

CHART ABSTRACTION TOOL FOR TB PROGRAM EVALUATION

This form was developed by the New York State Department of Health's Bureau of Tuberculosis Control (BTBC) as a self-evaluation tool for local TB programs. It is designed to (1) evaluate progress towards the goal of successful completion of TB treatment within 12 months, and (2) help programs identify patient and program factors associated with successful treatment completion.

The instrument was developed by BTBC and pilot tested in two counties, then revised and tested in three additional counties. The final version, below, consists of 53 questions in 15 sections; average time to complete the abstraction is approximately 30 minutes.

To use the tool, a program nurse, case manager, or other appropriate staff member should abstract data from all charts of TB patients diagnosed within a defined period (e.g., a calendar year). Use one form per chart. Data from the forms can be entered into a spreadsheet or database and analyzed to identify local factors associated with successful completion of treatment. Small sample size may limit the ability to identify statistically significant factors predictive of treatment completion. However, the tool can still be used to describe patient and program characteristics and help identify areas for improvement. Strategic application of this information may help increase the proportion of patients who complete therapy on time.

The accompanying TB Clinic Survey Form was also developed by BTBC but has not been systematically evaluated. It is designed to provide a general picture of a local TB clinic's organization and services.

County _____

Reviewer _____

Date _____

Case Number _____

CASE REPORTING

1. Source of Report

- Local Health Dept
- Private Physician
- Hospital
- Pharmacy
- Laboratory
- Death Certificate
- Federal Institution
- State Institution
- Other

2. Were all local and state reporting requirements met?

- YES
- NO

2a. If no, what was not met?

Hospitalization

3. Was the patient hospitalized?

- YES
- NO (Skip to #7)
- Unknown

4. Hospital Name: _____

5. Length of Stay (days): _____

6. If the case was hospitalized, was the discharge plan complete?

- YES
- NO
- Unknown

Initial Patient Interview Assessment

7. Where did the initial interview take place?

- Hospital
- Patient's home
- TB clinic
- Other _____

Symptom Review

8. Please check all symptoms reported by patient at initial interview:

- Cough
- Fever
- Weight loss
- Weakness or fatigue
- Chills

- Night sweats
- Other, please specify _____
- None

Lab Tests and Results

9. What is the patient's HIV status?

- Negative
- Positive
- Indeterminate
- Unknown
- Not Tested

10. Baseline liver function tests:

- Normal
- Abnormal
- Not Done

Sputum and Culture Results

11. What is site of disease? _____

12. Initial sputum smear result:

- Positive
- Negative
- Unknown
- Not Done

13. Was sputum culture conversion documented?

- YES
- NO (Skip to # 14)
- Not applicable (Skip to #14)

13a. Date specimen collected on initial positive sputum culture:

__/__/____

13b. Date specimen collected on first consistently negative sputum culture:

__/__/____

14. Was drug susceptibility testing done?

- YES
- NO

14a. If no, why not?

15. Was patient resistant to any TB drugs?

- YES
- NO

15a. If yes, which drugs?

TB Treatment Plan

16. Does the patient have a written treatment plan?

- YES
- NO

Social Needs/Barriers to Treatment

17. Does the patient have a permanent address?

- YES
- NO
- Unknown

18. Is the patient employed?

- YES
- NO (Skip to #20)
- Unknown

19. Is patient able to get time off from work to come to clinic when necessary?

- YES
- NO
- Unknown

19a. If no, what was done to overcome this barrier?

20. Does the patient have medical insurance?

- YES
- NO
- Unknown

21. Does the patient speak English?

- YES
- NO
- Unknown

22. Was an interpreter provided?

- YES (Skip to #23)
- NO
- Unknown

22a. If No, Why not?

23. Was patient education and other communication provided in the patients' preferred language?

- YES
- NO
- Unknown

24. Does the patient have any other barriers (cultural, religious, clinic accessibility, transportation, etc) to treatment?

- YES
- NO (Skip to #25)
- Unknown

24a. If yes, what are the barriers and what was done to overcome them?

