

TUBERCULOSIS INFECTION CONTROL PROGRAM
MODEL POLICIES
FOR
CHEMICAL DEPENDENCY TREATMENT AGENCIES
IN WASHINGTON STATE

Revised September 1, 2009

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PURPOSE

This document was developed to assist chemical dependency treatment providers to implement the guidelines issued by the Centers for Disease Control in 2005 to control the spread of Tuberculosis (TB).

The Centers for Disease Control and Prevention (CDC) issued:

- *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*, MMWR 2005; 54 (No. RR-17, 1-141) in December 2005 (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>).
- *Guidelines for Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC*, MMWR 2006; 55 (No. RR-09, 1-44) in July 2006 (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm>).

These guidelines are required for all chemical dependency treatment programs and enforced by:

- The federal Occupational Safety and Health Administration (OSHA) for federal programs and Tribal programs on Indian Reservations and Trust Lands.
- The Washington State Department of Labor and Industries, Division of Occupational Safety and Health (DOSH), for all other employers in the state of Washington.

Other requirements:

- [WAC 246-101-101](#) requires all health care providers to report every case of tuberculosis to the local health department immediately at the time of diagnosis or suspected diagnosis.
- The 1993 federal Substance Abuse Block Grant requires block grant recipients, directly or through arrangements with other entities, to make available tuberculosis services to each individual receiving treatment. Services must include tuberculosis counseling, testing, and treatment.

SUMMARY OF CDC GUIDELINES

The CDC [Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005](#) require chemical dependency treatment programs to do the following:

1. Appoint someone as your TB Infection Control Program Manager. (See page 7 of the CDC guidelines.)
2. Conduct an annual risk assessment of your health care setting in consultation with local or state health officials. (See pages 9 and 36 of the CDC guidelines.)

To assist you in your annual risk assessment, the CDC guidelines include:

- [Appendix B](#): Tuberculosis Risk Assessment Worksheet of the CDC guidelines (see pages 128-133 of the CDC guidelines).
 - Appendix C: Risk Classifications for Health-care Settings That Serve Communities with High Incidence of TB and Recommended Frequency of Screening for TB Infection Among Health Care Workers. (See page 134 of the guidelines.)
3. Write a TB Infection Control Plan, based on the annual risk assessment. (See pages 10 and 11 of the CDC guidelines.)

The plan must describe your agency's administrative, environmental, and respiratory-protection controls that are appropriate for your health care setting's level of risk.

At a minimum, the plan must include your agency's plan for:

- Baseline screening of all health care workers upon employment. (See "baseline TB screening" on page 57 of the CDC guidelines.)
 - Follow-up testing of health care workers appropriate for the level of risk of the setting. (See pages 10 and Appendix C on page 134 of the CDC guidelines.)
 - Initial TB training and education of all health care workers. (See Suggested Components of an Initial TB Training and Education Program for Health-Care Workers on pages 17-18 of the CDC guidelines.)
 - Prompt triage of patients for TB symptoms and isolation and referral for further medical evaluation of patients exhibiting symptoms of TB disease, suspect TB, or individuals with confirmed TB who remains infectious. (See pages 16-17 of the CDC guidelines.)
 - Education of patients about TB and training them on respiratory hygiene and cough etiquette procedures. (See Respiratory-Protection Controls on page 7 of the CDC guidelines.)
4. Update your TB Infection Control Plan annually.

FREQUENTLY ASKED QUESTIONS ABOUT CDC GUIDELINES

Q: Do all health care workers need to complete an initial base-line test for TB upon employment?

A: Yes.

Q: Is every health-care worker required to have a new TB test every year?

A: It depends on the results of the risk assessment of your health care setting. If you assess your setting as medium risk or higher, then all health care workers need a new test every year, unless they already tested positive. If your level of risk is low, there is no need to retest workers unless they are exposed to a person with infectious TB or exhibit TB symptoms.

Q: Should every patient be required to have a TB test before admission?

If your TB risk assessment of your treatment setting is low, and the patient has no history of TB infection, no TB risks, and no TB symptoms, then TB testing is not necessary. If the patient has history of TB infection, or exhibits risk factors for TB, and exhibits symptoms of TB disease, then the patient should be isolated from other patients and tested and/or referred for further medical evaluation.

GENERAL COMMENTS ON SCREENING (From the CDC Recommendation and Report titled [*Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations Recommendations of the Advisory Council for the Elimination of Tuberculosis*](#), September 08, 1995/44RR-11;18-34.

Screening is not recommended for those persons who use alcohol and other non-injecting drugs, but who are not members of high-risk groups, because this screening diverts resources from higher priority activities.

Persons who use alcohol and other non-injecting drugs, who are also members of high-risk groups (e.g., HIV-infected persons, the homeless, residents of correctional facilities, and medically underserved, low-income persons), should be included in screening activities.

RECOMMENDATIONS FOR SPECIFIC HIGH-RISK GROUPS

Contacts of Persons Who Have Infectious TB

Because the risk for infection and disease is high among close contacts of persons having TB, these persons should be identified promptly (usually within 3 days) and examined soon (usually within 7 days) after identification of the potentially infectious patient.

Persons Who Have HIV Infection

HIV infection is the strongest risk factor yet identified for the development of TB disease in persons having TB infection. All HIV-infected persons should be tested.

Persons Who Inject Drugs

Because they are at high risk for TB and HIV infection, the priority for screening is high for persons who inject illicit drugs. Drug treatment programs and other settings that provide care for persons who inject drugs should test injecting drug users.

STATE AGENCY RESOURCES FOR TB INFORMATION

For information about TB requirements for outpatient chemical dependency treatment programs, contact:

Deb Cummins, Certification Policy Manager
Division of Behavioral Health and Recovery
Department of Social and Health Services
Post Office Box 45330
Olympia, WA 98504-5330
360-725-3716 or 1-877-301-4557
Fax: 360-586-0341
cummida@dshs.wa.gov

For information about TB requirements for Residential Treatment Facility (RTF)-Chemical Dependency contact:

Barbara Runyon, RN MN, CIC
Health Professions/Facilities Office
Health Systems Quality Assurance Division
Department of Health
Post Office Box 47852
Olympia, WA 98504-7852
360-236-2937
Fax: 360.236.2901
Barbara.Runyon@doh.wa.gov

For information about TB requirements for adult corrections, contact:

Lara Strick, MD, Infectious Disease Consultant
Department of Corrections.
Post Office Box 41123
Olympia, WA 98504-1123
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For information on DOSH workplace TB requirements, contact:

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For information about DOH TB resources, contact:

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TB POLICY I.

IMPLEMENTING CDC GUIDELINES FOR INFECTION CONTROL OF TUBERCULOSIS (TB)

POLICY

The _____, chemical dependency treatment agency, must strive to protect staff and patients from *Mycobacterium Tuberculosis* (TB) by implementing federal and state guidelines for infection control of TB.

PURPOSE

1. To promote a safe environment for patients and health care workers.
2. To improve the integration of chemical dependency and TB services for alcoholics and other substance abusers in, or seeking admission to, chemical dependency treatment.
3. To promote effective cooperation and partnership between this agency and other health care providers in coordinating chemical dependency and TB patient care.

AUTHORITY

1. The Occupational Safety and Health Administration (OSHA) and the Washington State Labor and Industries, Division of Occupational Safety and Health (DOSH) require health care facilities, including chemical dependency treatment agencies, to implement the Centers for Disease Control guidelines to prevent the transmission of TB in the work place:
 - *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*, MMWR 2005; 54 (No. RR-17, 1-141). See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>
 - CDC Guidelines for the *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC*, MMWR 2006; 55 (No. RR-09, 1-44). See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm> or <http://www.cdc.gov/mmwr/PDF/rr/rr4508.pdf>
2. Federal disability-based anti-discrimination laws, including:
 - [Public Law 93-112](#), Section 504, Federal Rehabilitation Act.
 - [Public Law 101-336](#), The *Americans* with Disabilities Act.
3. [Federal Substance Abuse Prevention and Treatment Block Grant](#), requiring prevention and control of TB by recipients of block grant funds, 1993 forward.
4. Washington State law and rules requiring reporting of infectious disease:
 - [Revised Code of Washington \(RCW\) 70.28](#), *Control* of TB.
 - [Chapter 246-100 Washington Administrative Code \(WAC\)](#), *Communicable* and Certain Other Diseases.
 - [Chapter 246-101 WAC](#), Notifiable Conditions.

- [Chapter 246-170 WAC](#), TB Prevention, *Treatment*, and Control.
5. Federal and state confidentiality laws:
- [42 Code of Federal Regulations \(CFR\) Part 2](#): *Confidentiality of Alcohol and Drug Abuse Patient Records*.
 - [45 CFR Parts 160 and 164](#): Health Insurance *Portability* and Accountability Act (HIPAA) of 1996.
 - [Chapter 70.02 RCW](#), Health Care *Information* Access and Disclosure.
 - [Chapter 70.96A RCW](#), Treatment for *Alcoholism*, Intoxication and Drug Addiction.
6. Chemical Dependency Treatment rules in Chapter 388-805 WAC: (See Appendix K)
7. The federal *Treatment Improvement Protocol (TIP) Series 18: The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Treatment Providers*, published by the Center for Substance Abuse Treatment, 1995. See <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.38602>.

PROCEDURES

1. The administrator must designate a person or group with expertise in TB infection and disease, infection control, occupational health, environmental controls, and respiratory protection as the agency TB Infection Control Program Manager. (See page 10 of the [CDC guidelines](#).)
2. The administrator must ensure that the TB Infection Control Manager:
 - A. Conducts an annual health care setting TB risk assessment in consultation with local or state health officials, utilizing the *TB Risk Assessment Worksheet* and the *Risk Classifications for Health-care Settings That Serve Communities with High Incidence of TB and Recommended Frequency of Screening for TB Infection Among Health Care Workers* (See pages 9 and 128-133 of the [CDC guidelines](#).)
 - B. Writes a TB Infection Control Plan, based on the annual health care setting TB risk assessment that describes the agency’s administrative, environmental, and respiratory-protection controls that are appropriate for our setting’s level of risk. This includes implementing and documenting:
 - i. Baseline TB screening and testing of all health care workers upon employment. (See “baseline TB screening” on page 57 of the [CDC guidelines](#).)
 - ii. Follow-up testing of health care workers appropriate for the level of risk of the setting. (See pages 10 and Appendix C of the [CDC guidelines](#).)
 - iii. Initial TB training and education of all healthcare workers. (See Suggested Components of an Initial TB Training and Education Program for Health-Care Workers on pages 27-28 of the [CDC guidelines](#).)
 - iv. Prompt triage of patients for TB symptoms and isolation and referral for further medical evaluation of patients exhibiting symptoms of undiagnosed or inadequately treated TB disease. (See pages 16 of the [CDC guidelines](#).)

