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Introduction

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Forms Used in this Section

- [TB Consultation Form](#)

About the *Washington State Tuberculosis Services Manual*

Purpose

The tuberculosis (TB) services manual is intended to assist Washington State health care in providing the highest level of care possible, according to national/state guidelines and recommendations. Responsibility for the quality of care for TB patients belongs to the nurse case manager and treating physician.

Audience

The most likely readers of this manual are people working in the health field. This may include, but is not limited to:

- Nurses (clinic, hospital, city, county, regional public health)
- Physicians (health officers, physician consultants, physician's assistants, ARNP)
- State TB services staff
- Indian Health Services staff
- Public Health Officers
- Epidemiologists
- Outreach workers

This manual provides guidelines, recommendations, and examples from national, state, and local groups. Where there is a need for more information available a hyperlink is provided for you. A hyperlink is a reference to another document that will take you to that location. Click on the link to read more about the topic.

In Washington State, TB control is governed by state law and rule. You may find information on TB laws in Washington State in the Revised Code of Washington (RCW) [70.28.005](#) and the Washington Administrative Code [\(WAC\) 246-170](#).

How to Use This Manual

Portable Document Format

This manual is available electronically as a portable document format (PDF) file. To view the PDF file, you will need the free Adobe Reader, available at <http://www.adobe.com/products/acrobat/readstep2.html>.

Hyperlinks

When viewing this manual online with an Internet connection, you can go directly to underlined Web addresses by clicking on them.

Cross-References

When viewing this manual electronically, you can go directly to other sections or topics in the manual by clicking on text next to this icon:



Forms



Required and recommended forms are available as links in the specific chapters and in the **FORMS** section of the manual.

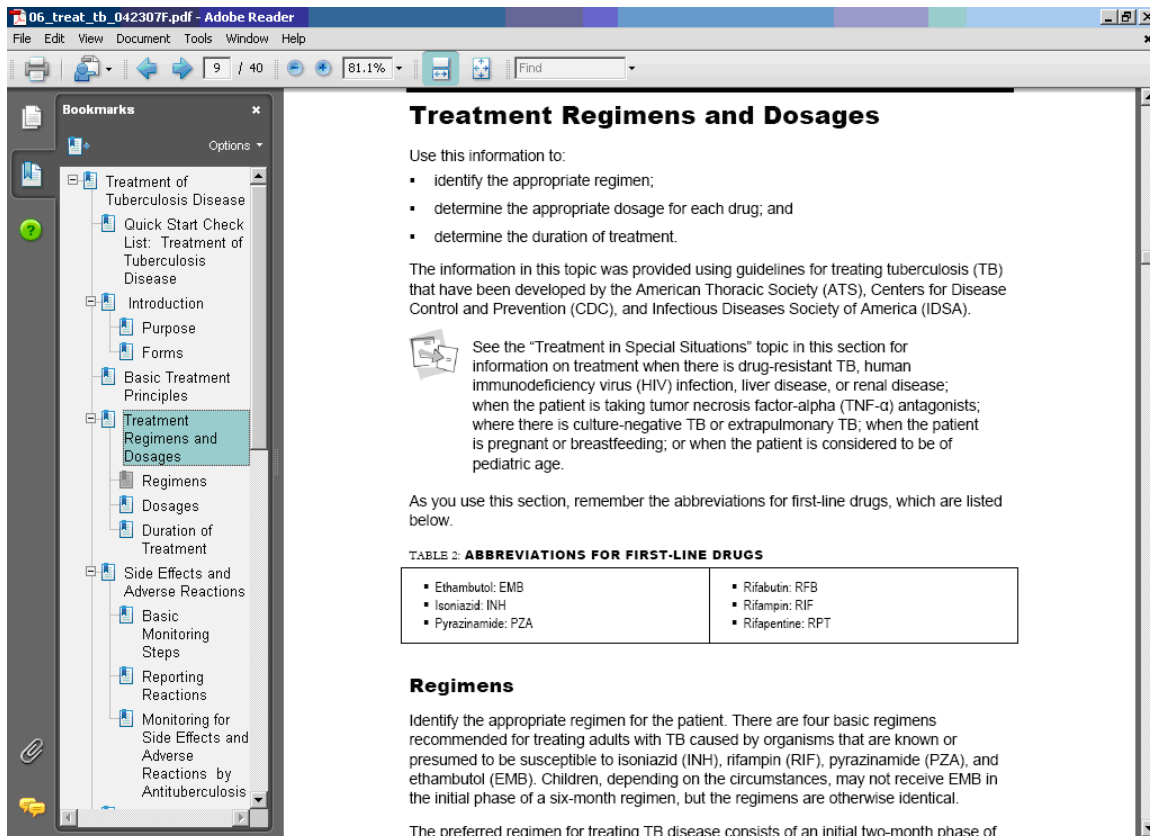
Bookmarks

In PDF files, you can use bookmarks to go quickly to a section or topic. If the bookmarks are not visible on the left, click the Bookmarks icon or tab on the left of the window.

