



Tuberculosis (TB) Nursing Across the Care Continuum

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Connect People • Close Gaps • Support Treatment • Protect Communities

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- 18.25 *AMA PRA Category 1 Credit™*
- 18.25 ANCC
- 18.25 Attendance
- 18.25 IPCE

Neither my organization nor I have had any financial or other relationships with ANY commercial interest organizations in the past 24 months.

Learning Objectives

- 1 Describe the active TB care continuum framework.
- 2 Describe the TB nurse's role across the active TB care continuum.
- 3 Demonstrate how nursing interventions improve outcomes for patients and communities.

One patient. Many systems. One connected continuum of care.

Why Think About TB Care as a Continuum?

- TB outcomes depend on successfully moving through multiple stages of care.
- Patients can be lost or delayed at every transition.
- Each gap represents an opportunity for intervention.
- TB nurses help patients navigate between stages—not just within them.

The nursing role is often most visible in the spaces between the steps.

The continuum quantifies patient retention and gaps in care delivery

The Active TB Care Continuum

Access TB
Testing



Diagnosis



Linkage to
Treatment



Retention
in
Treatment



Post-
Treatment
Survival



Durable
Cure

Tuberculosis (TB) Nursing

Assess • Educate • Connect • Coordinate • Support • Monitor • Advocate

(Subbaraman et al. 2019)

Potential Gaps Along the Continuum

- | | |
|-----------------------------|--|
| GAP 1 Case finding | Does not reach care / access TB testing |
| GAP 2 Diagnosis | Accesses testing but is not successfully diagnosed |
| GAP 3 Linkage | Diagnosed but not registered in treatment |
| GAP 4 Retention | Does not complete treatment |
| GAP 5 Post-treatment | Recurrence or death after treatment |

Where there is a gap, there is an opportunity for nursing intervention.

INTERACTION 1

Where can a patient be lost in the TB care continuum?

- A. Before accessing TB testing
- B. Between diagnosis and treatment initiation
- C. During treatment
- D. After treatment completion
- E. All the above

Answer: E — All of the above

Stage 1: Reaching Care & Accessing TB Testing

Potential gap: CASE FINDING

- Symptoms are not recognized
- Care-seeking is delayed
- Access to TB services is limited
- TB testing is not initiated after entering healthcare

TB NURSE CONTRIBUTION

- Recognize risk and symptoms
- Facilitate timely evaluation/testing
- Educate patients and families
- Address barriers to accessing care
- Coordinate with healthcare and community partners

Find → Connect → Facilitate Access

Stage 2: Diagnosis

Potential gap: **DIAGNOSTIC LOSS**

- Incomplete diagnostic work-up
- Difficulty obtaining specimens
- Negative initial test with unresolved clinical concern
- Delays in diagnostic evaluation
- Results are not effectively acted upon

TB NURSE CONTRIBUTION

- Coordinate specimen collection
- Track testing and results
- Facilitate communication
- Follow unresolved diagnostic work-ups
- Keep the patient engaged through uncertainty

Coordinate → Track → Communicate → Follow Through

Stage 3: Linkage to Treatment

Potential gap: **PRETREATMENT
LOSS TO FOLLOW-UP**

TB NURSE CONTRIBUTION

Diagnosis must lead to treatment

DIAGNOSED



TREATMENT

- ✓ Rapidly connect the patient to treatment
- ✓ Coordinate referrals and handoffs
- ✓ Establish communication across systems
- ✓ Locate and re-engage patients
- ✓ Identify immediate barriers
- ✓ Begin patient/family education
- ✓ Establish the therapeutic relationship



INTERACTION 2

**A patient has confirmed pulmonary TB but has not yet started treatment.
Where is the patient in the continuum?**

A. Case-finding gap

B. Diagnostic gap

C. Linkage-to-treatment gap

D. Retention-in-treatment gap

Answer: C — Linkage-to-treatment gap

Stage 4: Retention in Treatment

CLINICAL

Treatment monitoring
Side-effect assessment
Medication education

WHOLE PERSON

Housing
Transportation
Food | Language
Family | Work

Potential gap:
**TREATMENT FAILURE,
LOSS TO FOLLOW-UP, DEATH**

NURSE CASE MANAGEMENT

PUBLIC HEALTH

DOT | vDOT
Isolation support
Contact investigation

COORDINATION

Providers | Pharmacy
Public health partners
Community services

Treatment Adherence Is More Than Taking Pills

Instead of asking

“Why isn’t this patient taking the medication?”



