Tuberculosis and Hansen's Disease Unit

Tuberculosis Action Plan to Minimize Exposure to COVID-19

The *Tuberculosis (TB) Action Plan to Minimize Exposure to COVID-19* was created March 20, 2020, and updated April 21, October 20, 2020, and October 1, 2021. It outlines recommended modifications to TB case management activities for the Department of State Health Service's (DSHS) public health regions (PHRs) and local health department (LHD) TB programs as part of continued response to the COVID-19 pandemic. **This document reflects the most current recommendations for performing routine TB activities and remains in effect until further notice.**

Activity	Recommendations
General recommendations.	***Added October 1, 2021:*** • As the response to COVID-19 will vary over time given local epidemiology, resources, and mandates, modifications to TB prevention and care activities as listed in this document should be made based on COVID-19 response and not for other reasons. Follow these recommendations, unless otherwise directed by city/county/state/federal mandates or the Local Health Authority (LHA) or Medical Director responsible for a localized COVID-19 response. • Encourage all patients and staff to wear masks, even for non-infectious patients, while interacting in person. • For non-infectious patients who wish to travel outside the U.S. during TB care, the LHD/PHR should discuss with the patient and develop a plan for continuity of care (e.g. DOT), should the patient be restricted from entry back into the U.S. • Provide frequent updates and education to TB personnel on personal protection and infection prevention strategies, including cough etiquette and hand hygiene.
Performing directly observed therapy (DOT) and directly observed preventive therapy (DOPT) services.	***Updated October 1, 2021:*** Options listed in order of preference. • **Option 1:** Provide medications by video-enabled DOT (VDOT) • **Option 2:** Provide medications by DOT ○ Consider clinic visit (CV) *or* home visit (HV) protocols (see Attachment 1), as determined locally. Provide clear documentation of DOT visit (e.g. patient may sign DOT log if the pen can be cleaned as per HV/CV protocols or if the pen is kept in DOT folder for individual patient use). Otherwise, develop a local documentation plan.

	NOTE: Direct observation of TB medications remains the standard of care for the treatment of TB in Texas. Enhanced self-administered therapy (ESAT) may be needed in extenuating circumstances when VDOT or DOT is not an option. This may include when a client is being actively treated for or is on quarantine for exposure to COVID-19, or where the medical director/Local Health Authority has advised that in-person medical visits are not allowed. The decision to count any self-administered doses towards completion of therapy may be made by the treating physician, with the reason DOT is not provided documented in the medical record. A current medical order is required for every patient who was originally prescribed DOT but qualifies for ESAT due to COVID-19 constraints.
TB screening in persons recently vaccinated against COVID-19.	***Added October 1, 2021:*** Defer to DSHS Standing Delegation Orders (SDOs) for Tuberculosis Clinical Services Provided by Authorized Licensed Nurses, revised 8/31/2021 and updates to the Centers for Disease Control and Prevention's Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States: • Testing for TB infection with a Tuberculin Skin Test (TST)/Interferon-Gamma Release Assay (IGRA) can be done before, after, or during the same encounter as COVID-19 vaccination. • Consult with the treating physician before making decisions to delay or repeat a TST or IGRA for at-risk persons. • Vaccinations should not be delayed to accommodate TB screening procedures.

Evaluating new patients suspected of having TB disease (American Thoracic Society [ATS] Class V) based on any report (fax, phone call, walk-in, etc.).	***Unchanged:***
	
	Prioritize new patients based on information gathered in the initial report:
	• **For the following high priority patients, *screen as usual at the CV or HV:***
	  ○ Acid Fast Bacilli (AFB) smear positive, Nucleic Acid Amplification Test (NAAT) positive or not done, abnormal chest x-ray (CXR) consistent with TB, negative or positive TST or IGRA, may be symptomatic.
	  ○ AFB smear negative, NAAT negative or not done, abnormal CXR consistent with TB, positive TST/IGRA, may be symptomatic.
	  ○ Anyone NAAT/Polymerase Chain Reaction (PCR) or culture positive for MTB.
	  ○ Anyone with signs or symptoms of TB with a positive TST/IGRA and/or abnormal CXR and need more diagnostics.
	  ○ Any other report that is consistent with suspicion for TB disease as determined by the PHR or LHD TB program.
	• **For the following low-priority patients, *consider deferring CV/HV while further diagnostics are performed*.** PHR and LHD TB programs may mail sputum canisters, send CXR referrals, or perform a symptoms screening questionnaire over the phone to gather more diagnostic information before a classification is made.
	  ○ Any patient reported to the PHR or LHD and there is a low suspicion of TB disease based on current diagnostics and determined by the treating physician.