- v. Education of patients about TB and training them on respiratory hygiene and cough etiquette procedures. (See page 7 of the [CDC guidelines](#).)
- C. Maintains complete and accurate TB records of employees and patients.
- D. Ensures proper follow-up on TB status and treatment of employees and patients.
- E. Collects annual statistics of incidence of TB infection and disease in this agency's patients and health-care workers for use in annual risk assessment and TB Infection Control Plan updates.
- F. Manages health department and other medical referral resources and contacts.
- G. Updates our TB Infection Control Plan annually.
- H. Oversees the implementation of this agency's TB policies and procedures.
- I. Reviews this agency's TB policies and procedures annually, and updates them as needed.

TB POLICY I. A.

CONFIDENTIALITY OF PATIENT INFORMATION

POLICY

This chemical dependency treatment agency has a legal obligation to meet state requirements for the prevention and control of tuberculosis (TB) while protecting the confidentiality of patient information under:

- [42 Code of Federal Regulations \(CFR\) Part 2](#), on Confidentiality of Alcohol and Drug Abuse Patient Records.
- [45 CFR Parts 160 and 164](#), the [Health](#) Insurance Portability and Accountability Act of 1996 (HIPAA).
- [Chapter 70.02 Revised Code of Washington \(RCW\)](#), the [Uniform](#) Health Care Information Act.

There are four exceptions to the CFR that enable compliance with all state TB public health reporting, disclosure, and follow-up activities without violating the federal confidentiality laws. By using one of these exceptions, this agency must work with public health agencies to ensure that clients/patients with, or suspected of having, TB disease are treated without compromising the confidentiality of information related to their chemical dependency treatment.

PROCEDURES

1. Patient consent.

- A. This is the preferred option for releasing confidential chemical dependency treatment information. The rules and guidelines under Washington Administrative Code ([WAC](#) [388-805-305\(1\)\(e\)](#)) regarding patient consent must be followed. See sample consent for release of information, prohibition on redisclosure, and interagency information exchange forms in Appendices C, D, and E.
- B. Because individual patients have the right to refuse or revoke their consent, provision of chemical dependency treatment may be made contingent on each patient signing a consent form. Conditioning a patient's admission to or continuation in treatment on the patient's agreement to sign a consent form does not violate the federal confidentiality law, as long as all patients are treated equally.
- C. To assist in obtaining consent from a patient, staff must:
 - Explain to patients how chemical dependency treatment must be facilitated if they consent to disclosures relating to the prevention and control of TB.
 - Emphasize the agency must disclose only information that is relevant to TB treatment.
 - Nurture patient relationships in order to develop trust. Let patients know other agencies receiving confidential information are also bound by the confidentiality law.
 - Respect the patient's right to refuse or withdraw consent. See TB policy III regarding patient services.

- If a patient has no TB symptoms (see TB Risk Screen, Appendix I) and refuses to give consent, keep it as an open issue in the treatment plan while seeking other means through which to report the information, such as through a QSOA (discussed below). As the patient continues treatment, s/he may develop knowledge regarding the need for consent, and the confidence to sign a consent form.

2. Communications that do not disclose patient-identifying information.

- A. Disclosures that do not identify the patient as a former, current, or would-be participant in chemical dependency treatment do not violate state or federal alcohol and other drug confidentiality regulations.
- B. Confidentiality regulations do not protect the patient's identity per se, but his/her identity as a person who has been treated, is being treated, or has asked to be treated for drug or alcohol dependence.
 - Staff may disclose a patient's name and whereabouts as long as they do not reveal the patient is in, has been in, or has applied for chemical dependency treatment. For example, if the chemical dependency unit is part of a hospital, the name of the hospital may be given, not that of the chemical dependency treatment unit.
 - When the patient is in outpatient treatment, a report can be made without revealing where the patient is. Staff must not reveal the agency address but can use an address that does not reveal or identify the address as a chemical dependency treatment agency.
 - With the patient's documented approval, his/her home address may be given.

3. Qualified service organization agreements (QSOAs).

- A. A QSOA permits sharing of chemical dependency treatment patient-identifying information with an outside agency without patient consent, to secure needed services. See sample in Appendix F.
- B. The outside service agency is bound by federal confidentiality regulations and may only disclose confidential chemical dependency information with patient consent.
- C. Although patient consent is not necessary, staff must inform patients about QSOAs to which this agency is a party, in order to prevent surprise and protect the therapeutic relationship.

4. Medical emergency.

- A. Disclosures can be made without the patient's consent to public or private medical personnel to meet a bona fide medical emergency of the patient or any other individual. A "medical emergency" is a situation that poses an immediate threat to health and requires immediate medical intervention. Where a medical emergency arises, e.g., a drug overdose or a suicide attempt, the agency should report the emergency, including chemical dependency patient-identifying information, to medical personnel who need it to treat the individual involved.

- B. A chemical dependency clinical supervisor, with reason to suspect a patient or applicant has TB, must report his or her suspicions to local public health officials as a medical emergency. TB can be transmitted by casual contact (that is, the sharing of air space); therefore infectious TB poses an immediate health threat and requires immediate medical intervention. As public health officials tend to be "medical personnel," the report does not violate regulations.
- C. The supervisor who discloses information under the medical emergency exception must document the disclosure in the patient's record. Documentation must include:
- The name of the medical personnel to whom the disclosure is made, and the agency with whom the recipient is affiliated.
 - The name of the individual making the disclosure.
 - The date and time of the disclosure.
 - The nature of the emergency, including the circumstances surrounding the disclosure.

TB POLICY I. B. AMERICANS WITH DISABILITIES ACT

POLICY

Persons who have or are suspected of having TB disease are considered disabled under federal disability-based antidiscrimination laws. This chemical dependency treatment agency must not deny employment, terminate or alter the duties of applicants or employees who do not pose a risk to others and who are able to do their jobs. Reasonable accommodation must be made for persons suffering the effects of TB or TB prevention or treatment.

No laws require admission of patients or employment of staff who pose a direct threat to the health or safety of other individuals in the work place. The potential for transmission of TB to other patients and staff by an infectious person constitutes a direct threat, or a significant risk of substantial harm to the individual or others that cannot be eliminated or reduced by reasonable accommodation.

Employees and patients who are TB-infected (positive TB test, may or may not be taking TB medications), but are medically determined to not be infectious (contagious), must not be discriminated against and must have the same employment and admission opportunities as people without this disability.

PROCEDURES

1. Screening of all persons equally.

Health care personnel or a counselor must evaluate each employee and each patient on a case-by-case basis according to this agency's TB Infection Control Plan after reviewing the person's TB history, TB risk factors, TB symptom screen, and, where applicable, TB testing and referral for medical evaluation to assess whether the person has TB disease, and whether the person poses a significant risk of transmitting infection to others.

2. Deferred employment or admission.

- A. An applicant employee or patient who poses a significant risk must be considered for deferred admission or deferred employment. His or her admission or employment must be contingent upon treatment and medical certification that s/he no longer poses a significant risk of infecting others.
- B. This patient or employee must be given priority for chemical dependency treatment or employment once s/he is receiving appropriate medical treatment for TB and is no longer infectious.

3. Reasonable Accommodations.

Because of extreme fatigue and other side effects of TB medications, the administrator must consider modifying job or treatment schedules or restructuring the jobs of noninfectious employees or patients who are taking such medications.

TB POLICY I. C. TRAINING AND EDUCATION

POLICY

All staff and patients must be provided training and education in the basics of TB and the need for the TB Infection Control Program.

PROCEDURES

1. Training & Education.

- A. Training of staff must be provided by the agency's TB Infection Control Program Manager or designee who is a licensed health care provider, or a public health educator, who is qualified to present information about TB and respond to a variety of staff and patient questions.
- B. If the TB Infection Control Program Manager determines that a staff counselor is adequately trained to conduct TB training, that must be documented in the employee's personnel file, and the designated staff person may then conduct the training and field related questions.
- C. Training must be provided to staff:
 - Upon employment.
 - Annually, or more often if there is significant staff turnover.
- D. Education must be provided to patients:
 - Upon admission.
 - Periodically, as needed.
- F. Training of employees must be documented in each employee's personnel file. Education of patients must be documented in their patient record.
- G. Brochures and hand-outs must be available to staff and patients in English and other languages, as appropriate. Contact the State TB Control Unit at 360-236-3431 or <http://www.doh.wa.gov/cfh/TB/Education.htm> for materials.
- H. Individual consultation must be made available to any staff or patient who needs more information and assistance to resolve TB-related issues.

2. Content of training and education for staff and patients.

- A. Trainers must cover basic information including that described under "Risks" and "The Disease," in Appendix A and B. Training and education may include the use of videos, in-service classes, and written materials. Opportunities need to be provided for questions and answers.
- B. Training and education of staff and patients can occur together, since the basic information is the same. Information to be covered includes:

- Prevention.
- Basic symptoms.
- Transmission.
- Infection control procedures.
- Diagnosis of Latent TB Infection (LTBI) and diagnosis of TB disease.
- Treatment of LTBI and treatment of TB disease.
- Follow-up after exposure (Contact Investigation).
- Dangers of non-adherence to treatment for disease.
- Concerns about infection and disease.
- Respiratory hygiene and cough etiquette procedures.

