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 TRAINED 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/
Enter TB Clearance Manual in the Search Box
Choose Search Hawaii.gov

The Hawaii Administrative Rules (HAR) §11-164.2 Tuberculosis can be found at https://health.hawaii.gov/tb/
Enter 11-164.2 in the Search Box
Choose Search Hawaii.gov

***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

**TABLE 5**

**INITIAL AND ANNUAL EVALUATION FOR PERSONS LIVING OR WORKING IN DESIGNATED HEALTH CARE OR RESIDENTIAL CARE FACILITIES [2]**

| Category | When needed | Type of Testing |
|---|---|---|
| **Persons Living or Working in Designated Health Care facilities*** <br>• **Includes** residents, employees, contract workers and volunteers working more than 10 hours per week <br>• **Excludes** residents of acute inpatient facilities and infants under the age of 12 months, and persons not in contact with or who have not shared air space with patients or residents of the facilities or who will never be in contact with clinical specimens that may contain MTB | § 11-164.2-26 <br>**Initial** *first-ever or lapsed annual* <br>Must have TB clearance within 12 months prior to employment, volunteer services, or entry as a resident | **Initial** <br>• TST (2-step as indicated)* * or 1 IGRA or CXR if previous (+)TST or (+)IGRA <br>*NOTE: Not based on presence of Risk Factors questions 2-6 on Risk Assessment* <br>•Additional testing needed if significant symptoms present |
| CTA notation: residents include household members of any age. If there are household members, employees, caregivers, contract workers or volunteers that do not work with or have direct contact with clients for more than 10 hours per week, those persons are not required to obtain a TB Clearance and detailed documentation needs to be kept by the provider as to why | § 11-164.2-26 <br>**Annual renewal** <br>Must be within 11-13 months of previous clearance | **Annual renewal** <br>TST or IGRA or symptom screen if (prior (+) test) <br>Secondary assessment as indicated <br>*Not Based on Risk Assessment* |

* *One 2-step testing needed per lifetime
Two single tests within 12 months satisfied " 2-step"

*Designated facilities include
Adult day health centers;
Adult residential care homes;
Assisted living facilities;
Hospitals;
Nursing facilities (skilled nursing/ intermediate care facilities)
see http://health.hawaii.gov/ohca/type-of-hawaii-state-licensed-andor-federal-certified-facilities-or-agencies/

Also includes Certified Adult Day Care Centers

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.

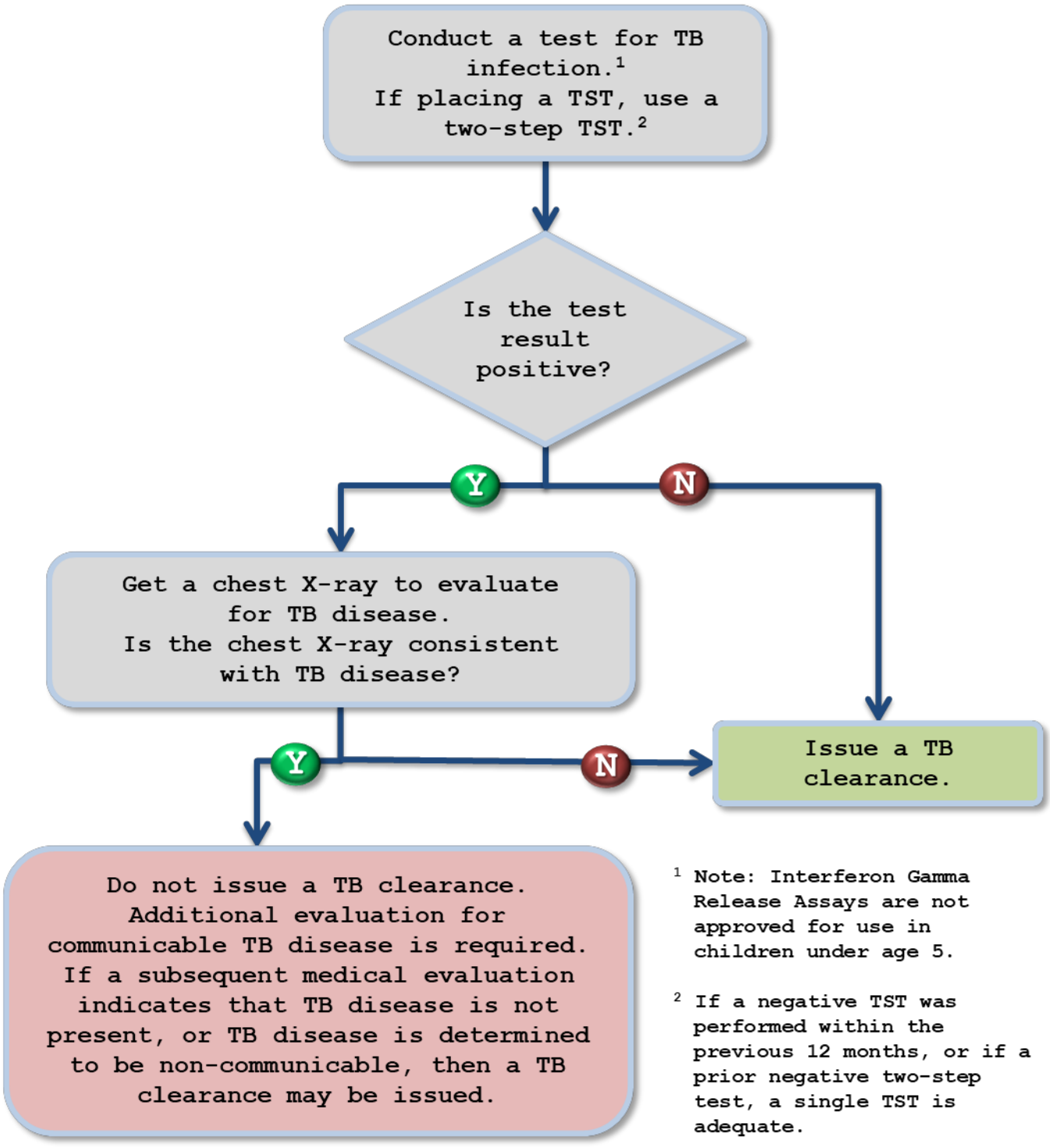
By signing this document, I verify the above is true.