Medical Needs

25. Does patient have medical conditions that would impact TB treatment?

- YES
- NO (Skip to #28)
- Unknown

26. If yes, please list medical conditions:

27. Is patient receiving treatment for these conditions?

- YES
- NO
- Unknown

Treatment

28. Was initial treatment a 4-drug regimen?

- YES
- NO

29. Indicate initial drugs used in patient regimen:

- INH
- EMB
- RIF
- RBT
- SM
- PZA
- Other_____

30. Who is prescribing TB medication?

- Public health clinic
- Private provider

31. If patient followed/referred by a private provider, were any difficulties encountered in exchanging information about this case?

- YES
- NO

31a. If yes, describe:

Directly Observed Therapy (DOT)

32. Was the patient evaluated for possible DOT/VOT?

- YES
- NO (Skip to #36)
- Unknown

33. If offered, did the patient accept DOT/VOT?

- YES (Skip to #34)
- NO

33a. If no, why not?

34. Was a schedule set up for DOT/VOT appointments?

- YES
- NO

35. Were *all* DOT/VOT appointments kept?

- YES
- NO

35a. If no, why not?

Medical Assessment While on Treatment

36. Were all clinical appointments kept (only consider appointments which were not rescheduled and attended as missed)?

- YES (Skip to #37)
- NO

36a. If no, why not?

37. Did patient suffer any adverse drug effects?

- YES
- NO (Skip to #39)
- Unknown

38. If yes, please indicate type of reaction (choose all appropriate):

- Increased LFT's
- Jaundice
- Rash
- Headaches
- Vision problems
- Other _____

39. Did treatment proceed as originally planned?

- YES
- NO
- Unknown

Completion of Therapy

40. Did patient complete treatment?

- YES
- NO (Skip to #43)

41. Did patient complete within 12 months of starting treatment?

- YES (Skip to #44)
- NO (Proceed to #42)

42. Reason for receiving greater than 12 months of treatment (Check all that apply):

- Hospitalized during treatment
- Rifampin resistant
- Comorbid conditions (diabetes, renal disease, AIDS, etc.)
- Incarceration
- Extrapulmonary disease
- Use of less effective drug regimen
- Non-compliance
- Adverse drug reaction
- Other (Specify _____)

43. Reason for stopping if not complete:

- Moved
- Lost
- Uncooperative/Refused
- Died
- TB ruled out
- Other _____

44. If patient refused medication, was the patient re-educated about importance of completion of treatment?

- YES
- NO
- Unknown

45. If patient refused medication, was legal action taken?

- YES
- NO
- Unknown

46. Were any incentives provided?

- YES
- NO
- Unknown

Supervisory review

53. How often was case reviewed by a supervisor?

- Weekly
- Monthly
- Other _____

Instructions for Completing the Chart Abstraction Form

Please begin by filling out the name of the county or other jurisdiction, name of the person reviewing the chart, the date the chart abstraction took place and the case number of the patient whose chart you are reviewing.

Case Reporting

1) Please check box indicating source of report.

2) Check box indicating whether reporting requirements were met. If not, please provide a detailed explanation as to what requirements were not met.

Hospitalization

3) Check appropriate box indicating whether or not the patient was hospitalized.

4) Indicate complete hospital name on line provided.

5) Indicate length of stay in days.

6) Indicate whether or not a complete discharge plan was received from the hospital

Initial Patient Interview Assessment

7) Check box indicating where the initial patient interview took place.

Symptom Review

8) Check box for all symptoms reported by patient.

Lab Test and Results

9) Check box indicating patient's HIV status.

10) Check appropriate box indicating results of baseline liver function tests.

Sputum and Culture Results

11) Indicate the patient's primary site of disease.

12) Check appropriate box indicating result of Initial (first) sputum smear.

13) Check appropriate box indicating sputum culture conversion was documented. If yes, please complete 13a. Date of initial positive sputum culture and 13b. Date of first consistently negative sputum culture.

14) Check appropriate box to indicate whether the drug susceptibility testing was performed. If no, then describe in detail why testing was not performed.

15) Check appropriate box indicating whether the patient was resistant to ANY TB drugs. If yes, please list all drugs the patient is resistant to.

TB Treatment Plan

16) Check appropriate box to indicate whether the patient has a written treatment plan. A simple prescription for TB drugs does not count as a treatment plan. The plan must include the original drugs and time frame for discontinuing or changing the regimen at minimum.

