



## Tuberculosis Control Program Health Facility Discharge Planning Guidelines

### Discharge of a Suspect or Confirmed Tuberculosis (TB) Patient

California State Health and Safety Codes mandate that patients with confirmed or suspected TB may not be discharged or transferred without prior Department of Public Health approval, unless the patient is being transferred to another health facility due to an immediate need for a higher level of care (though the Department of Public Health still needs to be notified of the patient's transfer). In order to ensure timely and appropriate discharge, providers should notify the Department of Public Health 1 – 2 days before anticipated discharge date.

### Tuberculosis Control Program (TBC) Response Plan

#### **Weekday Discharges – Non Holiday, Monday – Friday, 8 am to 4 pm**

Send a completed discharge request form by fax to (909) 381-8471 **AND** follow up with a phonecall to the Discharge Coordinator in the Tuberculosis Control Program (TBC) at (800) 722-4794. Include sputum smear and culture results, radiology reports, and any other supporting documentation. TBC staff will provide a response within 24 hours.

TBC staff will review the request and notify the submitter of approval or of the need for additional information or action prior to discharge. If a patient is still infectious, a home evaluation may be required to ensure the environment is suitable. TBC staff will make a home visit within 3 working days of notice. If the patient is homeless or there is concern for non-compliance, TBC staff will interview the patient prior to discharge. This interview will take place within one working day of notification to TBC.

#### **Holiday & Weekend Discharge**

Providers may page the Public Health Duty Officer at **(909) 677-7168**. Response time will usually be within one hour. After receiving a hospital call, the duty officer will request the hospital to immediately fill out the Confidential TB Discharge Plan and fax it to TBC. If the duty officer can confirm over the phone that the case in question meets all of the criteria listed below, he/she may verbally approve the discharge, to be reviewed on the next business day by the TB Controller.

#### **TB Criteria for Discharge**

- Patient is sputum smear acid fast bacilli (AFB) negative x 3.
- Sputum collection criteria: 1) Three sputa collections at least 8-24 hours apart with one being an induced early morning collection and 2) and obtain 2 MTB PCR nucleic acid amplification test (NAAT) on two respiratory specimens for rapid detection within 24-48 hours
- Patient is on a clinician prescribed regimen of treatment for TB for at least 2 weeks for a smear positive and 5 days for a smear negative and tolerating.
- There are no immunocompromised individuals, newborns, or children under 5 years old residing at the site to which the patient is being released, unless these individuals have been medically evaluate and are on appropriate prophylactic treatment.
- The patient is returning to the same household where he/she resided prior to hospitalization.
- The patient's address and phone number are known, permitting Department of Public Health follow up.

If these criteria cannot be met, discharge cannot be approved and the patient **MUST** be held until the criteria are met.

## EXPLANATION OF SELECTED QUESTIONS LISTED ON DISCHARGE REQUEST

### 1. COUNTRY OF ORIGIN/TRAVEL

This provides important information about the patient's risk of having TB and having drug-resistant TB.

### 2. Admission CXR/Current CXR:

The admission CXR provides critical information, as this might be the only clinical evidence a provider has that indicates the patient is a TB suspect. The most suspicious CXRs would show cavitory lesions in the upper lobes, but TB can also present as infiltrates or consolidation in the upper or lower lobe, as a pleural effusion, etc. Immunocompromised patients and children tend to have the least "typical" findings. The current CXR is also very important as this gives us information on the patient's progress. **PLEASE FAX ADMISSION AND/OR CURRENT CXR REPORTS.**

### 3. IGRA (Interferon Gamma Release Assay):

This is an important tool that can aid in the diagnosis of *Mycobacterium tuberculosis* infection. There are currently two FDA approved IGRA tests available in the United States: the QuantiFERON Gold test (QFT) and the T-SPOT test (T-Spot).