Evaluating new patients with known TB infection (ATS Class II).	***Unchanged:*** • Referrals for TB infection should be evaluated based on priority (see Texas TB Work Plan *Chapter I Introduction*) and as local resources allow.
Evaluating patients reported through the Electronic Disease Notification (EDN) system.	***Unchanged:*** • All patients reported to the local TB Program via the EDN system should be prioritized for evaluation and assessed by the TB program either via HV or CV. For initial information gathering, make phone contact where possible to minimize in-person interactions until assessments are needed.

	• During the COVID-19 response, timelines for completing the EDN follow-up worksheet may continue to be extended if local resources are limited.
Evaluating hospitalized patients in whom TB is suspected or known.	***Unchanged:*** • While visiting a newly diagnosed or suspected TB patient in the hospital facilitates a clear discharge plan, this may not be possible or allowed by the hospital in areas still experiencing high rates of COVID-19. Therefore, the Health Authority Warning Letters (HAWLs/TB 410s) can be deferred from being served in the hospital if the patient is not a flight risk; coordinate with the discharge hospital nurse. • When possible, the PHR/LHD may call the hospitalized patient to obtain an address and notify the patient of instructions upon discharge; document on the HAWL the date it was explained to the patient if over the phone. • After initial diagnosis, every effort should be made to coordinate a safe discharge plan. Considerations as to where the patient is being discharged to (i.e. homeless shelter, young children in the home, etc.) can be weighed and the decision made to remain hospitalized in airborne infection isolation (AII) or recommend discharge. Hospital beds should be made available *where possible* if currently held by patients with TB who do not require acute care and for whom the health department has developed a safe discharge plan. • If a hospital visit is deemed necessary, adhere to hospital policy for COVID-19.
Performing monthly assessments on patients with probable or confirmed TB disease.	***Unchanged:*** • To minimize time spent in person with patients, monthly toxicity exams may be performed over the phone by the nurse case manager asking toxicity screening questions **before** the in-person assessment via a CV/HV. • Refer to sections regarding blood draws and vital signs/physical exams for in-person assessments that are needed.
Performing monthly assessments on patients with TB infection.	***Updated October 1, 2021:*** • Monthly toxicity exams should be performed by the nurse case manager according to local/regional program procedures.

	• Refer to the Texas Tuberculosis Work Plan, *Chapter IV. Standards of Care*.

Performing initial, follow-up and end of treatment CXRs.	***Unchanged:***
	
	• Contact contracted radiology sites or sites where the PHR or LHD sends patients and identify if there are any changes to radiology services for COVID-19 response; relay any changes to the treating physician and patients.
	• Initial CXR is required before starting treatment for TB infection or disease.
	• Decisions to delay follow-up CXRs can be made by the treating physician.
	  ○ The clinician should document the rationale for deferring the CXR such as improvement in symptoms, bacteriology, and overall clinical course suggesting a positive response to therapy.
	  ○ If the end of treatment CXR is deferred due to concerns about COVID-19, it must be completed once the Coronavirus crisis passes.
	• Clinicians should order a CXR whenever clinically indicated and deemed essential.