Ask

“What is making treatment difficult?”

TB NURSE CONTRIBUTION

- ✓ Build trust
- ✓ Identify barriers early
- ✓ Individualize DOT/vDOT
- ✓ Use incentives and enablers
- ✓ Provide culturally responsive care
- ✓ Coordinate services
- ✓ Reassess as circumstances change

Adherence problems are often care-plan problems—not simply patient problems.

Monitoring Treatment

- Symptoms and clinical response
- Adverse effects
- Laboratory results
- Microbiology
- Medication adherence
- Weight and medication dosing
- Emerging barriers or concerns

ASSESS

COMMUNICATE

INTERVENE

REASSESS

TB nursing is a continuous cycle—not a checklist

INTERACTION 3

A patient is missing DOT because their work schedule changed and they are afraid of losing their job. What is the most appropriate first nursing response?

A. Reinforce that DOT is mandatory

B. Document nonadherence

C. Notify the provider immediately

D. Explore the barrier and redesign the care plan with the patient

Answer: D — Explore the barrier and redesign the plan with the patient

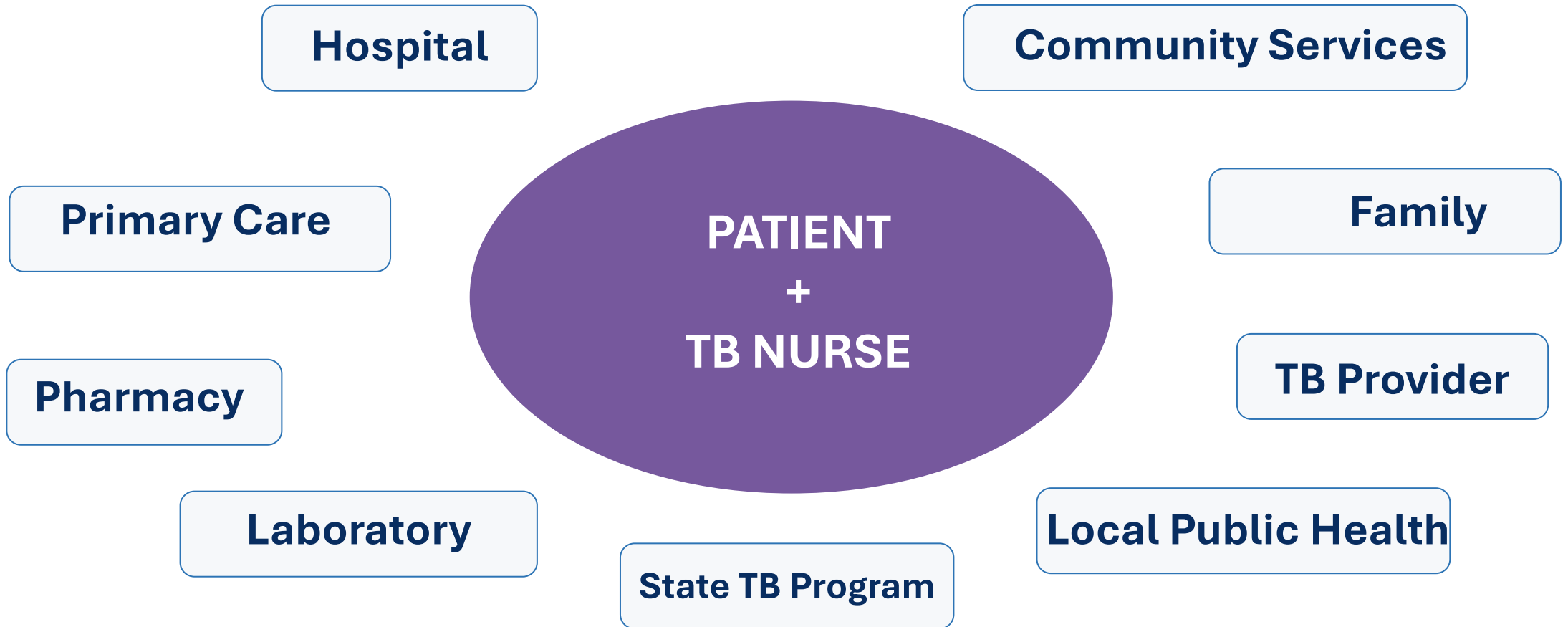
When Things Don't Go According to Plan

- Missed doses
- Medication toxicity
- Persistent smear/culture positivity
- Hospitalization
- Drug resistance
- Treatment interruption
- Relocation or loss to follow-up
- Changing social or medical needs



The care plan changes when the patient's circumstances change.

