The *Tuberculosis (TB) Action Plan to Minimize Exposure to COVID-19*, created March 20, 2020, outlines recommended changes-in-practice for Department of State Health Services (DSHS) public health regions (PHRs) and local health department (LHD) TB programs when performing routine TB activities during the COVID-19 outbreak. This document outlines updates to the March 20\textsuperscript{th} plan and remains in effect until further notice.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Updated Recommendations</th>
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</table>
| Performing directly observed therapy (DOT) and directly observed preventive therapy (DOPT) services. | **Modified**  
  - Enhanced self-administered therapy (ESAT) may be *extended* during CovID-19 for clients in whom video-enabled DOT (VDOT) is not an option.  
  - Programs may continue to provide medications to clients with known or suspected TB disease in **one-month** increments.  
  - The decision to count any self-administered doses towards completion of therapy after one month may be made on a case-by-case basis by the local TB program. Considerations to count or not count self-administered doses include but are not limited to:  
    - Client compliance history prior to ESAT.  
    - Client compliance during ESAT.  
    - Risk for relapse (including low body mass index [BMI], poorly controlled diabetes, sub-optimally treated HIV/AIDS, slow bacteriologic response).  
    - Intermittent dosing schedules (counting ESAT doses is not recommended for adult clients taking less than daily [at least 5x weekly] dosing).  
  - A current medical order is required for every patient who was originally prescribed DOT but qualifies for ESAT due to CovID-19 constraints. |
| Evaluating new patients suspected of having TB disease (Class V) based on any report (fax, phone call, walk in, etc.). | **Unchanged with emphasis:**  
  Services for clients for whom medical management cannot be delayed or interrupted:  
  - Initial evaluation and treatment of patients with suspected or confirmed TB disease  
| Evaluating new patients with known TB infection (Class II). | **Unchanged with emphasis:**  
- Patients reported to the public health program after a diagnosis of TB infection should be evaluated to determine risk for developing TB disease.  
- If risk cannot be assessed from the referral, then patients should be first contacted by phone. If the patient cannot be reached by phone, a decision to defer a home visit should be made on a case-by-case basis.  
- If patient is high risk, delaying treatment is not recommended. Follow steps outlined in *Performing Monthly Assessments* section and consider phone visits and mailing medications in lieu of in-person visits after initial evaluation.  
- If patient is low risk, maintain a system of tracking new referrals for when the program can offer case management services. |
| --- | --- |
| Evaluating patients reported through the Electronic Disease Notification (EDN) system. | **Modified:**  
- Services for clients that could be continued or delayed depending on local resources and response to COVID-19:  
  - Evaluation of Class B immigrants and refugees.  
| Evaluating hospitalized patients in whom TB is suspected or known. | **Unchanged** |
| Performing monthly assessments on patients with probable or confirmed TB disease. | **Unchanged** |
| Performing monthly assessments on patients with TB infection. | **Modified:**  
- The TB program may continue to order medications to mail to clients who do not require in-person exams.  
- Medications may be mailed or provided to clients in **one-month** increments (ordering in **two-month** increments is no longer allowed.) |
| Performing initial, follow-up and end of treatment CXRs. | **Unchanged** |
| Performing sputum collection, natural or induced. | **Unchanged, with addition:** |
### Texas Department of State Health Services
### Tuberculosis and Hansen’s Disease Branch
### Updates to Tuberculosis Action Plan to Minimize Exposure to COVID-19

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
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<tbody>
<tr>
<td>Performing TSTs, IGRAs and any blood draws.</td>
<td><strong>Unchanged</strong></td>
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<tr>
<td>Performing physical assessments/examination (may/may not require hands on evaluation).</td>
<td><strong>Unchanged</strong></td>
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<tr>
<td>Conducting contact investigations (CI).</td>
<td><strong>Unchanged</strong></td>
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</tbody>
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| Targeted Testing. | **Unchanged, with addition:**  
  - May continue to defer.  
  - Considerations to re-open or continue targeted testing:  
    - When an epidemiologic assessment determines the selected facility is considered high risk for TB and targeted testing is a reasonable response to prevent a recurrence of TB disease transmission, **and**  
    - When there is no longer a risk to staff and patients for exposure to COVID-19, as determined locally. |
| Personal Protective Equipment (PPE) Required for Infection Control Precautions. | **Unchanged, with updated resource:**  
  - Determined by the local or regional public health department.  
  - Refer to the Centers for Disease Control and Prevention (CDC):  
| Home Visits (HV) Protocol | **Unchanged, with updated resource:**  
  - Refer to the CDC, specifically “Protections that Pertain to Field-Based Public Health Staff” located at:  
| Clinic Visits (HV) Protocol | **Unchanged, with updated resource:**  
  - Refer to the CDC, specifically “Protective Measures That Pertain to Public Health Clinical Settings” located at:  

- The treating physician may consider decreasing frequency of sputum collection. For example, after initial specimens, the two-week samples may be deferred with the next three samples collected monthly.  
- Considerations include if patient has no high-risk contacts in the same airspace.