To view sections and topics in the bookmarks list:

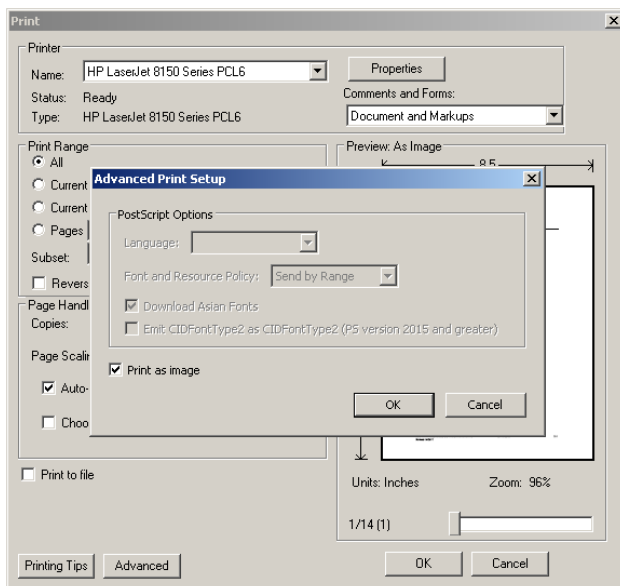
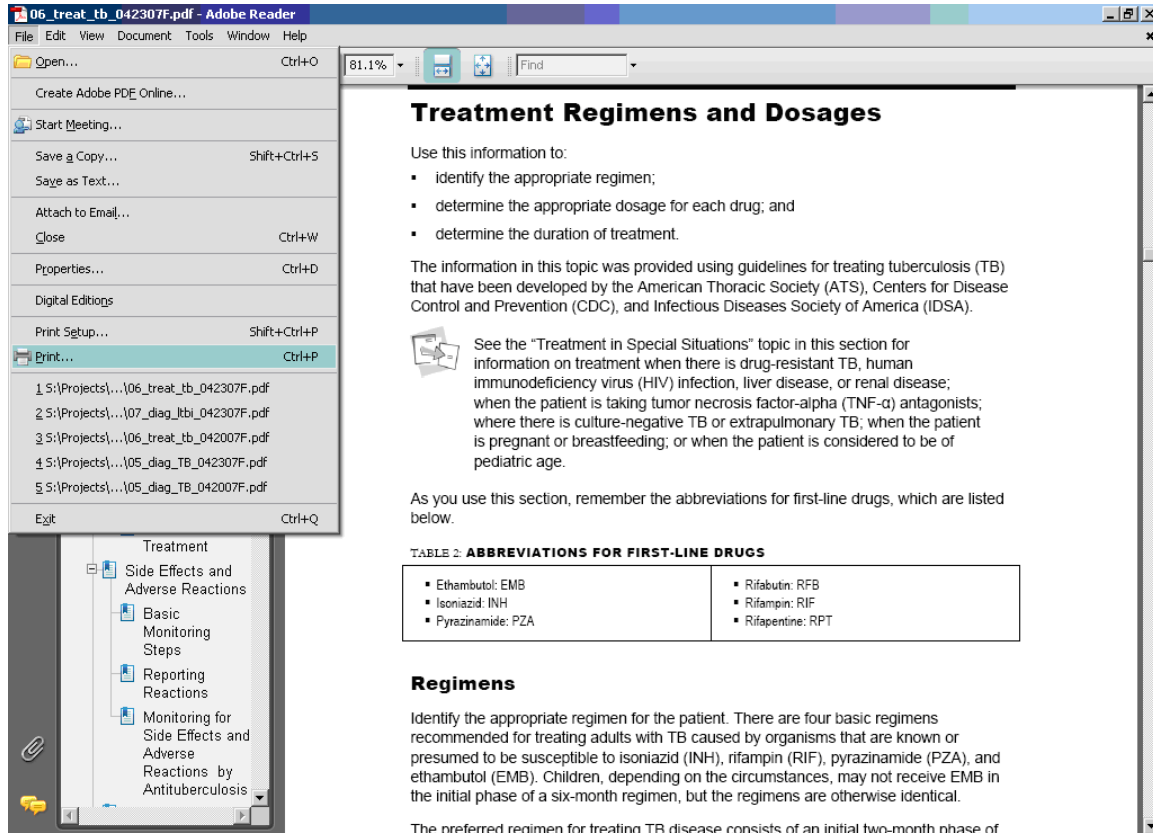
- Click + to see a more detailed list.
- Click – to hide the more detailed list.

