Virginia Department of Health
Tuberculosis Service Plan

Name_____ **WebVision#**_____

DOB _____ **ICD9 #** _____

Goal: Reduce morbidity and transmission with the community.
Objective: Identified case/suspect will complete recommended treatment plan and follow-up within standard timeframes.

DATE	IDENTIFIED NEEDS/PROB.	PLAN	DATE COMPLETED	PHN SIGNATURE
	Medical diagnosis affecting health status: Active tuberculosis disease	1. Assess medical history and risk factors for acquiring TB infection or for progression to active disease. Complete medical and social history. Assess for symptoms compatible with active TB . 2. Evaluate status of diagnostic evaluation. Obtain copies of all pertinent test results and medical records from physicians, hospitals, labs, etc. (TST results, CXR reports, HIV test results, bacteriology reports, treatment information, etc.) 3. In collaboration with medical provider and/or health director, arrange for completion of diagnostic examinations, if needed. 4. If patient hospitalized or incarcerated, ensure completion and approval of TB Treatment/Discharge Plan (2005A-TB-004) prior to release. Assure discharge appropriate for patient and plans in place for continuity of care. Assure that placement is appropriate and no high-risk individuals present in environment. LHD may request 2005A-TB-004 for any TB case/suspect at the health director's discretion. 5. Assess current treatment plan for conformity to ATS/CDC/ISDA recommendations. Take immediate action, within local district guidelines, to determine reason for deviation to treatment regimen and resolve issue. Involve health director, if needed. 6. Re-calculate all medication dosages. Review entire medication profile for potential drug-drug, drug-herbal and drug-food interactions. Assess for known drug allergies. 7. Arrange for medical management if no medical home. 8. Perform or arrange for Directly Observed Therapy (DOT) according to local and state guidelines. If treatment is not administered by DOT, document reason and initiate acceptable alternative compliance monitoring. Sign DOT Agreement. 9. Assess and monitor monthly for compliance with treatment regimen, clinical response to therapy (symptom reduction, weight and appetite increase, etc.), side effects and barriers to care. 10. Assess for potential infectiousness and initiate contact investigation as appropriate within local and state guidelines. 11. Patient education: a. Discuss difference between TB disease vs. TB Infection b. Instruct on signs/symptoms of tuberculosis, how		

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		transmitted, prevention activities and treatment. c. Explain that TB is both treatable and preventable. d. Instruct patient on importance of completion of treatment. e. Discuss diagnostic procedures used to make diagnosis of TB such as CXR, sputum, and TST. Stress importance of testing and follow-up. f. Discuss current medical treatment plan and rationale. g. Instruct on need for regular medical monitoring and follow-up during disease process. Discuss how treatment will be monitored (i.e. sputum, blood tests, vision screening, weight check, etc.) Encourage patient to be active participant in care and treatment. h. Discuss roles of patient (engage in trt.), discuss role of health department(case mgmt., monitoring, contact tracing, supervision of treatment), and role of private provider (treatment & monitoring) . Encourage patient to contact case manager for issues and problems that arise during treatment. i. Discuss risk of treatment relapse or failure and need to complete treatment to prevent relapse. j. Instruct patient on signs/symptoms of possible relapse/failure to report immediately to case manager		
	Medical diagnosis affecting health status: Latent tuberculosis infection	1. Assess medical history and risk factors for acquiring TB infection or for progression to active disease. 2. Evaluate status of diagnostic evaluation. Obtain copies of all pertinent test results and medical records from physicians, hospitals, labs, etc. (TST results, CXR reports, bacteriology reports, treatment information, etc.) 3. In collaboration with medical provider and/or health director, arrange for completion of diagnostic examinations, if needed. 4. Assure that active TB disease is adequately ruled-out before diagnosis of LTBI is finalized and any treatment for LTBI is initiated. 5. Assess and monitor monthly for compliance with treatment regimen and side effects.		