3. Additional staff training must include:

- A. A review of the agency's TB Infection Control Plan and TB policies and procedures.
- B. Information about tuberculin testing, the importance of chest radiographs for individuals who react positively to tuberculin tests or may have symptoms of TB, or have HIV; and the need for medical confirmation of infectious TB.
- C. Information about local health and social services resources to refer clients appropriately for both TB and other services. Counselors must be informed of key contacts at each of the agencies or organizations in the referral network.
- D. Steps to be taken when:
 - Assuring screening and, when applicable, testing of employees and patients.
 - A patient or employee has a positive reading.
 - Implementing work place policies and procedures for preventing the transmission of tuberculosis, including:
 - Consultation with a local health department, state health department or with a physician for immediate relocation for assessment, care, and treatment of a person suspected or confirmed of having infectious TB.
 - The location and use of respirators (see TB Policy II Employees) when a person with TB symptoms or infectious disease is detained pending relocation.
- E. Suggested components of an initial TB training and education program for health-care workers from pages 27-28 of the CDC [*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005*](#), under:

- Clinical Information.
- Epidemiology of TB.
- Infection-Control Practices to Prevent and Detect *M. tuberculosis* Transmissions in Health-Care Settings.
- TB and Immunocompromising Conditions.
- TB and Public Health.

4. Links to TB education and training resources:

[Educational Materials - Washington State Department of Health](#)

- Find links to state, regional and national educational and training materials at:
<http://www.doh.wa.gov/cfh/TB/Education.htm>
- Find links to Washington State TB statistics at:
<http://www.doh.wa.gov/cfh/TB/default.htm>
- Find TB Fact Sheet at:
<http://www.doh.wa.gov/cfh/TB/Education.htm>

Educational Materials - Division of Occupational Safety and Health (DOSH), Washington State Department of Labor and Industries

- Find DOSH requirements and links to educational resources at:
<http://www.lni.wa.gov/Safety/Topics/AtoZ/TB/default.asp>

TB POLICY I. D. SCREENING AND TESTING

POLICY

The TB Infection Control Manager must manage the TB screening and testing program for all employees and patients of the agency. The manager must:

- Screen employees and patients for TB medical history, TB risk factors and symptoms of TB.
- Administer and read tuberculin tests, when appropriate.
- Refer employees and patients for further medical evaluation and treatment, when indicated.
- Provide for directly observed therapy when necessary.

The TB Infection Control Manager must be qualified as a licensed health provider, who is certified to do tuberculin tests, or a tuberculosis community health worker (See Appendix G.)

PROCEDURES

1. Documentation TB Infection Control Manager's Qualification To Do TB Tests.

Documentation of the TB Infection Control Manager's training and qualifications to administer and read TB tests must be placed in the employee's personnel file.

2. Employee/Patient TB Screening and Testing Duties of the TB Infection Control Manager.

The TB Infection Control Manager must:

- A. Conduct the TB History, Risk Assessment and Symptom Screen found in Appendix I on all new employees upon being offered employment and all new patients during intake into the treatment program. If the person has symptoms of TB, defer employment or admission until the person provides documentation from his or her physician that s/he does not have infectious TB using the TB-related Medical Information and Services form in Appendix J.
- B. Conduct TB tests for patients whose screening indicates a need for a test and conduct baseline TB testing of all new employees.
 - i. Baseline TB Testing of new employees is conducted using either the two-step Mantoux skin test (TST) or the one-step interferon gamma release assay (IGRA). (See "baseline TB screening" on page 9-14 of the Centers for Disease Control and Prevention's 2005 *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*, <http://www.cdc.gov/mmwr/PDF/rr/rr4508.pdf> Baseline testing is not done on patients.
 - ii. If a person previously skin-tested positive, obtain documentation of the TB test results using the TB-related Medical Information and Services form in Appendix J, with millimeter readings of the TST, a radiograph report, and completion of treatment for Latent TB Infection (LTBI) or TB disease if applicable. If this documentation is not available, the person must be retested.
 - iii. Refer individuals who may be HIV positive or anergic (see Appendix B), for a medical evaluation.

- iv. Be alert to possible false negatives in individuals whose immune systems are weakened. See Appendix B, TB: The Infection and the Disease, under Detecting TB Infection.
 - v. In consultation with the local health department, follow up with individuals who test positive on a tuberculin test, those who are recent converters, and those who show symptoms of TB.
- C. Complete or obtain a copy of the TB-related Medical Information and Services form in Appendix J as part of employee baseline testing and for patients whose initial TB History, Risk Assessment and Symptom Screen indicate the need for testing or further medical evaluation.
- D. Establish and maintain a complete TB record system (TST, IGRA, treatments for LTBI or TB disease, contact investigations, chest radiographs, micro bacteriology reports, respiratory fit testing) for the TB Infection Control Program in accord with TB Policy I. E., Record Keeping.

3. Staff not qualified to do tests.

If the TB Infection Control Manager is not qualified to do TB testing, the manager should perform only the tasks identified and agreed upon in the Interagency Agreements (Appendix H) with the health department and other primary care providers.

TB POLICY I. E. RECORD KEEPING

POLICY

Thorough, accurate, timely, and confidential records of TB screening, testing, and other TB infection control activities must be maintained by the TB Infection Control Program Manager for both employees and patients. Confidentiality of medical records must be maintained in accord with TB Policy I. A.

PROCEDURES

1. Log of all TB testing conducted or due.

- A. Whether testing is done on or off the premises, separate logs must be maintained by the TB Infection Control Program Manager for employees and patients, including:
- Identifying information (name).
 - Date of employment or admission.
 - Date of risk screen.
 - Date of referral for test. If not done on site, use referral form in Appendix J.
 - Date(s) of tuberculin test(s).
 - Date(s) test(s) read, by whom, and results, including size of induration in millimeters for TST.
 - Documentation of additional medical procedures and clearance for admission or employment.
 - Documentation of follow-up medication monitoring, when applicable.
- (Note: maintenance of the log, where it is easily referenced, must be valuable for patients who leave and are readmitted, to avoid retesting persons who already tested positive.)
- B. If tests are negative, identify the next TB screen or test due date and note above information in the employee's medical record or the patient's record within seven days. Repeat the documentation for annual TB medical history, risk assessment, symptom screening, and, if applicable, testing.

2. Follow-up referrals and monitoring.

- A. If referrals are necessary to obtain diagnostic or treatment information, use the sample referral and request for medical information form in Appendix J and file the information received in patient progress notes or employee medical records.
- B. Records may be maintained in a central location originally, and then placed in the employee's medical file or patient's record.

- 3. OSHA 200 Log:** This log must be kept of all employment and occupational exposures to TB for Labor and Industries purposes, since there may be a presumption of work-relatedness in health care settings.

TB POLICY I. F. SUPPLIES AND COSTS FOR TB SERVICES

POLICY

If qualified licensed health providers are not available onsite, patients and employees must be referred to their personal physician, private clinic or local health department for the conduct and reading of TB tests and, if necessary, further medical evaluation and services necessary to diagnose and treat TB disease and latent TB infection (LTBI). Those agencies are then responsible for billing and collections.

TB services to employees are provided by the employer at no cost to the employee, including time and travel, if necessary, as required by the federal Occupational Safety and Health Administration (OSHA) and the Washington State Department of Labor and Industries, Division of Occupational Safety and Health (DOSH). These include baseline tests and medical evaluations to all new employees, routine follow-up TB tests, and TB tests to potentially exposed employees, and follow-up medical evaluations. Treatment for TB disease and LTBI of employee converters are covered by industrial insurance.

When TB services are provided onsite to patients that have private insurance, those insurance companies must be billed the allowable charges.

When patients have Medicaid and the agency has a contract to provide Medicaid services, Medicaid must be billed the allowable costs.

Patients who are low income, but do not qualify for ADATSA, GAU, or Medicaid, and are in a program funded by the Substance Abuse Prevention and Treatment Block Grant, the treatment agency must pay the costs of the TB test and further medical evaluation and treatment if necessary to diagnose and treat TB disease or latent TB infection (LTBI).

If testing is done on site, supplies needed for providing TB tests must be obtained at the least possible cost.

PROCEDURES

1. On-site TB testing supplies.

TB testing supplies may be only ordered by a physician or a licensed pharmacy. For pharmacy licensing regulations, contact the Washington State Board of Pharmacy at:
<http://www.doh.wa.gov/hsqa/professions/Pharmacy/default.htm>

2. Billing for employee administered on-site testing.

- A. When the test and reading are provided by an employee of the chemical dependency treatment agency who is a licensed health provider or Tuberculosis Community Health Worker (See Appendix G) trained by the local health department, the following applies:
- Private insurance companies must be billed for allowable costs, when a patient or employee has private insurance.
 - Providers under contract with their county or DBHR to provide chemical dependency treatment services should contact their contract manager to see if there are any special instructions on how to bill for TB services.
 - Provider Type 75, chemical dependency treatment providers who have a state contract with the Division of Medical Assistance (DMA), and patients who are

Medicaid-eligible, must bill DMA under Procedure Code 86580: Skin test, Tuberculosis, Intradermal. The rate of \$4.46 includes the skin test and the reading.

3. Off-site testing.

When testing is not done at this agency and the patient or employee is referred to his/her personal physician, private clinic, or local health department for testing, that agency is responsible to arrange fees and collection.

For low income patients, this agency must make arrangements with a physician, private clinic, or the local health department for reimbursement for TB tests, and if necessary, further medical evaluation and treatment for the diagnosis and treatment of TB disease and LTBI.

TB POLICY 1. G. INTERAGENCY AGREEMENTS

POLICY

This agency must maintain an effective partnership with the local health department, individual medical providers or other agencies as needed to ensure chemical dependency treatment and tuberculosis (TB) services are provided to chemically dependent persons, while improving access to both services and promoting efficiency.