To go to a section or topic in the bookmarks list, point to its name and left-click.



Printing

To access the print dialog box, click the File drop-down menu, click Print, and then make your selections in the Print dialog box.



Some printers have older printer drivers that cause spaces to appear in the middle of words. To avoid this problem, select File/Print, click the advanced button, check Print as Image, and then click OK. If you need further assistance with printing, call the Curry International Tuberculosis Center's IT staff at 415-502-5810.

Icons

Throughout the manual, these icons quickly cue you about important information and other resources:



This warns about high-consequence information you must understand when performing the task.



This signals when you should call to report or to consult on the task.



This highlights special considerations for pediatric patients.



This suggests another relevant area in the manual or another resource that you may want to review.



This alerts you that a form is available for the task.

Abbreviations

Refer to the list below for abbreviations used in the manual.

ACET	Advisory Council for the Elimination of Tuberculosis
ACH	air changes per hour
AFB	acid-fast bacilli
AIDS	acquired immunodeficiency syndrome
All	airborne infection isolation
ALT	alanine aminotransferase
ARPE	<i>Aggregate Report for Program Evaluation</i>
ART	antiretroviral therapy
AST	aspartate aminotransferase
ATS	American Thoracic Society
BAMT	blood assay for <i>Mycobacterium tuberculosis</i>
BCG	bacille Calmette-Guérin
CDC	Centers for Disease Control and Prevention
CT	computed tomography
CXR	chest radiograph
DNA	deoxyribonucleic acid
DOT	directly observed therapy
DRSS	drug resistance screening by sequencing
DTBE	Division of Tuberculosis Elimination
DTH	delayed-type hypersensitivity
ED	emergency department
EMB	ethambutol
EMS	emergency medical service
ESRD	end-stage renal disease

FDA	U.S. Food and Drug Administration
HAART	highly active antiretroviral therapy
HCW	healthcare worker
HEPA	high-efficiency particulate air
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
IDSA	Infectious Diseases Society of America
IGRA	interferon gamma release assay
INH	isoniazid
LTBI	latent tuberculosis infection
M. tuberculosis	Mycobacterium tuberculosis
MDR-TB	multidrug-resistant tuberculosis
MIRU	mycobacterial interspersed repetitive units
MOTT	mycobacterium other than tuberculosis
NAA	nucleic acid amplification
NIOSH	National Institute for Occupational Safety and Health
NNRTI	nonnucleoside reverse transcriptase inhibitors
NTCA	National Tuberculosis Controllers Association
NTNC	National Tuberculosis Nurse Coalition
NTM	nontuberculous mycobacteria
OSHA	Occupational Safety and Health Administration
PAPR	powered air-purifying respirator
PCR	polymerase chain reaction
PHIMS	Public Health Issue Management System
PHSKC	Public Health Seattle - King County
PI	protease inhibitor
PPD	purified protein derivative

PZA	pyrazinamide
QA	quality assurance
QFT	QuantiFERON®-TB test
QFT-G	QuantiFERON®-TB Gold test
RFB	rifabutin
RFLP	restriction fragment length polymorphism
RIF	rifampin
RNA	ribonucleic acid
RPT	rifapentine
RVCT	Report of Verified Case of Tuberculosis
RZ	rifampin and pyrazinamide
SHD	Snohomish Health District
TPCHD	Tacoma – Pierce County Health Department
TB	tuberculosis
TNF- α	tumor necrosis factor-alpha
TST	tuberculin skin test
TU	tuberculin units
USCIS	U.S. Citizenship and Immigration Services
UVGI	ultraviolet germicidal irradiation
XDR-TB	extremely drug-resistant tuberculosis

Purpose of Tuberculosis Control

Tuberculosis (TB) is caused by a bacterial organism named *Mycobacterium tuberculosis* (These organisms are sometimes called tubercle bacilli). Mycobacteria can cause a variety of diseases. Some mycobacteria are called tuberculous mycobacteria because they cause TB or diseases similar to TB. The MTB complex consists of *M. tuberculosis*, *M. bovis*, *M. africanum*, *M. microti*, *M. canetti*, *M. pinnipedi*. Tuberculous mycobacteria readily spread from person to person. Other mycobacteria are called nontuberculous mycobacteria (NTM) because they do not cause TB. One common type of nontuberculous mycobacteria is *M. avium* complex. Tuberculous mycobacteria readily spread from person to person; nontuberculous mycobacteria do not usually spread from person to person.