Case Management: Holding the Pieces Together



The nurse often sees the whole patient, while individual systems see only one part.

Stage 5: Post-Treatment Survival

Potential gap: POST-TREATMENT CARE

- TB recurrence
- Persistent or recurrent symptoms
- Post-TB lung disease
- Functional limitations
- Ongoing psychosocial needs

TB NURSE CONTRIBUTION

- ✓ Educate about symptoms requiring reevaluation
- ✓ Reinforce follow-up
- ✓ Facilitate transition back to routine healthcare
- ✓ Address residual health and social needs

Treatment completion ≠ end of continuum



Stage 6: Durable Cure

The endpoint is not simply:

~~FINISHED MEDICATION~~

1-YEAR RECURRENCE-FREE
SURVIVAL

Successful TB care extends beyond the last dose.

Alive + TB-free + recurrence-free after treatment



TB Nursing Extends Beyond the Clinical Continuum



Isolation Is More Than an Infection-Control Order

Work

Income

Family

Housing

Childcare

Stigma

**Social
Connection**

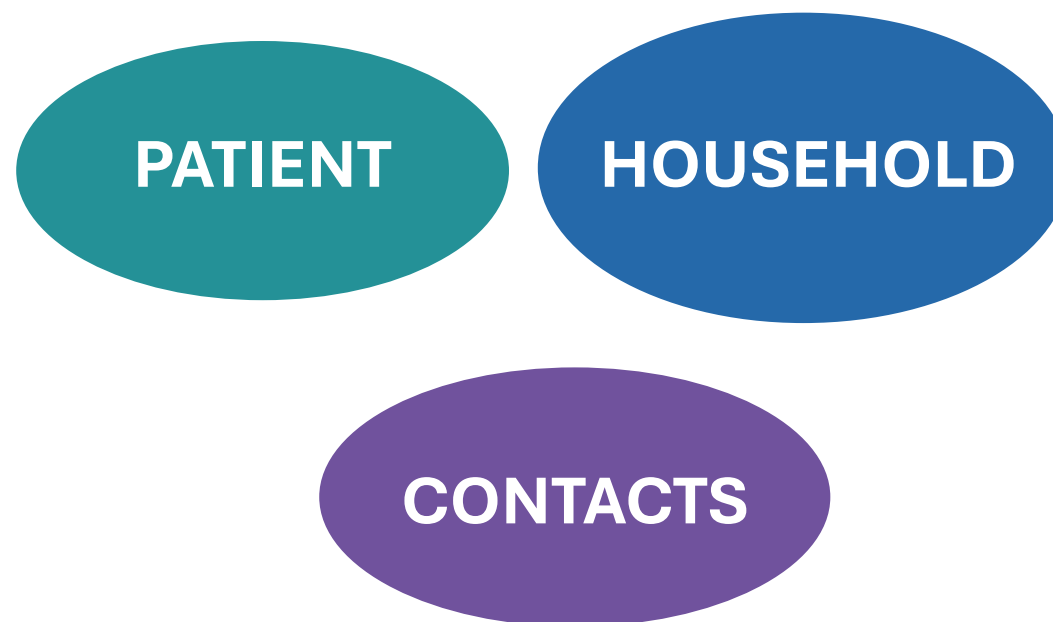
**Mental
Well-being**

“What will make it difficult for you to follow this plan?”

That question changes nursing care.

Contact Investigation

- Identify and prioritize contacts
- Evaluate risk of infection and disease
- Arrange testing and clinical evaluation
- Facilitate treatment of TB infection
- Educate and support contacts
- Prevent the next case of TB



Patient → Contacts → Prevention

TB Care Across Geography

COUNTY → STATE → COUNTRY → CONTINUITY

- Coordinate with receiving jurisdictions
- Use interstate and international referral systems
- Ensure transfer of essential information
- Maintain continuity of treatment and follow-up

The patient may move. The continuum of care cannot stop.