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		6. Patient education: a. Instruct on signs/symptoms of tuberculosis, how transmitted, prevention activities and treatment. b. Discuss difference between TB disease vs. TB infection c. Discuss diagnostic procedures such as CXR and TST used to make diagnosis of TB infection. Stress importance of testing and follow-up. d. Discuss recommended treatment plan and rationale. Discuss risk and benefits to patient of preventive treatment. Discuss risk of potential active TB if treatment not accepted. 7. Encourage patient to contact case manager for issues and problems that arise during treatment.		
	Potential for recent TB Infection: Identified as contact to active TB disease	1. Instruct on signs/symptoms of active tuberculosis disease, how transmitted, prevention activities and treatment. 2. Discuss difference between TB disease vs. TB Infection 3. Discuss diagnostic procedures used in diagnosis of active TB and LTBI and meaning of potential test results. 4. Arrange for evaluation of contact as appropriate for history. Stress importance of planned evaluation and follow-up. 5. Explain that TB is both preventable and treatable. Discuss possible treatment scenarios based on personal history and evaluation outcome. 6. Monitor until evaluation process and any recommended treatment is completed. 7. Instruct on signs/symptoms of concern to report after completion of evaluation/treatment to case manager.		
	Potential for drug side effects/toxicity	1. Instruct patient on names, dosages and rationale for drug treatment plan as well as importance of treatment. 2. Instruct patient on common side effects and methods to improve symptoms. 3. Instruct patient on signs and symptoms of drug toxicity. 4. Instruct patient on actions to take if side effects or signs and symptoms of toxicity appear. 5. Schedule monthly clinical assessment with physician or case manager. 6. Collect appropriate lab work for patient to		

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		monitor for toxicity. 7. Perform other monitoring tests as appropriate for treatment plan, i.e. vision while on ethambutol, hearing while on ototoxic med. 8. Instruct patient on potential effects of ETOH/drug use on treatment and increased risk for side effects/toxicity. 9. Assess patient use of other prescribed medications as well as OTC meds and herbals. Assess medication list for potential for interactions. Instruct patient on personal potential for interactions and signs/symptoms to immediately report to case manager.		
	Need for isolation/precautions if infectious	1. Assess for potential infectiousness. If deemed infectious, follow standard infection control procedures. 2. Collect additional sputum samples according to DTC guidelines to monitor infectiousness and conversion. 3. Instruct on isolation precautions and restrictions, if appropriate. Sign isolation contract. 4. Instruct on patient behavior changes needed for infection control. • Discuss permitted and prohibited activities. • Discuss limiting/excluding visitors. • Discuss covering during cough/sneeze • Discuss use of mask 5. Instruct on home environmental changes needed for Infection control. • Discuss ventilation and sunlight. • Discuss disposal of items soiled with potentially infectious material. 6. Discuss requirements for release from isolation. Provide written documentation for clearance, when appropriate. Advise patient clearance is contingent upon clinical condition and continued compliance with treatment regimen.		
	Potential for communit transmission of TB. Potential need for Contact Investigation	1. Assess for potential infectiousness. 2. Conduct interview with client for identification of potential contacts. • Determine time period of potential infectious period. • Determine places and activities during infectious period		

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		• Determine names/contact information of known people or places of possible exposure. 3. Discuss contact investigation process with client. Reinforce confidentiality of investigation but warn client of potential for contacts to guess identity. 4. Evaluate contacts according to VDH/DTC guidelines. Evaluate all contacts with risk assessment and appropriate evaluation, testing, treatment and follow-up , as required. 5. Maintain awareness for identification and evaluation of additional contacts. 6. Complete investigation and contact evaluation within appropriate timeframes.		
	Housing Needs	1. Assess housing options; assess for need and qualification for VDH HIP program. 2. Encourage patient to accept realistic housing options. 3. Provide information on community resources with phone numbers and encourage follow through. 4. Discuss financial concerns including job prospects, educational needs, utility costs, furnishings, etc. 5. Make referrals as needed to community svcs/prog.		
	Potential for non-compliance with appointments and prescribed treatment	1. Assess individual's ability and willingness to engage and participate in treatment plan. Assess for overt hostility towards case manager/diagnosis of TB. 2. Instruct on the importance of regular monitoring visits. 3. With client, identify potential barriers to treatment and adherence to treatment. 4. With client, establish mutual goals and plans for treatment and outcomes. 5. Monitor compliance and reschedule appts. as soon as possible. 6. Assist with problem-solving reasons why non-compliance occurs, make plans as needed. 7. Review Virginia TB Control Laws and actions that may be taken if non-compliant with treatment course. 8. Review community resource guide for transportation and other services such as child care, etc. that may assist in compliance. 9. Provide appropriate incentives and enablers to remove barriers and reward effective efforts. 10. Make referrals as needed. 11. Enroll patient in DOT program. Patient will assist in developing DOT schedule. Offer scheduling alternatives		

