INTERSTATE TB NOTIFICATION PROTOCOL

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INTERSTATE TB NOTIFICATION PROTOCOL

EFFECTIVE DATE: November 1999, revised June 2003

PURPOSE:

To ensure that patients with active TB, their contacts and LTBI patients receiving treatment who move in or out of New York City (NYC), or travel for greater than one month to or from NYC, receive proper follow-up and ensure that they complete TB treatment and that reporting to the Centers for Disease Control and Prevention (CDC) is maintained.

This policy complies with the National TB Controllers Association (NTCA) recommendations of April 2003.

POLICY:

1. When patients with active TB, their contacts and LTBI patients receiving treatment move out of NYC for 30 days or more, the NYC Department of Health and Mental Hygiene (DOHMH) BTBC Interstate Coordinator (IC) will notify the Health Department in the patient's new jurisdiction using the NTCA Interjurisdictional TB Notification form (NTCA 5-2002) within three days of becoming aware of the patient's departure. The NYC BTBC Interstate Coordinator will follow-up 30 days later to verify that the patient was found and connected to care. Notification and follow-up are mandatory for class 3 and 5 patients and for contacts; notification is optional for LTBI patients.
2. The IC will obtain TB testing and management information for all contacts and patients on LTBI treatment and will obtain treatment completion and related information for active TB cases, as described below, within 30 days of the move and within a month of expected time of treatment completion.
3. The BTBC will submit a Case Completion Report to the CDC for all TB cases counted by NYC regardless of their final place of residence.
4. Patients with active TB, their contacts and LTBI patients receiving treatment who move into NYC will be brought under medical supervision (i.e., will have an appointment made and kept) within four weeks of notification from the outside jurisdiction and location of the patient. BTBC staff will manage the patient in the same manner as if the patient was initially counted in NYC. BTBC will send case completion information to the counting jurisdiction at the end of treatment.
5. When issues arise about which jurisdiction should count a case, it may be necessary for the Office of Surveillance to discuss with the health department in the other jurisdiction. A decision about which jurisdiction will count the case should be made within 120 days of case report.
6. This policy does not apply to TB patients who have moved outside of the United States. No follow-up is done after the initial international notification. See Protocol for International Notification for further information on this subject.
7. Use the Interjurisdictional TB Notification (NTCA 5-2002) (Notification form) and the Interjurisdictional TB Notification Follow-up form (NTCA 5-2002) (Follow-up form). The BTBC Interstate form will no longer be used.

ELEMENTS OF THE PROTOCOL:

1.0 Transfer of Verified Cases or TB Suspects OUT of NYC

If the patient informs the DOH treating physician or case manager that s/he will be relocating or traveling for >1 month outside of NYC (but within the USA), **immediately obtain an address or any available contact information for the patient in the new jurisdiction**. If possible, schedule or advise the patient to schedule an appointment with a medical provider PRIOR to the patient's departure.

1.1 BTBC Treating Physician's Responsibilities - for Chest Center Patients:

1.1.1 Perform a medical examination, obtain laboratory and other studies as needed and discuss the plan for follow-up care in the patient's new place of residence.

1.1.2 Dispense a one-month supply of medications. In the case of patients who have had a high compliance level, the physician may decide to dispense up to a maximum of 2 months supply of medications, if the patient will travel for more than a month but less than 2 months. The physician is to instruct the patient to receive medical follow-up immediately upon arriving in the new place of residence.

1.1.3 Providers should not continue to dispense anti-TB medications to a patient who is no longer living in NYC and not coming in for medical visits.

1.1.4 Document the above clearly in the patient's medical record, including the plan for completing treatment.

1.2 Case Manager's Responsibilities - for all Patients:

1.2.1 Obtain new contact information immediately and note it in the patient's clinic or field record.

1.2.2 Immediately complete the Notification form and the Interstate Referral Request Cover Sheet, after review by the Network Liaison, place a copy in the patient's medical or field record. Fax AND send via interoffice mail a copy of the form to the IC in CRS at 212-788-4179, 125 Worth Street, Room 214, Box 74, <u>within 3 business days of learning that the patient has moved</u>. **Do not wait until months later or cohort time to request follow-up information**.

1.2.3 Send a copy of the PIF, TB registry printout, selected relevant sections of the patient's clinic or field record (such as select physician's notes or a physician's summary of the case), TST result, chest X-ray report, and select laboratory results to the IC via the Network Liaison. The information should be reviewed so that contacts' names or other information not directly relevant to the case is not sent to the other jurisdiction.