PROCEDURES

The TB Infection Control Program Manager must develop strategies and protocols for state/local consultation to promote efficiency and avoid duplication of efforts in the provision of TB services to employees and patients. This person must:

1. Develop and update, as needed, interagency agreements that describe the roles and responsibilities of all parties in TB risk assessment, symptom screening, testing, medical evaluation, treatment and follow-up of chemically dependent patients in need of TB services. (See sample interagency agreement in Appendix H.)
2. Establish referral and cost reimbursement arrangements for TB services, including a formal process to document each referral and to track ongoing status and outcomes.
3. Ensure collaborating parties are familiar with legal requirements of mandated infectious disease reporting and patient confidentiality: Understanding obligations of both parties fosters professional respect and a respect for employee and patient dignity and privacy.
 - A. Ensure confidentiality procedures do not prevent collaboration.
 - B. Offer services at the chemical dependency treatment site where possible.
 - C. Develop strict guidelines for dealing with breaches of confidentiality.
 - D. Train staff regarding the options for disclosure under the confidentiality law.
4. Assure in-service training of chemical dependency treatment staff and TB prevention and treatment staff on both chemical dependency and infectious disease issues:
 - A. Modify existing public health TB training packages to address issues of chemical dependency, homelessness, non-compliance and other topics relevant to the chemically dependent population.
 - B. Ensure chemical dependency trainings integrate TB and other infectious disease topics.
5. Provide informational brochures and posters for use by patients and staff.
6. Work together to create safe environments for chemical dependency staff and patients.
7. Develop uniform or shared reports and record keeping forms to avoid the needless transfer of information from one form to another.
8. Maintain lists of contacts (names and phone numbers) in collaborating agencies. Treatment programs, public health departments, and other cooperating institutions (such as

correctional agencies) should assemble lists of contacts in other agencies. These contacts are the people to call if there are questions or concerns about the agreement's implementation.

9. Identify and access all available resources and funding streams.
10. Develop shared quality assurance procedures:
 - A. Encourage frequent communication by phone and periodic meetings between agencies to lessen misunderstanding.
 - B. Monitor the effectiveness of collaborative efforts to better understand which strategies work and to target areas for improvement.
 - C. Ensure partnership agreement content and implementation are met, or modify as needed, at appropriate intervals.

TB POLICY II EMPLOYEES

POLICY

_____ treatment agency must comply with the following guidelines as required by the federal Occupational Safety and Health Administration (OSHA) and the Washington State Labor and Industries Division of Occupational Safety and Health (DOSH) to protect employees from on-the-job hazards, including exposure to TB:

- The Centers for Disease Control *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*, MMWR 2005; 54 (No. RR-17, 1-141) (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>) or, if applicable,
- The guidelines for *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC*, MMWR 2006; 55 (No. RR-09, 1-44) in July 2006 (See <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm> or <http://www.cdc.gov/mmwr/PDF/rr/rr4508.pdf>)

These policies and procedures establish a comprehensive TB prevention and control system for employees, ensuring:

- Staff with TB infection are identified early, do not pose a risk of infection to others, and are not discriminated against.
- Confidentiality of the employee's health status and records must be maintained in accord with TB Policy I-A.
- Nondiscrimination must be assured in accord with TB Policy I-B.
- TB testing and medical evaluation services to employees must be provided at no cost to the employee, including time and travel, if necessary.

PROCEDURES

1. Baseline TB screening and testing of employees.

All employees must be provided baseline TB screening and testing at the time of employment at no cost to the employee following the protocol for health care worker screening found on pages 28-30 of the [Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings](#) or for correctional and detention workers found on page 11 of the [guidelines for Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from the CDC](#) to:

- A. Establish a baseline for TB infection status; and
- B. Provide information on future potential exposure and worker's compensation claims.

2. Retesting of employees.

- A. Retesting of employees must be completed at no cost to the employee in accordance with the agency's TB Infection Control Plan. Facilities with a low risk assessment only have to retest employees who actually come into contact with patients with TB disease. Facilities with a medium risk assessment should retest employees every twelve months.

Facilities with the classification of potential for ongoing transmission could retest employees as frequently as every 8 – 10 weeks until the classification of potential ongoing transmission has been lifted.

- B. Workers who may have been recently exposed to TB must be retested in accordance with local health department recommendations at no cost to the employee.

3. Health care follow-up and treatment.

- A. Annual TB evaluations for employees who had prior TB infection or disease must be conducted by the TB Infection Control Manager to monitor for symptoms. Documentation of findings permitting the employee to work must be maintained in the employee's medical file.
- B. Converters or prospective employees with newly identified positive TB test results must be provided with chest radiographs and medical evaluations at no cost to the employee as required by OSHA and DOSH.
- C. Costs of additional medical examinations and treatment for TB infection or disease contracted in the workplace are covered by industrial insurance.

4. Employee Training.

Each new and current employee must be trained about TB risks, the disease and transmission, in accord with TB policy I. C, so they can be supportive and committed to the need for the TB Infection Control Program.

5. Respiratory-Protection Program.

The respiratory-protection program must meet the Centers for Disease Control requirements for respiratory protection found in pages 38-40 of the [*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*](#) or pages 17-18 of the guidelines for the [*Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC.*](#)

Personal Respirators.

- A. Personal respirators approved by the National Institute of Occupational Safety and Health must be used to prevent the transmission of TB. These respirators may be obtained from surgical supply houses and:
 - i. Must be fitted prior to use:
 - a. Persons with facial hair or unusual facial structure cannot be fitted.
 - b. Sizes come in small, medium, and large.
 - c. A testing device must be used with the respirator.
 - ii. Are located in the administrator's office (or specify room or area).
 - iii. Must be maintained clean and in operable condition by following the manufacturer's posted instructions.
- B. Staff must use a respirator in the following circumstances:

- i. Whenever an employee is in a room with a person who is suspected or known to have infectious TB. A person is "suspected" of having TB if s/he has symptoms consistent with TB, such as: drenching night sweats of more than two weeks duration; unexplained weight loss; loss of appetite; cough lasting more than two weeks; coughing or spitting up of blood; hoarseness; or chest pain; and
 - ii. Whenever an employee transports an individual with known or suspected TB in a closed vehicle.
- C. Refusal to wear the respirator in the above instances is grounds for termination.

6. Temporary care of a patient suspected of or having TB.

- A. The number of staff who enter the work area and deal closely with a potentially infectious patient must be limited to one or two staff persons, at most, if shift exchange occurs, or if the patient needs additional assistance.
- B. Use controls, such as a surgical mask or tissue over the patient's mouth; move the patient outside, if weather and timing permit.
- C. Any staff that has had contact with an infectious TB patient must be retested or otherwise followed-up by a medical practitioner eight to ten weeks after exposure at no cost to the employee.

POLICY II. A. JOB APPLICANTS

POLICY

Job applicants must be informed of occupational health hazards including the potential for exposure to TB.

When a job is offered, applicants must be informed TB screening and testing are job requirements.

TB testing and medical evaluation services to prospective employees must be provided at no cost to the employee, including time and travel, if necessary.

PROCEDURES

1. Job applicant interviews.

- A. When interviewing job applicants, applicants must not be asked whether the person has TB, has had TB, has been tested for TB, or is being treated for TB.
- B. Questions about current or past medical conditions must be asked *after* the job offer has been made. This must ensure hiring decisions are based on an applicant's current ability to perform job-related functions - not on the basis of misperceptions about the impact a disability an applicant may have, may have had, or may be perceived as having.

2. Screening and testing applicants when a job offer is made.

- A. Inquiries must be made into a prospective employee's medical status and history only *after* the applicant received an offer of employment.
- C. Date of employment must be contingent on the applicant's being screened, tested, and, when necessary, treated for TB.
- D. All applicants must be provided baseline TB screening and testing at the time of employment at employers expense following *TB Policy II Employees* and the protocol for health care worker screening found on pages 28 of the [Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings](#) or for correctional and detention workers found on page 11 of the guidelines for [Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC](#).
- E. TB tests must be done on site, in accord with TB Policy I. D., or the employee must be referred to his or her private physician, health clinic, or the local health department.

3. Hiring or not hiring.

- A. A positive reaction to a TB test must not be used as a basis for denying employment to a qualified prospective employee. This may be a person who has non-infectious TB or whose past TB was properly treated and who does not pose a risk of transmitting infection to others.
- B. A prospective employee with infectious TB, or symptoms of TB, must not be allowed to begin work as s/he would be a significant health risk to staff and patients of the program.
 - This person must be referred for immediate medical evaluation and treatment at the

employee's expense, and must not be permitted to begin work until s/he has been medically certified to be non-infectious.

- It is unlawful to withdraw an offer of employment, unless the individual poses a threat to the health of others, and that threat cannot be reasonably accommodated.

TB POLICY III. PATIENT SERVICES

POLICY

All patients must be screened for TB risk factors and, where applicable, tested or referred for TB testing, medical evaluation and treatment in accordance with this agency's TB Infection Control Plan and the Centers for Disease Control [*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*, MMWR 2005; 54 \(No. RR-17, 1-141\)](#). TB-infected persons who are not infectious, or suspected of being infectious, must not be denied chemical dependency treatment.

PROCEDURES

1. Pre-admission screening.

- A. A counselor must orient each potential patient about the importance of screening and, if necessary, testing for TB, in a nonthreatening manner.
- B. A counselor (nurse) must complete the TB History, Risk Assessment, and Symptom Screen (Appendix I) prior to admission of each patient.
- C. TB tests must be provided or arranged for all patients who do not have a prior documented positive test, and testing is indicated by the results of their TB History, Risk Assessment, and Symptom Screen and this agency's TB Infection Control Plan.
 - Follow TB Policy I.D.
 - If TB testing services are not available on-site, refer the patient/potential patient to his/her private physician, medical clinic, or local health department, as indicated.
 - Follow up on referrals to ensure compliance and safety.
 - Maintain records in accord with TB Policy I.E.
 - Obtain documentation of the results of a chest radiograph or other medical evidence ensuring a person with a prior positive test is not infectious.

2. Youth consent.

When a youth consents to treatment without parental or guardian consent, that youth can also consent to TB testing without further consent, since such testing is an inherent part of chemical dependency treatment.

3. Building confidence and trust.

- A. Educate clients about TB and multi-drug-resistant (MDR) TB.
- B. Explain how services are available and accessible.
- C. Assure patients how confidentiality must be maintained.
- D. Identify and resolve negative perceptions and attitudes toward health authorities, if applicable. Explain:

- The partnership agreement with the health department.
- Mutual confidentiality requirements.

