Newsletter #81 October 6, 2020 TB REQUIREMENTS

CTA is sending this information at the request of the Office of Health Care Assurance (OHCA) Department of Health (DOH).

September 25, 2020

To: All Community Care Foster Family Homes, Adult Day Care Centers and Case Management Agencies

RE: TUBERCULOSIS (TB) REQUIREMENTS FOR RESIDENTIAL CARE FACILITIES AND ADULT DAY CARE CENTERS

Community Ties of America, Inc (CTA) recently became aware that the Department of Health (DOH) TB Branch revised its administrative rules and issued a clearance manual for the public's use. The Office of Health Care Assurance (OHCA) and CTA has reviewed this manual, and by way of this letter, is providing guidance to providers.

Attached to this letter are documents from the TB Branch and below is a summary pertinent to facilities.

INITIAL TB TESTING (before admission of a resident or starting employment or providing care to residents)
(**Refer to documents B, C and E**)

1. For all staff, caregivers or household members who have direct contact with residents for more than 10 hours a week, requirements include:
    a. Two-step Tuberculin Skin Test (TST): Two (2) single-step TST within a 12-month period, or one Interferon Gamma Release Assays (IGRA) blood test; or
    b. If prior documented two-step TST greater than 12 months, a single-step TST or IGRA is required; or
    c. If prior positive TST – documentation of positive test, TB Clearance Certificate from the DOH TB Branch or DOH TB Clearance Form (Document F) completed by medical provider within the last 12 months with a negative chest x-ray (CXR) documentation or negative symptom screen., after a negative initial negative x-ray.
2. For persons with no resident contact or contact less than 10 hours a week:

No TB clearance is needed.

3. Urgent client admission:
    a. CXR immediately or within 30 days prior to admission. Follow up two-step TST or single IGRS blood test within 2 weeks of admission
    b. If CXR not available, a negative TB Risk Assessment (Document G) followed by standard TB clearance within 2 weeks of admission

ANNUAL TB TESTING:
All clients and all staff, caregivers and household members with direct contact with residents for more than 10 hours a week:

a. Single-step TST, IGRA blood test, or TB Clearance Certificate from the DOH TB Branch
b. If prior positive TST: : documentation of positive test from a medical provider, TB Clearance Certificate from the DOH TB Branch AND TB Document H
   OR
   DOH TB Clearance Form (Document F)
   OR
   TB Document H completed by medical provider within last 12 months with negative CXR documentation (***note CXR is not needed every year, just initially for those that have had positive TB***)

Enclosed are “TB Clearance Evaluation Procedures for Persons Living or working in Health Care Facilities or Residential Care Settings Licensed or otherwise Regulated by the Department” and TB forms:

1. Table 5 (Initial and Annual Evaluation): General outline of requirements
2. Document B (Initial Evaluation): Procedures used for persons with NO documented previous positive test for TB infection and NO documented history of TB disease
3. Document C (Initial Evaluation): Procedures used for persons WITH documented previous positive test for TB infection or a documented history of TB disease
4. Document D (Annual Evaluation)
5. Document F (TB Clearance Form): used by medical providers (physician/advanced practice registered nurse) to document TB clearance
6. Document G (TB Risk Assessment Form): used in conjunction with Document F for emergency admission if CXR is not immediately available
7. Document H (TB Symptom Screen Form): used in conjunction with Document F for annual rescreening of clients/staff/caregivers/household members with PREVIOUS positive TST and negative CXR

TB CLEARANCE FORM F MUST BE SIGNED BY A PHYSICIAN, PHYSICIAN ASSISTANT OR APRN. FORMS G AND H MAY BE COMPLETED AND SIGNED BY MEDICALLY AUTHORIZED AND TAINED STAFF SUCH AS MA, LPN, OR RN.

For the complete DOH TB Clearance Manual (July 18, 2017) and additional forms, please visit the DOH TB Branch website at https://health.hawaii.gov/tb/files/2018/03/Hawaii-TB-Clearance-Manual-10-30-17.pdf

The Hawaii Administrative Rules 11-164.2 Tuberculosis can be found at https://health.hawaii.gov/tb/files/2018/03/11-164.2-2.pdf

Note: For persons needing a single TST, the entire testing process takes a minimum of 2 calendar days. After your TST is administered, you must return to the same DOH TB testing location within 48-72 hours to have your TST read.
For persons needing a two-step TST, the entire process takes a minimum of 9 calendar days and you will receive a total of two TST’s. If your first TST is negative, a second TST is administered 1-3 weeks later.

If CTA Survey Compliance Managers have any questions on whether or not provider documents meet DOH TB requirements, the provider will be expected to take their documentation and obtain a DOH TB Clearance Certificate from the DOH TB Branch.

If you have any questions please contact the Department of Health, Tuberculosis Department.

Respectfully,

Angel England, RN
Operations Manager

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings *(TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings *(TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include cough for 3 weeks or more, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious TB disease*? (Do not check "Yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

Provider Name with Licensure/Degree:	**Person's Name and DOB:**
Assessment Date:	**Name and Relationship of Person Providing Information (if not the above-named person):**

CommunityTies
of America, Inc.

Care Management, Therapy and Consulting Services

Date: _____

Provider No. _____

Mr./Ms.:

On _____, Community Ties of America, Inc. (CTA) completed an inspection of my:

- ☐ Community Care Foster Family Home (CCFFH)
- ☐ Adult Day Care Center (ADCC)

During the inspection, I informed CTA that the individual(s) listed below are not required to obtain a TB clearance due to:

- ☐ A substitute caregiver (SCG) works less than 10 hours a week.
- ☐ A household member (HHM) does not have patient contact or share patient care area air space.
- ☐ An ADCC staff/volunteer works less than 10 hours a week.

Below is a list of the SCGs, HHMs, and ADCC staff/volunteer who meet the above requirements and are not required to obtain a TB clearance.

SCG/HHM and ADCC Staff/Volunteer Not Required to Obtain TB Clearance
(A copy is filed in each persons' administrative file)

_____
_____
_____
_____
_____
_____
_____

CTA is required to review TB clearance for all caregivers and HHM's including children. CTA may instruct you to take your TB clearance to the Department of Health for review and The Department of Health will review your TB clearance and issue you a TB clearance if the requirements have been met.

I am responsible for obtaining a TB clearance for the people listed above if they no longer meet the exclusion criteria for a TB clearance.

By signing this document, I verify the above is true.

_____ _____
Signature Date

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