One Patient, Multiple Levels of Nursing Practice

LOCAL / CASE MANAGEMENT LEVEL

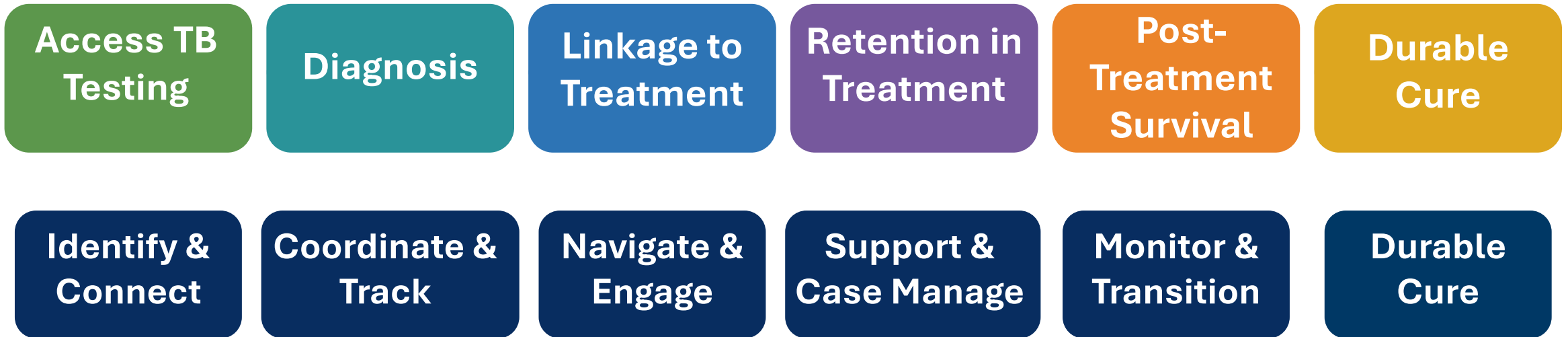
- Direct patient and family relationship
- Home/community assessment
- DOT/vDOT and monitoring
- Identify and address barriers
- Contact investigation
- Connect community resources

STATE / CONSULTANT LEVEL

- Consultation and clinical/public health guidance
- Support for complex cases
- Cross-jurisdiction coordination
- Education and capacity building
- Policy and standards
- Systems and quality improvement

One continuum | Different levels of nursing intervention

TB Nurses Close the Gaps



Nursing action at each transition

**No single intervention carries a patient through the continuum.
Relationships and continuity do.**

INTERACTION 4

Where does the TB nurse have the greatest impact in the care continuum?

A. Diagnosis

B. Treatment

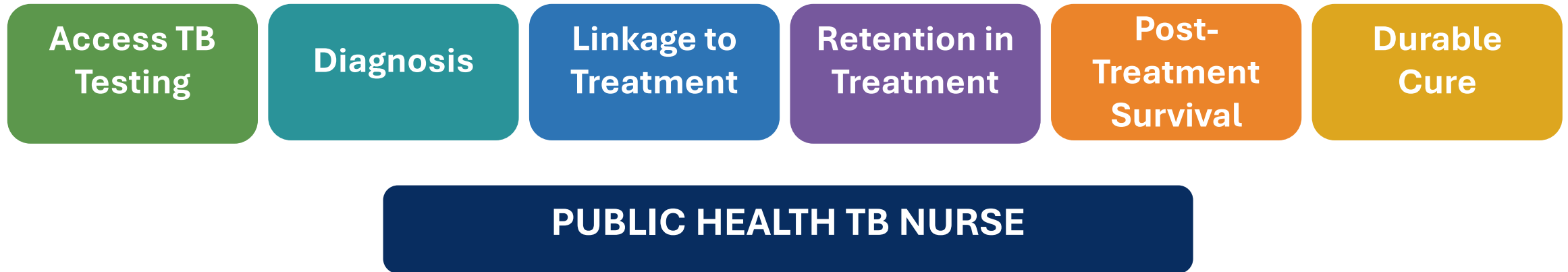
C. Adherence

D. Treatment completion

E. Across the entire continuum

Answer: E — Across the entire continuum

The TB Nurse Across The Care Continuum



**Connects people.
Closes gaps.
Supports treatment.
Protects communities.**

*“The TB care continuum shows us where patients can be lost.
Tuberculosis nursing helps ensure they are not.”*

References

- Subbaraman, R., Nathavitharana, R. R., Mayer, K. H., Satyanarayana, S., Chadha, V. K., Arinaminpathy, N., & Pai, M. (2019). Constructing care cascades for active tuberculosis: A strategy for program monitoring and identifying gaps in quality of care. *PLOS Medicine*, 16(2), e1002754. <https://doi.org/10.1371/journal.pmed.1002754>
- National Tuberculosis Coalition of America. Tuberculosis Nurse Case Manager Core Competencies. (2024, December). <https://nationaltbcoalition.org/tb-resources/ntca-publications-and-tools/tb-nurse-case-manager-core-competencies/>

Thank You!

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