E. Address patient concerns about TB and related services:

- Assure the patient that health officials must not contact immigration authorities or investigate their immigration status, if applicable.
- Hypersensitivity to TB skin test agent is extremely unlikely; if still concerned, refer to a medical person.
- The disease cannot be contracted from the test.
- The results must not be used in some adverse way by child welfare officials, criminal justice, or others.
- The results must not be reported, except to public health officials as required by law.
- The test is in the person's best interest.

4. No admission of potentially infectious persons.

- A. If a person is identified as being infectious or at risk of being infectious by use of the TB History, Risk Assessment and Symptom screen or other information, the person must not be admitted until s/he has medical evidence of being noninfectious.
- B. Provide priority admission to chemical dependency treatment for persons whose admission has been deferred until medically verified as no longer infectious.

5. Patient refusal.

If a potential patient has no history, risks, or symptoms of TB when assessed with the TB History, Risk Assessment and Symptom Screen, but refuses to be tested or provide medical evidence of being noninfectious:

- Admission may be made contingent on the applicant's consent to be tested for TB, if the policy applies equally to all applicants.
- The patient may be admitted (if all patients are treated the same) contingent on the patient not showing any symptoms of TB during the course of treatment.

6. Annual tests.

Counselors must inform patients in chemical dependency treatment who have risk factors for TB that they should obtain annual TB tests, if there is no prior positive test, because of the weakened immune system of some chemically dependent persons.

7. Noninfectious, on medications.

- A. Assist with monitoring TB medications of patients who are medically determined to not be infectious, and are placed on medications for prevention or treatment of TB.
- B. Communicate with the primary care physician, when medications are administered

elsewhere, to ensure no medication monitoring is needed. Medications and chemical dependency treatment need to be evaluated to determine need for medication adjustments, when:

- Patients are treated for TB with rifampin (RIF), in combination with other anti-TB drugs. RIF reduces the effectiveness of methadone and can cause withdrawals. Methadone dosages may need to be increased.
 - Patients are treated for opiate addiction by Levi-alpha-acetyl-methadol (LAAM). In this case, RIF may increase LAAM's peak activity and/or shorten its duration of action.
 - INH can (rarely) cause patients on Antabuse to have psychotic episodes, ataxia (inability to coordinate muscular movements), liver damage and hepatitis. Health officials need to be informed of the patient's health status, so close monitoring may occur.
- C. Collaborate with public health officials to provide TB medications on-site at the chemical dependency treatment agency, since noncompliance with TB treatment can lead to a recurrence of disease or development of MDR TB.
- D. Observe for signs of chemical dependency relapse which might affect the completion of TB treatment. Interruption of TB medications may cause the tubercle bacillus to become resistant to TB treatment. When relapse occurs with a person taking TB medications, the primary medical provider must be informed, to prevent exposure of others.

8. Infectious, immediate transfer.

- A. Contact the local health department for immediate transfer of persons with known or suspected infectious TB. If infectiousness is suspected during non-office hours of the local health department, send the patient home to remain in seclusion until a medical evaluation can be made, or to a hospital. Pending transfer:
- Isolate the person in a single room, and post the room as "Special Respiratory Isolation."
 - Limit the number of employees who enter the "Special Respiratory Isolation" room and deal closely with a potentially infectious TB patient.
 - Use personal respirators in accord with TB Policy II, 4.
- B. Clean the patient's room or temporary care area by:
- Opening a window for six to eight hours to air the room.
 - Closing the door for 24 hours, allowing the organisms to fall out of the air.

TB POLICY IV. POLICIES AFFECTING OTHERS

POLICY

Since close contacts of infectious persons are at increased risk for TB, staff must advise infectious patients about the risk of TB to close contacts and offer to refer them for TB testing. Agency staff must also assist with contact investigations of the local health department as requested. Also, procedures must address risks of visitors and volunteers.

PROCEDURES

1. Family and Household Members.

- A. Patients must be informed that TB, like substance abuse, is a social problem that can affect families, household members, and other close contacts of infected persons.
- B. Patients infected with TB must be encouraged and offered assistance to refer their potentially exposed contacts for TB testing, if they do not have a private physician or insurance.

2. Visitors and other occasional contacts.

- A. Visitors and other occasional contacts such as speakers, who have short-term periodic contact with our patients, are not required by this agency to have TB tests.
- B. If the lifestyle of these persons puts them in frequent or prolonged contact with potentially infectious persons, recommend they have TB tests.

3. Contact investigations

Agency staff must assist with contact investigations as requested by the health department.

TB RISKS

Tuberculosis (TB) is not distributed evenly across the state. In 2008, sixteen of Washington State's 39 counties reported no new cases of TB while King, Snohomish, and Pierce Counties accounted for 72 percent of the 228 new cases. Rates of infection per 100,000 populations in 2007 were also higher than the Healthy People 2010 Objective in Clark, Island, Kitsap, Thurston, Spokane, Whatcom, and Yakima Counties.

Rates of TB also vary among race-ethnicity groups in our state. In 2008, the prevalence rate per 100,000 was:

36.9	Native Hawaiian/Other Pacific Islanders;
22.9	Black, non-Hispanic;
18.6	Asian/Pacific Islander, non-Hispanic;
8.5	Hispanic;
6.3	American Indian/Alaskan Native, non-Hispanic; and
0.6	White, non-Hispanic

Seventy-six percent of the 228 new cases of TB reported in Washington State in 2008 were among foreign-borne individuals.

Eleven cases were reported by persons who were also HIV positive.

Persons who use tobacco, alcohol, illegal drugs, including injection drugs and crack cocaine may also be at increased risk for TB infection and disease, especially if combined with other risk factors for TB, such as:

- Close contact (shared air space) with a person with a person with pulmonary TB disease for days or weeks.
- Foreign-borne persons who have arrived from areas with a high incidence of TB disease, such as: Eastern Europe, Mexico, the Philippines, Russia, Vietnam, Somalia, Ethiopia, and India.
- Residents and employees of congregate settings that are high risk, such as: Correctional Facilities, long-term care facilities, and homeless shelters.
- Health-care workers (HCW) who serve patients who are at high risk.
- HCWs with unprotected exposure to a patient with TB disease.
- Low income persons who are medically underserved.

Persons with latent TB infection (LTBI) are at higher risk for progressing from LTBI to infectious TB disease, especially if they have other risk factors, such as:

- HIV.
- Diabetes mellitus.
- Body weight ten percent or more below ideal body weight.

Because TB is transmitted through the air, it is a threat not only to chemically dependent persons, but to those who serve them as well. Outbreaks of TB disease and deadly multidrug-resistant (MDR) TB have been reported in chemical dependency treatment programs. For this reason, many public health authorities view chemical dependency treatment programs as ideal settings for the identification and monitoring of TB in chemically dependent persons.

APPENDIX A Continued

Persons with HIV/AIDS have a rate of tuberculosis that is 300 times higher than that of the general population. HIV disease accelerates the progression from TB infection to active disease in the co-infected and increases the susceptibility of the HIV-infected person to multidrug-resistant (MDR) TB. MDR TB bacteria are immune to the standard anti-TB drugs and are consequently deadlier than the more common strains of TB bacteria.

These high rates of TB infection may be accounted for by the fact that alcoholism and other chemical dependencies weaken the immune system, making the chemically dependent person much more vulnerable to TB, and making it much likelier that the infected chemically dependent person must develop active disease.

Also, besides being in poorer health than people who do not abuse alcohol or drugs, alcoholics and drug addicts often find themselves in environments that are conducive to spread of TB, such as jails, prisons, homeless shelters, substandard housing, public hospitals, and congregate living situations.

Finally, because of their problems with alcohol and drugs, chemically dependent persons often have difficulty complying with the complicated medical treatment regimen required of people with active TB disease. As a result, many substance abusers have recurring bouts of TB and go on to develop MDR TB.

For a more complete list of risk factors, see page 5-6 of the Center for Disease Control's [Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, MMWR 2005: 54 \(No. RR-17, 1-141\)](#)

THE INFECTION AND THE DISEASE

What causes TB?

Tuberculosis (TB) is caused by infection with *Mycobacterium TB* (also called *M. TB* or tubercle bacilli) and is characterized by two separate stages: infection and disease (often called infectious TB or active disease). The distinction between the two stages is significant because many infected individuals never progress from the first stage - TB infection - and persons who are merely infected with TB do not pose a risk of infecting others. In fact, only 10 percent of persons infected with *M. TB* must develop disease.

How TB infection occurs?

TB is an airborne disease. TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment. In order for an individual to become TB infected, the tubercle bacilli must be small enough to pass through the mouth or nose and upper respiratory tract and be drawn directly into the small air sacs in the lower part of the lungs. This is called latent TB infection (LTBI).

Once TB infection occurs, the bacilli can remain within the respiratory system or spread through the lymphatic system and bloodstream to other sites. Although TB infection and disease can occur anywhere in the body, e.g., the kidneys, the brain, or even the bones, the most commonly infected organs are the lungs. When it lodges in the lungs, the disease is known as pulmonary TB. TB disease in a site other than the lungs is called extrapulmonary TB.

Extrapulmonary TB is likelier to develop in persons with suppressed immune systems, since an ineffective immune response must allow the bacilli to spread throughout the body. Because of their ability to expel live tubercle bacilli into the air, people with infectious pulmonary or laryngeal TB disease are potential transmitters of TB. With some exceptions, persons with extrapulmonary TB disease cannot transmit TB to others.

Detecting TB infection

The primary methods used for detecting the presence of TB infection is the single-step interferon gamma release assay (IGRA) or the two-step tuberculin skin test (TST).

The IGRA involves taking a sample of blood and having that sample tested in a laboratory. The advantage of the IGRA is that the patient does not have to come back to have the results of the test read within the next 48 to 72 hours, it does not require retesting, and it does not result in false positives due to inoculations by a non-virulent form of mycobacterium (BCG) or infections with nontuberculin mycobacterium.

