TB STAFF SUPPORT FOR CASE MANAGEMENT

September 16, 2025

Situation

The Spokane Regional Health District (SRHD) TB Program requires an additional full-time public health nurse to maintain safe and effective tuberculosis case management amid rising case volumes and increasing patient complexity. Despite the addition of a second nurse in 2024, current staffing levels remain insufficient to manage the sustained high burden of TB disease (11 cases as of September 2025) while maintaining quality care standards and staff sustainability.

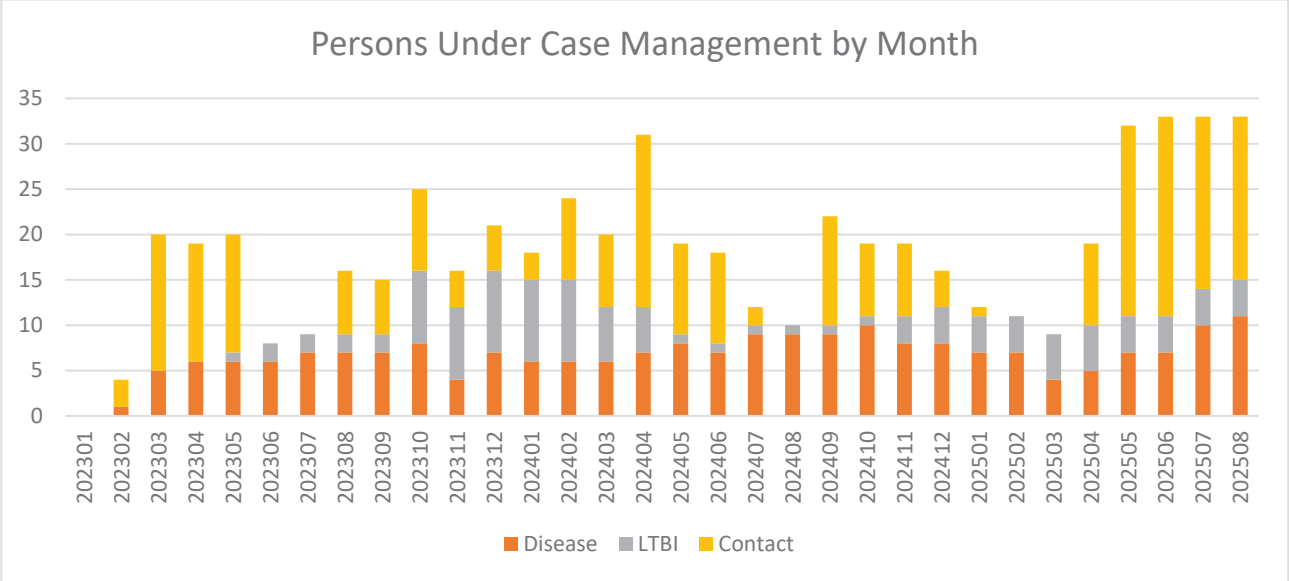
Our program currently operates with two nurses and one community health worker who monitor cases that often require 6-12 months of case management and Directly Observed Therapy (DOT) per patient, as well as sometimes extensive contact tracing. This creates a compounding workload as new cases arrive before existing cases complete treatment, resulting in overlapping patient cohorts that strain our capacity.

Background

Rising Case Burden and Complexity

TB case management in Spokane County has experienced significant changes:

- Sustained increase in managed cases: SRHD had 5 cases in 2020, increased to 12 (11 reportable) cases in 2024, and have 11 (9 reportable) cases already in 2025
- Extended treatment duration: 18% of cases managed in 2025 require extended treatment beyond the standard 6 months
- Medical complexity: Cases present with significant medical complications requiring clinical expertise
- Language barriers: Many patients are non-English speakers, requiring interpreter services and extended visit times



Unique Demands of TB Case Management

Unlike other infectious diseases managed by traditional healthcare providers, TB requires public health intervention due to:

Daily Direct Observed Therapy (DOT)

- Nurses must observe medication administration Monday-Friday, in most cases at patient homes
- Each patient requires 6-12 months of DOT visits (120-240 visits per patient)

- Commute time to patient locations often equals or exceeds actual visit time
- Multiple active cases create overlapping daily route requirements

Clinical Complexity

- Cases occur in foreign-born individuals with limited healthcare access
- Common comorbidities include diabetes, HIV, hepatitis, and substance use disorders
- TB medications carry significant toxicity risks requiring clinical assessment
- Drug-drug interactions may necessitate ongoing medication adjustments and/or collaboration with other medical providers

Household Management

- Household sizes range from 2-17 members
- Multi-generational households require extensive contact investigations
- Isolation requirements may necessitate managing patients across multiple locations

Current Staffing Vulnerability

Even with two nurses, SRHD remains a poorly staffed TB program relative to disease burden in Washington State. Comparable jurisdictions maintain more staff for similar or lower-case volumes, recognizing that TB management requires redundancy for surge capacity and continuity of care.

Assessment

Why Alternative Solutions Fall Short

Part-time staffing limitations:

- TB case management requires relationship continuity that part-time staff cannot maintain
- DOT visits must flex around patient schedules (early morning, evening), making part-time scheduling impractical
- Clinical assessments and medication adjustments require consistent provider knowledge of patient history
- Part-time positions have proven difficult to fill due to the demanding nature of TB work

Borrowing staff from other programs:

- While other CDIP staff currently provide surge support for DOT visits, they cannot perform clinical assessments, medication management, or manage provider collaboration
- Borrowed staff lack the specialized TB knowledge required for complex case management
- Pulling staff from other programs creates vulnerabilities elsewhere and is unsustainable long-term
- TB case management is relationship-driven; rotating staff disrupts patient trust and compliance

Risk Analysis

Without additional nursing capacity:

- Risk of missing critical medication side effects due to rushed visits or when staff who do not have a clinical background are providing coverage
- Delayed contact investigations could lead to increased transmission risk
- Staff burnout, leading to turnover and loss of institutional knowledge
- Potential for drug-resistant TB development due to inadequate monitoring
- Inability to manage simultaneous complex cases or outbreak scenarios

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Recommendation

We recommend funding an additional 1.0 FTE Public Health Nurse position for the TB Program. This investment will:

- Ensure Safe Patient Care: Maintain appropriate nurse-to-patient ratios for complex medical management
- Build Surge Capacity: Enable response to contact investigations and outbreak scenarios
- Improve Efficiency by allowing specialization: e.g., one nurse focusing on DOT routes while another manages contact investigations
- Reduce Long-term Costs: Prevent drug resistance and transmission through comprehensive case management
- Align with State Standards: Bring SRHD closer to staffing levels of comparable Washington jurisdictions

This position is essential infrastructure for a program managing infectious tuberculosis, which poses significant public health risk if inadequately controlled. The investment in prevention through adequate staffing far outweighs the public health impacts from gaps in case management.

Implementation Plan

- Recruit for full-time position to ensure schedule flexibility and continuity
- Utilize other SRHD staff to provide temporary surge support where it is applicable while the hiring process moves forward.
- Develop processes internally that would allow surge support from other programs that have nursing staff (including Treatment Services and Nurse Family Partnership)
- Develop new position description that will allow existing epidemiologists with nursing licenses to utilize their nursing license while acting as an epidemiologist.

The TB Program's track record of fiscal responsibility, combined with the sustained increase in case complexity and volume, necessitates this critical investment in public health infrastructure. Adequate staffing today prevents costly outbreaks and bad patient outcomes tomorrow.