_____ _____

Signature Date

# TB Document B: TB Clearance Evaluation Procedures for Persons Living or Working in Health Care Facilities or Residential Care Settings Licensed or Otherwise Regulated by the Department.

## I. Initial Evaluation Procedure for Persons with No Documented Previous Positive Test for TB Infection and No Documented History of TB Disease.

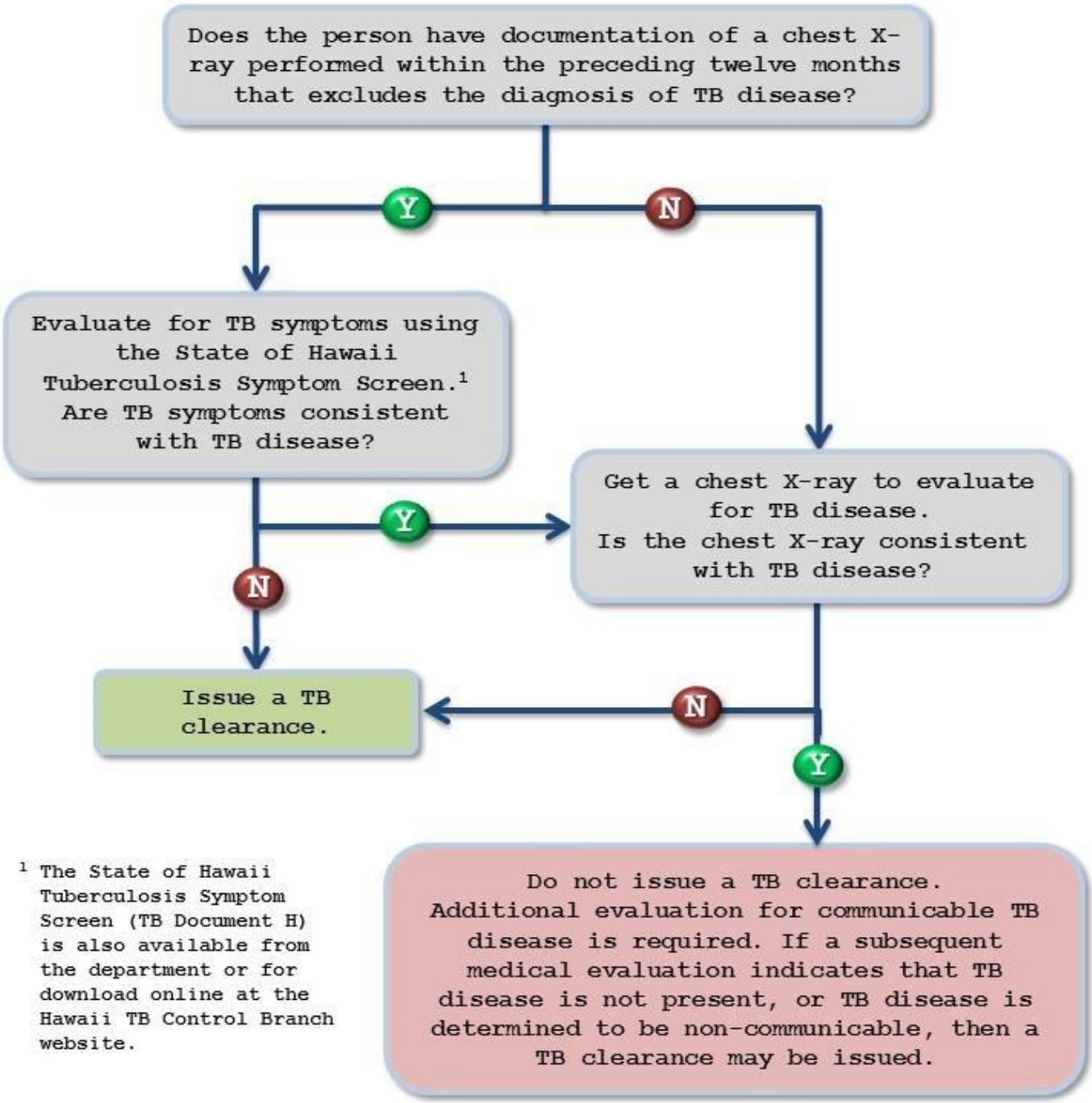



[1] Note: Interferon Gamma Release Assays are not approved for use in children under age 5.

