Frequently Asked Questions – New TB Testing Rules for Healthcare Settings

The Department of Public Health's Substance Abuse/Problem Gambling Program made administrative rule changes regarding TB testing effective November 7, 2012. The Department of Inspection and Appeals made administrative rule changes regarding TB testing for health care workers of Iowa licensed hospitals and health care workers and residents of Iowa health care facilities effective March 26, 2013.

The TB Control Program worked extensively on the rule changes which are consistent with published recommendations from the Centers for Disease Control (CDC) Division of TB Elimination. The rules provide uniform TB screening, testing, and serial testing procedures for health care workers (HCWs) and residents of licensed health care and substance abuse facilities.

For most hospitals and health care facilities, the new rules will diminish the frequency of serial testing of HCWs while assuring that Iowa's HCWs are properly screened and evaluated for TB infection and disease.

Q: Why did Iowa change the TB rules?

A: The previous rules did not address how to properly evaluate HCWs or residents for latent TB infection (LTBI) or TB disease based upon published recommendations from the CDC Division of TB Elimination. Previous rules were inconsistent, out of date with national recommendations, and lacked guidance on how to properly evaluate HCWs and residents for LTBI/TB disease. Further, the previous rules did not provide guidance to conduct facility risk assessments.

Q: Why are the new rules so long and complicated?

A: At first glance – the new rules may seem complicated and long. However, the new rules actually provide step by step guidance to conduct TB screening and testing for HCWs and residents of long-term care and substance abuse facilitates. Infection Control staff familiar with current CDC procedures should find the rules easy to follow and implement.

Q: Are all employees in a covered facility required to be tested or should only HCWs be tested?

A. The intent of the TB Rules is to have all persons in the facility receive baseline TB screening upon hire. HCW is intentionally used broadly in this context. The term 'HCW' means any paid or unpaid person working in a health care facility or hospital, including any person who is paid either by the health care facility or hospital, or paid by any other entity (i.e., temporary agency, private duty, Medicaid/Medicare or independent contractors), or any volunteer who volunteers in a health care facility or hospital on a consistent and regularly scheduled basis for five or more hours per week. Specifically excluded from the definition of "health care worker "are individuals such as visitors, building contractors, repair workers or others who are in the facility or hospital for a very limited purpose and are not in the facility or hospital on a regular basis.

Q: What are the significant changes for HCWs in Iowa?

A: HCWs in Iowa still need to be evaluated at the time of hire for LTBI / TB disease. Changes include HCWs receiving a TB disease sign/symptom screen upon hire. This sign/symptom screen protects against HCWs with infectious TB disease working with patients/other HCWs before the TB testing evaluation is completed.

For most hospitals and health care facilities, the new rules will diminish the frequency of serial testing of HCWs while assuring that Iowa's HCWs are properly screened and evaluated for TB.

Q: What are the significant changes for residents of long-term care facilities?

A: The same evaluation procedure for HCWs is now used for residents of long-term care facilities. Previously, residents only received a single TB test upon admission. Residents now receive either a two-step TB test or a single blood test for TB upon admittance. In addition, a TB disease sign and symptom screen is now required upon admittance. Residents are not subject to serial TB testing.

Q: What are the significant changes for residents of substance abuse facilities?

A: The same evaluation procedure for HCWs is used for residents of substance abuse facilities. Previously, residents only received a single TB test upon admission. Residents receive either a two-step TB test or a single blood test for TB upon admittance. In addition, a TB disease sign and symptom screen is now required upon admittance.

Further, if a resident is discharged and readmitted to a facility and less than 12 months have passed since the last TB test, residents should receive a symptom screen upon re-admittance. Previous rules required TB testing every 90 days for residents discharged and re-admitted to substance abuse facilities.

Q: How often do facilities conduct a TB risk assessment?

A: Facilities should conduct a TB risk assessments annually. The TB risk assessment serves as an ongoing evaluation of the risk for transmission of *M. tuberculosis* in a particular health care setting. The risk assessment includes community rate of TB and more importantly, the number of persons that, upon review, had undiagnosed infectious pulmonary or laryngeal TB *and* for whom proper airborne isolation precautions were not implemented upon admission or encounter. The TB risk assessment will determine the frequency of TB testing for HCWs.

Q: When conducting risk assessments, which patients do we count as having TB during the preceding year?

A: Only count those patients that, upon review, had infectious pulmonary or laryngeal TB *and* for whom proper airborne isolation precautions were not implemented upon admission or encounter.