The goal of TB control in the United States is to reduce TB morbidity and mortality by doing the following:

- Preventing transmission of *M. tuberculosis* from persons with contagious forms of the disease to uninfected persons, and
- Preventing progression from latent TB infection (LTBI) to active TB disease among persons who have been infected *M. tuberculosis* infection.¹



For information on the transmission of *M. tuberculosis* and on how LTBI progresses to TB disease, see the Centers for Disease Control and Prevention's (CDC's) *Core Curriculum on Tuberculosis* (2011) at: <http://www.cdc.gov/tb/education/corecurr/index.htm>

The four fundamental strategies to reduce TB morbidity and mortality include the following:

1. Early and accurate detection, diagnosis, and reporting of TB cases, leading to initiation and completion of treatment
2. Identification of contacts of patients with infectious TB and treatment of those at risk with an effective drug regimen
3. Identification of other persons with latent TB infection at risk for progression to TB disease, and treatment of those persons with an effective drug regimen
4. Identification of settings in which a high risk exists for transmission of *M. tuberculosis* and application of effective infection control measures²



For more information on these strategies and the thinking behind them, see "Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America" (*MMWR* 2005;54[No. RR-12]) at: <http://www.cdc.gov/MMWR/PDF/rr/rr5412.pdf> .

Washington State Laws and Rules on Tuberculosis Control

Washington State laws and rules on tuberculosis (TB) are located in the Washington Administrative Code (WAC) and the Revised Code of Washington (RCW).



In the WAC, see Chapter 246-170 (Tuberculosis Control) in Title 246 (Department of Health) at:

<http://apps.leg.wa.gov/WAC/default.aspx?cite=246-170>



In the RCW, see chapter 70.28 (Control of Tuberculosis) at:

<http://apps.leg.wa.gov/RCW/default.aspx?cite=70.28>



In the WAC, see Chapter 246-101 (Notifiable Conditions) in the Title 246 (Department of Health) at:

<http://apps.leg.wa.gov/wac/default.aspx?cite=246-101>

Also, see Notifiable Conditions Guidelines, at

<http://www.doh.wa.gov/notify/guidelines/pdf/tuberculosis.pdf>



Contact Washington State TB Services at 360-236-3443 for assistance with interpreting Washington State laws and rules regarding TB control.

National/State Indicators & Measures

Core Objectives	Target	Origin of Indicator	Definition
Index of Completion at 12 months- For whom 12 months or less TX indicated	WA-93% NTIP- 93%	NTIP	Percent of patients with newly diagnosed TB for whom 12 months or less of treatment is indicated who complete treatment.
Sputum Culture Conversion	NTIP- 61.5%	NTIP	Percent of TB patients with positive sputum culture results who have documented conversion to sputum culture-negative within 60 days of treatment initiation
Sputum smear (+) Result to Starting TB Medications	7 days 100%	NTIP	Percent of TB patients with positive AFB smear results from a respiratory specimen who initiate treatment within 7 days of specimen collection. Reported for all smear (+) cases—including respiratory specimens such as sputum, BAL and bronchial washing.
Total Contacts Evaluated	WA- 93% NTIP- 93%	NTIP	Percent of contacts to sputum AFB smear-positive TB patients who are evaluated for infection and disease Completed evaluation could refer to any of the following: 1) contacts that were TST/QFT tested <8 weeks after exposure once and if not infected on first test, tested again \geq 8 weeks after exposure. If they were infected on their first test, they were followed-up with a chest x-ray. If they tested positive on their second TST/QFT test, that test was also followed up with a chest x-ray. 2) contacts that were TST/QFT tested once at least 8 weeks after the exposure. If they were newly infected on the test, they were followed-up with a chest x-ray. 3) Prior positive contacts with documented positive TST/QFT results have a symptom screen and if symptomatic have a chest x-ray.
Contacts Who Started LTBI Treatment who Complete Treatment	NTIP- 79%	NTIP	Percent of contacts to sputum AFB smear-positive TB patients who have started treatment for the newly diagnosed LTBI, increase the proportion who complete treatment. (completion of a recommended regimen of INH, Rifampin, or Rifapentine/INH, or a recommended regimen for drug-resistant TB)
Treatment Failure Rates and Relapse Rates	WA- <u>\leq10%</u>	WA	Among all cases undergoing or having completed treatment those who fail treatment (defined as continued or recurrently positive cultures during the course of antituberculosis therapy, whose sputum cultures remain positive after 4 months of treatment) or relapse (defined as the circumstance in which a patient becomes and remains culture negative while receiving therapy but, within 12 months after completion of therapy, either becomes culture positive again or has clinical or radiographic deterioration that is consistent with active tuberculosis).