Performing sputum collection, natural or induced.	***Updated October 1, 2021:***
	
	• **Initial sputum specimen collection**:
	  ○ Observe the first specimen *if the patient can come in for a CV or if the observation can be safely done at an HV*; perform where possible: outside with PPE, inside the clinic with PPE, or in a sputum induction booth with a window between patient and observer. If outside, maintain patient privacy.
	  ○ If an HV is necessary, staff should collect sputum outside maintaining six feet of distance from the patient; follow the protocol for HV with appropriate PPE.
	  ○ If the above is not possible, defer to a licensed healthcare provider for guidance.
	• **Follow-up sputum collection**:
	  ○ If observed sputum collection is not deemed safe or possible as per local/regional directives, subsequent sputum collection may be performed by the patient alone. Canisters may be mailed to the patient with a laboratory slip already filled out and the patient can place the canister in the mail.
	  ○ Do not collect more specimens than necessary. For example, the DSHS Standing Delegation Orders (SDOs) recommend initial sputum collection x3,

	then every other week until three consecutive negative sputum smears. Do not collect weekly just to have more specimens, unless an extenuating circumstance is needed to get the patient off isolation. Extra testing drains DSHS laboratory resources. • The treating physician may consider decreasing the frequency of sputum collection. For example, after initial specimens, the two-week samples may be deferred with the next three samples collected monthly. Considerations include if the patient has no high-risk contacts in the same airspace.
Performing TSTs, IGRAs and <u>any</u> blood draws.	***Unchanged:*** • Continue **bloodborne precautions along with PPE** as specified under CV/HV protocols (Attachment 1). • Decisions to defer TSTs or blood draws should be made on a case-by-case basis by the treating physician. • Follow CV/HV protocols when bloodwork is needed.
Performing physical assessments/ examination (may/may not require hands-on evaluation).	***Updated October 1, 2021:*** • Defer to the licensed healthcare provider and local/regional directives on patient exams. If an examination is indicated, practice hand hygiene before and after assessment and **use PPE** as necessary. • If the patient is thought to have extrapulmonary TB, a physical examination may be required, especially if the medical record does not support a specific site of infection. This is commonly seen in lymphatic TB where examination of the cervical, supraclavicular, and axillary regions can be high yield. • Clean any equipment used (i.e. stethoscopes).
Performing vital signs, visual acuity examinations, weights, assessments using equipment (i.e. ECGs).	***Unchanged:*** • Follow CV/HV protocols for monthly toxicity assessments. • Clean equipment after each patient encounter, including any equipment the patient touches.

Conducting contact investigations (CI).	***Unchanged:*** • Visiting primary residences for CIs may be delayed more than three days if there is a justification for delay. Patients may be interviewed on the phone to elicit contacts initially. Any further delays should be done on a case-by-case basis considering the safety of staff, patients, and resource allocation. • Prioritize CIs*** and perform testing based on prioritization of contacts: ○ **High priority CI**- sputum smear-positive and or NAAT positive cases ▪ Prioritize contacts; evaluate and test **high** and **medium** risk contacts individually and not in a group setting. ▪ Evaluate and test **low**-risk contacts if expansion is indicated by positivity rate. ○ **Medium priority CI**- sputum smear-negative, culture-positive cases; cavitation on CXR despite negative sputum smear results. ▪ Evaluate and test contacts individually and not in a group setting. ▪ Follow prioritization as specified in high. ○ **Low priority CI**- sputum smear-negative, NAAT negative, non-cavitary. ▪ Conduct evaluation and testing of **high**-risk contacts *if resources allow.* ***cdc.gov/mmwr/preview/mmwrhtml/rr5415a1.htm
Targeted Testing.	***Updated October 1, 2021:*** • It is recommended that targeted testing resume per epidemiological findings that support targeted testing. The decision to resume or defer should be made by the local TB program in coordination with local/regional directives. • Considerations to re-open or continue targeted testing: ○ When an epidemiologic assessment determines the selected facility is considered high risk for TB and targeted testing is a reasonable response to prevent a recurrence of TB disease transmission, **and** When there is no longer a risk to staff and patients for exposure to COVID-19, as determined locally.