The TST, also called a Mantoux test or purified protein derivative (PPD) test, can detect if an infection by the TB bacteria has occurred at some point in the person's life, but it does not reveal if the infection is currently active. It involves the injection of a measured amount of PPD into the skin of the forearm. The test should be "read" within 48 to 72 hours by checking the skin around the injection site for evidence of an induration, an area of raised or swollen skin.

Unless his/her immune system is compromised, a person must be sensitive to PPD within two to ten weeks after being infected with *M. TB*, and must react by producing antibodies to fight certain proteins in the PPD. The immune response must manifest itself through the development of an induration at the injection site. A person who is not infected with TB must have little or no reaction to the TST. TB infection, then, is indicated by a "positive" reaction to the TST.

APPENDIX B Continued

A reaction is classified as "positive" depending on the size of the induration. In order to capture variations in immunologic responses to the TST and the presence of varying risk factors for TB infection or disease, different measurements are used to classify indurations as "positive" in certain populations.

- A reaction of 5 mm is classified as positive for:
 - Persons who are human immunodeficiency virus (HIV)-infected.
 - Persons who are in close contact with an individual with infectious TB disease.
 - Persons with a history of TB infection or chest radiograph that suggest a past infection or disease.
- A reaction of 10 mm or more is usually classified as "positive" for most other persons.

A person with a positive tuberculin test is considered infected, but not "infectious" (or contagious) unless so determined by further testing. A TB-infected person who is not infectious poses no health risk to others. If the person has a normal chest radiograph and no symptoms, a positive test simply means that a person has been exposed to and infected with the tubercle bacillus. Such a person has a 10 percent chance over the course of his or her life of developing TB disease. In 90 percent of the cases, the TB must remain dormant. Persons with HIV or AIDs, however, have a 10 percent per year chance of developing infectious TB.

False positive reactions to a PPD skin test can occur in persons from some parts of the world with high incidence of TB who have been BCG inoculated to produce an immune response and decrease the incidence of TB in their countries. These persons need to be tuberculin tested and, if 10 millimeters or more of induration, referred for medical evaluation.

Anergy or false negatives to a PPD skin test may occur with some individuals whose immune systems are compromised. An anergic individual must not react to certain antigens and may therefore have a false negative reaction to a PPD skin test. Typically, people with HIV disease and cancer patients undergoing chemotherapy are anergic. Alcoholics and injecting drug users may be anergic because of bad health, poor eating habits, or diets and stress. When this is suspected, anergic individuals should be referred to a physician or the health department for follow-up chest radiograph and sputum analysis to determine whether they have infectious TB.

Persons with previously diagnosed TB must usually stay positive. Critical information for these persons is:

- The date and place of the past diagnosis.
- The dates of the treatment course.
- The person's compliance with treatment.
- Whether their doctor told them they were cured.
- Their ability to describe treatment with appropriate medication.
- The provision of medical records to corroborate completion of treatment.

When records are unavailable, the person should be screened for TB by a physician or referred to a health clinic or the health department. Persons who are still on TB medication should be monitored for medication adherence. Decisions about the health of a patient with past TB must be made in consultation with a physician experienced in the diagnosis and care of TB.

As a rule, the individuals who are likeliest to become infected are those who have prolonged daily contact over a period of months with individuals with pulmonary or laryngeal TB disease. Although it is possible to be infected after an exposure of only two or so hours, such cases are rare and have been linked to extremely high airborne concentrations of infectious tubercle bacilli.

Treating TB infection

Once TB infection occurs, the TB organisms multiply either within the respiratory system or elsewhere in the body. In most persons, the immune system limits such multiplication within two to ten weeks after the initial infection. In some persons, the tubercle bacilli are not eliminated, but, instead, remain dormant (perhaps to be activated later). This condition traditionally has been called latent TB infection (LTBI). People with LTBI do not have symptoms and are not contagious; their infection must only be revealed through a tuberculin test. For these individuals, the purpose of TB preventive treatment is to prevent the latent infection from developing into active TB disease.

The standard recommended therapy for those with TB infection is isoniazid (INH), an oral drug that is taken for nine months.

Some people, such as substance abusers, are at a greater risk for progressing from TB infection to TB disease. The greatest risk is associated with people whose immune systems are compromised or suppressed, such as persons with HIV infection. For these high risk individuals, preventive treatment may be recommended.

Diagnosing pulmonary (lung) TB disease

The traditional methods for diagnosing pulmonary TB disease are chest radiographs, sputum smears, and laboratory cultures. Chest radiographs are the traditional method for detecting pulmonary TB disease in persons with generalized symptoms such as a persistent cough, fever, or chills. Knowledgeable physicians need to evaluate the results of the radiographs and lab tests, being cautious of inaccurate chest radiographs in immune-suppressed individuals. Usually sputum tests are used to confirm the diagnosis of pulmonary TB. It takes up to 21 days to grow a culture of tubercle bacilli.

Infectiousness and transmission of TB

The infectiousness of a person with TB disease depends upon:

- The presence of pulmonary, laryngeal, or other oral forms of TB.
- The number of TB organisms into the air through coughing or similar activities.
- A culture of TB or positive sputum smear for acid-fast bacilli.
- Cavitation, or holes, in the lungs by the destruction of lung tissue.
- The duration, adequacy, and completeness of the person's drug therapy.

Once a person begins taking anti-TB medication, there is no determined point at which infectiousness automatically ceases. The treatment must decrease infectiousness because there must be a decrease in the amount of bacilli in the sputum and the patient must cough less and produce less infectious bacilli into the air. The risk of transmission is also eliminated or diminished when the patient has three consecutive negative sputum smear examinations for Acid-Fast Bacilli and negative cultures.

Treating TB, MDR TB and XDR TB Disease.

In order for treatment to be effective, the TB organisms must be sensitive to the anti-TB drugs given and the patient must routinely comply with the recommended therapy. The preferred regimen for treating TB disease consists of an initial regimen of four drugs: Isoniazid (INH), Rifampin (RIF), Pyrazinamide and Ethambutol followed by a four month continuation phase of INH and RIF.

Generally, successful TB treatment confers a degree of immunity to reinfection. However, one recent study of HIV-infected patients found that the possibility of reinfection with a new strain of *M. TB* does exist. Drug resistance is proven only by drug-susceptibility testing performed in a competent laboratory. A patient with a strain of *M. TB* resistant to both INH and RIF has multidrug-resistant TB (MDR-TB). Refer MDR-TB patients immediately to a specialist or seek consultation with a specialized treatment center.

The Centers for Disease Control (CDC) in collaboration with the World Health Organization (WHO) published in March 24, 2006, a definition of extensively drug-resistant tuberculosis (XDR TB) as cases of TB disease in persons whose *M. TB* isolates were resistant to INH and RIF and at least three of the six main classes of second-line drugs (aminoglycosides, polypeptides, fluoroquinolones, thioamides, cycloserine and para-aminosalicylic acid). Since the original publication additional reports have documented the presence of XDR TB in Iran and South Africa with high mortality among persons infected with HIV who are benefiting from antiretroviral therapy.

TB treatment issues for chemical dependency treatment programs

Chemical dependency treatment providers must consult health care experts for information on what accommodations, if any, need to be made for chemically dependent patients receiving both substance abuse and TB treatment. For example, RIF, an effective anti-TB drug, has been reported to increase the excretion of methadone and cause withdrawal symptoms in some patients. And, INH, another commonly-used and highly-effective anti-TB drug, can cause liver damage and hepatitis.

Treatment providers and local health and public health agencies must work closely together.

**CONSENT FOR THE RELEASE OF CONFIDENTIAL ALCOHOL OR
DRUG ABUSE PATIENT INFORMATION**

I,

(NAME OF PATIENT)

(BIRTHDATE)

authorize:

(SPECIFIC NAME OR GENERAL DESIGNATION OF THE ALCOHOL/DRUG PROGRAM OR PERSON MAKING THIS DISCLOSURE)

to disclose to:

(NAME OR TITLE OF THE PERSON OR ORGANIZATION TO WHICH DISCLOSURE IS TO BE MADE)

the following
information:

(NATURE AND AMOUNT OF INFORMATION TO BE DISCLOSED, AS LIMITED AS POSSIBLE)

The purpose of this disclosure is to:

(PURPOSE OF DISCLOSURE, AS SPECIFIC AS POSSIBLE)

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(SPECIFICATION OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES)

I understand that generally the alcohol and/or drug treatment program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

(DATE)

(SIGNATURE OF PATIENT)

(SIGNATURE OF PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE (WHEN REQUIRED))

**NOTICE PROHIBITING REDISCLOSURE
OF ALCOHOL AND DRUG ABUSE PATIENT INFORMATION**

Each disclosure of information made with the patient's written consent must be accompanied by the following written statement:

**NOTICE
PROHIBITING REDISCLOSURE
OF ALCOHOL AND DRUG ABUSE PATIENT INFORMATION**

This information has been disclosed to you from records protected by Federal confidentiality rules, 42 Code of Federal Regulations (CFR) Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION
ABOUT ALCOHOL OR DRUG TREATMENT AND [TB] [STD]
[AND/OR] [HIV/AIDS] CARE**

I, _____, authorize
(name and address of patient)

The following alcohol or drug treatment program(s): [name and address of the treatment program authorized to make and receive disclosures],

AND

The following health care provider(s): [name and address of the [TB] [STD] [and/or] [HIV/AIDS] care provider authorized to make and receive disclosures],

AND

[Designate staff of the State/local Department of Health responsible for [TB] [STD] [and/or] [HIV/AIDS] prevention, control and care, specify appropriate name and address] --

To communicate with and disclose to one another the following information (initial each category that applies)*:

* _____ Alcohol or drug treatment: Information about my participation and attendance in the alcohol or drug treatment program(s) named above that is needed to enable the persons and agencies listed above to provide, coordinate and monitor my treatment for [TB] [STD] [and/or] [HIV/AIDS].

* _____ Tuberculosis (TB): Information about my diagnosis and treatment for TB that is needed to enable the persons and agencies listed above to provide, coordinate and monitor my treatment for [TB] [STD] [and/or] [HIV/AIDS].

* _____ Sexually transmitted disease(s) (STD): Information about my diagnosis and treatment for any STD that is needed in order to enable the persons named above to provide, coordinate and monitor my treatment for [TB] [STD] [and/or] [HIV/AIDS].

