Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-93-064

June 4, 1993

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: VA (Department of Veterans Affairs) Employee TB (Tuberculosis) Testing Program

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) directive is to provide guidelines to be utilized in conjunction with VA Manual MP-5, part I, chapter 792, change 7. This directive replaces VHA Directive 10-92-019 and will not be incorporated into a manual.

2. BACKGROUND

a. TB continues to be a public health problem in the United States with over 20,000 cases reported annually.

b. Substantial increases in TB morbidity are occurring in certain areas with a high prevalence in patients with HIV (Human Immunodeficiency Virus) infection. In 1986, after 3 decades of steadily decreasing TB morbidity, there is now an increase in annual TB morbidity seen in the United States. The increase occurred mainly in geographic areas and demographic groups with large numbers of AIDS (Acquired Immune Deficiency Syndrome) cases, which suggests that the HIV epidemic has begun to influence TB morbidity.

c. Outbreaks of MDRTB (multi-drug resistant tuberculosis) were reported in several areas of the United States.

(1) Several factors may have contributed to these outbreaks. First, diagnosis of TB in HIV-infected patients was delayed in many cases because of unusual clinical and radiographic characteristics of TB in HIV-infected patients. In addition, recognition of drug resistance was delayed because of the lengthy time used for laboratory identification, confirmation, susceptibility testing, and reporting of drug resistance patterns.

(2) Ineffective patient isolation may have played a role. AFB (Acid-Fast Bacillus) isolation procedures were delayed and/or not maintained; doors to isolation rooms may have been left open; employees and visitors entered rooms wearing no respiratory protective devices or devices were used improperly. Lastly, AFB isolation rooms often did not have ventilation (i.e., negative air pressure, etc.) in alignment with CDC (Centers for Disease Control and Prevention) guidelines for prevention of transmission of TB.

3. POLICY: Each VA facility will develop a TB Testing Program in accordance with VA manual MP-5, part I, chapter 792, change 7, and this directive.

4. ACTION

a. The program should include all full and part-time employees, volunteers, trainees, and VA Central Office employees assigned to field facilities, who are considered by the Personnel Health Physician to be at risk for contracting TB in the course of their assigned duties.

b. All hospital personnel including volunteers who may be exposed to patients with suspected or known infectious tuberculosis should be educated about the medical consequences of becoming infected with TB and should follow appropriate precautions for minimizing such exposure.

c. When aerosolized pentamidine is administered, precautions must be taken as the HIV infected individual may also be infected with TB.

d. All VA facilities, especially those where HIV-infected patients receive care, should implement the most current published recommendations for prevention of TB transmission.

e. After the initial screening TB skin test (using the most current methodology as noted in CDC guidelines) or chest X-ray, policies for repeat testing should be established at each facility considering factors that contribute to the risk that a person will acquire new infection. These factors include the location and prevalence of untreated infectious TB in the community, in the institution, and among personnel.

f. For personnel considered to be at risk, repeat skin tests may be necessary on a routine basis (for example, every 6 months or yearly). This may be of particular relevance in geographic areas of high AIDS (Acquired Immune Deficiency Syndrome) incidence and in certain specific locations within VA medical centers, such as AIDS units and facilities for the delivery of aerosolized pentamidine (repeat skin test no greater than every 6 months). If the risk of exposure to infectious TB is documented to be negligible, it is not necessary to repeat skin tests routinely.

g. Policy for repeat tuberculin testing should be established by the Infection Control Committee at each facility based on these individual medical center's characteristics and most current CDC guidance on the subject.

h. A TB test prior to separation is recommended for all covered employees, unless the employee is known to be tuberculin positive.

i. Health care workers and other persons exposed to patients with potential infectious TB for whom appropriate AFB isolation precautions are or were not in place should be evaluated to determine whether treatment for TB or preventive therapy for TB infection is indicated.

j. Employees who have been meaningfully exposed to the risk of contracting TB shall undergo TB testing at their request or that of the personnel health physician, and follow-up if needed, as addressed in VA manual MP-5, part I, chapter 792, change 7.

k. This is a rapidly evolving issue and future guidelines should also be consulted to assure an up-to-date TB Prevention Program is in place at each facility.

5. REFERENCES

a. Circular 10-91-084, and Supplement No. 1, Administration of Aerosolized Pentamidine to HIV Positive Patients.

b. MP-5, Part I, Chapter 792, Change 7, "Health Services."

c. M-1, Part III, Chapter 4, "Services and Benefits Available to Volunteers."

d. M-5, Part IV, "Geriatrics & Extended Care, Domiciliary Care."

e. CDC, Nosocomial Transmission of Multidrug-Resistant TB Among HIV-Infected Persons - Florida and New York, 1988-1991. MMWR (Morbidity and Mortality Weekly Report) 1991; 40(34):585-591.

f. CDC, Guidelines for Preventing the Transmission to Tuberculosis in Health-Care Settings, with Special Focus on HIV-Related Issues. MMWR 1990;39(RR-17).

g. CDC, Guidelines for Infection Control in Hospital Personnel. Personnel Health/July 1983.

h. CDC, Screening for Tuberculosis and Tuberculous Infection in High-Risk Populations and The Use of Preventive Therapy for Tuberculous Infection in the United States - Recommendations of the Advisory Committee for Elimination of Tuberculosis. MMWR 1990;39 (RR8).

i. CDC, Typhoid Immunization, Recommendations of the Immunization Practices Advisory Committee (ACIP) and Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly, Recommendations of the Advisory Committee for Elimination of Tuberculosis. MMWR 1990;39 (RR-10).

j. CDC, National Action Plan to Combat Multidrug-Resistant Tuberculosis, Meeting the Challenge of Multidrug-Resistant Tuberculosis: Summary of a Conference, Management of Persons Exposed to Multidrug-Resistant Tuberculosis. MMWR 1992; 41 (RR-11)

k. Core Curriculum on Tuberculosis. American Lung Association, June 1990.

6. FOLLOW-UP RESPONSIBILITY: ADCMD for Clinical Programs (111A).

7. RESCISSION: VHA Directive 10-92-019 is rescinded. This VHA directive will expire June 6, 1994.

Signed 6/4/93 John T. Farrar, M.D.

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