[2] If a negative TST was performed within the previous 12 months, or if a prior negative two-step test, a single TST is adequate.

**TB Document C: TB Clearance Evaluation Procedures for Persons Living or Working in Health Care Facilities or Residential Care Settings Licensed or Otherwise Regulated by the Department.**

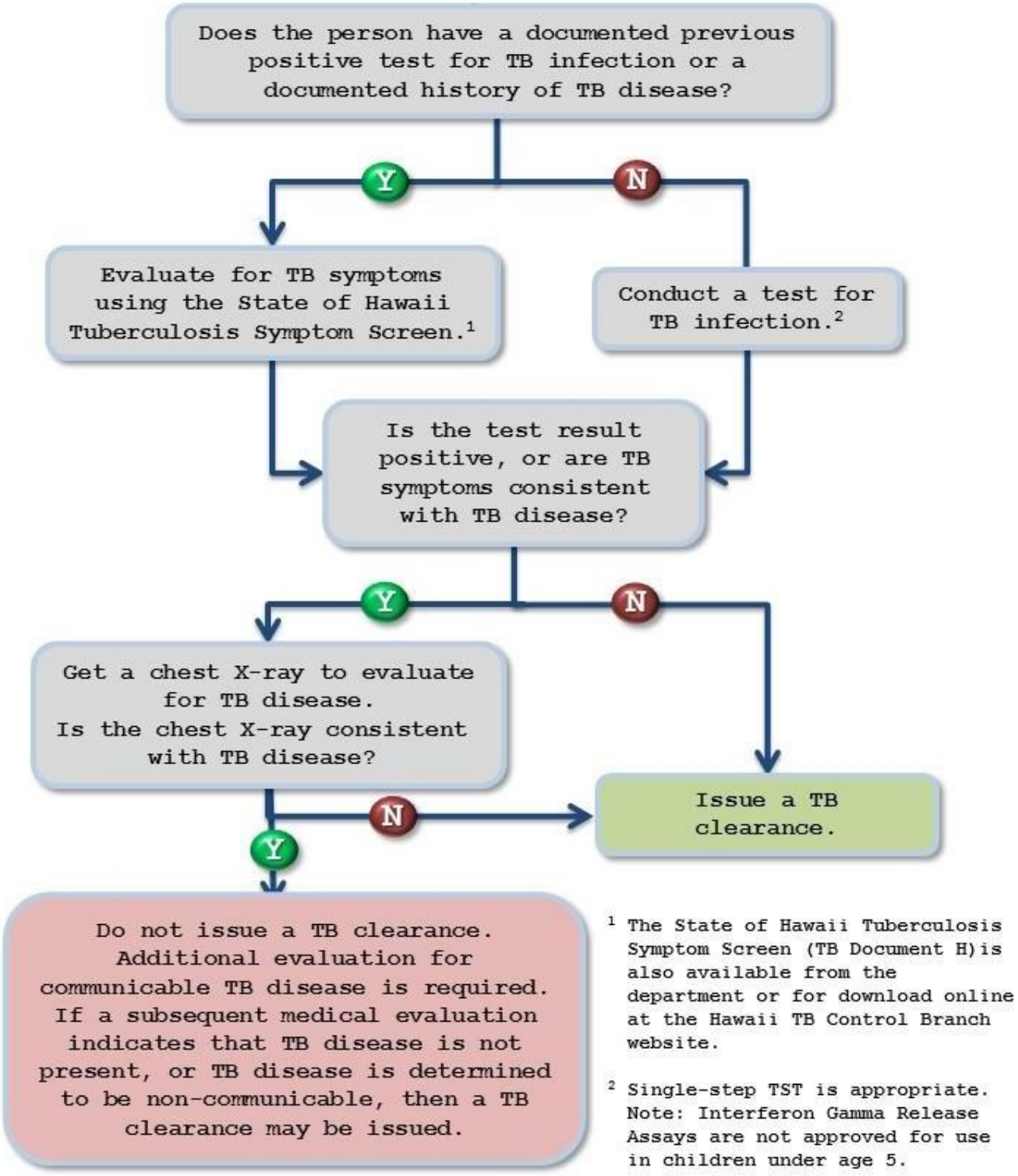
## II. Initial Evaluation Procedure for Persons with a Documented Previous Positive Test for TB Infection or a Documented History of TB Disease.




[1] The State of Hawaii Tuberculosis Symptom Screen (TB Document H) is also available from the department or for download online at the Hawaii TB Control Branch website.

**TB Document D: TB Clearance Evaluation Procedures for Persons Living or Working in Health Care Facilities or Residential Care Settings Licensed or Otherwise Regulated by the Department.**

## III. Follow-up Annual TB Evaluation Procedure




[1] The State of Hawaii Tuberculosis Symptom Screen (TB Document H)is also available from the department or for download online at the Hawaii TB Control Branch website.

[2] Single-step TST is appropriate. Note: Interferon Gamma Release Assays are not approved for use in children under age 5.

# 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<br>☐ No | **Does this person have significant TB symptoms?**<br>Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following:<br>☐ Coughing up blood ☐ Fever ☐ Nightsweats<br>☐ 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<br>☐ No | **Was this person born in a country with an elevated TB rate?**<br>Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. |
| ☐ Yes<br>☐ No | **Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?** |
| ☐ Yes<br>☐ 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<br>☐ No | **Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?**<br>*(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)* |
| ☐ Yes<br>☐ 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):** |

# TB Document H: State of Hawaii TB Symptom Screen

Hawaii State Department of Health
Tuberculosis Control Program

Dear Provider,

- Hawaii Administrative Rules mandate that specified health care workers in healthcare settings, volunteers and health facility residents have TB certification every year.
- If these persons have a previously documented positive tuberculin skin test (TST) and a chest X-ray negative for TB, then re- certification requires a TB symptom screen with further evalution if significant symptoms.
- Please complete the following form and give back to your patient as evidence of compliance. If there are significant symptoms, DOH will accept referral for CXR.

**SECTION 1**

Client Name: DOB: ____/____/____

BASELINE

TST Placed: ____/____/____ TST Read: ____/____/____ Result: _____ mm

CXR Date: ____/____/____ CXR Result: Negative for Active TB Disease

**SECTION 2**

| TB Symptom Screening | | | Onset and Duration of Symptoms |
|---|---|---|---|
| 1. Cough for ≥3 weeks duration | ☐ No | ☐ Yes | |
| 2. Coughing up blood | ☐ No | ☐ Yes | |
| 3. Fever | ☐ No | ☐ Yes | |
| 4. Night sweats | ☐ No | ☐ Yes | |
| 6. Unexplained weight loss | ☐ No | ☐ Yes | Amount: |
| 5. Unusual weakness or fatigue | ☐ No | ☐ Yes | |

NOTE: Refer the client for a chest X-ray to rule out TB if he/she reports having a cough for ≥3 weeks duration and at least one of the other symptoms (#2-#5).

**SECTION 3**

**TB Symptom Screening Outcome** (check one):

- ☐ Client does not report TB symptoms at this time.
- ☐ Client was referred for chest X-ray to rule out TB.
- ☐ Other: _____

_____ ____/____/____
Signature of Health Care Provider Date

_____
Printed Name of Health Care Provider