Personal Protective Equipment (PPE) Required for Infection Control Precautions.	***Unchanged:*** Infection control measures should be determined by the local or regional public health department. Refer to the Centers for Disease Control and Prevention (CDC): cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html **Airborne Precautions:** cdc.gov/infectioncontrol/pdf/airborne-precautions-sign-P.pdf • N95 respirator or higher **Droplet Precautions:** cdc.gov/infectioncontrol/pdf/droplet-precautions-sign-P.pdf • Surgical Mask • Face shield or eye shield **Contact Precautions:** cdc.gov/infectioncontrol/pdf/contact-precautions-sign-P.pdf • Disposable gown • Gloves **Standard Precautions:** cdc.gov/infectioncontrol/basics/standard-precautions.html • Used for all patients • Assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting • Based on a risk assessment and making use of common-sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient **Universal Precautions:** osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html • Universal precautions apply to blood and other body fluids containing visible blood
Home Visits (HV) Protocol	***Unchanged:*** • Refer to the CDC, specifically "Protections that Pertain to Field-Based Public Health Staff" located at: cdc.gov/coronavirus/2019-ncov/hcp/non-covid-19-client-interaction.html#protections-public-health-staff

Clinic Visits (CV) Protocol	***Unchanged:*** • Refer to the CDC, specifically "Protective Measures That Pertain to Public Health Clinical Settings" located at: cdc.gov/coronavirus/2019-ncov/hcp/non-covid-19-client-interaction.html#protective-measures-public-health-settings

Attachment 1: Protocols to Minimize Staff and Patient Exposure to COVID-19

Home Visits (HV) Protocol

HVs during COVID-19 require additional precautions. Consider HV as an option if it is not possible for the patient to come into the clinic or be seen through other locally determined means. If an HV occurs, all efforts should be made to meet outside, maintaining six feet distance, using PPE as necessary, and minimizing passing of pens, papers, or other potential fomites when possible. When signatures are required, leave the pen with the patient if they must sign, if sanitizing the pen is not possible after HV. ***Follow local PPE protocols during COVID-19.***

Prior to HV

1. Call patient/guardian and ask about any new symptoms that have changed from any TB symptoms they had at baseline (if it is the first visit, this is the baseline). Use the questions below, unless otherwise directed by PHR/LHD COVID-19 questionnaire:
   1) Have you been exposed, that you know of, to COVID-19? This may include any travel in the past 14 days.
   2) Has anyone in the household been exposed to COVID-19 or is anyone in the household experiencing any of the symptoms (fever, shortness of breath, or cough) or is currently under Quarantine for COVID-19?
   3) Do you have a new/worsening cough?
   4) Do you have difficulty breathing or shortness of breath?
   5) Do have you fevers? What degree? _____F
   6) Do you have (*insert additional COVID–19 symptoms here as determined locally*)?

   Response to Answers 1-2

   If either is YES:
   - **Stop** and do not proceed with HV; contact the treating physician and supervisor for an individual plan of care.

   If both are NO: Proceed to the next questions.

   Response to Answers 3-6

   If any are YES:
   - **Stop** and do not proceed with HV; contact the treating physician and supervisor for an individualized plan of care.
   - If the treating physician and supervisor determine the need to proceed with HV, follow local protocols for COVID-19 disease screening, reporting, and recommendations on PPE before the visit.

   If all are NO:
   - At a minimum, use standard precautions if the health care worker can maintain six feet of distance (if the patient is still in TB airborne isolation, use an N95 or higher). Use at minimum, an N-95 or higher anytime sputum collection is required, as this is an aerosolizing procedure. Sputum collection should be done outside when possible.

2. If proceeding with HV, a supervisor should view documentation of the ***Self Observation Log*** (Attachment 3) to ensure the staff member is able to make an HV.

When performing an HV:

- Enter home, taking in the minimum necessary supplies; avoid touching anything upon entry.
- Use hand sanitizer and offer to the patient (do not hand them the bottle).
- Put on PPE as specified by PHR/LHD protocols.
- When HV is complete, remove gloves appropriately if worn (inside-out).
- Remove and discard PPE as specified by PHR/LHD protocols.
- Leave home.
- Use hand sanitizer.
- Wipe down any surfaces that may have touched something in the home.
    - Consider placing folders, papers, and pens in a zip-lock baggie that may be wiped down before and after the visit.
- Reminder: wash hands regularly, do NOT touch face, mouth, nose.