1.2.4 If the patient has already left NYC, complete the Notification form in consultation with the BTBC treating physician and/or Medical Manager and proceed as described in #1.2.2 above.

1.2.5 Thirty days after the patient has moved and around the expected time of treatment completion, obtain treatment completion and related information from the IC.

1.2.6 Clearly specify what follow-up information is needed from the IC in the comment section of the Notification form.

1.2.7 Case managers can undertake extra follow-up beyond what is done by the IC coordinator as needed for case management purpose.

1.2.8 The case manager will update the TB Registry with all information received from the patient's new jurisdiction and enter the appropriate disposition.

1.3 RVCT Coordinator Responsibilities:

1.3.1 After receipt of the monthly standard download of TB cases and suspects and the file of interstate contacts, identify and generate a list of TB cases, suspects, contacts, and LTBI patients receiving treatment who have initial or current out-of-NYC addresses and give it to the IC for review and follow up.

1.3.2 Oversee the entry of newly identified interstate patients into the interstate database (by the unit's college aide or the IC).

1.4 CRS Responsibility

1.4.1 Change the TB Registry patient status information as requested by the IC (See Appendix __ for registry status and disposition codes).

1.5 Interstate Coordinator (IC) Responsibilities

1.5.1 **Review of Cases and Suspects List:** Upon receipt of the monthly list of TB cases, suspects, contacts and LTBI patients under treatment who have initial or current out-of-NYC addresses, review the TB Registry and request from the outside jurisdiction follow-up information on patients for whom BTBC does not have follow-up information and on those who are within one month of treatment completion.

1.5.2 **Paperwork Completion**

1.5.2.1 Upon receipt of the Notification form, enter all required patient information into the interstate database.

1.5.2.2 Within 3 days of receipt of the Notification form, call the State Health Department in the patient's new jurisdiction to inform them of the patient transfer and of the materials they will receive by fax. See section 7.0 for Communication Information.

1.5.2.3 Fax copies of the Notification form and all documents as listed in 1.2.3 (such as PIF and select portions of clinic/field records) received from the Network Liaison to the Health Department in the patient's new jurisdiction.

1.5.2.4 If the only copy of the Notification form is a faxed copy, complete a new form (i.e., transcribe the same information on a blank form), as a fax of a faxed form will not be legible.

1.5.2.5 Verify that the interstate notification documents were received by calling the new jurisdiction.

1.5.2.6 Scan the interstate documents in the Electronic Filing System (EFS) (See the Patient Record Scanning Protocol).

1.5.2.7 File copies of the Notification form in the patient's CRS record. Put a note in the patient's record (in the PIF) stating that the patient moved to another jurisdiction and that an interstate referral was made.

1.5.3 Follow-up

1.5.3.1 Carefully review requests for follow-up and return them to the networks and clinic staff if the request is not clear, incomplete or outdated. Discuss with the RVCT Coordinator, Surveillance Director or Surveillance Deputy Director as needed.

1.5.3.2 The IC will attempt to obtain follow-up information from the health department in the patient's new place of residence 30 days after the Notification form has been sent and around the expected time of treatment completion. The purpose of the 30-day follow-up is to verify if the patient has been located and was linked to care.

1.5.3.3 The IC will send a (pre-made, standard format) letter AND a fax (verify that the fax was received) to the health department to request the needed information.

1.5.3.4 If after a week, no information was received, up to 3 telephone calls will be made; the last telephone call will be made 60 days after the Notification form was sent (i.e., 30 days after the follow-up request was sent).

1.5.3.5 If there is no response, the results will be noted in the interstate database and the Network Liaison informed. No further attempts will be made.

1.5.3.6 If the other jurisdiction could not find the patient, close the case as lost in the registry and inform the case manager. The case manager can continue to follow-up if wished by the case management team.

1.5.3.7 If an incomplete response is received from the health department, 2 telephone calls will be made to request complete information. No further attempt will be made beyond these 2 telephone calls.

1.5.3.8 Treatment completion information should include at least treatment regimen, final negative smear and culture, latest susceptibility results, updated chest X-ray, DOT compliance and total weeks on treatment.

