



Roles of Contact Investigation Partners

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Learning Objectives

- Identify the key members of a contact investigation team.
- Examine legal and reporting requirements.
- Describe the TB contact investigation workflow.
- Apply clear communication pathways for successful implementation.

Who Are the Members of the Contact Investigation Team?

Roles, workflow, communication, and legal duties across hospitals, clinicians, public health nurses, DOT workers, and community partners

Why contact investigation matters

Contact investigation is the single highest-yield activity for finding TB infection and preventing the next generation of cases.

~10

contacts identified, on average, per infectious pulmonary case

20–30%

of close contacts are found to have TB infection

1%

of close contacts already have active TB disease at first screening

5–10%

lifetime risk of progression if infection is left untreated

Highest priority contacts: children under 5 years and people with immunocompromising conditions, including HIV. They can progress to severe disease within weeks, so they are evaluated first and started on treatment for presumed infection even when the initial test is negative.

What this presentation covers

1 Legal & reporting duties

Mandated reporting, timelines, isolation authority, and the statutory basis for public health access to contacts.

2 Roles & responsibilities

Who does what: hospitals, physicians, laboratories, public health nurses, DOT workers, and community partners.

3 The investigation workflow

Index case evaluation, decision to investigate, contact elicitation, testing, treatment, and closure.

4 Communication pathways

How information moves between the hospital, clinic, lab, health department, and the field.

5 Coordination best practices

Joint case conferences, shared care plans, warm handoffs, and standing agreements.

6 Measuring performance

Program targets for contact identification, evaluation, treatment initiation, and completion.

Contact Investigation Vocabulary

Term	What it means in practice
Index case	The first reported person with TB disease that triggers the investigation.
Source case	The person who transmitted infection to the index case — sought when a young child has TB.
Contact	Anyone who shared air space with an infectious case during the infectious period.
Infectious period	Typically begins 3 months before symptom onset or first positive finding, and ends after effective treatment, clinical improvement, and three negative sputum smears.
Close contact	Prolonged, frequent, or intense exposure — household members, intimate partners, shared sleeping or workspace.
TB infection (LTBI)	Positive TST or IGRA with no symptoms, normal chest imaging, and no infectiousness.
Window period	The 8–10 weeks after last exposure before an immune response is reliably detectable; drives the second test.
Concentric circle	Prioritization method: evaluate highest-risk contacts first, then expand outward only if transmission is documented.



Legal and reporting requirements

TB is a mandated-report condition in every state. Reporting is a legal duty, not a courtesy, and it is what authorizes the entire investigation.

Polling Question

Who is responsible for reporting a TB Case?

- A. Physicians, hospitals, and often nurses, and pharmacists
- B. Labs
- C. Correctional and long-term care facilities
- D. All of the above

Legal duties: who must report, and what authority follows

Mandated reporters

Physicians, hospitals, labs, correctional and long-term care facilities, and often nurses, and pharmacists

What is reportable

Suspected as well as confirmed TB. A positive AFB smear, compatible chest film, or started regimen is reportable.

Reporting timeline

Most jurisdictions require notification within 24 hours of suspicion; labs report positive smears immediately.

Isolation authority

Health officers may order isolation, examination, or directly observed therapy, with due process and court review.

Access to information

HIPAA expressly permits disclosure to public health — no patient authorization is required for records or names.

Confidentiality duty

The index case's identity is protected. Contacts are told they were exposed to TB, never who exposed them.

From Suspicion to Investigation: the reporting clock

Hour 0	≤ 24 hrs	≤ 1 business day	≤ 3 business days	≤ 7 business days
Suspicion Clinician or lab identifies possible TB. Airborne isolation begins immediately.	Report Case reported to the local health department by phone and written report.	Assign Health department assigns a public health nurse case manager and opens a case record.	Interview First index case interview completed; contact elicitation begins.	Field visit Site visits to home, workplace, or congregate setting to identify shared air space.

Delay is the enemy. Every day between diagnosis and the first interview is a day of continued exposure for household members and coworkers who do not yet know they are at risk.



Roles and Responsibilities

A contact investigation succeeds when each partner performs a defined role and hands off cleanly to the next. Ambiguity about ownership is the most common cause of lost contacts.