Measures	Measurement	Origin of Indicator	Definition
Reporting of HIV status	Percent	NTIP	Among all cases; the percent for whom a definitive (i.e. positive or negative) HIV status is reported.
Drug Sensitivity Results Reported	Percent	NTIP	Percent of culture-positive TB cases with initial drug susceptibility results reported
Sputum Culture Reported	Percent	NTIP	Percent of TB cases with a pleural or respiratory site of disease in patients ages 12 years or older that have a sputum-culture result reported
Culture Specimen Collection to Arrival at Lab	Mean, Median, Mode , and Range	WA	Among cases from whom any culture specimen is collected—the time from which the first viable culture specimen was collected to the time the specimen was received at the initial processing lab.
Report of (+) Sputum Smear Results to LHJ	Mean, Median, Mode , and Range	WA	Among sputum smear (+) cohort cases—the time from which the smear positive specimen was collected to the date the LHJ is notified of sputum smear (+) results.
Report of (+) Culture Results to LHJ	Mean, Median, Mode , and Range	WA	Among culture (+)cases—the time from which the culture positive specimen was collected to the date the first culture (+) result is reported to the LHJ.
Report of DST to LHJ on positive culture	Mean, Median, Mode , and Range	WA	Among culture (+) cases—the time from culture (+) specimen collection to the date in which 1st-line DST results are reported to LHJ.
Sputum smear + Receiving Appropriate DOT	Percent	WA/King	Among cases initiating treatment who are sputum smear positive—the percent who have received 90% or more of non-holiday weekday doses under directly-observed therapy (DOT) during their treatment course.
Recommended Initial Therapy	Percent	NTIP	Percent of patients who are started on the recommended initial 4-drug regimen when suspected of having TB disease
Universal Genotyping	Percent	NTIP	Percent of culture-confirmed TB cases with a genotyping result reported
Genotyping TAT	Mean, Median, Mode , and Range		Of all culture-positive isolates, the time between date of initial culture growth to genotype reported back to DOH.
NAA Testing	Percent	WA/ PHSKC	Percent of pulmonary culture positive cases having had NAA testing completed
Sputum smear + cases with contacts elicited	Percent	NTIP	Percent of TB patients with positive acid-fast bacillus(AFB) sputum-smear results who have contacts elicited
Infected who Started LTBI Treatment	Percent	NTIP	Percent of contacts to sputum AFB smear-positive TB patients with newly diagnosed latent TB infection (LTBI) who start treatment
Class B1 Post-Arrival Screening	Percent	WA	Percent of class B1 refugees and immigrants diagnosed with active TB in WA State who did not complete a post-arrival TB screening.
Class B1 Diagnosed with TB Post-Arrival	Percent	WA	Percent of Class B1 refugees and immigrants diagnosed with active TB in WA State.
Class B1 Time to TB Diagnosis	Mean, Median, Mode , and Range	WA	The time between arrival in the U.S. to the diagnosis of TB in WA State.

National Program Objectives

The national TB program objectives reflect the national priorities for TB control in the United States. In 2006, a team representing TB programs and the Division of Tuberculosis Elimination (DTBE) selected 15 high-priority TB program objective categories. The program objective categories are:

1. Completion of treatment
2. TB case rates (in populations: U.S.-born persons, foreign-born persons, U.S.-born non-Hispanic blacks, and children younger than 5 years of age)
3. Contact investigations
4. Laboratory reporting
5. Treatment initiation
6. Sputum culture conversion
7. Data reporting (Report of Verified Case of Tuberculosis [RVCT], the Aggregate Reports for Tuberculosis Program Evaluation [ARPEs], and the Electronic Disease Notification [EDN] system)
8. Recommended initial therapy
9. Universal genotyping
10. Known HIV status
11. Evaluation of immigrants and refugees
12. Sputum culture reporting
13. Program evaluation
14. Human resource development plan
15. TB training focal points

TB programs funded through cooperative agreements will be expected to report on their progress toward achieving all 15 national TB program objective categories starting in 2010. These objectives can be found at

<http://www.cdc.gov/tb/publications/factsheets/statistics/NTIP.htm>.