1.5.3.9 Forward case completion information on moved cases counted by NYC to the Report of Verified Cases of TB (RVCT) Coordinator for inclusion in the Case Completion Report submitted to the CDC (and to the case managers as per #1.5.4).

1.5.3.10 If the patient was a verified case of TB when she/he moved from NYC or became confirmed after the move and is being counted by NYC, the IC will contact the health department in the patient's new jurisdiction no later than 30 days after the patient's expected date of treatment completion to obtain final information on the patient.

1.5.3.11 If no information is received after one fax (verify that the fax was received), a letter was sent and 3 phone attempts to contact the health department over a one-month period (i.e., 2 months after the Notification form was sent), enter disposition as moved or lost (if the patient was not found).

1.5.4 Updates:

1.5.4.1 Provide all updates (at 30 days, at cohort time/treatment completion) to the designated Network Liaison. Obtain the name of the Network Liaison from the Network Director.

1.5.4.2 A month before a scheduled cohort review, start gathering up-to-date information on all interstate active TB patients and contacts for the upcoming cohort review even if the patient is not expected to conclude treatment at the time of the cohort; include the number of attempts and level and type of effort made to obtain updated information (i.e., number of telephone calls made or fax sent).

1.5.4.3 Send the updated information to the Network Liaison by close-of-business Thursday before the cohort for Tuesday cohorts or at least two days before the

scheduled cohort.

1.5.4.4 Send a complete package on each cohort patient for the given network to the Surveillance Coordinator of that network, including printouts from the interstate database and copies of relevant note pages. Meet as needed with the Surveillance Coordinators before cohort to discuss problems cases.

1.5.4.5 The IC will update the Interstate database with all relevant information received from the patient's new jurisdiction.

1.5.5 Scenario 1:

1.5.5.1 If the patient was a suspect when she/he moved out of NYC but later becomes a verified case of TB in the new jurisdiction, in most instances NYC will count the case.[1] (For more information regarding guidelines for counting cases, refer to the CDC Recommendations for Counting Reported Tuberculosis Cases; if additional clarification is needed, consult the Surveillance Director).

1.5.5.2 The IC will obtain the relevant documentation from the patient's new jurisdiction and send them to the Network Liaison.

1.5.5.3 The IC will then request that CRS change the TB Registry record from status 1 to status 2 (see Change of Status Protocol).

1.5.5.4 The IC will inform the new jurisdiction that NYC will be counting the case and send a copy of all the relevant documentation to the Network Liaison and file a copy in the patient's CRS record.

1.5.6 Scenario 2:

1.5.6.1 If the patient was a suspect at the time he/she moved from NYC but later becomes a verified case of TB in the new jurisdiction and the new jurisdiction will be counting the case (for example, when a patient is hospitalized or dies in a NYC hospital and the only available address at the time is that of the hospital; only later it becomes known that the patient is a resident of another jurisdiction), the IC will request that CRS change the TB Registry record from status 1 to status 4 (counted by other) and disposition to 4 (moved to another jurisdiction).

1.5.6.2 CRS will enter the code of the new jurisdiction after the disposition code and close the record.

1.5.6.3 The IC will send a copy of all documentation describing why the case is being counted by another jurisdiction to the Network Liaison and file a copy in the patient's CRS record.

1.5.7 Other Scenarios:

1.5.7.1 If the patient is a suspect at the time he/she transferred out of NYC and is confirmed never to have been a NYC resident but no information can be obtained from the other jurisdiction about the case status (confirmed TB or not), give the

[1]Cases diagnosed in NYC and which later move to a NY prison upstate will not have a disposition of 4 because NYC BTBC continues to case manage these patients. The only exception is cases that are diagnosed with TB at a NYC hospital but are incarcerated at an upstate prison, as these cases will be counted by the upstate county and will have a disposition of 4. Individuals incarcerated in an upstate prison can be sent to a NYC hospital for medical care.

patient a disposition of non-count.

1.5.7.2 If a suspect was found not to be a verified case of TB by the new jurisdiction, close the record as a "non-countable" on the TB Registry (see Change of Status Protocol).

1.6 Surveillance Coordinator's Responsibilities:

1.6.1 Serve as the representative of the Interstate Coordinator and Surveillance Office at cohort review meetings.

1.6.2 Receive a package of updated information on interstate patients before each cohort from the Interstate Coordinator. Review the information and meet with the IC as needed to clarify issues.

