## Patient’s Name: Initial Report Date & Source:

**Nurse Case Manager: Case Management Team:**

**Directions:** Blank boxes indicate week(s) TB service is to be provided. ***Document date and initials of the provider in the***

***appropriate box when the task is completed*.** Document comments in progress notes.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action****Interval:** | **0****Begin** | **2****Wks** | **4****Wks** | **8****Wks** | **12****Wks** | **16****Wks** | **20****Wks** | **24****Wks** | **26****Wks** |
| **Date:** |  |  |  |  |  |  |  |  |  |
| **Consents** |  General Consents, L-30, L-36, HIPAA, TB-209, interpreter form PRN; TB 409, TB 410, TB 411, etc.  |  |  |  |  |  |  |  |  |  |
| **Responsibility** | Assign nurse case manager; establish team; document in client’s record |  |  |  |  |  |  |  |  |  |
| **Medical Evaluation** | Obtain medical history; document on TB-202  |  |  |  |  |  |  |  |  |  |
|  Obtain release (L-30); request previous medical records |  |  |  |  |  |  |  |  |  |
|  MD evaluation/review; document in progress notes  |  |  |  |  |  |  |  |  |  |
|  RN evaluation |  |  |  |  |  |  |  |  |  |
| IGRA or Mantoux skin test recorded in mm (if not previously done)  |  |  |  |  |  |  |  |  |  |
|  Chest X-ray (PA & Lateral if less than 18 years) |  |  |  |  |  |  |  |  |  |
| Supervised sputum for AFB smear/culture according to protocol |  |  |  | 🗸susceptibility  |  |  |  |  |  |
| HIV testing, unless patient has knowledge of HIV+ status or has documented negative HIV test result within 14 days of TB diagnosis |  |  |  |  |  |  |  |  |  |
| Labs per protocol or specific order  |  |  |  |  |  |  |  |  |  |
|  Nutritional assessment |  |  |  |  |  |  |  |  |  |
| **Treatment** | Drug regimen according to protocol or specific order |  |  |  |  |  |  |  |  |  |
| Initiate DOT on all cases/suspects: Recommended Daily X 8 weeks, then daily or 3X/week (Mon/Wed/Fri) until completion of adequate therapy; document DOT on TB-206; other DOT dosing schedules may be ordered. |  |  |  |  |  |  |  |  |  |
| Pyrazinamide X2 months and ethambutol X2 months(or until susceptibilities are reported and client’sorganism is known to be pan sensitive)  |  |  |  |  |  |  |  |  |  |
| Vitamin B6 (if pregnant, diabetic, at risk for peripheralneuropathy) |  |  |  |  |  |  |  |  |  |
| Obtain Informed Consent form TB-411 (TB-411A, ifSpanish speaking, only) initially and for any drugs added to regimen. |  |  |  |  |  |  |  |  |  |
| **Consultation** | Obtain expert consult for drug resistant cases,complicated adult/pediatric cases or client who remains symptomatic or sputum positive after 2 months’ therapy; written consult in client record |  |  |  |  |  |  |  |  |  |
| **Toxicity/ Clinical Assessment** | Clinical assessment according to protocol; document(TB-205 and progress note as appropriate) |  |  |  |  |  |  |  |  |  |
| Visual acuity (Sloan or Snellen) and color discrimination(Ishihara Plates) initially and monthly if on EMB or Rifabutin; document (TB-205) |  |  |  |  |  |  |  |  |  |
| Hearing sweep check initially and monthly if onamikacin, capreomycin, kanamycin or streptomycin; document (TB-205) |  |  |  |  |  |  |  |  |  |

TB 201- Case Management Plan for Outpatient Care - Revised 08/2017

**TB Case and Suspect Management Plan for Outpatient Care**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Action Interval:** | **0****Begin** | **2****Wks** | **4****Wks** | **8****Wks** | **12****Wks** | **16****Wks** | **20****Wks** | **24****Wks** | **26****Wks** |
| **Date:** |  |  |  |  |  |  |  |  |  |
| **Adherence** | Issue Order to Implement Measures for a Client WithTuberculosis form TB-410 (TB-410A, if Spanish speaking, only) on all cases/suspects |  |  |  |  |  |  |  |  |  |
| Follow-up missed appointments within 1 workingday. Initiate court-ordered management as indicated according to DSHS policy; (notify Regional office) |  |  |  |  |  |  |  |  |  |
|  Evaluate barriers to treatment (interpreter form PRN) |  |  |  |  |  |  |  |  |  |
| **Isolation** |  Conduct **site visit** to assess living situation. |  |  |  |  |  |  |  |  |  |
| Institute isolation in congregate living situation orhome and exclude from work or school, if infectious |  |  |  |  |  |  |  |  |  |
| Discontinue congregate setting isolation or allow to return to work/school following at least 2 wks appropriate therapy (unless otherwise indicated, see SDOs for release from isolation), must have at least 3 consecutive negative smears on different days |  |  |  |  |  |  |  |  |  |
| **Education** | Appropriate client education provided initially andmonthly per protocol; written instructions and monthly review of medication side effects, document on TB-203 or equivalent |  |  |  |  |  |  |  |  |  |
| **Public Health/ Contact Investigation** | Interview case/suspect and contacts; plan contactinvestigation using the “Concentric Circle” approach |  |  |  |  |  |  |  |  |  |
| Initiate contact investigation within 3 working days;interview and evaluate within 7 working days (IGRA/ skin test/reading, CXR, medical evaluation); document on TB-340 and make inter-jurisdictional referrals for contacts to regional office as needed |  |  |  |  |  |  |  |  |  |
| Expand contact investigation according to CDCGuidelines, TX TB Work Plan, and local criteria |  |  |  |  |  |  |  |  |  |
| Provide second evaluation 8-10 weeks after break incontact with index to all contacts IGRA or skin test negative on initial test; document on TB-340 |  |  |  |  |  |  |  |  |  |
|  Provide education and counseling for contacts |  |  |  |  |  |  |  |  |  |
| **Reporting** | Initial report suspect/case within 1 working day of notification, reclassification of suspect within 90 days  |  |  |  |  |  |  |  |  |  |
| Document on TB-400A and TB-400B or equivalent within 7 working days of diagnosis; submit RVCT if case; see TX TB Work Plan for reporting deadlines |  |  |  |  |  |  |  |  |  |
| Submit TB-340 or equivalent (such as mass contact spreadsheet) after second testing of negative contacts is complete. See TX TB Work Plan for reporting deadlines for contact investigations |  |  |  |  |  |  |  |  |  |
| **Quality Assurance Review** | Clinical supervisor or TB Program Manager reviewsand evaluates contact investigation |  |  |  |  |  |  |  |  |  |
|  Team review of client record |  |  |  |  |  |  |  |  |  |
| **Social Services** | Refer to Medicaid, if eligible; make appropriatereferrals to drug/alcohol treatment programs, nutritional support programs, and refer for HIVservices, if necessary |  |  |  |  |  |  |  |  |  |

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INITIALS: \_\_\_\_\_\_**\_\_\_\_\_\_

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INITIALS: \_\_\_\_\_\_\_\_\_\_\_\_**

**PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INITIALS: \_\_\_\_\_\_\_\_\_\_\_\_**

TB 201- Case Management Plan for Outpatient Care - Revised 08/2017