Roles at a Glance

Partner	Owns	Hands off to
Hospital / infection prevention	Isolation, exposure assessment among staff and patients, discharge planning	Health department, receiving clinic
Treating physician	Diagnosis, treatment regimen, infectiousness determination, reporting	Health department, PHN case manager
Laboratory	Smear, NAAT, culture, drug-susceptibility results, immediate critical-value reporting	Clinician and health department simultaneously
Public health nurse	Case management, index interview, contact elicitation, field investigation, testing plan	DOT workers, clinicians, community partners
DOT worker / outreach	Observed therapy, adherence support, symptom checks, locating contacts	PHN case manager
TB controller / medical consultant	Clinical oversight, complex-case decisions, expansion decisions, orders	PHN and treating clinicians
Congregate & community partners	Site access, roster provision, space for screening, trusted messaging	PHN case manager

Hospitals and infection prevention

- Place any patient with suspected TB in an airborne infection isolation room immediately — before confirmation, not after.
- Report the suspected case to the local health department within the required window; do not wait for culture results.
- Notify the health department again at discharge, and never discharge an infectious patient to a shelter, congregate setting, or unstable housing without a health department discharge plan.
- Conduct an internal exposure assessment when a patient was managed without isolation: identify exposed staff, roommates, and visitors, and share the list with public health.
- Coordinate employee-health testing for exposed staff on the same 0 and 8–10-week schedule used in the community.
- Provide the health department with the admission record, imaging, laboratory results, treatment start date and known household contacts.
- Designate a single named liaison — usually infection prevention — so public health is never routed through a general switchboard.

A discharge without a public health plan converts a contained hospital exposure into a community outbreak.

Physicians and treating clinicians

Report and document

Report suspected and confirmed TB within the mandated window. Reporting is a legal obligation of the individual clinician, not only the facility.

Define the infectious period

Provide symptom-onset dates, smear and NAAT results, imaging findings, and cavitation status — public health cannot set exposure dates without them.

Determine infectiousness

Document when the patient meets criteria for release from isolation: effective therapy, clinical improvement, and three consecutive negative sputum smears.

Evaluate referred contacts

Perform symptom review, testing, chest imaging, and rule out active disease before any contact starts treatment for TB infection.

Treat TB infection

Prescribe short-course rifamycin-based regimens for infected contacts and communicate the start date and regimen to the health department.

Consult early

Engage the TB controller for drug resistance, pediatric cases, HIV coinfection, pregnancy, or suspected treatment failure.

Laboratories: the trigger for everything downstream

- Report positive AFB smears and nucleic acid amplification results as critical values — to the ordering clinician and the health department at the same time.
- Target turnaround: smear and NAAT within 24–48 hours of specimen receipt; identification within 21 days; first-line drug-susceptibility results within 30 days.
- Flag rifampin resistance immediately — it changes contact management, regimen choice, and the urgency of expansion.
- Retain isolates and forward them for genotyping; matched genotypes confirm or refute suspected transmission chains and can redirect an investigation.
- Send IGRA's test results for contacts to both the ordering provider and the TB program, so screening completion can be tracked.
- Report negative and indeterminate results too — public health needs the denominator to know who still requires evaluation.

Polling Question

The local Health Department (PHN) owns the investigation from the beginning to the end-regardless of numerous partners contributing to the CI?

- A. True
- B. False

Public health nurse: the case manager and hub

The PHN owns the investigation from beginning to end — every other partner contributes to a plan the nurse holds.

Assess and interview

Interview within 1–3 business days, then re-interview — lists continue to grow as the investigation proceeds.

Map the exposure

Set the infectious period, visit homes and work sites, and build a defensible contact list.

Prioritize and test

Assign priority, arrange baseline and 8–10-week testing, and prioritize the highest-risk contacts first.

Ensure treatment

Confirm every infected contact is cleared of active disease, treated, and followed to completion.

Coordinate the team

Direct DOT workers, brief clinicians, negotiate site access, and convene case conferences.

Document and close

Maintain the record, report program data, decide on expansion, and close the investigation.

DOT workers, outreach staff and sometimes the PHN

Observe every dose

Watch the patient swallow each dose, in person or by video where policy allows, and record it the same day.