1.6.3 At cohort review meetings, present and clarify the efforts made by the interstate coordinator when needed. If there are issues that need resolution, bring them back to the Interstate Coordinator after the cohort. The Interstate Coordinator will then follow-up with each network to clarify these issues.

1.7 Network Liaison's Responsibilities

1.7.1 Coordinate communication between Networks and the Interstate desk.

1.7.2 Obtain needed information from network staff as requested by the IC, including copies of PIF, clinic or field records, all laboratory results and TB registry printout.

1.7.3 Forward all information received from the IC to the relevant network staff.

1.7.4 Ensure that the Notification form is filled correctly and is complete and that all pertinent information is included in the package before sending it to the IC.

2.0 Transfer of TB Cases and Suspects INTO NYC

2.1 Interstate Coordinator Responsibilities:

2.1.1 Creation of Registry Records:

2.1.1.1 Upon receipt of a Notification form from an outside health department, arrange for CRS to create a Registry record for the patient and assign an A# and status 4 if the patient has a culture positive for *M. tuberculosis*, otherwise assign status 1. CRS will also assign the case to the appropriate Network based on the patient's address listed on the Notification form.

2.1.2 Send follow-up information at 30 days and when the final status is known to the referring jurisdiction.

2.1.3 Treatment completion information should include at least treatment regimen, final negative smear and culture, updated chest X-ray, DOT compliance and total weeks on DOT.

2.1.4 The IC will complete the top portion of the Follow-up form immediately and place it in the patient's interstate file. This form should be completed whenever an update is sent.

2.1.5 If the patient will be incarcerated at Riker's Island, notify the Queens Network.

2.1.6 **Scenario 1:** If the patient was a suspect at the time of transfer into NYC but later became a verified case of TB once in NYC, the referring jurisdiction will count the case (for further information regarding guidelines for counting cases refer to the CDC Recommendations for Counting Reported Tuberculosis Cases; if additional clarification is needed, consult the Surveillance Director). The IC will obtain the relevant

documentation regarding the TB case verification (such as copy of physician's notes, laboratory reports, at in 1.2.3 above) and send copies to the referring jurisdiction.

2.1.6.1 The IC will request that CRS change the TB Registry record from status 1 to status 4 and enter the code of the referring jurisdiction.

2.1.6.2 File a copy of relevant documentation in the patient's CRS record.

2.1.7 **Scenario 2:** If the patient was a suspect at the time of transfer into NYC but later becomes a verified case of TB once in NYC and NYC will count the case (this will happen infrequently, for example, if a patient is a suspect in another jurisdiction but is a resident of NYC), the IC will request that CRS change the TB Registry record from status 1 to status 2 (see Change of Status Protocol).

2.1.7.1 Inform the new jurisdiction and BTBC RVCT Coordinator that NYC will be counting the case.

2.1.7.2 Send a copy of all the relevant documentation to the Network Liaison and file a copy in the patient's CRS record.

2.1.8 **Scenario 3:** If the patient was a verified case of TB at the time he/she transferred into NYC or was verified after transfer into NYC and will be counted by the referring jurisdiction, contact the health department in the patient's old jurisdiction within one month of the patient's expected date of treatment completion to provide the required follow-up information needed for the CDC Case Completion Report.

2.1.9 **Scenario 4:** If the patient was a suspect at the time of transfer into NYC and does not become a verified case of TB once in NYC, notify the referring jurisdiction and send copies of relevant documentation.

2.1.10 **Scenario 5:** If a patient cannot be found, upon notification that the Case Manager has been unable to locate the patient within two weeks of assignment, the IC will call the referring health department to verify the patient contact information.

2.1.10.1 The IC will provide any new information received to the Network Liaison.

2.1.10.2 If the Case Manager is still unable to locate the patient, the Case Manager, through the Network Liaison, will notify the IC who in turn will inform the referring health department that the patient was not located.

2.1.10.3 The IC will confirm that the Network staff closes the record with a disposition of 3 (lost to follow up) if it was a status 4 case or a disposition of 6 if the status was 1.

2.1.11 **Scenario 6:** If the IC is notified (via the Notification form) by a Network Liaison of a patient who may have been treated for TB outside of NYC, the IC will inquire from the appropriate Health Department whether the patient was a reported and/or verified case of TB and follow the above guidelines. If the case was reported in the outside jurisdiction, request a Notification form and pertinent medical information.

