# Tuberculosis Patient Discharge

# Hospital to Community

Massachusetts Department of Public Health

Division of Global Populations and Infectious Disease Prevention



**INTRODUCTION**

# Massachusetts regulation 105 CMR 300.000 establishes reporting, surveillance, isolation, and quarantine requirements for specific diseases, including tuberculosis (TB). This regulation establishes the process for immediate reporting of confirmed or suspected TB, defines requirements for isolation of persons with infectious tuberculosis, and provides guidance for determining the infectious period for the patient.

Massachusetts regulation 105 CMR 365.000 requires hospitals and other institutions to collaborate with the Massachusetts Department of Public Health (MDPH) TB Program to plan discharge into the community of persons with suspected or diagnosed tuberculosis.

The rationale for a proactively planned discharge is to ensure a comprehensive plan is in place to address the individual’s needs in the community for continuity of effective care and to ensure the safety of others who may share residence or spend time with the TB patient. Developing a concrete discharge plan requires review of the clinical status of the patient, the setting to which the patient will be discharged, and any extenuating circumstances or concerns.

This document offers inpatient providers and local public health departments practice guidelines for developing a sound discharge plan that serves the patient and protects the public. In addition, the document outlines the importance of engaging local public health resources in the city or town to which the patient is being discharged.

**REPORTING REQUIREMENTS**

Hospitals are required to report any individual with suspected or confirmed active TB to the MDPH by calling 617-983-6801 or completing and faxing a case report form. See [www.mass.gov/how-to/report-a-case-of-tuberculosis-disease-or-latent-tb-infection](http://www.mass.gov/how-to/report-a-case-of-tuberculosis-disease-or-latent-tb-infection).

Reporting in a timely manner allows for optimal patient management. It is never too early to collaborate with TB Program staff and the local public health nurse for discharge planning and development of an outpatient case management plan. TB Program staff will be in contact with the inpatient facility to provide technical assistance on formulating the outpatient plan of care. **For Division staff to advise hospitals on community discharges for suspected or confirmed cases of TB, a case report must be received.**

**PLANNING REQUIREMENTS: ALL PATIENTS**

*A pre-discharge conference and/or consultation between hospital staff, MDPH, and the local public health nurse is required before discharge of the patient to the community, regardless of site of TB disease. However, persons with suspected extra-pulmonary tuberculosis, who have been ruled out for pulmonary tuberculosis, generally are not infectious.*

Essential elements for discharge planning for all hospitalized patients:

* Hospital staff and the local public health nurse case manager participate in, and agree upon, the discharge plan. Early collaboration with state and local public health can expedite the formulation of the discharge plan.
* A pre-discharge home evaluation by the local public health nurse case manager is conducted to confirm the discharge address and assess the appropriateness for the patient. Note that for patients with pulmonary or laryngeal TB, a more comprehensive home evaluation is required (see below).
* The hospital is responsible for arranging the first outpatient TB appointment with a qualified provider prior to the patient’s discharge. To meet standards of care, this visit usually occurs within one month of discharge. Information on state-supported TB clinics is available at <https://www.mass.gov/service-details/massachusetts-tb-outpatient-services> for patients who will be followed by a state TB clinic provider.
* The hospital is responsible for providing the patient with adequate TB medications **in hand** to last until the outpatient TB appointment. Providing patients with written prescriptions at the time of discharge is not considered acceptable.

These elements for discharge planning are the same whether the patient is planning to receive community-based care from a private provider or through a state-supported TB clinic. MDPH TB Program staff can assist in identifying resources and appropriate follow-up care for the patient.

**PLANNING FRAMEWORK: PATIENTS WITH PULMONARY OR LARYNGEAL TB**

For patients with pulmonary or laryngeal TB, additional considerations must be reviewed and addressed for discharge planning. These include the patient’s clinical status and post-discharge setting, as well as person-level factors.

1. **Clinical Presentation**

The patient’s clinical status, including infectiousness, and identified and possible infecting organism drug resistance pattern, will inform the pre- and post-discharge process. These are reviewed below.

1. **Sputum AFB smear-positive, but not with identified or suspected multi-drug resistant TB (MDR-TB)**

**Allow discharge when these criteria are met:**

* Treatment regimen is consistent with American Thoracic Society/Centers for Disease Control and Prevention/Infectious Disease Society of America (ATS/CDC/IDSA) standards and specific for the suspected strain.
* The patient is improving clinically with treatment.
* Hospital staff **and** local public health nurse case manager have in place a plan to support patient adherence to treatment.
* A community assessment has been done by the local public health nurse, the setting to which the patient is going has been identified and safe provision of community care has been assured.
* Patient is willing, able, and motivated to cover mouth appropriately when coughing or wear a mask in the presence of visitors.
* Local public health nurse case manager has appropriate outpatient follow-up arrangements, including directly observed therapy (DOT) to be administered by a healthcare worker (not family member).