### 4. MAJOR SITE OF DISEASE:

This tells us about the patient's possible infectiousness. TB can affect all organs of the body. TB is spread via respiratory droplets. Laryngeal and pulmonary TB are the most communicable. Extra-pulmonary TB is not a public health threat; however, it must be reported and treated appropriately to prevent dissemination.

### 5. HIV STATUS/HIV LABS:

HIV status and level of immune suppression profoundly affect how TB presents and how it is treated. All TB patients should be tested for HIV if their status is unknown. If a TB patient is HIV+, **please provide the CD4 count and viral load.**

### 6. CO-MORBIDITIES/COMMENTS

Many conditions besides HIV can affect how TB presents and is treated, e.g. diabetes, renal disease, auto-immune disorders. Medications for other illnesses may also interact with TB meds. Please provide information on the patient's underlying medical conditions and other medications they will be taking when discharged.

### 7. BACTERIOLOGY:

This section helps Public Health in preparing discharge guidance. Patients can be safely discharged into a High Risk Setting or a Lower Risk Setting.

- a. High risk settings can be housing (i.e. SNF, LTACH, prison/jail, Dialysis centers) or a work setting where others can share air with the TB patient or suspect for tuberculosis. Discharge criteria for this group is:

- i. Collect 3 sputum 8-24 hours apart (one in early morning) for acid fast bacilli (AFB) smear, culture and susceptibility testing.
- ii. Obtain MTB PCR nucleic acid amplification test (NAAT) on at least two separate respiratory specimen for rapid detection within 24-48 hours
- iii. Have completed and tolerated a TB regimen for at least 2 weeks for a smear positive and 5 days for a smear negative.

*If the above is not met the patient must go into a negative pressure room.*

- b. Low risk setting can be a place of residence. This is a setting where others do not share the air with the TB patient or suspect. It is also somewhere where the persons sharing the air with the TB patient are not at increased risk for progressing to the disease, if infected.
- c. Persons at increased risk for progressing to TB disease if they become infected are: children <5 years old, those infected with HIV, poorly controlled diabetics, those with end stage renal disease, intravenous users, cancers of the head and neck, those on anti-TNF- $\alpha$  agents, those receiving chemotherapy, organ recipients, lymphoma, leukemia, those who have had gastric bypass surgery or agastrectomy, low BMI, chronic malabsorption, and silicosis.

## PLEASE FAX ALL LABORATORY REPORTS.

### 8. SENSITIVITIES:

This information is not usually available by the time a patient is discharged – it can take several weeks after a TB culture grows out before this testing can be done. However, if this information is known, the patient’s medication regimen may need to be adjusted. **If drug resistant TB is suspected** – the patient has been treated for TB in the past or is failing treatment, the patient comes from an area of the world with high rates of drug resistance, or the patient is known to have been exposed to someone with drug-resistant TB) – special rapid molecular testing can be done at the California Dept. of Public Health State Lab. This testing can be arranged through TBC.

### 9. TB MEDICATION REGIMEN:

Most TB suspects or cases need to be on the RIPE regimen: Rifampin (RIF), Isoniazid (INH), Pyrazinamide (PZA) and Ethambutol (EMB). There are other second line medications; however, they are typically not prescribed unless the patient is resistant to or cannot tolerate first line drugs. Please call TBC with any questions regarding adult or pediatric dosages and appropriate alternative regimens. Please include the start date and the dosages of all TB medications.

### 10. DISCHARGE PLANS:

- a) Anticipated Date of Discharge: Please give TBC at least 24-72 hours’ notice before patient is to be discharged.
- b) The TBC Program needs detailed information regarding the destination of discharge. TBC may need to perform a home visit or a visit with the patient in the hospital prior to discharge.
- c) The TBC Program must be aware of the number of children, adults, and immunocompromised persons in the household; infants are of special concern

- dueto the risk of progression to disseminated TB or TB meningitis.
- d) If discharging the patient on medication, please give or prescribe enough meds to last until the first follow up appointment with medical provider or TBC.