2.2 CRS Responsibility:

2.2.1 CRS will create a Registry record for each patient transferred into NYC and assign an A#. Assign status 4 if the patient has a culture positive for *M. tuberculosis* or if the patient is already a clinically-confirmed case, otherwise assign status 1.

2.2.2 CRS will also assign the case to the appropriate Network for case management based on the patient's address listed on the Notification form.

2.3 Case Manager's Responsibilities – for Chest Center or Field Patients:

2.3.1 Upon assignment of a new case that recently transferred into NYC, call or make a home visit to bring the patient under medical supervision. If the patient cannot be located within two weeks of assignment, notify the IC.

2.3.2 If information from an initial interview suggests that a patient was previously under treatment for TB outside of NYC, notify the IC by phone or fax (may fax the appropriate page(s) from the Patient Information Form [PIF]) to request that the outside health department be contacted to obtain information about the patient.

2.3.3 Follow-up and case manage all patients as per case management protocol.

2.4 Network Liaison's Responsibilities:

2.4.1 If the Chest Center/Field Office directly receives a Notification form or other documentation about a patient from an outside jurisdiction, fax and mail a copy of the form/documentation to the IC in CRS so that the IC can follow up as per section 2.1 above.

2.4.2 Coordinate communication between Networks and the Interstate desk.

2.4.3 Send the Notification forms for all patients to be transferred out of NYC.

2.4.4 Obtain needed information from network staff as requested by the IC.

2.4.5 Forward all information received from the IC to the relevant network staff.

2.4.6 Ensure that the Notification form is filled correctly and is complete.

3.0 Contact Investigation Referrals Going OUT of NYC:

3.1 This protocol relates to tracking or follow-up of contacts of a NYC case and who may live outside of or have moved from NYC. The other jurisdiction(s) needs to be contacted for assistance in the investigation. Always send a Notification form and Cover Sheet for all contact investigations.

3.2 Interstate Coordinator's Responsibility:

3.2.1 Information on a Contact Investigation that was initiated in NYC but will require follow up in another state should be noted in the appropriate space on the Notification form and details provided in the remarks section.

3.2.2 The IC will request follow-up information on contact testing using the TB 151 Contact Information Sheet for the contact(s) and the Follow-up form for the index patient. This will ensure that information for all contacts is captured on the TB 151 form and clinical information on the index case is also obtained.

3.2.3 The IC will forward the contact investigation referral to the appropriate jurisdiction. The receiving jurisdiction is responsible for the contact investigation.

3.2.4 The IC will inquire whether infected contacts have been started on LTBI treatment and will follow-up with the new jurisdiction around the expected time of completion to find out the contact's final disposition.

3.2.5 Interstate Notification is done by the IC within 3 working days for first circle contacts who were exposed to a NYC case but reside in another jurisdiction upon identification of these first circle contacts.

3.2.6 The IC will follow-up at 30 days to verify that the contact was located and find out the outcome of the contact testing.

3.3 Case Manager's Responsibilities:

3.3.1 When requesting contact investigation and testing in another jurisdiction, all available information should be included on the Notification form. A form needs to be completed for EACH contact to be followed. Include pertinent information on the index patient: smear results, culture, susceptibility results, response to treatment, if available, period of infectivity, number of close contacts infected, if available).

3.3.2 The Notification form should be filled out for the index case as usual, and the name of the contact(s) needing testing should be listed in the comment section. In addition, the infectious period, last date of exposure, and the extent of the exposure (close, casual, or other contact) should be included in the comment section. The state receiving the referral will return the form if it does not include this information.

3.3.3 If there are two or more contacts to be referred to more than one jurisdiction for TB testing, the Case Manager should list the contact(s) for each jurisdiction on a separate contact information form.

3.3.4 The Case Manager will request the Network Liaison to notify the Interstate Coordinator of these contacts immediately upon their identification.

3.4 Network Liaison's Responsibilities:

3.4.1 Send the required information and requests to the IC on contacts to be investigated outside of the city. Coordinate communication between Networks and the Interstate desk.

3.4.2 Send the Notification forms and all relevant documents sent by the Network Liaison for all patients to be transferred in and out of NYC.

3.4.3 Obtain needed information from network staff as requested by the IC.

3.4.4 Forward all information received from the IC to the relevant network staff.

3.4.5 Ensure that the Notification form is filled correctly and is complete and that all pertinent information is included in the package before sending it to the IC.