In addition to the national program objectives listed above, the CDC has two goals (listed below) that do not have national program objectives established at this time. Specific objectives relating to these two goals will be established in the future.

1. National Goal: Increase the percentage of immigrants and refugees designated as Class A, B1, or B2 who are appropriately evaluated and treated.
2. National Goal: For jurisdictions with greater than 50 reported cases of TB occurring annually in U.S.-born African Americans, decrease the case rate.

National Standards & Recommendations

Program standards are what the stakeholders of the TB program would consider to be “reasonable expectations” for the program. For TB, standards have been established by nationally accepted authorities, such as the American Thoracic Society (ATS), the Infectious Diseases Society of America (IDSA), and the CDC, and generally recognized TB control

experts, such as the National Tuberculosis Nurse Coalition (NTNC) and the National Tuberculosis Controllers Association (NTCA). Many state programs, and some local TB control programs, have established their own standards and objectives for case management.³ In 2011, the NTCA revised its Tuberculosis Nursing manual which will contain the most current program, structural and patient care standards that the NTCA recommends. Copies can be ordered from the NTCA at <http://tbcontrollers.org>.

The standards of care for the medical treatment and control of TB are published jointly by the ATS, IDSA, and CDC. These standards should be available for reference by each TB staff member.

The standards are included in the following guidelines:

- ATS, CDC, IDSA. “Controlling Tuberculosis in the United States: Recommendations from the American Thoracic Society, CDC, and the Infectious Diseases Society of America” (*MMWR* 2005;54[No. RR-12]). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5412.pdf> .
- ATS, CDC, IDSA. “Diagnostic Standards and Classification of Tuberculosis in Adults and Children” (*Am J Respir Crit Care Med* 2000;161[4 Pt 1]). Available at: <http://www.cdc.gov/tb/publications/PDF/1376.pdf> .
- ATS, CDC, IDSA. “Treatment of Tuberculosis” (*MMWR* 2003;52[No. RR-11]). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf> .
- CDC, NTCA. “Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis: Recommendations from the National Tuberculosis Controllers Association and CDC” (*MMWR* 2005;54 [No. RR-15]). Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf> .
- CDC. “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-care Settings, 2005” (*MMWR* 2005;54[No. RR-17]). Available at: <http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf> .
- CDC. “Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection” (*MMWR* 2000;49[No. RR-6]). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf> .

For additional guidelines, see the Division of Tuberculosis Elimination’s “TB Guidelines” Web page (Division of Tuberculosis Elimination Web site; accessed December 12, 2011). Available at: <http://www.cdc.gov/tb/publications/guidelines/default.htm>.

Roles, Responsibilities, and Contact Information

Washington State Tuberculosis Services Staff

TABLE 3: WASHINGTON STATE TUBERCULOSIS ROLES, RESPONSIBILITIES AND CONTACT INFORMATION

Roles and Responsibilities	Contact Information
<p>Role and Responsibilities of Washington State Tuberculosis Medical Consultant</p> <p>The Washington State Tuberculosis Services Medical Consultant provides a liaison for health care providers, particularly physicians treating patients with tuberculosis, and to educate them in matters related to diagnosis, treatment and case management of tuberculosis patients.</p> <p>Participate in seminars and workshops designed to educate health care providers on tuberculosis related issues; review medical records; provide consultation on interstate issues and policy development related to local health jurisdiction guidelines for treatment and control of tuberculosis; provide analysis of statewide genotyping database.</p>	<p>Scott Lindquist, MD, MPH</p> <p>Washington State Tuberculosis Services Medical Consultant</p> <p>Tel: 206-718-2664 E-mail: scott.lindquist@kitsappublichealth.org</p> <ul style="list-style-type: none"> • TB Consultation Form
<p>Role and Responsibilities of Washington State Program Manager</p>	<p>Washington State Tuberculosis Services Program Manager</p> <p>PO Box 47837 Olympia, WA 98504 Tel: 360-236-3443 Fax: 360-236-3405 Email: tbservices@doh.wa.gov</p>

