INPATIENT MANAGEMENT OF NEWLY ADMITTED TB OR RULE OUT TB PATIENTS
When a patient is admitted to the hospital with TB or suspected TB diagnosis, the treating team will:

1. **Notify the Infection Prevention and Control Department**
   Communicate the patient's name, patient file number, unit, and bed number to Infection Prevention and Control at extension 57447.

2. **Institute Airborne Isolation for Suspected or Confirmed Pulmonary TB**
   The suspected or confirmed pulmonary TB patients will be placed in an appropriate Respiratory Isolation room:
   a. Respiratory isolation room will be a private room with single bath
   b. The area of isolation is the patient's room
   c. Patients will not be cohorted
   d. Respiratory isolation precautions will be the same for all pulmonary TB, including those that are multi-drug resistant
   e. Patients must wear a surgical mask while:
      - Being transported within the health facility or by car
      - Leaving the room for diagnostic procedures
   f. The door to the isolation room will be kept closed to maintain control over air-flow direction. The door will be kept closed even when the patient has temporarily left the room
   g. Post Airborne isolation sign on the door. This sign will list the precautions to be taken before entering the room
   h. Visitors and personnel must be instructed in proper application and fitting of the mask
   i. Instruct the patient to cover his/her mouth and nose with tissues during coughing

3. **Personal Controls**
   Personal fit tested respirators filter out infectious particles. All staff assigned to work with infectious TB patients must wear a disposable NIOSH-approved N95 or HEPA respirator while:
   - In a room with an infectious patient who is undergoing a high risk procedure such as Sputum Induction, Pulmonary Function Tests and Bronchoscopes
   - Occupying the room with an unmasked coughing, suspected, or confirmed smear-positive TB patient

- Entering the room previously occupied by an unmasked infectious TB suspect or TB case before sufficient time to clean contaminated air from the room has elapsed
- Transporting an infectious patient in an enclosed vehicle, even if the patient is masked
- Changing filters in the HEPA filtration machine

Failure of Health care workers (HCWs) to appropriately use personal protective equipment will result in disciplinary action per hospital policy. Each department manager is responsible for monitoring their personnel for compliance with hospital policies. N-95 Respirators will be readily accessible on the isolation cart for family/visitors.

4. Engineering Controls

The following are the minimum requirements for atmospheric isolation (negative pressure) rooms:

- A minimum of 12 air exchanges (ACH) per hour
- Negative pressure in relation to surrounding area
- Direct air exhaust to the outside or high efficiency particulate air (HEPA) filtration of any air which is re-circulated into the ventilation system.
- The ventilation system must be properly cleaned, maintained, and functional. It must be tested after installation, alteration, and maintenance, and at least annually to ensure it is functioning properly
- Records of each test must be kept for five years. All airborne precaution isolation areas must be identified and posted when in use as “Airborne Precautions or High-Risk Atmospheric Procedure.”

Airborne Isolation Rooms

3 West	Rm 6 13039
3 West	Rm 7 13041
PACU	Rm 2036

Facilities Management Staff will:

- Adjust air flow to create negative pressure in the atmosphere isolation room
- Install HEPA filter and change air flow to a continuous exhaust mode

- Monitor the room for negative pressure daily, i.e. via smoke check
- Monitor air exchange at least monthly to ensure it is at least 12 ACH
- Change HEPA filter according to manufacture instruction, at least once a year
- Document and maintain record of above air control activities

5. TB Evaluation and Diagnosis

A complete history and physical examination must be done. Medical history and physical examination consists of the elements as follows:

a. History of present illness and current symptoms
b. History of skin test results, TB exposures, previous treatment for latent TB infection (LTBI) or TB disease, or Bacille Calmette-Guérin (BCG) vaccination
c. Review of high-risk status situations, such as country of origin or current living situation (e.g., homelessness or congregate living)
d. Review of high-risk behaviors, such as drug and alcohol use
e. Review of current medications and allergies
f. Evaluation of HIV risk factors, including sexual activity
g. Review of medical conditions, including liver disease, diabetes, seizure disorder, malignancy, or other medical condition which may be associated with TB disease or which may interfere with TB medication
h. Assessment of pregnancy status in females
i. Review of systems
j. Social assessment, which includes an evaluation of ability to adhere to medication regimen.

6. Report to LA County TB Control Program as mandated by the California Health and Safety Code: Title 17, Chapter 4, section 2500**:** *Within twenty-four (24) hours of admission*, the physician or designee will complete and submit the Confidential Tuberculosis Suspect Case Report – Hospitalized Patient Report (Form H803, Attachment A) to TB Control via phone, fax, or mail. See directions on the backside of the form H803. The form H803 can be printed from Rancho Intranet under: “Forms.”

7. Sputum Collection

Patients suspected of having active TB will have three sputum samples for acid-fast bacilli (AFB) collected at least 8 hours apart, one of which should be an induced or early morning specimen, for smear and culture

- Sputum collection may be done in the patient's isolation room
- For a patient unable to produce spontaneous sputum, aerosol induction is advised and should be ordered by the physician. Request the Respiratory Care staff to collect the specimen. The employee must use strict airborne isolation precautions and proper PPE with N-95 respirator.

8. Baseline Lab

Baseline testing as recommended by the LA County TB Control Program for standard TB regimen (INH, RIF, PZA, and EMB) order are : CBC, LFT, Blood urea nitrogen, creatinine, glucose, uric acid, HIV Ab, UA, visual acuity, red-green color testing.

9. Institute appropriate drug therapy

Induction Phase:

The standard initial anti-TB regimen for TB suspect or confirmed TB cases should be treated initially with a four-drug regimen of Isoniazid (INH), Rifampin (RIF), Pyrazinamide (PZA), and Ethambutol (EMB), unless otherwise contraindicated. Multi-drug administration prevents the development of resistance and shortens the treatment length than the use of INH and RIF alone. For most patients, the initial treatment phrase is two months, but this phrase should be continued until the patient's sputum culture results are negative.

Continuation Phase:

This phrase of treatment usually consists of INH and RIF for four months to complete a total of six months treatment. If smears or cultures remain persistently positive, at least six months of therapy must be completed post culture conversion to negative.

Alternative treatment Regimens, treatment of Drug –Resistant TB, and treatment for HIV-infected Individuals and other detailed TB treatment information:

See TB Control Manual for details. The TB Control Manual is available on the DHS Web site at: http://lapublichealth.org/tb/TB%20Manual/TB_manual.pdf

10. Once the Diagnosis is Confirmed

When a new pulmonary TB case is confirmed, the medical provider will initiate a plan to transfer the patient to an appropriate facility. When the diagnosis is a non-pulmonary TB case, the medical provider will initiate treatment and report to LA County TB Control and the Infection Prevention and Control Department.

11. Education of Patients/Visitors

a. In collaboration with the nurse, physicians will provide the following education to the patient and document all education provided in the patient's medical record:
   - The patient must remain in his/her isolation room, except when necessary to leave for therapy, diagnostic tests, or bathing
   - Explain to the patient that he/she is not permitted free access to the cafeteria, unit, lobbies, clinic, and other patient rooms
   - The patient will be escorted and wear a properly applied surgical mask when leaving the isolation room. The patient will be instructed how to use, when to use, and where to use the face mask
   - The patient will be instructed to keep the door closed at all times, the importance of not visiting other patients and to always cover mouth and nose with tissues when coughing or sneezing and to dispose of the tissues in the proper receptacle as instructed

b. Nursing staff will be responsible for educating visitors entering the airborne isolation room regarding the application of the N-95 respirator that is secured and snugly fitted, while in the patient's room

c. The physician and nurse will document all education provided in the patient's chart

d. Patients failing to comply with precautions will be handled in the following manner:
   - The physicians will warn patient of consequences of non-compliance (i.e., notifying TB Control for Legal Order of Isolation)
   - If still non-compliant, notify the Risk Manager at x 57900 and report the patient to the LA County TB Control Program Office at (213) 744-6271 for disposition.

12. Monitor and Follow-up Evaluation

Upon discharge, the case should be approved by the LA County TB Control Program for discharge so that proper follow-up in the public health clinic or patient’s own

medical provider can be arranged. The following table specifies the minimum frequency of sputum and radiographic examinations for pulmonary TB Cases or Suspects per LA County TB Control:

Characteristic	Test	Interval
All Patients	Chest Radiograph	At three months, then at end-of-treatment
Smear Negative	Sputum smear and culture	Every four weeks until persistently negative cultures, and one at end of treatment
Smear Positive	Sputum smear and culture	Every two weeks until three negative smears
Culture-positive	Drug susceptibility studies	Repeat if still positive at three months

Other laboratory tests for drug-specific monitoring depend upon the specific TB treatment regimen being used, see table below:

Medication	Test	Interval
INH or PZA	LFTs	Monthly
Rifampin	CBC, LFTs	Monthly
PZA	Uric acid	As needed if abnormal or if symptoms of gout occur
EMB	Visual acuity, red-green color testing	As needed if abnormal or if symptoms of gout occur.
SM	a. Electrolytes, including blood urea nitrogen and creatinine b. Vesticular exam, audiogram	Monthly Monthly and as needed if symptomatic

13. TERMINATING ISOLATION

Patients may return to non-isolation rooms when they meet the following criteria established by the LA County TB Control Program:

A. Patient with only negative sputum smears

- Has three (3) consecutive negative AFB sputum smear results from sputum collected on different days; and
- Has completed a minimum of four (4) days of appropriate multi-drug anti-TB therapy; and
- Has continued close medical supervision, including direct observed therapy (DOT), if needed; and
- Continues multi-drug therapy pending negative culture results from at least three (3) sputum specimens.

B. Patient with positive sputum smears

- Has three (3) consecutive negative AFB sputum smear results from sputum collected on different days; and
- Has completed at least two (2) weeks of appropriate multi-drug anti-TB therapy; and
- Exhibits clinical improvement; and
- Has continued close medical supervision, including direct observation therapy, (DOT), if needed; and
- Continues multi-drug therapy, even if another pulmonary process is diagnosed, pending negative culture results from at least three (3) sputum specimens.

After respiratory isolation is terminated and if the patient still coughs, the patient should be instructed to cover his/her mouth and nose with tissues during coughing.

Note: Patients with multiple drug resistant (MDR) TB may require more stringent criteria; consult with LA County TB Control Program MDR Unit.

14. EMPLOYEE AND PATIENT EXPOSURE MANAGEMENT
See IC Policy 300E

15. DISCHARGE PLANNING
A medically stable patient with infectious TB can be treated entirely in the outpatient setting. Prior to discharging a TB patient:

a. Obtain discharge approval from TB Control
As of January 1, 1994, State Health and Safety Codes mandate that patients suspected or confirmed with TB may not be discharged or transferred from a hospital without prior Health Department approval.

b. Complete and submit the Tuberculosis Discharge Care Plan (Form H804, Attachment B) 24 hours prior to discharge by fax to (213) 749-0926; or by phone at (213) 744-6271. The H804 form can be printed from Rancho Intranet under “Forms.”
c. TB Control staff will review the discharge plan and notify the medical provider within 24 hours of approval plan or inform the provider of additional information or action that is required or needed prior to discharge
d. When weekend discharge is anticipated, the medical provider should make all arrangement for discharge in advance
e. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the TB Control Physician on call. Response will usually occur within one hour. If the discharge cannot be approved, the patient must be held until the next business day for appropriate arrangements to be made
f. Provide patient with appropriate TB medications and follow-up appointment
g. Notify Infection Prevention and Control prior to the patient being discharged or transferred

16. LA COUNTY TB CONTROL PROGRAM DISCHARGE AND TRANSFER GUIDELINES

Sputum Smear-Positive Pulmonary Tuberculosis Suspect and Laryngeal Tuberculosis Suspect

1) Criteria for discharge to home, with no high risk individuals[i] in the home:

   a) Appropriate TB treatment has been initiated that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection for California.
   b) A home evaluation performed by a Community Health Services (CHS) Public Health Nurse (PHN) is completed to assess environment and identify high risk individuals.
   c) The patient understands and can comply with home isolation until the Public Health Clinician overseeing the patient has determined that he/she is no longer infectious.
   d) There is a documented plan (Request for Hospital Discharge/Transfer Approval Form H-804) for continued TB care either by private physician or the Department of Public Health.

2) Criteria for discharge to home with high risk individuals in the home:

   a) Completed at least 14 days of multi-drug anti-tuberculosis therapy that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection and exhibits clinical improvement (e.g., reduction in fever and cough).
   b) A home evaluation performed by a Community Health Services (CHS) Public Health Nurse (PHN) is completed to assess environment and identify high risk individuals.
   c) All previously exposed high-risk individuals, including children 3 years old and younger are on appropriate LTBI treatment or window period treatment for presumed LTBI.

i) If a previously unexposed high risk individual enters the household while the patient is hospitalized, then patient must have three (3) consecutive AFB smear negative sputum.

d) The patient understands and can comply with home isolation until the Public Health Clinician overseeing the patient has determined that he/she is no longer infectious.
e) There is a documented plan (Request for Hospital Discharge Approval/Transfer Form H-804) for continued TB care either by private physician or the Department of Public Health.

3) Criteria for discharge into a high-risk setting[ii]

a) Have three (3) consecutive AFB smear-negative sputum collected at least 8 hours apart, one of which should be an induced or early morning specimen.
b) Completed at least 14 days of multi-drug anti-tuberculosis therapy that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection and exhibit clinical improvement (e.g., reduction in fever and cough).
c) The patient's ability to ambulate and perform all activities of daily living should be appropriate for the discharge setting
   i) If patient requires TB housing, client must be able to live independently.
   ii) If patient requires CHS transportation to and from clinic appointments, patient must be able to enter and exit a passenger vehicle independently.
d) Have continued close medical supervision, including directly observed therapy (DOT)
e) Continues multi-drug therapy, even if another pulmonary process is diagnosed, pending negative final culture results from at least three (3) sputum specimens.
f) There is a documented plan (Request for Hospital Discharge/Transfer Approval Form H-804) for continued TB care either by private physician or the Department of Public Health.

A pulmonary TB suspect can be presumed to have infection with non-tuberculous mycobacteria (NTM) if there are at least two (2) AFB smear positive respiratory samples which are 1) Nucleic acid amplification test (NAAT) negative for MTB and 2) Testing for the presence of inhibitors to the test are negative. Patient may be discharged into a high risk setting after consultation and approval of TB Control Program. [iii]

Pulmonary Tuberculosis Suspect with Negative Sputum Smears
Criteria for discharge:

a) Appropriate TB treatment has been initiated that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection for California (at least one dose taken and tolerated).
b) If being discharged to a high risk setting, the patient has completed at least five (5) days of multi-drug anti- tuberculosis therapy that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection.
c) There is a documented plan (Request for Hospital Discharge/Transfer Approval Form H-804) for continued TB care either by private physician or the Department of Public Health.

Known MDR-TB Case
Criteria for discharge:

a) Have three (3) consecutive AFB smear negative sputum specimens collected on separate days, one of which should be induced, an early morning specimen, or bronchoalveolar lavage (BAL), and no subsequent sputum specimen is smear positive.
b) At least 14 daily doses of MDR-TB treatment taken and tolerated.
c) Exhibit clinical improvement.
d) If being discharged to a high risk setting, the patient meets the above criteria AND has at least two (2) consecutive negative sputum cultures without a subsequent positive culture.
e) There is a documented plan (Request for Hospital Discharge/Transfer Approval Form H-804) for continued TB care either by private physician or the Department of Public Health.

Extra-pulmonary Tuberculosis Suspect
Criteria for discharge:

a) There has been an adequate work-up initiated which includes an evaluation of current symptoms, CXR, and sputum collection for AFB smear and culture (if abnormal CXR or immunocompromised)
b) Appropriate TB treatment has been initiated that is consistent with CDHS/CTCA Guidelines for the Treatment of Tuberculosis and Tuberculosis Infection for California (at least one dose taken and tolerated).
c) There is a documented plan (Request for Hospital Discharge Approval Form H-804) for continued TB care either by private physician or the Department of Public Health.

Inter-facility Transfer to Olive View Medical Center Infectious Disease Inpatient Unit
Criteria for transfer:

a) Refer to DHS Policy for Referral and Transfer of Tuberculosis Patients to the Olive View-UCLA Medical Center Infectious Disease Inpatient Unit.
b) Request for Hospital Discharge Approval Form H-804 must be submitted to TB Control Program.

County of Los Angeles • Department of Public Health •TB Control Program
TEL (213) 744-6160 FAX (213) 749-0926

Confidential Hospitalized TB Suspect/Case Report (H-803)

**PATIENT: _____
Last First MI

ADDRESS: _____

_____

PHONE (___) _____

BIRTH DATE: ___/___/___ Sex: ☐ Male ☐ Female

Social Security Number: _____

**IF PT. UNDER 18, (PARENT NAME/DOB):

_____

Employer/School: _____

OCCUPATION: _____

Race: ☐ White ☐ Black ☐ Am. Indian ☐ Alaska Native
☐ Asian (*Specify*)_____ ☐ Pacific Islander (*Specify*)_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Country of Origin: _____ Date of Entry: ___/___/___

Contact Person (name/ph#) _____

Date of Diagnosis ___/___/___ Pulmonary TB ☐

Skin Test Date ___/___/___ Chest X-ray Date: ___/___/___

Result _____ MM

☐ Not done ☐ Unknown

If Pulmonary, check symptoms.

☐ Cough ☐ Night sweats

☐ Sputum production ☐ Hemoptysis

☐ Weight loss _____(No. of lbs.)

RECORDED BY: _____

Phone (___) _____ Fax (___) _____

Hospital/Clinic where diagnosed _____

Medical Record # _____

Pt. currently hospitalized? ☐ Yes ☐ No Adm. Date: ___/___/___

Treating Physician: _____

Address: _____

_____

Phone (___) _____

Referred for F/U _____

Address: _____

_____

_____

Phone (___) _____

Will MD be continuing TB care? ☐ Yes ☐ No

Extra Pulmonary TB ☐ (Site) _____

Cavitary ☐ Non-Cavitary ☐

Impression: _____

_____

_____

Past history of TB Treatment? ☐ Yes ☐ No

If yes, where, when treated?

_____

If asymptomatic, reason for evaluation _____

Other medical conditions relevant to diagnosis:

_____

_____

BACTERIOLOGY

Pathology Report: _____

_____

Lab Name and Account #: _____

HIV STATUS DATE: ___/___/___

☐ POSITIVE ☐ NEGATIVE ☐ UNKOWN

☐ NOT DONE ☐ REFUSED ☐ PENDING

Patient weight _____

Psychosocial History: _____

_____

Allergies: _____

Specimen Number	Specimen Collection Date	Specimen Type	Smear AFB	Culture M.TB +/-

MEDICATIONS	DOSE	START DATE
Isoniazid		
Rifampin		
Rifabutin		
Ethambutol		
Pyrazinamide		
Rifamate®		
Other		

Additional Comments _____

_____

Date Reported ___/___/___

H-803

Rev: 7/06

COUNTY OF LOS ANGELES • DEPARTMENT OF PUBLIC HEALTH • TUBERCULOSIS CONTROL PROGRAM

Confidential Hospitalized TB Suspect/Case Report (H-803) Instructions

Reporting of all patients with confirmed or suspected Tuberculosis is mandated by the State Health and Safety Codes (HSC) Division 105, Part 5 and Administrative Codes, Title 17, Chapter 4, Section 2500 and must be done within 1 day of diagnosis.

Why do you report?

Because it is required. The Health Department performs many vital functions to ensure public health and safety. These functions include contact investigation, home visits, patient education, patient compliance assessment and directly observed therapy (DOT). Tuberculosis Control staff also will assist in facilitating appropriate discharge planning. HSC section 121361 also mandates that, prior to discharge, all tuberculosis suspects and cases in hospitals and prisons have an individualized, written, discharge plan approved by the Local Health Officer (i.e. TB Controller).

Who must report?

1. All health care providers (including administrators of healthcare facilities and clinics) in attendance of a patient suspected to have, or confirmed with, active tuberculosis, must report within 1 working day from the time of identification (California Code: Title 17, Chap. 4, Sec. 2500).

2. The director of any clinical lab or designee must report laboratory evidence suggestive of tuberculosis to the Health Department on the same day that the physician who submitted the specimen is notified (California Code: Title 17, Chap. 4, Sec. 2505).

When do you report?

1. When the following conditions are present:
   - signs and symptoms of tuberculosis are present, and/or
   - the patient has an abnormal CXR consistent with tuberculosis, or
   - the patient is placed on two or more anti-TB drugs
2. When bacteriology smears or cultures are positive for acid fast bacilli (AFB)
3. When the patient has a positive culture for *M. tuberculosis* complex (i.e., *M. tuberculosis, M. bovis, M. canettii, M. africanum, M. microti)*.
4. When a pathology report is consistent with tuberculosis

How do you report?

The Confidential Hospitalized TB Suspect/Case report (H-803) (on the back of this form) is to be completed in its entirety and submitted to Tuberculosis Control. The Confidential Morbidity Report (CMR) should not be used for hospitalized patients.

1. BY FAX: (213) 749-0926

2. BY PHONE: (213) 744-6160: After hours, leave your name, phone or pager #, patient's name, DOB and medical record number on voicemail.

3. BY MAIL: Tuberculosis Control Program
   2615 S. Grand Avenue, Room 507
   Los Angeles, CA 90007

Reporting tuberculin skin test

Definition of a Positive Tuberculin Skin Test:

≥ 5 mm of induration is considered positive for contacts, suspects and HIV+ or immuno-suppressed individuals of any age.

≥10 mm of induration is considered positive for all other screening subjects of any age.

A positive tuberculin skin test with a normal chest x-ray is not reportable unless the patient is age 3 years or younger. However, health department follow-up may be requested for PPD reactors who also meet one of the following criteria. The reason for referral must be noted on the Remarks section.

a. HIV infected or at risk for HIV infection
b. Contact to infectious case of tuberculosis
c. Abnormal chest film consistent with old TB or silicosis
d. Children 3 years old or under with a positive tuberculin skin test
e. Documented converters
f. Medical conditions that increase TB risk:
   - Diabetes mellitus
   - Prolonged steroid therapy
   - Immunosuppressive therapy
   - End stage renal disease
   - Unexplained rapid weight loss

County of Los Angeles • Department of Public Health • TB Control Program
TEL (213) 744-6160 FAX (213) 749-0926

Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request

Patient Name: _____ **Submitted By:** _____

D.O.B. ___/___/_____ MR# _____ Phone (___) _____ Pager (___) _____

Facility _____

Fax # (___) _____

If Pulmonary: Dates of three consecutive negative smears

___/___/_____, ___/___/_____, ___/___/_____

Discharge to: [ ] Home [ ] Shelter [ ] SNF [ ] Jail/Prison [ ] Other _____

Discharge address and phone: _____

_____

Date patient to be discharged ___/___/_____ **F/U Appt. Date** ___/___/_____

Physician agreeing to assume TB care _____ Phone # (___) _____

Health Care Facility _____

Address _____

Discharge TB medication regimen:
(Indicate total daily dose)

Rifamate® (INH+RIF)* _____ pills/day
Rifater®(INH+RIF+PZA) _____ pills/day
INH _____ mg
Rifampin _____ mg
Ethambutol* _____ mg
Pyrazinamide* _____ mg
Other _____ mg
Side Effects _____

*Current CDC/ATS and Los Angeles County TB Control recommendations for treatment of uncomplicated TB for 2 months followed by INH & RIF for 4 months.