#### 11. WHO WILL PROVIDE TB CARE?

This information is extremely important and discharge will not be approved until a follow up appointment is made for the patient. Please provide us with the name and contact information of the clinician who will be providing TB care as we are mandated by law to follow all TB cases in the county. If a patient has a clinician, please provide this information also.

Submission of the attached form for discharge request will also fulfill state requirements for disease reporting. NO ADDITIONAL FORM IS REQUIRED.

#### **References**

Heartland National TB Center . (2019, June). *www.HeartlandNTBC.org*. Retrieved May 11, 2021, from [www.heartlandNTBC.org](http://www.heartlandNTBC.org)



**TUBERCULOSIS DISCHARGE PLAN  
SUSPECT / DISCHARGE REPORT FORM  
Phone: (800) 722-4794 Fax: (909) 381-8471**

Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

Contact person: \_\_\_\_\_

Fax: \_\_\_\_\_

<input type="checkbox"/> (A) SUSPECT REPORT			Date Submitted:		
Name:		Sex:	D.O.B.:	Age:	
Current Address:			Phone:		
Legal Guardian:	Payor Source:	SSN:	Country of origin/travel history <sup>1</sup> :		
MR #:	Location:	Admit Date:			

**Clinical Information**

Admission CXR <sup>2</sup> : <input type="checkbox"/> NEAD <input type="checkbox"/> ABN-Cavitary <input type="checkbox"/> ABN Non-cavitary		Current CXR: <input type="checkbox"/> Worse <input type="checkbox"/> Improved <input type="checkbox"/> No change <input type="checkbox"/> None			
Patient weight/Kg	IGRA blood test: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Previous HX of TB: <input type="checkbox"/> Yes <input type="checkbox"/> No		Major site of disease <sup>4</sup> :
HIV Status <sup>5</sup> : <b>Provide copies of HIV results, CD4 count, and Viral Load for HIV positive patients<sup>5</sup>.</b>					
Why is patient a TB suspect? <input type="checkbox"/> Symptoms <input type="checkbox"/> CXR <input type="checkbox"/> Other (explain)					
TB Symptoms: <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Wt. loss <input type="checkbox"/> Other:					
Co-morbidities/comments <sup>6</sup> :					

<input type="checkbox"/> (B) DISCHARGE PLAN REQUEST	Date Submitted:
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**BACTERIOLOGY<sup>7</sup>**

PULMONARY TB REQUIRES 3 CONSECUTIVE SPECIMEN SMEARS				Specimen submitted for sensitivities to laboratory <sup>8</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Specimen Date	Source	Smear	Culture	Specimen Date	Source	Smear	Culture

**TB Medication Regimen<sup>9</sup>**

Medication	Dosage	Start Date	Medication	Dosage	Start Date
Rifampin					
INH					
PZA					
Ethambutol					
B <sub>6</sub>					

**DISCHARGE PLANS<sup>10</sup>**

Date of Discharge:	Discharge to: <input type="checkbox"/> Home <input type="checkbox"/> SNF	Discharge Address if not home:
Household: # of Adults	# of children	ages of children
Patient's Verbal Understanding of TB dx: <input type="checkbox"/> Yes <input type="checkbox"/> No		# of immunocompromised
TB Care provided by <sup>11</sup> : <input type="checkbox"/> Other		Follow up TB provider Name:
Health Dept.: <b>606 E. Mill St. San Bernardino, CA 92415</b>		Medical Provider Name:
<b>Phone Number: 800-722-4794</b>		Phone:
<b>Appt Date:</b>		<b>Appt Date:</b>
Final DX (if not TB):		

<input type="checkbox"/> (C) TUBERCULOSIS CONTROL PROGRAM REVIEW
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Discharge Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Problems Identified: <input type="checkbox"/> Yes <input type="checkbox"/> No	Action required prior to approval: <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		
Signed: For: Michael Sequeira, MD, Tuberculosis Controller	Title:	Date: Time: