

Introduction

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Forms Used in this Section

- [TB Consultation Form](#)

About the *Washington State Tuberculosis Services Manual*

Purpose

The purpose of the tuberculosis (TB) services manual is for readers to understand how public health staff complete TB control tasks in Washington State. Please keep in mind that it contains technical terms not well understood by the general public. The most likely readers of the manual are people who work in the public health field. This may include, but is not limited to:

- Nurses (city, county, regional public health)
- Physicians and physician consultants
- 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. When there is a need for more information there will be a hyperlink 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.

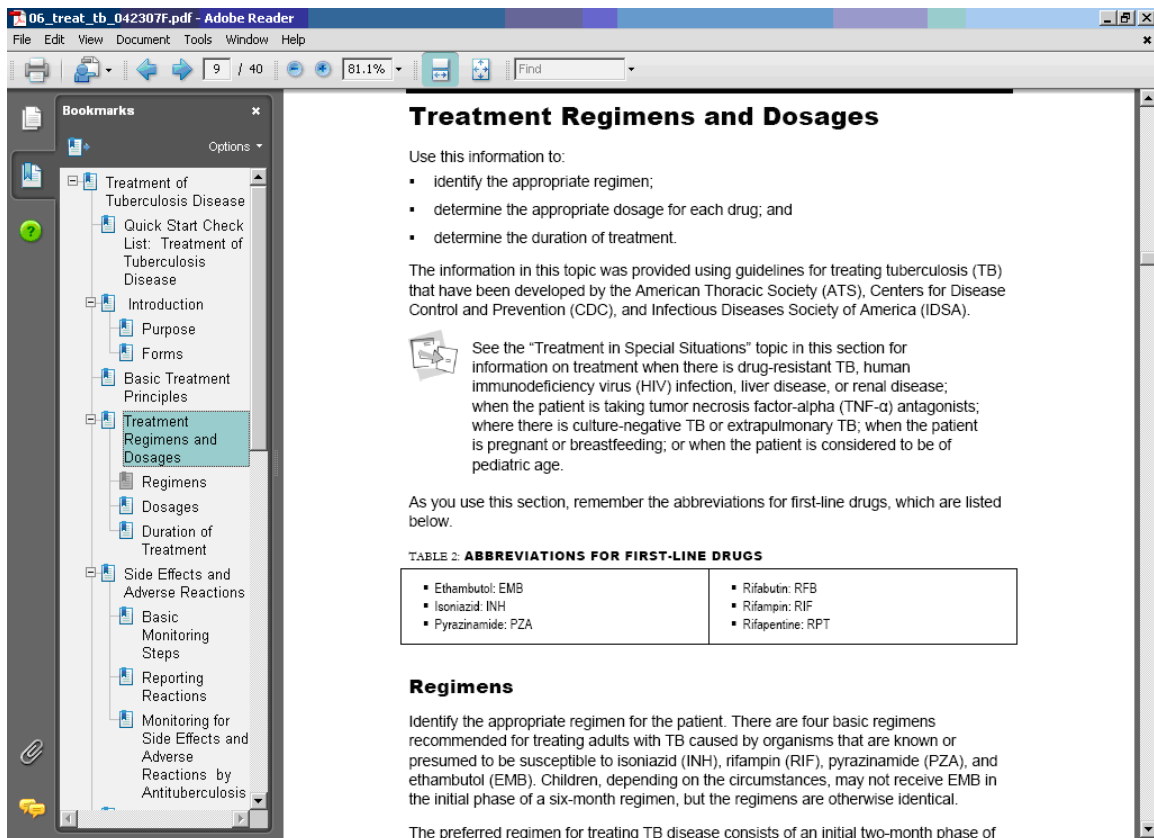
Bookmarks

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:

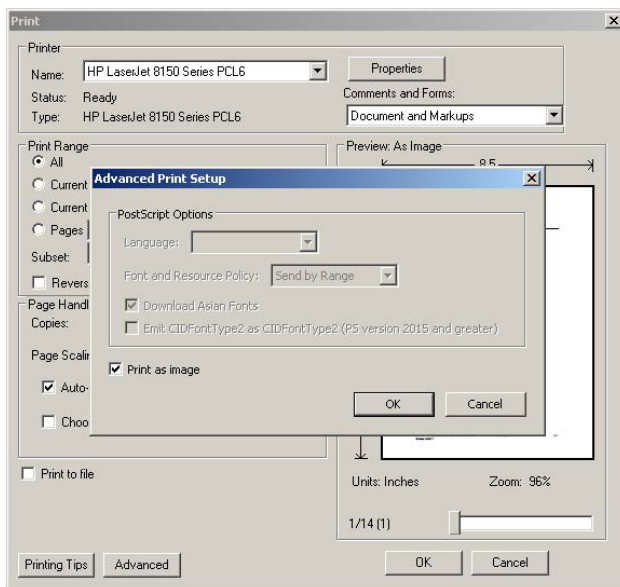
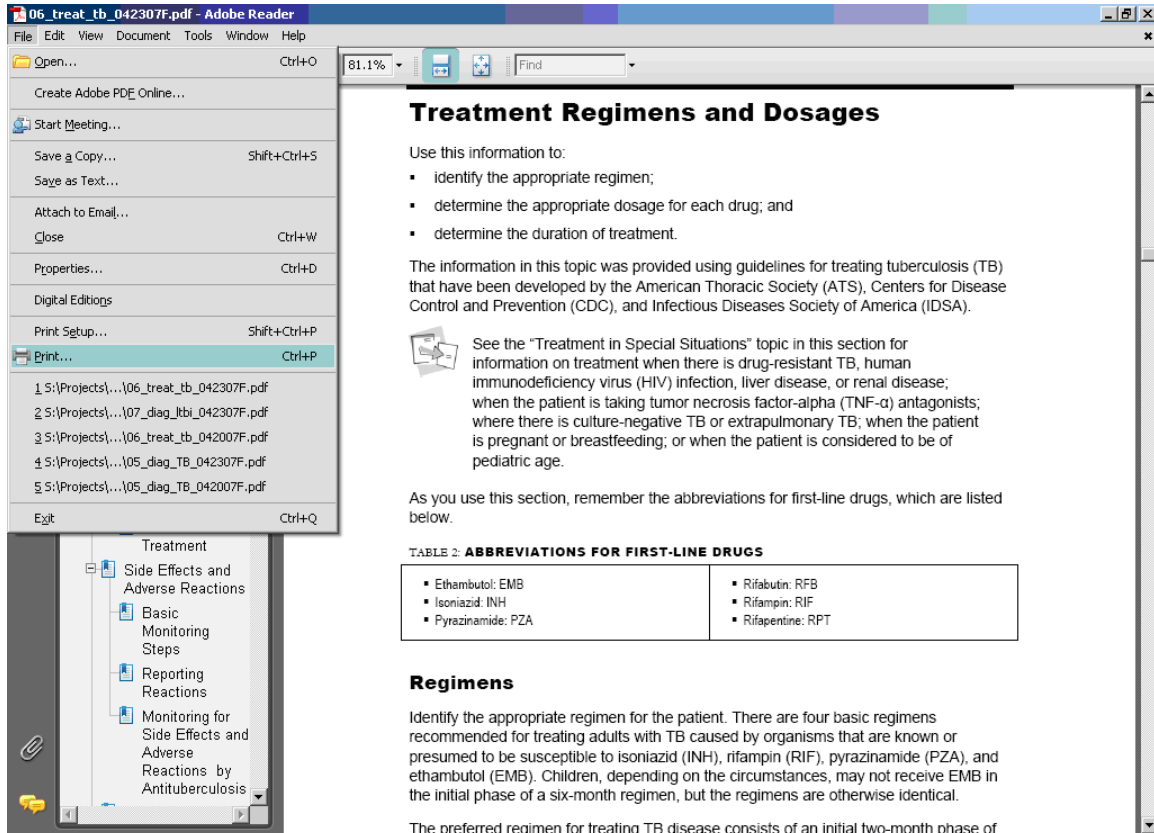
- Click + to see a more detailed list.
- Click – to hide the more detailed list.

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 Francis J. Curry National 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
<i>ARPE</i>	<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
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
<i>M. tuberculosis</i>	<i>Mycobacterium tuberculosis</i>
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
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
<i>RVCT</i>	<i>Report of Verified Case of Tuberculosis</i>
RZ	rifampin and pyrazinamide
SHD	Snohomish Health District
TPCHD	Tacoma – Pierce County Health Department
TB	tuberculosis
TIMS	Tuberculosis Information Management System
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. These mycobacteria are *M. tuberculosis*, *M. bovis*, and *M. africanum*. 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 contracted *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) online course *Interactive Core Curriculum on Tuberculosis* (2004) at:

<http://www.cdc.gov/tb/webcourses/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 360-236-3447 for assistance with interpreting Washington State laws and rules regarding TB control.

Washington State and National Objectives

Washington State Tuberculosis Services Objectives— 2009

Below are state tuberculosis (TB) program objectives. Each objective is targeted by the Washington State TB Services for 2009, based on Washington State epidemiology and recent program performance.

TABLE 1: WASHINGTON STATE TUBERCULOSIS SERVICES OBJECTIVES

Treatment and Case Management
<p>By 2009</p> <ol style="list-style-type: none">1. At least 90% of patients with newly diagnosed TB, for whom therapy for 12 months or less is indicated, will complete a course of curative TB treatment within 12 months of initiation of treatment.2. At least 80% of patients being treated for active tuberculosis will be on Directly Observed Therapy (DOT).3. Drug susceptibility results will be reported for at least 95% of all newly reported, culture positive TB cases. HIV status will be reported for at least 90% of all newly reported culture-positive TB cases age 25 – 44.
Contact Investigation
<p>By 2009</p> <ol style="list-style-type: none">4. Contacts will be identified for at least 80% of newly reported sputum AFB-smear positive TB cases.5. At least 60% of contacts to sputum AFB-smear positive TB cases will be evaluated for infection and disease.6. At least 60% of infected contacts who are started on treatment for latent TB infection will complete a regimen.
Surveillance
<p>By 2009</p> <ol style="list-style-type: none">7. All newly diagnosed cases of TB will be reported to CDC using the electronic reporting system developed by CDC. There will be at least 95% completeness for the key variables in the expanded RVCT.8. At least 80% of immigrants and refugees designated as Class B1, B2 were appropriately evaluated within 60 days.
Training & Education
<p>By 2009</p> <ol style="list-style-type: none">9. Decrease the TB incidence rate to 13.0 cases / 100,000 among American Indian/ Native Alaskan persons.10. The American Lung Association of Washington will develop a plan to establish and improve existing in-service TB training and human resource development.

National Program Objectives

Below are the Centers for Disease Control and Prevention (CDC) program objectives, current as of December 2006.³

TABLE 2: NATIONAL PROGRAM OBJECTIVES AND PERFORMANCE TARGETS⁴

Indicator		National TB Program Objectives and Performance Targets
1	Percent completion of treatment	<p>Increase timely completion of treatment</p> <p>National Objective: At least 93% of patients with newly diagnosed tuberculosis (TB), for whom therapy for 12 months or less is indicated, will complete treatment within 12 months by 2015.</p>
2	TB case rate	<p>Decline in TB rates</p> <ul style="list-style-type: none"> a. National Objective: The average yearly decline in TB rates in US-born will be >11%. b. National Objective: The average yearly decline in TB rates in foreign-born will be >4%. c. National Objective: The TB rate in US-born will be <0.7 cases/100,000 by 2015. d. National Objective: The TB rate in foreign-born will be <14 cases/100,000 by 2015. e. National Objective: The TB rate in US-born black non-Hispanics will be <1.3 cases/100,000 by 2015. f. National Objective: The TB rate in children <5 years of age will be <0.4/100,000 by 2015.
3	Thorough contact investigations	<p>Improve contact identification, evaluation, and treatment</p> <ul style="list-style-type: none"> a. National Objective: All sputum-AFB-smear-positive TB cases will have at least one contact listed by 2015. b. National Objective: At least 93% of contacts to sputum-AFB-smear-positive TB cases will be evaluated for infection and disease by 2015. c. National Objective: At least 88% of infected contacts will start treatment by 2015. d. National Objective: At least 79% of contacts who start treatment will complete treatment.

Indicator		National TB Program Objectives and Performance Targets
4	Timely laboratory reporting	<p>Ensure timely laboratory reporting</p> <ul style="list-style-type: none"> a. National Objective: State public health labs will report 100% of results of culture identification of <i>M. tuberculosis</i> complex to submitter and state TB program within 21 days of receipt of specimen by 2015. b. National Objective: Increase the percentage of TB patients with initial positive cultures who also are tested for and receive drug susceptibility results to 100% by 2015.