* _____ HIV/AIDS: Information about my HIV status (including HIV test results and information about my diagnosis and treatment for HIV-related conditions, including AIDS) that is needed to enable the persons and agencies listed above to provide, coordinate and monitor my treatment for [TB] [STD] [and/or] [HIV/AIDS].

The purpose of these disclosures is to enable the persons and agencies listed above to provide, coordinate and monitor the treatment I receive for [TB] [STD] [and/or] [HIV/AIDS]; and to discuss with me any [sexual/needle sharing] partners or contacts and/or family members who might be infected with [TB] [STD] [HIV] and need treatment.

I understand that my alcohol and drug abuse treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that HIV-related information about me, STD-related information about me, and TB-related information about me is protected by state law, and cannot be disclosed except as authorized by state law.

APPENDIX E Continued

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

[Specify the date, event or condition upon which this consent expires, not to exceed 90 days. If exchange of the above information is necessary beyond 90 days, updated signatures are required according to RCW 70.02.030.

Dated: _____

Signature of participant

Signature of parent, guardian or authorized representative when required

Dated: _____

Signature of participant

Signature of parent, guardian or authorized representative when required

Dated: _____

Signature of participant

Signature of parent, guardian or authorized representative when required

**QUALIFIED SERVICE ORGANIZATION /
BUSINESS ASSOCIATE
AGREEMENT**

_____ and,
(Name of Chemical Dependency Treatment Agency hereafter referred to as “CD treatment agency”)

_____ County (or District) Health Department, TB Control Unit [and HIV/STD] STAFF)

1. Agrees to enter into a qualified service organization/business association agreement, whereby the Health Department TB/HIV/AIDS/STD Unit(s) agree to provide, coordinate and/or monitor the treatment and/or related services for TB/HIV/AIDS/STD being provided to patients of the above named CD treatment agency, who are diagnosed and reported as having TB/HIV/AIDS/STD and are provided TB/HIV/AIDS/STD-related services by the named Health Department HIV/AIDS/STD/TB Unit(s).
2. Acknowledges that in receiving, storing, processing or otherwise dealing with any information from the above named CD treatment agency about the patients in its program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2; and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 142, 160 and 164, and may not use or disclose the information except as permitted or required by this agreement or by law;
3. Agrees to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.
4. Agrees to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information;
5. Agrees to report the above named chemical dependency treatment agency in writing within one business day when it becomes aware of any use or disclosure of the protected information not provided for by this agreement.
6. Agrees to ensure protected information received from the CD treatment agency must not be redisclosed to any other agency or subcontractor who provides services to:

_____ (Name of County (or District) Health Department, TB Control Unit [and HIV/STD] STAFF)

7. Agrees to provide access to the protected information within one business day at the request of the CD treatment agency or to an individual as directed by the CD treatment agency in order to meet the requirements of 45 CFR § 164.524 which provides patients with the right to access and copy their own protected information.
8. Agrees to make any amendments to the protected information within one business day as directed or agreed to by the CD treatment agency pursuant to 45 CFR. § 164.526.
9. Agrees to make available within one business day its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of protected information received from the CD treatment agency or created or received by (Name of business providing service) _____ on behalf of the CD treatment agency, or to the Secretary of the Department of Health and Human Services for purposes of the Secretary determining the Program’s compliance with HIPAA.

- 10. Agrees to document, in written form by letter or fax within one business day, disclosures of protected information, and information related to such disclosures, as would be required for the Program to respond to a request by an individual for an accounting of disclosures in accordance with 45 CFR § 1 64.528
- 11. Agrees to provide, within one business day by written letter or fax, to the CD treatment agency or to an individual, information in accordance with paragraph (10) of this agreement to permit the CD treatment agency to respond to a request by an individual for an accounting of disclosures in accordance with 45 CFR. § 164.528

Termination

- 1. The CD treatment agency may terminate this agreement if it determines that (Name of business providing service) _____ had violated any material term;
- 2. Upon termination of this agreement for any reason, (Name of business providing service) _____ must return or destroy all protected information received from the CD treatment agency, or created or received by (Name of business providing service) _____ on behalf of the CD treatment agency. This provision must apply to protected information that is in the possession of subcontractors or agents of (Name of business providing service) _____, if such information has been redisclosed to subcontractors or agents of (Name of business providing service) _____. (Name of business providing service) _____ must retain no copies of the protected information.
- 3. In the event that (Name of business providing service) _____ determines that returning or destroying the protected information is infeasible, (Name of business providing service) _____ must notify the CD treatment agency in writing within one business day of the request, of the conditions that make return or destruction infeasible. Upon notification that the return or destruction of the protected information is infeasible, (Name of business providing service) _____ must extend the protections of this Agreement to such protected information and limit further uses and disclosures of the information to those purposes that make the return or destruction infeasible, for so long as (Name of business providing service) _____ maintains the information.

Executed this ____ day of _____, 20__.

(Signature:)

(Signature:)

(Title of person authorized to sign)

(Title of person authorized to sign)

(Name of business providing service)

(Name of the CD treatment agency)

[Address]

[Address]

Chapter 246-170 WAC Tuberculosis – Prevention, Treatment and Control

(Department of Health WAC for: Tuberculosis Community Health Worker Definition and Duties)

(Note: Tuberculosis Community Health Worker training is not available in all counties. Contact your local health department to inquire about the availability of this training in your area.)

WAC 246-170-011 DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter. (Note: Only the definitions of terms used in [WAC 246-170-035](#) are listed below.)

- "Directly observed therapy (DOT)" and "directly observed preventive therapy (DOPT)" mean providing oral medications to patients and observing ingestion of medications by patients.
- "Infected" means an individual who has tubercle bacilli as identified by a positive tuberculin skin test, but is not capable of transmitting the organism to another person.
- "Personal protective equipment" means respirators and other equipment as required by the department of labor and industries.
- "Prevention" means the interventions that interrupt the spread of tuberculosis, either within an individual, within the population, or both.
- "Preventive therapy" means either treatment to prevent infection in an uninfected person or treatment to prevent disease in an infected person.
- "Treatment" means a course of long-term multiple drugs or other appropriate therapy prescribed for an individual with suspected or confirmed disease in accordance with accepted medical practice and current applicable national and state guidelines, and may include preventive therapy.
- "Tuberculin skin test" means the introduction of purified protein derivative (PPD) by the Mantoux method.
- "Tuberculosis health worker" means an unlicensed person trained to perform tuberculin skin testing, directly observed therapy, and directly observed preventive therapy and working pursuant to chapter [70.28](#) RCW as part of a program established by a state or local health officer to control tuberculosis.

[WAC 246-170-035 TUBERCULIN SKIN TESTING and MEDICATION ADMINISTRATION TRAINING.](#) The department shall make available a course to be used by the state tuberculosis control program or local health departments to train tuberculosis community health workers.

This course shall include, but not be limited to:

1. Tuberculosis infection and disease, including prevention, transmission, pathogenesis, diagnosis and treatment.
2. Administration, reading, and interpretation of the Mantoux tuberculin skin test.
3. The performance of oral directly Observed therapy and Directly Observed Preventive Therapy.
4. Adverse reactions to tuberculosis medications and how to monitor patients for adverse reactions.
5. Appropriate referral mechanisms for positive skin tests, adverse reactions, or other medical needs.
6. Personal health and safety requirements including the use of personal protective equipment.

SAMPLE INTER-AGENCY AGREEMENT

This agreement is made between _____ chemical dependency treatment agency and _____ health department (district) tuberculosis (TB) Control unit, on _____.

_____ and _____ agree to work closely together to assure patients must receive needed tuberculosis services. The parties further agree that TB screening and treatment responsibilities must be shared as follows:

PROCEDURE

AGENCY RESPONSIBLE AND TIME IN WHICH PROCEDURE MUST BE DONE

1. Initial Intake: TB history, risk assessment, and symptom screen according to TB Infection Control Plan.

1. CD Program: Immediate upon intake

2. Referral for medical assessment and treatment according to TB Infection Control Plan. Obtain informed consent for release of information.

2. CD Program: Immediate whenever TB history, risk assessment, or symptom screen indicate.

3. Application of interferon gamma release assay (IGRA) or PPD Mantoux TB test, as appropriate.

3. _____
Time: _____

4. Reading of PPD Mantoux test, or IGRA lab results, if applicable.

4. _____
Time: _____

5. Referral to Medical/Laboratory Services

5. _____
Time: _____

6. Follow-up: preventive/curative treatment and directly observed treatment.

6. _____
Time: _____

7. Follow-up: isolation/quarantine

7. _____
Time: _____

8. Re-entry into AOD program

8. _____
Time: _____

9. Contact tracing (staff and others)

9. _____
Time: _____

TB HISTORY, RISK ASSESSMENT & SYMPTOM SCREEN

Once an applicant receives a job offer, or a patient is being assessed for admission, and has been informed about the importance of monitoring for tuberculosis (TB), obtain the following information about their TB history, TB risk assessment, and symptom screen:

A. TB HISTORY:

1. Ask the person the following questions:
 - a. Have you ever tested positive for TB infection?
 - i. If no, complete risk assessment.
 - ii. If yes, ask have you ever been treated for Latent TB Infection (LTBI)? If yes, ask did you complete treatment for LTBI?
 - b. Have you ever been diagnosed with having TB disease?
 - i. If yes, ask were you treated for TB disease?
 - ii. If yes, ask did you complete treatment for the disease?
2. Request medical records for any yes answers and any no answer to questions 1. a. ii, b. i, or b ii, and complete symptom screen.

B. RISK ASSESSMENT:

1. Ask the patient/applicant the following questions:
 - a. Have you worked or lived with or spent time with or been exposed to anyone who has been sick with TB in the last two years?
 - b. Have you lived or traveled in Africa, Western Europe, Russia, Mexico, Central or South America, Asia, India, or the Philippines?
 - c. Have you lived or worked in a correctional facility, long-term care facility, or homeless shelter?
 - d. Are you infected with HIV?
 - e. Have you ever injected illegal drugs?
 - f. Do you smoke?
2. If the patient/applicant answers no to all the above questions, admit the patient, and conduct or refer the employee for baseline TB testing.
3. If the patient/applicant answers yes to any of the risk assessment questions, conduct a symptom screen.