Clinic Visit (CV) Protocol

When CVs occur, all efforts should be made to meet the patient before entering the clinic, maintaining six feet distance, using PPE, and minimizing any passing of pens, papers, or other potential fomites when possible. Before and after the CV, the clinic room and any equipment used should be cleaned and/or sanitized. ***Follow local PPE protocols during COVID-19.***

Prior to CV

1. Call patient/guardian to ask about any new symptoms that have changed from any TB symptoms they had at baseline (if it is the first visit, this is the baseline). Use the questions below unless otherwise directed by PHR/LHD COVID-19 questionnaire:
    1) Have you been exposed, that you know of, to COVID-19? This may include any travel in the past 14 days.
    2) Has anyone in the household been exposed to COVID-19 or is anyone in the household experiencing any symptoms (fever, shortness of breath, or cough) or currently under Quarantine for COVID-19?
    3) Do you have a new/worsening cough?
    4) Do you have difficulty breathing or shortness of breath?
    5) Do have you a fever? What degree? _____F
    6) Do you have (*insert additional COVID–19 symptoms here as determined locally*)?

Response to Answers 1-2

If either is YES:

- **Stop** and do not proceed with CV; contact treating physician and supervisor for an individual plan of care.

If both are NO: Proceed to the next section.

Response to Answers 3-6

If any are YES:

- **Stop** and do not proceed with CV; contact treating physician and supervisor for an individualized plan of care (consider if this is an active TB case vs. TB infection vs. contact).
- If the treating physician and supervisor determine the need to proceed with CV, follow local protocols for COVID-19 disease screening, reporting, and recommendations on PPE prior to the visit.

If all are NO:

- Use *at minimum*, standard precautions if the health care worker can maintain six feet distance (if the patient is still in TB airborne isolation, use an N95 or higher). Use *at minimum*, an N-95 or higher anytime sputum collection is required, as this is an aerosolizing procedure. Sputum collection should be done outside or in sputum induction booths when possible.

2. If proceeding with a CV, the supervisor should view the documentation on the ***Self Observation Log*** (Attachment 3) to ensure the staff member is able to work in the clinic.

When arranging a CV:

- Coordinate with the patient before entering the clinic. Meet at the entrance of the clinic and escort to the clinic room to avoid waiting.
- Ensure those accompanying patients are screened per local protocols.
- Perform visit with PPE as determined by the PHR/LHD.
- Wipe down any surfaces that may have been touched during the visit.
- Reminder: wash hands regularly, do NOT touch face, mouth, nose.

Tuberculosis Action Plan to Minimize Exposure to COVID-19

Attachment 2: COVID-19 Screening Logs for Patients Prior to TB Home or Clinic Visit

Patient Name:	**DOB:**
Telephone:	
Call patient/guardian to ask about any new symptoms that have changed from any TB symptoms they had at baseline (if first visit, this is the baseline). **Call prior to each scheduled visit.**	

Signs/Symptom Screen: (Y) = Yes (N) = No To be completed prior to each visit

MONTH/YEAR:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
1. Have you been exposed, that you know of, to COVID-19? This may include recent travel* (Y/N)																
2. Has anyone in the household been exposed to COVID-19, is currently under Quarantine for COVID-19, or is experiencing cough, shortness of breath or fever**? (Y/N)																
3. Do you have a new/worsening cough? (Y/N)																
4. Do you have difficulty breathing or shortness of breath? (Y/N)																
5. Do have you a fever**? (Y/N) What degree? _____F																
6. Do you have any additional symptoms (insert here)?																
Employee Initials																
Interpreter Initials																

	17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
1. Have you been exposed, that you know of, to COVID-19? This may include recent travel* (Y/N)															
2. Has anyone in the household been exposed to COVID-19, is currently under Quarantine for COVID-19, or is experiencing cough, shortness of breath or fever**? (Y/N)															
3. Do you have a new/worsening cough? (Y/N)															
4. Do you have difficulty breathing or shortness of breath? (Y/N)															
5. Do have you a fever**? (Y/N) What degree? _____F															
6. Do you have any additional symptoms (insert here)?															
Employee Initials															
Interpreter Initials															

* cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

**Fever is either a measured temperature ≥100.0°F or subjective fever. Note: fevers can be intermittent or absent in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0°F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue).

Tuberculosis Action Plan to Minimize Exposure to COVID-19

Preparing for the Visit
Response to Answers **1-2** **If YES: Stop** and do not proceed with visit; contact treating physician and supervisor for individual plan of care. **If NO:** Proceed to next section. Response to Answers **3-6** **If YES: Stop** and do not proceed with visit; contact treating physician and supervisor for individualized plan of care (consider if this is an active TB case vs. LTBI vs. contact). ○ If treating physician and supervisor determine the need to proceed with visit, follow local protocols for COVID-19 disease screening, reporting, and recommendations on PPE prior to visit. **If NO:** ○ Prepare for the visit by coordinating with patient prior to visit; instruct them on any changes to expect. ○ Use *at minimum* standard precautions if health care worker can maintain six feet distance (if patient is still in TB airborne isolation, use an N95 or equivalent). Use *at minimum* an N-95 or equivalent anytime sputum is collected, as it is an aerosolizing procedure; preferably collect outside or in sputum induction booths if possible. ○ Follow process on DOT visits to include maintaining six feet distance, using *at minimum* universal precautions for handing over of medications, and locally developed plan for documentation. ○ Follow local protocols on PPE prior to visit**. Practice frequent hand hygiene;** don't touch nose, eyes, mouth.

Date	Notes/Comments on Responses
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Signature(s) of staff **Date**

COVID-19 Screening Logs for Patients Prior to TB Home or Clinic Visit, continued from previous page

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Attachment 3: COVID-19 Self-Observation Log for TB Staff

Name:	**Program:**	**Telephone:**

Take your temperature (oral or temporal) ***as frequently as recommended by Local/Regional Medical Director***. Temperatures should be taken before brushing teeth and prior to drinking hot/cold liquids. Document temperature and signs and symptoms listed below. If you have a sign or symptom, mark "+" on the day and report to your supervisor. Each column represents the day at the top of the column (for example, information for the 13th of the month is marked in the column with the "13" at the top). Print and sign your name at the bottom and turn in to the supervisor at the end of the month. **Frequency (supervisor check all that apply):** ☐ Morning (A.M.) ☐ Noon (P.M.) ☐ Evening (Eve)

Signs/Symptom Screen: + = Yes -- = No * If temperature is greater than 100.4°F, notify your supervisor

	MONTH/YEAR:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
A.M.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
P.M.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
Eve.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																

	MONTH/YEAR:		**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
A.M.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
P.M.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
Eve.	Temperature (oral or temporal), °F*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																

Signature of staff **Signature of Supervisor** **Date**

Attachment 4: Prioritization of TB Program Activities

Activities that must CONTINUE

- Evaluation of high-priority suspects (class V).
- Evaluation of new TB cases (class III).
- Management of TB cases and suspects on therapy.
- Evaluation of patients with TB infection based on Texas TB Work Plan prioritization recommendations.
- Management of patients on treatment for TB infection, with modifications as outlined in this document (i.e. may limit in-person monthly examinations where possible).
- Medication administration to patients on treatment for TB disease, contacts to cases with TB infection (including window prophylaxis), and others with TB infection- when given by direct observation, follow HV/CV protocols as determined locally.
- Contact investigations prioritized as high or medium; limit large group testing where possible so that social distancing can be maintained.
- In-person assessments for patients with TB infection who need monthly laboratory specimen collected.*
- Reporting of new cases, suspects, and contacts to DSHS Central Office.
- Submission of the Annual Progress Report.
- Evaluation of EDN referrals.
- Investigation of large TB clusters (10 cases or more).
- Collecting monthly jail reports.*
- Collecting annual jail plans.*
- Reporting Incident Reports to the TB Unit.*
- Cohort review.*

Activities that may continue AS RESOURCES ALLOW

- Low Priority CIs.
- Cluster investigations with fewer than 10 cases.
- Targeted testing.*

**re-prioritized as of October 1, 2021*