3.5 Expanded Contact Investigations in Congregate Settings Referred to Another Jurisdiction:

3.5.1 This refers to notification of possible contacts in a congregate setting (such as worksites or schools) located in another jurisdiction and in which a NYC patient spent time during the potentially infectious period.

3.5.2 **Case Manager's Responsibility:** Upon learning of a possible need for expanded contact investigation in a congregate setting, the Case Manager must notify the Network Epidemiologist of these locations immediately.

3.5.3 **Epidemiology Office's Responsibility:**

3.5.3.1 The Network Epidemiologist will make a verbal notification of the exposure to the appropriate TB Control person in the other jurisdiction by telephone within 3 working days of becoming aware of the exposure.

3.5.3.2 The epidemiologist will provide the information needed to assist the TB Control staff in their decision to test contacts in that setting including clinical and bacteriologic characteristics of the case, extent of exposure in the congregate setting, and the TST results in closest contacts (pre-window), as available.

3.5.3.3 At the end of the telephone conversation, the epidemiologist will complete and send a Notification form to the Interstate Coordinator and attach a copy of the Epidemiology Note.

3.5.3.4 The reason for notifying other health departments about TB exposures in congregate settings that occur in their jurisdiction is to give other TB control

programs information so they can make a decision about the indication for testing of contacts at that site according to their program practices and priorities.

3.5.4 **Interstate Coordinator's responsibility:** the IC will send the Notification form and any other relevant information to the relevant TB Control staff in the outside jurisdiction.

4.0 Contact Investigation Referrals Coming INTO NYC:

4.1 This refers to contact investigations started in another jurisdiction that need to be continued in NYC.

4.2 Interstate Coordinator's Responsibility:

4.2.1 When the IC receives notification from an outside department of health regarding a contact investigation that will require follow up in NYC, the IC will ask CRS to assign a Z number to the patient (regardless of whether the contact is yet tested or not). In case of contact investigation in a congregate setting, see section 4.5.

4.2.2 This assignment will be based on the network which will case manage the index patient if she/he is a NYC patient and the facility where the patient will receive care.

4.2.3 If the index patient is not in NYC, the case manager will be selected based on the contact's address.

4.2.4 If the contacts are linked to an index case on the registry, then their status should be 5A.

4.2.5 If an incoming interstate contact does not have an A# to be linked to, one will be created with the information available on the index case and with a status of 4 and a disposition of "moved". The registry will be updated to allow a disposition of "contact investigation only" to be selected.

4.2.6 The IC will forward all relevant information to the Network Liaison in the network where the contact resides.

4.2.7 The IC will send an update at 30 days and at case closure to the initial jurisdiction.

4.3 Epidemiology Office's Responsibility:

4.3.1 If the Network Epidemiologist or Expanded Contact Investigation Unit becomes aware of an exposure, they will forward the information to the IC.

4.4 Case Manager's Responsibility:

4.4.1 Request that the Network Liaison notify the IC upon becoming aware of a contact investigation that will require sending updates to another jurisdiction.

4.4.2 Once a network is assigned to do a contact investigation, the case-manager is responsible for testing, follow-up and ensuring treatment completion of the contact.

4.5 Network Liaison's Responsibilities:

4.5.1 Coordinate communication between Networks and the Interstate desk.

4.5.2 Send the Notification forms for patients who were transferred into NYC directly from another jurisdiction.

4.5.3 Obtain needed information form network staff as requested by the IC.

4.5.4 Forward all information received from the IC to the relevant network staff.

4.5.5 Ensure that the Notification form is filled correctly and is complete.

4.6 Expanded Contact Investigations in Congregate Settings Referred TO NYC from an

OUTSIDE Jurisdiction

4.6.1 Interstate Coordinator's Responsibility:

4.6.1.1 When the IC receives notification from an outside department of health regarding an exposure in a congregate setting that will require follow up in NYC, the IC will inform the Expanded Contact Investigations (ECI) Coordinator within 24 hours of receipt of the information.

4.6.2 Epidemiology Office's Responsibility:

4.6.2.1 The Expanded Contact Investigations Coordinator will review the characteristics of the case and the exposure and make a determination about the need for testing contacts at the site.

4.6.2.2 If testing is indicated, the ECI Coordinator will assign the investigation to a Network Epidemiologist or other appropriate Epidemiology Unit staff.