**Do not allow discharge into any of the following living situations without consulting MDPH TB Program staff:**

* Congregate living sites (e.g., shelter, nursing home, jail, group home);
* Where infants and children also reside until an evaluation is made and the risk of transmission is minimized;
* Where immunosuppressed persons also reside; or
* Where healthcare/social service providers are present in the home several hours a day and are subject to prolonged airborne exposure.

1. **Sputum AFB smear-positive patients with identified or suspected MDR-TB**

**Do not discharge until these criteria are met:**

* An appropriate treatment regimen has been defined and initiated, and the patient is improving clinically on therapy.
* The regimen details should be clearly noted, including the route of medication administration. Patients with intramuscular (IM) or intravenous (IV) treatment may require additional services, such as those provided by an infusion therapy company or Visiting Nurse Association. These services must be in place prior to discharge.
* The local public health nurse case manager has appropriate outpatient follow-up arrangements in place, including for DOT by a healthcare worker.

1. **Sputum AFB smear-negative patients, but not identified or suspected of being infected with MDR-TB**

**Allow discharge when these criteria are met:**

* + An appropriate treatment regimen has been defined and initiated, and the patient is improving clinically on therapy.
  + The home evaluation has been completed and conditions to support the patient, such as DOT, medications and monitoring plans, have been arranged by the local public health nurse case manager.

1. **Setting post-discharge**

A review of the setting to which the individual is being discharged can inform whether a less - or more - restrictive plan of care may be needed. Until that review is done by the local public health department, *all* settings initially should be considered high risk for ongoing transmission pending evaluation by Public Health.

* **High Risk Setting**

A *high-risk setting* is a household in which others will share air with the person known or suspected to have pulmonary tuberculosis and characterized by one or more of the following factors:

1. Large number (>5) or high density of persons;
2. Presence of persons at high risk of progression to active disease, including children less than five years of age, persons with immune-suppression;
3. Presence of persons who have not been previously exposed to the person known or suspected to have pulmonary tuberculosis.

* **Lower Risk Setting**

A *lower risk setting* is a residential or home setting that is not characterized as high risk and for which the following is true:

* 1. No other persons share the same space or re-circulated ventilation OR
  2. Other persons who share the same space are not at increased risk for progression to active disease OR
  3. All at-risk persons have been evaluated and previously exposed children under five years of age have been started on “window” prophylaxis.

1. **Person Considerations**
2. There may be instances where the hospitalized patient is unable or unwilling to accept appropriate outpatient care and needs a more restrictive environment at the onset of therapy. Referrals can be made to the MDPH Lemuel Shattuck Hospital, TB Treatment Services for interim hospitalization. Examples of situations when hospitalization may be appropriate include:

* An individual is unable or unwilling to adhere to a community TB care plan;
* An individual has demonstrated or documented mental health or substance abuse issues that adversely affect their ability to manage their TB treatment;
* An individual is currently experiencing homelessness and has no community supports or resources; or
* An individual who cannot be discharged to the community because they live in a congregate setting or with vulnerable persons in the home. Once determined to be non-infectious, this individual may be able to return to their regular residence.

1. The Lemuel Shattuck Hospital also provides hospital level of care for individuals with complex co-morbidities and/or treatment for which additional observation and interventions in a clinical setting are required.

In these situations, the discharging facility should consult with the MDPH TB Program staff at 617-983-6970 for further guidance.

**RESOURCE INFORMATION**

For more information, guidance, or questions regarding discharge of a person with suspected or confirmed TB to the community, hospitals and local public health departments can contact the Massachusetts TB Program at 617-983-6970.

For referrals to the DPH Lemuel Shattuck Hospital, contact the hospital’s Case Management Department at 617-971-3780. Information and consultation on referral to Lemuel Shattuck Hospital is also available from the MDPH TB Program staff.

**REGULATIONS**

**105 CMR 300**

Reportable diseases, surveillance, and isolation and quarantine requirements

<https://www.mass.gov/regulations/105-cmr-30000-reportable-diseases-surveillance-and-isolation-and-quarantine>

**105 CMR 360**

Tuberculosis treatment unit standards for admission, treatment, and discharge

<https://www.mass.gov/regulations/105-CMR-36000-tuberculosis-treatment-unit-standards-for-admission-treatment-and>

**105 CMR 365**

Standards for management of tuberculosis outside hospitals

<https://www.mass.gov/regulations/105-CMR-36500-standards-for-management-of-tuberculosis-outside-hospitals>