Screen at every visit

Ask about cough, fever, night sweats, weight loss, vision changes, jaundice, rash, and nausea; escalate side effects to the nurse immediately.

Keep people in care

Arrange transport, appointment reminders, incentives and enablers, and re-engage patients who miss doses before they are lost.

Extend the field reach

Locate hard-to-reach contacts, deliver appointment notices, and confirm addresses the interview could not resolve.

Report what you see

Household composition, new occupants, or a coughing family member observed in the home is investigation-critical information.

Protect trust

Discretion in the home and workplace is essential — no discussion of diagnosis with anyone but the patient.

Other partners and congregate settings

Partner	What public health needs from them
Schools and childcare	Rosters and seating or classroom groupings, space for on-site testing, letters to families, and a designated administrator contact.
Correctional facilities	Housing and movement records, rapid identification of transferred contacts, and continuity of therapy on release.
Homeless shelters and encampments	Bed logs and stay dates, on-site screening space, and trusted outreach staff to reach clients who move between sites.
Employers and occupational health	Shift schedules, workspace layout and ventilation, and time allowed for employees to be screened without penalty.
Long-term care and dialysis centers	Immediate identification of exposed residents, most of whom are at elevated risk of progression.
Community and faith organizations	Culturally appropriate messaging, interpretation, and reassurance that reduces stigma and increases turnout.
Federally qualified health centers	Capacity to evaluate and treat contacts locally, with results reported back to the TB program.



The investigation workflow

Five phases, each with a decision point. Work is sequential in principle and overlapping in practice, but no phase may be skipped.

Phase 1–2: Evaluate the index case, decide whether to investigate

PHASE 1 Index case evaluation

- Confirm site of disease, smear and NAAT status, and chest imaging including cavitation.
- Establish symptom-onset date and set the infectious period — usually 3 months before onset or first positive finding.
- Review treatment start date, regimen, and drug-susceptibility results.
- Assess behavior and setting: singing, shouting, poor ventilation, crowding, and time spent indoors.

PHASE 2 Decision and prioritization

- Investigate whenever the case is pulmonary, laryngeal, or pleural — smear-positive and cavitory cases are the highest priority.
- Extrapulmonary-only disease usually does not require an investigation, but a source-case search may.
- Apply concentric circles: household and closest contacts first.
- Expand outward only if transmission is documented in the inner circle.

Phase 3: Identify and interview contacts

- Interview the index case in private, in their preferred language, using a trained interpreter rather than a family member.
- Explain confidentiality explicitly and early — fear of exposing family, employers, or immigration status is the leading reason contact lists are incomplete.
- Reconstruct the infectious period day by day: where the person slept, worked, socialized, worshipped, travelled, and sought care.
- Re-interview at least once after 1–2 weeks. This is an ongoing process. Every conversation is the opportunity to identify additional contacts.
- Conduct field visits to confirm shared air space; a floor plan and ventilation assessment beat a verbal description.
- Record for each contact: name, locating information, physical description, relationship, exposure setting, duration and frequency, and risk factors for progression.
- Assign priority immediately — high-priority contacts should be evaluated within 7 business days of identification.

Contacts are informed that they were exposed to TB. They are never told who the index case is — even when they can guess.

Phase 4: Evaluate and test contacts

Contact group	Baseline (within 7 days)	Second test (8–10 weeks after last exposure)
Children under 5 years	Symptom review, IGRA or TST, chest radiograph regardless of test result, clinical exam	Repeat test; stop window-period treatment only if repeat is negative and the child is well
Immunocompromised, including HIV	Symptom review, IGRA preferred, chest radiograph regardless of test result	Repeat test; treat presumptively in the interim
Other close contacts	Symptom review and IGRA or TST; imaging if positive or symptomatic	Repeat test if baseline negative; imaging if it converts
Medium-priority contacts	Symptom review and test	Repeat test if baseline negative
Low-priority contacts	Evaluate only if transmission is documented in higher-priority circles	Per expansion decision

Window-period treatment: high-risk contacts start treatment for presumed infection at baseline even with a negative test, because their immune response may not yet be detectable and progression can be rapid.

Phase 5: Treat, follow up, and close

Rule out disease first

No contact starts treatment for TB infection until active disease is excluded by symptom review, imaging and medical evaluation—treating disease with an infection regimen creates resistance.

