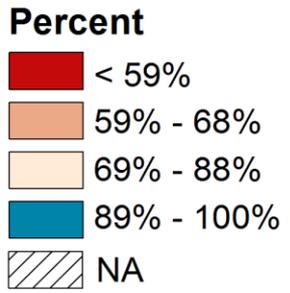
Percent of LTBI Contacts Starting Treatment by TB Service Area, 2013



Source: Texas Department of State Health Services, TB Contact Database, 2013
 Prepared by: TB/HIV/STD Surveillance and Epidemiology Group
 Texas Department of State Health Services
 *TDCJ and Houston Excluded

Percent of LTBI Contacts Completing Treatment by TB Service Area, 2013

Goal = 79%



Source: Texas Department of State Health Services, TB Contact Database, 2013
 Prepared by: TB/HIV/STD Surveillance and Epidemiology Group
 Texas Department of State Health Services
 *TDCJ and Houston Excluded

Take home points

- ▶ Individuals identified during a contact investigation should be reported using the TB-340/341
- ▶ This information is reported in aggregate to the CDC
- ▶ Complete contact reporting is important- Get credit for the hard work you do!



Thank You!

MIRANDA FANNING

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