Roles and Responsibilities	Contact Information
<p>Role and Responsibilities of Washington State Tuberculosis Controller</p> <p>Establishes short and long range program goals for prevention of infection and controlling disease; Assists in directing the planning, implementation and evaluation of program activities/special projects develops program policies, procedures and standards; provides oversight of preparation, allocation and monitoring of program resources and budget; collaborates with the TB Services Medical Consultant; supervises the maintenance of appropriate records and data collection systems and responds to inquiries regarding interpreting state TB laws and regulations. Provides direct consultation and technical assistance to local health jurisdictions (LHJ), schools, clinics, long-term care facilities, correctional facilities, homeless shelters, and other public and private agencies regarding TB policies and procedures.</p>	<p>Washington State Tuberculosis Services TB Controller</p> <p>PO Box 47837 Olympia, WA 98504 Tel: 360-236-3443 Fax: 360-236-3405 Email: tbservices@doh.wa.gov</p>
<p>Role and Responsibilities of Washington State Tuberculosis Services Nurse Consultant</p> <p>Advises personnel in local health jurisdictions, schools, clinics, long-term care facilities, correctional facilities, homeless shelters, and other public and private agencies within Washington State regarding TB programs, policy recommendations, practice standards for case management completion, contact investigation activities, treatment of latent TB infection, and distribution of nursing services.</p> <p>Participates in quarterly group reviews of case management activities, Cohort Review, by providing and discussing information such as treatment timing, nursing services-involved, practice standards, state and national objectives, and what is or is not contributing to successful management of TB cases</p> <p>Documents all TB cases reported, evaluating and forming recommendations regarding laboratory testing, treatment interruptions, medications, time to complete treatment.</p>	<p>Washington State Tuberculosis Services Nurse Consultant</p> <p>PO Box 47837 Olympia, WA 98504 Tel: 360-236-3443 Fax: 360-236-3405 Email: tbservices@doh.wa.gov</p>

Roles and Responsibilities	Contact Information
<p>Role and Responsibilities of Washington State Tuberculosis Services Support Staff</p> <p>As TB Services Support Staff, these positions support the program's mission by providing nursing care for patients with suspect or confirmed TB, conducting interviews and contact investigations of confirmed TB cases, providing community education for clients and healthcare providers, collecting/organizing TB case and treatment data and conducting various special projects</p>	<p>Washington State Tuberculosis Services Support Staff</p> <p>PO Box 47837 Olympia, WA 98504 Tel: 360-236-3443 Fax: 360-236-3405 Email: tbservices@doh.wa.gov</p>

Local Health Jurisdictions and Private Medical Providers

TABLE 4: LOCAL HEALTH JURISDICTIONS' ROLES AND RESPONSIBILITIES

Local Health Jurisdictions	
<p>Role and Responsibilities of Local Health Jurisdictions (WAC 246-170-031)</p> <ol style="list-style-type: none"> 1. Each local health jurisdiction (LHJ) shall assure the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis. Services shall include: <ol style="list-style-type: none"> a. Prevention and screening, with emphasis on screening of high risk populations; b. Diagnosis and monitoring, including laboratory and radiology; c. Individualized treatment planning consistent with American Thoracic Society/Centers for Disease Control and Prevention statements based on the least restrictive measures necessary to assure appropriate treatment; and d. Case management. 2. In the absence of third party reimbursement, the local health jurisdiction shall assure the provision of inpatient or outpatient care, including DOT/DOPT and case management. 3. Each local health jurisdiction shall maintain a register of all diagnosed or suspected cases of tuberculosis. In addition, each local health jurisdiction shall also maintain a register of individuals to whom that health department is providing preventive therapy. Quarterly status reports on suspected and diagnosed cases shall be furnished to the department of health tuberculosis control services. 	<ol style="list-style-type: none"> 4. A physician knowledgeable in the diagnosis and treatment of tuberculosis approved by the department shall be available to provide review of diagnoses, plans of management and, if appropriate, discharge from inpatient facilities. 5. Sufficient nursing, clerical, and other appropriate personnel shall be provided to furnish supervision of preventive and outpatient treatment, surveillance, suspect evaluation, epidemiologic investigation, and contact workup. <p>For a list of local public health jurisdiction contacts, see http://www.doh.wa.gov/LHJMap/LHJMap.htm</p>

