LLUCH Medical Staff Policy CH-MS-#1

Policy Title: Tb Screening Requirements for Medical Staff Members and for other Health Care Workers granted privileges by the Medical Staff.

Background:

Tb screening is an effective tool for detecting tuberculosis in "High Risk" populations. Tb screening is less useful for populations that are not at "High Risk" or when applied without prior risk assessment. The low Tb Skin Test (TST) conversion rate among LLUCH employees (where screening is mandated), particularly among LLUCH employees involved in direct patient care, is evidence that LLUCH is not in general a "High Risk" occupation site. Therefore it is prudent to implement a screening program for Medical Staff Members and other Health Care Workers granted privileges by the Medical Staff that includes a "Risk Assessment" component.

Policy:

1. Medical Staff members and others granted privileges by the Medical Staff shall undergo Tb screening at the time of appointment and at the time of each reappointment. For those found to be at "High Risk", a TST (or equivalent) shall be required at least yearly and may be required more frequently if exposure has occurred. For those not at "High Risk" a TST at the time of initial appointment shall be required and any additional TST shall be guided by the Risk Assessment required for each reappointment.
2. An individual shall be considered "High Risk" if any of the following are applicable:
    a. They immigrated to the US from a country or region with increased prevalence of infectious tuberculosis.
    b. They live with a person with infectious tuberculosis.
    c. They have within the previous 12 months had exposure to a patient with infectious tuberculosis:
        1) They have occupied the same room as a patient with infectious tuberculosis for one hour or more without the use of respiratory protection.
        2) They have performed an examination or procedure without respiratory protection that brought them into proximity of the patient's airway on a patient with infectious tuberculosis.
        3) They are part of a group in which individual members of the group have experienced TST conversion.
    d. They have a recognized Medical Risk Factor:
        1) HIV Infection
        2) Diabetes
        3) Prolonged (> 4 weeks) high dose (> 20 mg prednisone equivalent) corticosteroid therapy or similar immune modulating therapy during the previous 12 months.
        4) Chronic renal failure
        5) Leukemia or lymphoma
        6) Carcinoma of head or neck
        7) Weight less than 90% of ideal body weight
        8) Silicosis
        9) Gastrectomy
        10) Jejunoileal bypass
        11) Chronic fibrotic changes on chest X-Ray
    e. They are or within the prior 12 month have been a resident or an employee of High-Risk Congregate Setting such as prison, jail, nursing home, homeless shelter, HIV residential shelter.
    f. They have any combination of two or more of the following:
        1) Productive or persistent cough (lasting more than 3 weeks)
        2) Blood in sputum
        3) Undiagnosed fever lasting more than 5 days
        4) Soaking night sweats
        5) Unexplained weight loss
        6) Unexplained loss of appetite

References:

- Morbidity and Mortality Weekly Report - CDC (MMWR) 1995: 44 (RR-11)
- MMWR 2000; 49 (RR-6)

Tuberculosis Screening Questionnaire

Name_____ Specialty_____

Read each of the following questions and mark your response at the bottom of this page.

1. Have you immigrated to the US from a country or region with increased prevalence of tuberculosis?
2. Do you live with someone who has infectious tuberculosis?
3. Within the past 12 months, have you occupied the same room as a patient with infectious tuberculosis for one hour or more without the use of respiratory protection?
4. Within the past 12 months, have you performed an examination or procedure that brought you into proximity of the patient's airway on a patient with infectious tuberculosis without the use of respiratory protection?
5. Within the past 12 months have any friends, family members or fellow workers had a Tb Skin Test conversion?
6. Do you have any of the following recognized Medical Risk Factor(s) for tuberculosis?
    a. HIV Infection
    b. Diabetes
    c. Prolonged (> 4 weeks) high dose (> 20 mg prednisone equivalent) corticosteroid therapy or similar immune modulating therapy
    d. Chronic renal failure
    e. Leukemia or lymphoma
    f. Carcinoma of head or neck
    g. Weight less than 90% of ideal body weight
    h. Silicosis
    i. Gastrectomy
    j. Jejunoileal bypass
    k. Chronic fibrotic changes on chest X-Ray
7. Have you within the past 12 month been a resident or an employee of a High-Risk Congregate Setting such as prison, jail, nursing home, homeless shelter, HIV residential shelter?
8. Do you have any of the following?
    a. Productive or persistent cough (lasting more than 3 weeks)
    b. Blood in sputum
    c. Undiagnosed fever lasting more than 5 days
    d. Soaking night sweats
    e. Unexplained weight loss
    f. Unexplained loss of appetite

____ My answer to all of the above questions is NO.

If your answer to all of the above questions is NO then sign below; you have passed Tb Screening; you will again be subject to Tb screening at next re-appointment date. (Initial applicants must submit results of your recent TST with this form.)

Signature Date

If you answered **YES** to any of the above questions continue to the next page.

Return this original form to Medical Staff Administration

Tuberculosis Screening Questionnaire

Name_____ Specialty_____

If your answer to any of the questions on the previous page is "Yes" then continue. These questions must be answered by circling Yes or No.

1. I have had a positive TST in the past Yes No
2. I have received BCG in the past Yes No
3. I have had an allergic reaction to TST in the past Yes No
4. I have had a "false positive" TST in the past Yes No

You must now go to LLUCH Employee Health Service (EHS) or to a U.S. licensed physician and have the following attestation completed:

If LLUCH EHS: Results of Tuberculin Skin Test _____

_____ _____
(Signed) – EHS Nurse Date

If Personal Physician:

I have reviewed the history provided in this document and any other information the patient may have provided. I have performed a pertinent physical examination. Using my professional judgment, I have or have not performed a Tb Skin Test, and Chest X-Ray. Based on the entirety of my evaluation I find:

The patient is free of Infectious Tuberculosis _____
The patient needs additional evaluation for Infectious Tuberculosis _____

_____ _____
Examining Physician Signature Date

_____
Print Examining Physician Name

Return this original form to Medical Staff Administration