4.6.2.3 The results of the investigation will be sent to the referring jurisdiction within 3 days of completing the investigation report.

5.0 LTBI Patients on Treatment Who Move OUT of NYC:

5.1 Notification and follow-up are optional for LTBI patients and will depend on the patient's risk level and the IC's workload. Efforts will be made to send notifications and follow-up on high-risk LTBI patients.

5.2 Interstate Coordinator's Responsibility:

5.2.1 The IC will follow the usual steps for an interstate referral by sending the patient's information both by fax and mail to the receiving jurisdiction using the Notification form.

5.2.2 If the patient is at high-risk for progression to active TB, then the IC will attempt to request an update 60 days after the interstate notification was sent and treatment completion information within 30 days of expected treatment completion date. The process to obtain follow-up information will follow the same guidelines as in 1.5 above.

5.2.3 The IC will send all updates to the Network Liaison if and when received from the other jurisdiction.

5.2.4 Include information on date of TST, history of prior TST and risk factors for developing active TB, if available.

5.3 Network Liaison's Responsibilities:

5.3.1 Coordinate communication between Networks and the Interstate desk.

5.3.2 Send the Notification forms for all patients to be transferred out of NYC.

5.3.3 Obtain needed information form network staff as requested by the IC.

5.3.4 Forward all information received from the IC to the relevant network staff.

6.0 LTBI Patients Moving INTO NYC:

6.1 Interstate Coordinator's Responsibilities:

6.1.1 When the IC receives a notification that an infected patient needs to be started on LTBI treatment, a letter is sent to the patient to notify him or her to go for care and where to go. No Z# is given.

6.1.2 If the IC is notified of a patient who has been started on LTBI treatment in another

jurisdiction and needs follow-up, the IC notifies the patient by mail to contact the health department chest center most convenient for appropriate follow-up.

6.1.3 If the patient is a correctional facility resident, a recent converter (<2 years), an HIV-infected person or a child <5 years of age, the IC will assign the patient to the appropriate Network for follow-up based on the patient's address.

6.1.4 The IC will provide follow-up information to the initial jurisdiction once the patient is located and on treatment.

6.1.5 At the end of treatment period, the IC will forward treatment completion information to the referring jurisdiction.

6.1.6 If the patient could not be found, the IC will immediately notify the other jurisdiction that the patient was not found at the address given at the time of the referral.

6.2 Case Manager's Responsibilities – for Chest Center or Field Patients:

6.2.1 The Network Case Manager will contact the patient to offer LTBI treatment.

6.2.2 If the patient consents to LTBI treatment, a Z# will be created by the case manager once the patient has come for care.

6.2.3 The case manager will manage the patient according to protocol and send treatment information on the patient to the IC via the Network Liaison to forward to the referring jurisdiction when LTBI treatment is completed.

6.3 Network Liaison's Responsibilities:

6.3.1 If a LTBI patient from another jurisdiction comes to the attention of a case manager or comes to a chest center for treatment, the patient will be assigned a Z number.

6.3.2 Notification will be sent to the IC so the patient can be entered into the interstate database and follow-up sent.

6.3.3 The Network Liaison will send follow-up information to the IC.

7.0 Communication:

7.1 **New York State:** The IC will communicate directly with Westchester, Nassau, Suffolk and Rockland county health department staff both for incoming and outgoing communications, CC the state health department in Albany for the initial notification only. The IC will communicate with the Metropolitan Regional Public Health Representative located at 5 Penn Plaza for the rest of the state and for correctional facility residents. A copy of case completion information should be sent to the state.

7.2 **California:** The IC will communicate directly with each county health department.

7.3 **Rest of USA:** Communicate with the state health department.

7.4 It is not recommended to contact providers directly.

8.0 Abbreviations

BTBC	Bureau of Tuberculosis Control
CDC	Centers for Disease Control and Prevention

SURVEILLANCE PROTOCOLS NYCDOHMH BTBC
SECTION: INTERJURISDICTIONAL TB NOTIFICATIONS No. 3.10

NTCA	National Tuberculosis Controllers Association
TB	Tuberculosis
LTBI	Latent TB Infection
IC	Interstate Coordinator
CRS	Central Registry System (surveillance)
DOT	Directly-Observed Therapy
RVCT	Report of a Verified Case of Tuberculosis
PIF	Patient Information Form
ECI	Expanded Contact Investigation

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