Q: Shouldn't we include all patients with TB disease in our facility risk assessment?

A: No. **Do not** include patients with treated or untreated extrapulmonary TB disease, or patients with pulmonary or laryngeal TB that have met criteria for non-infectiousness. Do not include the number of patients with LTBI.

Q: Should we include all infectious TB patients in our risk assessment?

A: That depends on several factors. Patients for whom proper airborne isolation procedures were implemented immediately likely caused no transmission and therefore should not be counted. The facility risk assessment must address the speed with which persons with infectious TB disease are suspected, isolated, and evaluated to determine if persons with infectious TB exposed staff or others in the facility or hospital.

- **Count** the patient in the annual risk assessment, if the infection control team determines that exposure may have occurred and as a result, conducts a contact investigation of exposed HCWs. **Do not count** the patient in the annual risk assessment, if the infection control team determines no exposures occurred and does not conduct a contact investigation of HCWs. For documentation purposes, it

is recommended that the infection control team document this number in a 'sub-category' of 'infectious patients promptly isolated' or similar language.

Q: Our facility's risk assessment demonstrates the facility classification to be 'low risk' and serial TB testing of HCWs is not recommended. Our infection control team is not comfortable with this approach. Are we allowed to conduct serial testing of HCWs as we deem necessary?

A: Yes. The new TB Rules represent the minimum level of TB testing required in covered facilities. Facilities wishing to conduct testing beyond the minimum requirements are free to do so. The TB Rules are consistent with national recommendations which in part, are aimed at limiting unnecessary TB testing for those persons deemed at low risk of TB exposure. However, each facility is able to conduct serial testing of HCWs if the facility deems it necessary.

Q: Our facility is classified as low risk, yet the facility still conducts a serial TB testing program and requires all HCWs to participate in the serial testing program. Since the Iowa Administrative Code states this is not necessary, can HCWs opt out of this testing?

A: The TB Rules in the Iowa Administrative Code represent the minimum level of TB testing required in covered facilities. Facilities choosing to conduct testing beyond the minimum requirements may do so. Iowa Code does not address HCWs ability to opt out of serial screening beyond minimum requirements. That decision is left to the individual HCW and their employer.

Q: Many of our HCWs feel we will now 'miss' TB exposures because we are not conducting serial testing of HCWs. They argue that we don't always know when an infectious TB patient has been in our hospital/facility and therefore these 'unknowns' can't be counted in the facility risk assessment. How can we assure them TB is not being transmitted in our facility?

A: First, review the historical records of the facilities serial TB testing program to determine if nosocomial transmission of TB has occurred in the past. Chances are the historical records will demonstrate no transmission or statistically low/insignificant levels of nosocomial TB.

Secondly, communicate to HCWs the nature of TB transmission. Most persons who develop LTBI have had long-term repeated exposures to infectious TB patients, in most cases, these were family members or close social/work contacts.

Q: If a HCW only had a single TST at a health care facility and then is hired at a new health care facility, do they need to re-start the two-step TST method?

A: 59.5(6) A second TST is not needed if the HCW has a documented TST result from any time during the previous 12 months. If a newly employed HCW has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting.

Q: If a HCW properly received baseline TB screening at another health care facility and is able to provide documentation; does the new health care facility need to repeat the baseline TB screening?

A: 481—59.7(135B) Screening of HCWs who transfer to other health care facilities or hospitals. 59.7(1) HCWs transferring from a low-risk health care facility or hospital to another low-risk health care facility or hospital. After a baseline result for infection with *M. tuberculosis* is established and documented, serial testing for *M. tuberculosis* infection is not necessary for HCWs transferring from a low-risk health care facility or hospital to another low-risk health care facility or hospital.

Q: We have long-term HCWs who have been part of serial TB testing in the past but we cannot locate documentation of a two-step being given. Do we need to give the HCW a two-step TST now?

A: No. Two–step TST is the procedure used for baseline skin testing of newly employed HCWs. It is not used for HCWs with a documented history of serial TST.

Q: Our company places HCWs in multiple facilities/hospitals, how does our company track or *know the other facilities or hospitals risk classification?*

A: Almost all facilities in Iowa are appropriately classified as low risk. Thus, the HCW shall only receive baseline TB screening and testing. If the HCW reports they receive annual testing at another facility, that facility is conducting testing consistent with facilities/hospitals classified as medium risk. Check specifically with any facility/hospital conducting annual testing to see if they are appropriately classified as medium risk. In the rare event a HCW works in both settings, follow serial testing procedures for the higher-risk facility.