Source: National TB Indicators Project. *Initial Indicators and Performance Targets*. Atlanta, GA: CDC Division of Tuberculosis Elimination; November 1, 2006. [Cleared by CDC but unpublished as of December 2006.]

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.⁵ As of 2008, the NTCA currently is revising its Tuberculosis Nursing manual which will contain the most current program, structural, and patient care standards that the NTCA recommends. Check for updates 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 June 25, 2009). 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 SERVICES MANAGER ROLES, RESPONSIBILITIES, AND CONTACT INFORMATION

Roles and Responsibilities	Contact Information
<p>Role and Responsibilities of Washington State Tuberculosis Services Staff</p> <p>Establishes short and long range program goals for prevention of infection and controlling disease; directs 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.</p> <p>Supervise the TB Services Nursing Consultants and 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>Plans, writes, promotes and conducts TB and nursing service-related educational programs, orientations, lectures and in-services for health care providers.</p> <p>Responds to inquiries from the general public, media and legislators regarding TB morbidity, disease outbreaks and disease trends.</p>	<p>Kim Field, RN, MSN</p> <p>Washington State Tuberculosis Section Manager Department of Health</p> <p>PO Box 47837 Olympia, WA 98504</p> <p>Tel: 360-236-3447 Fax: 360-236-3405 E-mail: kim.field@doh.wa.gov</p>

TABLE 4: WASHINGTON STATE TUBERCULOSIS SERVICES MEDICAL CONSULTANT

Roles and Responsibilities	Contact Information
<p>Role and Responsibilities of Washington State Tuberculosis Services 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</p> <p>E-mail: lindqs@health.co.kitsap.wa.us</p> <ul style="list-style-type: none"> • TB Consultation Form

TABLE 5: WASHINGTON STATE TUBERCULOSIS SERVICES NURSE CONSULTANTS

Roles and Responsibilities	Contact Information
<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>Tel: 360-236-3431</p>

TABLE 6: WASHINGTON STATE TUBERCULOSIS SERVICES SUPPORT STAFF

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>Tel: 360-236-3431</p>

Local Health Jurisdictions and Private Medical Providers

TABLE 7: 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 8: 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 9: 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.</p> <p>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

- CDC. "Framework for Program Evaluation in Public Health" (*MMWR* 1999;48[No. RR-11]). Available at: <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf>.
- Division of Tuberculosis Elimination. *A Guide to Developing a TB Program Evaluation Plan* (Division of Tuberculosis Elimination Web site; accessed November 1, 2006). Available at: <http://www.cdc.gov/tb/programs/evaluation/guide.htm>.
- Division of Tuberculosis Elimination. *Understanding the TB Cohort Review Process: Instruction Guide* (Division of Tuberculosis Elimination Web site; accessed November 1, 2006). Available at: <http://www.cdc.gov/tb/publications/guidestoolkits/cohort/default.htm>.
- New Jersey Medical School National Tuberculosis Center. *Planning & Implementing the TB Case Management Conference: A Unique Opportunity for Networking, Peer Support and Ongoing Training* (Newark, NJ; 2004). Available at: <http://www.umdnj.edu/globaltb/products/planning&implementing.htm>.

References

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- ¹ 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):14.
 - ² 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):15.
 - ³ National TB Indicators Project. *Initial Indicators and Performance Targets*. Atlanta, GA: CDC Division of Tuberculosis Elimination; November 1, 2006. [Cleared by CDC but unpublished as of December 2006.]
 - ⁴ National TB Indicators Project. *Initial Indicators and Performance Targets*. Atlanta, GA: CDC Division of Tuberculosis Elimination; November 1, 2006. [Cleared by CDC but unpublished as of December 2006.]
 - ⁵ Division of Tuberculosis Elimination. National Center for HIV, AIDS and Tuberculosis Prevention, Centers for Disease Control and Prevention. *A Guide to Writing a TB Program Evaluation Plan* [Division of Tuberculosis Elimination Web site]:24. Available at: <http://www.cdc.gov/tb/programs/evaluation/guide.htm> . Accessed June 25, 2009.