Social Needs/Barriers to Treatment

17) Check appropriate box to indicate whether the patient has a permanent address.

18) Check appropriate box to indicate if patient is employed.

19) Check appropriate box to indicate whether the patient is able to get time of from work to come to clinic when necessary. If no, then describe what may have been done to work around this problem.

20) Check appropriate box to indicate whether patient has medical insurance.

21) Check appropriate box to indicate whether patient speaks English.

22) Check appropriate box to indicate whether an interpreter was provided. If not, please indicate reason why interpreter was not provided.

23) Check appropriate box to indicate whether patient education and other forms of communication were provided in the patients' preferred language.

Medical Needs

25) Check appropriate box to indicate whether the patient has any other medical conditions that would have any effect on the patients TB treatment.

26) If the patient has other medical conditions, then you must list them here.

27) Check appropriate box to indicate whether patient is receiving treatment for these other medical conditions.

Treatment

28) Check appropriate box to indicate whether the patient was started on a 4-drug regimen.

29) Please check box next to all drugs patient received on the day treatment was first received.

If other than these drugs were received, please check other and indicate drug(s) on the line provided.

30) Check appropriate box to indicate whether TB medication is being prescribed by a public health clinic or private provider. If medication was prescribed while patient was in the hospital then please check, private provider.

31) Check appropriate box to indicate whether any difficulties were encountered while exchanging information with patients' private provider. If yes, then describe in detail the problems and what you did to try and overcome these problems.

DOT

32) Check appropriate box to indicate whether patient was evaluated for DOT/VOT.

33) Check appropriate box to indicate whether patient accepted DOT/VOT. If no, then describe in detail why patient did not accept DOT/VOT.

34) Check appropriate box to indicate whether a schedule was set up for DOT/VOT appointments.

35) Check appropriate box to indicate whether all DOT/VOT appointments were kept. Check no if patient missed even one appointment. If you check no, please provide and explanation for why appointments were not kept.

Medical Assessment While on Treatment

36) Check appropriate box to indicate whether all clinical appointments were kept. Check no if patient missed even one appointment, however please only consider appointments which were not rescheduled and attended as missed. If no, then describe in detail why patient was unable to keep all clinic appointments.

37) Check appropriate box to indicate whether patient suffered any adverse drug effects.

38) If patient suffered adverse drug effects check box indicating type of reaction. You may check more than one box if necessary.

39) Check appropriate box to indicate whether treatment proceeded as originally planned. The intent of this question is to ascertain whether treatment proceeded as would have been expected. If there were any unexpected changes to the patients treatment, please check no.

Completion of Therapy

40) Check appropriate box to indicate whether patient completed treatment for TB disease.

41) Check appropriate box to indicate whether patient completed treatment within 12 months of starting (12 months = 365 days).

42) If patient was on treatment for longer than 12 months check all boxes indicating reasons for this extended length of treatment. If the specific reason is not present in check list, please check other and provide a description on the line provided.

43) If patient did not complete treatment check appropriate box to indicate the reason patient stopped treatment.

44) If patient refused treatment check appropriate box to indicate whether they were re-educated about the importance of completing a full course of treatment.

45) If patient refused treatment check appropriate box to indicate whether legal action was taken in order to encourage patient to take treatment.

46) Check appropriate box to indicate whether incentives were provided to patient. If yes, describe in detail the incentives that were provided.

47) Check appropriate box to indicate whether enablers were provided to patient. If yes, describe in detail the enablers that were provided.

Answer questions 49-52a only if a patient moved to another jurisdiction while on treatment.

49) Check appropriate box to indicate whether an interjurisdictional form was completed and forwarded to new jurisdiction when patient moved.

50) Indicate date patient moved out of your jurisdiction.

51) Indicate date interjurisdictional form was completed.

52) Check appropriate box to indicate whether treatment completion information was received from new jurisdiction. If no, describe in detail what the local health unit did to try and obtain this information.

Patient Education

53) Check appropriate box to indicate who provided patient education at initial meeting.

Supervisory Review

54) Check appropriate box to indicate how often the case was reviewed by a supervisor. If Other, please indicate frequency on line provided.