Offer short-course regimens

Rifamycin-based regimens of 3–4 months complete at far higher rates than 9 months of isoniazid and are the preferred option for most contacts.

Match the source's susceptibility

Choose the contact's regimen based on the index case's drug-susceptibility results, not on empiric assumptions.

Follow to completion

Track monthly: adherence, side effects, and completion. A referral is not an outcome — completion is.

Decide on expansion

If infection rates in the inner circle exceed the expected local background rate, or a secondary case appears, expand to the next circle.

Close deliberately

Close only when every contact has a documented outcome; report unfinished work rather than closing it.



Communication pathways

Most failed investigations are communication failures, not clinical ones. Every handoff needs a named person, a channel, and a deadline.

Who tells whom, and how fast

From	To	What moves	When
Laboratory	Clinician + health department	Positive smear, NAAT, culture, resistance	Immediately, as a critical value
Clinician / hospital	Health department	Suspected or confirmed case report	Within 24 hours
Hospital	Health department	Discharge plan and destination	Before discharge
Health department	PHN case manager	Case assignment and record	Within 1 business day
PHN	Index case and contacts	Notification, education, testing plan	1–3 days / 7 days
PHN	DOT worker	Adherence plan and locating tasks	At treatment start
DOT worker	PHN	Missed doses, symptoms, side effects	Same day
PHN	Evaluating clinician	Contact referral with exposure history and index susceptibility	At referral
Clinician	PHN	Evaluation result, regimen, completion	Within 1 week of each visit
PHN + TB controller	All partners	Expansion decision or closure	At decision point

Confidentiality, documentation, and data

HIPAA permits this

Disclosure to a public health authority for disease control is expressly permitted without patient authorization — clinicians should not withhold records on privacy grounds.

Minimum necessary

Public health shares only what a partner needs: an employer learns an exposure occurred and when, never who was diagnosed.

Protect the index case

Never confirm or deny the identity of the source case to contacts, employers, media, or family members.

Secure the record

Use the TB surveillance system of record. No case detail in personal email, unsecured text, or shared drives.

Document decisions

Record why the infectious period was set as it was, why a contact was assigned a priority, and why the investigation expanded or closed.

Report program data

Contacts identified, evaluated, infected, started on treatment, and completing treatment feed both local review and national reporting.

Best practices: clinical and public health coordination

- Establish standing agreements before the next case: named liaisons, after-hours numbers, and an agreed reporting channel with each hospital and lab.
- Hold a joint case conference within the first two weeks — PHN, treating clinician, TB controller, infection prevention, and DOT lead in one conversation.
- Maintain one shared care plan per case so the clinic and the field are never working from different contact lists or testing schedules.
- Use warm handoffs: a referred contact who is introduced by name to the evaluating clinic shows up far more often than one handed a phone number.
- Close every loop in writing — the referring party confirms the result was received, not just that the referral was sent.
- Debrief every investigation: what delayed the first interview, which contacts were missed, and what would be done differently.
- Invest in the workforce: interpreters, cultural brokers, and field staff who reflect the affected community are the strongest predictor of a complete contact list.

How we measure a good investigation

100%

of cases reported within the
mandated window

$\geq 90\%$

of identified contacts
evaluated

$\geq 90\%$

of infected contacts started
on treatment

$\geq 80\%$

of contacts started
completing treatment

- Also track interval measures: report to case assignment, assignment to first interview, and identification to evaluation for high-priority contacts.
- Review the proportion of contacts with infection against the local background rate — a high-rate signals recent transmission and argues for expansion.
- Count children under 5 evaluated within 7 days separately; this is the most time-sensitive measure in the program.
- Audit closed investigations for contacts with no documented outcome — these are the misses that become next year's cases.

Key takeaways

- Report on suspicion, not on confirmation — the clock starts at the first positive finding.
 - The public health nurse owns the investigation; every other partner delivers into that plan.
 - Evaluate children under 5 and immunocompromised contacts first, and treat them through the window period.
 - Re-interview. The complete contact list almost never emerges from the first conversation.
 - Follow contacts to treatment completion, not to referral.
 - Close the loop in writing with a named person at every handoff.
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Questions and Answers





Thank you