TABLE 5: PRIVATE MEDICAL PROVIDERS' ROLES AND RESPONSIBILITIES

Private Medical Providers	
<p>Role and Responsibilities of Private Medical Providers (WAC 246-101-105)</p> <ol style="list-style-type: none"> 1. Notify the local health jurisdiction where the patient resides (in the event that patient residence cannot be determined, notify the local health jurisdiction where the medical providers practice) regarding: <ol style="list-style-type: none"> a. Cases or suspected cases of notifiable conditions specified as notifiable to local health jurisdictions in Table HC-1; b. Cases of conditions designated as notifiable by the local health officer within that health officer's jurisdiction; c. Outbreaks or suspected outbreaks of disease. These patterns include, but are not limited to, suspected or confirmed outbreaks of chickenpox, influenza, viral meningitis, nosocomial infection suspected due to contaminated food products or devices, or environmentally related disease; d. Known barriers which might impede or prevent compliance with orders for infection control or quarantine; and e. Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures. 2. Notify the department of health of conditions designated as notifiable to the local health jurisdiction when: <ol style="list-style-type: none"> a. A local health jurisdiction is closed or representatives of the local health jurisdiction are unavailable at the time a case or suspected case of an immediately notifiable condition occurs; b. A local health jurisdiction is closed or representatives of the local health jurisdiction are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs. 	<ol style="list-style-type: none"> 3. Notify the jurisdiction of pesticide poisoning that is fatal, causes hospitalization or occurs in a cluster. 4. Notify the jurisdiction as specified in Table HC-1 regarding cases of notifiable conditions specified as notifiable to the jurisdiction. 5. Assure that positive cultures and preliminary test results for notifiable conditions of specimens referred to laboratories outside of Washington for testing are correctly notified to the local health jurisdiction of the patient's residence or the jurisdiction as specified in Table Lab-1. This requirement can be satisfied by: <ol style="list-style-type: none"> a. Arranging for the referral laboratory to notify either the local health jurisdiction, the department, or both; or b. Forwarding the notification of the test result from the referral laboratory to the local health jurisdiction, the department, or both. 6. Cooperate with public health authorities during investigation of: <ol style="list-style-type: none"> a. Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and b. An outbreak or suspected outbreak of disease. 7. Provide adequate and understandable instruction in disease control measures to each patient who has been diagnosed with a case of a communicable disease, and to contacts who may have been exposed to the disease. 8. Maintain responsibility for deciding date of discharge for hospitalized tuberculosis patients. 9. Notify the local health officer of intended discharge of tuberculosis patients in order to assure appropriate outpatient arrangements are arranged.

State Laboratory and Private Laboratories

TABLE 6: ROLE, RESPONSIBILITIES, AND CONTACT INFORMATION OF THE STATE LABORATORY AND PRIVATE LABORATORIES

Role and Responsibilities	Contact Information
<p>State Laboratory</p> <p>The Washington State Department of Health's Public Health Laboratory (PHL) is an integral part of the DOH and the Public Health Improvement Plan (PHIP), the state's blueprint for improving the health status of Washington residents. As the state's primary reference laboratory, the PHL provides LHJs, hospitals, clinics and specialty laboratories with a wide range of services including identification, confirmation, susceptibility testing of pathogenic organisms, consultation and training in laboratory methodologies. The TB Unit receives and processes <i>Mycobacterium tuberculosis</i> (MTB) specimens five days a week. Microscopic results are provided within 24 hours of receipt except on weekends. The Acid-Fast Bacilli (AFB) positive results received by the PHL are entered into a TB computer database and reported within a day (by phone and fax) to submitting laboratories, physicians and to TB Control personnel. Using state of the art technology, the unit performs isolation and definitive identification on all mycobacterial isolates received by PHL. Drug susceptibility testing is also routinely performed on all first time MTB isolates and on isolates from patients whose symptoms suggest they are not responding to primary drugs. As a reference laboratory, the TB Unit also functions to help other laboratories improve their capabilities and services.</p>	<p>Washington State Department of Health Public Health Laboratory</p> <p>Street/Mailing address: 1610 NE 150th ST Shoreline, WA 98155 (King County) http://www.doh.wa.gov/eshphl/phl/</p> <p>TB Lab Supervisor: 206-418-5474 TB Lab Lead: 206-418-5473</p>
<p>Private Laboratories</p> <p>Laboratories on this list provide primary specimen smear and culture testing for mycobacteria. Most refer isolates either to a Core Lab (reference Lab) or to the Washington State Department of Health Public Health Laboratories for identification and susceptibility testing.</p>	<p>For information on private laboratories see Laboratory Services Contact Information in the Laboratory section of the manual (10.4)</p>

Resources and References

Resources

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