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		when feasible.		
	Non-compliance with prescribed medical treatment and follow-u appointments	1. Instruct on importance of treatment and follow-up for active tuberculosis. 2. Advise patient on Virginia laws regarding TB disease and isolation. Advise patient on responsibilities and expected behavior regarding treatment compliance and follow-up activities. 3. Initiate corrective action for non-compliance according to local and state policies and procedures. Evaluate with local health director for possible official Counseling Order, Outpatient Treatment Order or Emergency Detention Order.		
	Potential for cultural barriers to treatment.	1. Allow patient to discuss beliefs about TB disease process and treatment. 2. Instruct patient on treatment plan and expectations. 3. Accommodate patient beliefs and needs in treatment plan as much as possible. Mediate differences between traditional practices and expected health practices. Instruct patient regarding issues that are not negotiable. 4. Identify potential/actual sources of TB-related stigma. 5. Provide reassurance that TB can be cured and Expectation is for full recovery. Tailor message for indiv with drug resistant disease.		
	Potential Language Barrier	1. Assess patients ability to speak and understand instructions, including not speaking English as primary language, deaf, speech deficit or learning disabled. 2. Assess literacy in primary language. 3. Provide all instruction and communications in appropriate lang 4. Utilize Tele-interpreters, 711-relay, e-mail or visual education methods to promote understanding. 5. If ORW available, match language/culture of patient with ORW, if possible. 6. Provide patient with language and reading level appropriate educational materials. 7. Make referrals to appropriate service and notify of language/comprehension concerns.		

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	Multiple medical providers/ Coordination of care	1. Provide regular up-dates to PCP/other providers to assist with continuity of care 2. Enc. compliance with doctor visits/ reschedule appts. as soon as possible 3. Maintain communication with patient on status of all visits. 4. Maintain communication with care providers regarding status of tuberculosis treatment. 5. Make referrals to community programs as needed.		
	Mental retardation Emotional problems Mental illness	1. Instruct responsible patient/family member on support services available for assistance with needs. 2. Make appropriate referrals for evaluation and services. 3. Monitor compliance with appts. and any medications. 4. Provide DOT for TB treatment. 5. Provide psychosocial support.		
	Substance abuse (ETOH/Drugs/Tobacc	1. Inquire about pt. drug/ETOH/tobacco history and current usage. 2. Instruct on effects of use on pt. and potential for interference with treatment of TB disease including increased risk of drug toxicity. 3. Monitor pt's behavior/environment for current use. 4. Refer to counseling and monitor compliance with TB treatment plan. 5. Make referrals to substance abuse programs as needed.		
	Nutritional Support	1. Instruct on nutritional guidelines for age, including food choices, preparation and portions. 2. Discuss impact of nutrition on TB disease process 3. Instruct on community/emergency services that will Help with food; food closet/WIC/food stamps, etc. 4. Access funding from VDH HIP program, if qualified 5. Enc. to apply for appropriate food programs. 6. Make referral to community services as needed 7. Monitor weight change. 8. Provide supplements such as Ensure, if appropriate. 9. Make referrals for evaluation by nutritionist as needed		
	Social Support	1. Assess client support system. Encourage patient to identify positive support including family, friends, peers. 2. Assess education level 3. Assess job training/employment needs. 4. Make referrals to appropriate community programs/services/cl 5. Provide encouragement.		

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