C. SYMPTOM SCREEN:

1. Ask the person, “Do you currently have any of the following symptoms?”
 - a. Drenching night sweats of more than two weeks duration;
 - b. Unexplained weight loss;
 - c. Body weight 10% below ideal body weight;
 - d. Loss of appetite;
 - e. A cough lasting more than three weeks;
 - f. Coughing or spitting up of blood;
 - g. Hoarseness; and/or
 - h. Chest pain.
2. If the person answers "yes" to two or more of the above symptoms, isolate the person and provide or refer the person to his/her personal physician, private clinic or the local health department for TB testing (if the person has never had a positive TB test), medical evaluation, treatment and documentation of a non-infectious state, prior to employment or admission.
3. If the person answers “no” to all the above, admit the patient, and provide or refer the employee applicant for baseline TB testing.

Note: Under TB Policy I.B., persons who have latent TB infection (LTBI) and persons who are being treated for TB disease, but have documentation they are not contagious must not be refused treatment or employment. These persons must be provided or referred to their physician, clinic, or health department for treatment. This agency must monitor satisfactory compliance with and completion of TB and LTBI treatment regimens of employees and active patients under its care.

REFERRAL AND REQUEST FOR TB-RELATED MEDICAL INFORMATION AND SERVICES

[Washington Administrative Code 388-805-255\(3\)\(a\)](#) requires persons seeking employment or treatment from this agency to have a *Mycobacterium tuberculosis* (TB) test and, if positive, further medical evaluation for TB. Please complete the applicable sections of this form and return it to the agency listed below.

I, _____ authorize _____
 (Name of Patient) (Name of Physician or Clinic)
 to release the information requested on this form to _____
 (Name of Agency Requesting the Information)

 (Signature of Patient) (Date Patient signed authorization)

1. TB test was: Mantoux Skin Test (TST) _____ QuantiFERON®-TB Gold (QFT-G) _____
 Date of test: _____ Results: _____
 If a TST was performed, the millimeters of induration _____ mm and date read: ____/____/____
 If a second TST was performed, the millimeters of induration _____ mm and date read: ____/____/____
2. List any TB-like symptoms being exhibited _____

IF QFT-G is positive or TST result is 10mm or greater (5mm in the HIV infected), previously positive, or if TB-like symptoms exist, please continue:

1. Date of last chest radiograph: _____ Results (Suggestive of TB?): _____
2. Sputum smears: Were _____ or were not _____ collected /analyzed for presence of acid fast bacilli.
 If yes, were three consecutive smears negative for acid fast bacilli? ____ yes ____ no
3. Are you providing treatment for this condition? ____ yes ____ no If yes, please describe:
- Treatment recommended:
 - Dates of the treatment course:
 - Progress of treatment and/or follow-up:
 - Date and place of referral for follow-up evaluation:
 - Results of the follow-up evaluation:
4. Based on the above information, is this individual free of communicable TB? _____

Name and title of person completing this form: _____

Name of Clinic: _____ Phone: _____

Signature of physician: _____ Date: _____

Please return this form to: _____

**TUBERCULOUS-RELATED WAC RULES
FOR
CHEMICAL DEPENDENCY TREATMENT PROVIDERS**
(With WAC Implementation Guidelines (WIG) in Italics)

WAC 388-805-140 What are the requirements for a provider's governing body?

- (8) Ensure the administration and operation of the agency is in compliance with:
(b) Applicable federal, state, tribal, and local laws and rules;

WIG : This includes applicable Tribal codes; Code of Federal Regulations (CFR); regulations of the United States Department of Labor, Occupational Safety and Health Administration (OSHA); Revised Code of Washington (RCW); state of Washington Administrative Code (WAC); Washington State Department of Labor and Industries (L&I), Division of Occupational Safety and Health (DOSH) requirements and directives; local governmental business licensing codes; and local fire codes.

WAC 388-805-150 What must be included in an agency administrative manual?

WIG: See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

WAC 388-805-200 What must be included in an agency personnel manual?

- (4) If a nonresidential provider, provides for prevention and control of communicable disease, including specific training and procedures on:
(a) Bloodborne pathogens, including HIV/AIDS, Hepatitis B, and Hepatitis C;
(b) Tuberculosis; and
(c) Other communicable disease.

WIG: See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

WAC 388-805-205 What are agency personnel file requirements?

- (3) Each person's file must contain:
(a) A copy of the results of a tuberculin skin test or evidence the person has completed a course of treatment approved by a physician or local health officer if the results are positive.

WIG:

- *Results of TB tests, X-rays, or other medical reports need to be confidential.*
- *For the purpose of TB testing, "employee" includes each employee, trainee, student, volunteer, and contract staff persons who provide or supervise patient care. This does not apply to guest speakers, visitors, or non-patient care contractors.*
- *Employee TB testing should be consistent with the agency's TB infection control plan and appropriate to the level of TB risk at the health care setting.*
- *For health care setting risk assessment, see page 11 and Appendix C on page 154 of the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>*
- *If you have questions, contact DOSH, at P.O. Box 44610, Olympia, WA 98504-4610. Phone: 360-902-5666.*
- *See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>*

WAC 388-805-205(6) Documentation of health department training and approval for any staff administering or reading a TB test.

WIG:

- Contact your local health department for information about the availability of tuberculin test training for tuberculosis community health workers.
- Contact the state DOH TB program for information about TB test training for licensed health care providers at 360-236-3443.
- Patients should be referred to their primary care physician, medical care clinic or local health department as specified in the agency's TB Infection Control Plan, for testing if there is not a trained staff member to conduct TB tests.

WAC 388-805-300 What must be included in the agency clinical manual? Each chemical dependency service provider must have and adhere to a clinical manual containing patient care policies and procedures, including:

(3) Identification of resources and referral options so staff can make referrals required by law and as indicated by patient needs.

- WIG: DOH laws require referrals for communicable diseases, such as for HIV/AIDS, Hepatitis, and TB.

(8) Tuberculosis screening for prevention and control of TB in all detox, residential, and outpatient programs, including:

- (a) Obtaining a history of preventive or curative therapy;
- (b) Screening and related procedures for coordinating with the local health department; and
- (c) Implementing TB control as provided by the department of health TB control program.

WIG:

- See WAC 388-805-325(9) for patient record content documentation requirements.
- Youth who can consent to treatment under [RCW 70.96A.020\(21\)](#) can also consent to TB testing.
- The decision on whether or not to require TB testing of patients depends on the results of each patient's TB medical history, TB risk assessment, and TB symptom screen, and the agency's risk assessment of the treatment site. See page 11 of the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>
- See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

WAC 388-805-300(12) Provision of education to each patient on:

(c) HIV/AIDS, hepatitis, and TB

WIG: See links to information and educational materials for patients, clinicians, and health care workers at the DOH Tuberculosis Web site at <http://www.doh.wa.gov/cfh/TB/default.htm>.

WAC 388-805-305 What are patients' rights requirements in certified agencies?

- (1) Each service provider must ensure each patient:
 - (a) Is admitted to treatment without regard to race, color, creed, national origin, religion, sex, sexual orientations, age, or disability, except for bona fide-program criteria.
 - (b) Is reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences.

WIG: Disabilities include but are not limited to orthopedic, visual, speech, and hearing impairments; cerebral palsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease, and TB.

(3) A service provider must obtain patient consent for each release of information to any other person or entity. This consent for release of information must include:

WIG: It is becoming more important to have QSO/BAs or release of information consents between chemical dependency treatment providers and local health departments because of the necessity to work together on certain communicable diseases, especially TB and HIV/AIDS. See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

(c) Name of the person or organization to whom the information is to be released.

WIG: If redisclosure is necessary for a local health department to report TB or HIV/AIDS information to DOH, it is recommended the authority for this redisclosure be incorporated into the original consent. See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

WAC 388-805-325 What are the requirements for patient record content?

(9) Documentation of the patient's tuberculosis test:

WIG:

- *Documentation of patient screening and testing must be consistent with the agency's TB infection control plan.*
- *See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>*
- *See WAC 388-805-300(8).*

(12) Documentation of referrals made for specialized care or services:

WIG: This includes referrals made to a private physician, clinic or local health department for TB testing, medical evaluation, or treatment for TB disease.

WAC 388-805-410 What are the requirements for detox staffing and services?

(1) The service provider must ensure staffing as follows:

(c) All personnel providing patient care, except licensed staff and CDPs, must complete a minimum of forty hours of documented training before assignment of patient care duties. The personnel training must include:

- (i) Chemical dependency;
- (ii) HIV/AIDS and hepatitis B education;
- (iii) TB prevention and control; and
- (iv) Detox screening, admission, and signs of trauma.

WIG: See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>

WAC 388-805-610 What are the requirements for intensive outpatient services?

(2) Each chemical dependency service provider must ensure intensive outpatient services are designed to deliver:

(d) Education totally not more than fifty percent of patient treatment services regarding alcohol, other drugs, relapse prevention, HIV/AIDS, hepatitis B, hepatitis C, and TB prevention, and other air/blood-borne pathogens;

WIG: Should include training patients on respiratory hygiene and cough etiquette procedures.

WAC 388-805-830 What are the requirements for information and crisis services?

- (2) The information and crisis service administrator must:
- (e) Ensure all staff complete forty hours of training that covers the following areas before assigning unsupervised duties:
- (iii) Prevention and control of TB and Bloodborne pathogens.

WIG:

- *TB education should be consistent with the agency's TB infection control plan.*
- *See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>*

WAC 388-805-840 What are the requirements for emergency service patrol?

- (1) The emergency service patrol provider must ensure staff providing the service:
- (d) Have training on communicable diseases, including:
TB prevention and control; and

WIG:

- *TB education should be consistent with the agency's TB infection control plan.*
- *See DBHR's Tuberculosis Infection Control Program Model Policies at <http://www.dshs.wa.gov/pdf/hrsa/DASA/certforms/TBPolicy.pdf>*