Medical complications (*specify*):

_____

_____

# of days of medication supply_____
(Must be sufficient to supply patient until follow up provider appointment).

Does the patient have risks that indicate Directly Observed Therapy (DOT)?

[ ] Mental Impairment
[ ] Homeless
[ ] HIV
[ ] Hx of any non-compliant behavior
[ ] Substance

*Contact TB Control if uncertain about risk.

Contact Information/Household composition:

Number of people in household? _____
Are there children age 5 years and younger? [ ] Yes [ ] No
Are there individuals immunocompromised? [ ] Yes [ ] No

Tuberculosis Control use only:

DHS Review - Problems Noted _____

_____

Action taken before discharge _____

_____

Reviewed by _____ *Date reviewed* ___/___/_____
Approved by _____ *Date approved* ___/___/_____

Discharge Approved
[ ] Yes [ ] No
Date ___/___/_____

The Confidential Tuberculosis Suspect Case Report (H-803) form must be on file at Tuberculosis Control or submitted with this form

Los Angeles County • Department of Public Health
Tuberculosis Control Program
2615 S. Grand Ave. Room 507 Los Angeles, CA 90007
Phone: 213-744-6160 Fax: 213-749-0926

Confidential Hospitalized TB Suspect/Case Discharge Care Plan / Approval Request (H- 804) Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the Local Health Officer (i.e., TB Controller).

To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to Tuberculosis Control 1 to 2 days prior to the anticipated discharge. Tuberculosis Control will review the discharge plan for approval or denial.

Health Department Response Plan:

Weekly discharge (Non holiday 8:00 am- 5:00 pm): The written discharge plan should be submitted preferably by FAX or mail.

Tuberculosis Control staff will review the discharge plan and notify the provider **within 24 hours** of approval or inform the provider of any additional information/action required or needed for approval prior to discharge.

If a home evaluation is required to determine if the environment is suitable for discharge, health department staff will make a visit.

Holiday and Weekend Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the **Public Health Administrative Officer of the Day** (AOD). A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made *(to fulfill State requirements for communicable disease reporting, the Confidential Hospitalized Tuberculosis Suspect/Case Report must be completed and submitted prior to or concurrently with the Confidential Hospitalized Tuberculosis Suspect/Case Discharge Care Plan /Approval Request).*

(NOTE: This form is used for discharge care planning only. Call the Tuberculosis Control Program prior to faxing documents to ensure timely processing.)

[i] **High risk individuals:** Persons at increased risk of progression to TB disease if infected including children 3 years old and younger and persons with medical conditions associated with an increased risk of progression to active TB disease including those with HIV infection, diabetes mellitus, end-stage renal disease, injection drug use, cancer of the head and neck, immunosuppressive treatment, post-transplant therapy, hematologic malignancy, intestinal bypass or gastrectomy, low body weight, chronic malabsorption, malnutrition and clinical situations associated with rapid weight loss, silicosis.

[ii] **High risk setting:** e.g., health care facilities, nursing home, congregate living site for persons infected with Human Immunodeficiency Virus (HIV), drug treatment residential facilities, homeless shelter, jail, board and care, other congregate living sites especially those housing persons at increased risk of progression to TB disease if infected, public living accommodations, including single room occupancy hotels, if air is shared in common areas or through the building ventilation system.

[iii] **NAAT**: The above NAAT testing must be performed within 7 days of multidrug TB chemotherapy having been administered as prior TB treatment may decrease the sensitivity of the NAAT test.