Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-93-094

August 6, 1993

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

SUBJ: TB (Tuberculosis) Control Responsibilities of VA (Department of Veterans Affairs) Facilities

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) directive is to outline the responsibilities and policies of VA facilities in tuberculosis control. This directive replaces VHA directive 10-92-063, and will not be incorporated into a manual.

2. BACKGROUND

a. In April 1989, CDC (Centers for Disease Control and Prevention), U.S. (United States) Public Health Service, published a plan for the elimination of TB in the U.S. Elimination of this disease will depend upon the cooperation between state and local health departments, whose mandate is to protect the public's health, and other health care providers, including VA. VA and state health department personnel have conducted surveys which indicate a need for improved cooperation between the VA and health departments to achieve better community TB control and elimination of problems, regarding responsibility in the care of TB patients. Both provide timely and effective medical services to promote health of the veteran, the veteran's family, and the community. A greater understanding of the roles and responsibilities of each and improved information sharing have been identified as essential elements in accomplishing these objectives.

b. Specific opportunities for improvement include:

(1) Reporting of veterans with TB and those suspected of having TB to the health department.

(2) Utilization of laboratories which provide for the most rapid confirmation of *M. tuberculosis*.

(3) Transfer of medical information between VA facilities and health departments.

(4) Management of TB cases and suspects.

(5) Definition of the specific mechanisms of this process and defining the responsible functional element.

3. POLICY: It is the policy of VHA to cooperate fully with CDC, state and local health departments for the control of TB.

4. ACTION

a. Reporting

The disclosure of patient medical record information is governed by the provisions of the Privacy Act of 1974 (5 U.S.C. 552a) and the VA confidentiality statutes, Title 38, United States Code, sections 5701, formerly section 3301, (patient name and address),

and 7332, formerly section 4132 (medical records related to patients who are treated for drug or alcohol abuse or sickle cell anemia and patients who are treated or tested for HIV (human immunodeficiency virus)). Consistent with the authority of 38 U.S.C. sections 5701(e) and (f)(2), VA will cooperate with officials of any criminal or civil law enforcement governmental agency or instrumentality (including state, county and local government health departments) charged under applicable law with the protection of public health or safety. Section 5701(f)(2) permits the reporting of the names and addresses of patients who are diagnosed with, or treated for, communicable diseases, including TB, to the state or local health department without the written consent of the patient when a qualified representative of the health department makes a written request for the reporting of such information. The request must include the specific law under which the reporting of the information is required. These reporting provisions are discussed in M-1, part 1, chapter 9, paragraph 9.51, dated November 10, 1990.

b. The reporting of information concerning patients with TB is important because of the potential spread of infection to other persons in the community. Health departments have the responsibility of ensuring that infectious cases become noninfectious. They are also responsible for examining contacts of TB cases. Control of the disease in the community is dependent upon the rapidity and thoroughness of these contact investigations. Timely reporting of cases to the health department is crucial for the success of these efforts. For each VA facility, there should be a mutually agreed upon method for reporting communicable diseases to the state health department. Veterans suspected of having TB because of positive acid fast smear, symptoms, and/or X-ray findings should be reported within 3 days after the diagnosis is reasonably suspected, or earlier if state law requires. Each facility's infection control committee, in coordination with Medical Administration Service, should designate, and identify to the health department, a person who is responsible for case reporting. This could be the hospital's person(s) in infectious disease control or another individual who is in a position to receive information about newly diagnosed reportable disease. To facilitate reporting, laboratory reports indicating disease or suspected disease should be forwarded directly to the person responsible for reporting to the health department. Local procedures that are established for reporting information to public health authorities will include provisions for documenting the disclosure in the patients' medical records as required by the Privacy Act and 38 CFR 1.576(c).

c. Laboratory

(1) In situations where the VA uses the West Haven VA Medical Center Reference Laboratory, arrangements should be made for copies of all positive mycobacteriology reports, both smear and culture, to be sent to the health department to avoid inordinate delays. Many state health department laboratories can provide laboratory services free of charge to VA. VA facilities may explore the availability of such services. The laboratory facility that will most effectively provide for optimal patient care, promotion of the public health goal of TB elimination, and assure appropriate cost containment should be chosen. With increases in the incidence of

multidrug resistant TB, the choice of reference laboratory may be most critical.

(2) By law, health departments must investigate contacts of VA diagnosed TB suspects and cases. The contacts of these suspects and cases should be evaluated by Mantoux TB skin testing with 5 TU PPD. Those with positive reactions are given a chest x-ray. After careful evaluation, contacts may be placed on preventive therapy with isoniazid or other appropriate drugs. In order to make appropriate and informed decisions about preventive therapy for contacts, health departments must have the available laboratory information, including drug susceptibility test results, as soon as possible.

(3) Follow-up mycobacteriology information should be made available to health departments by the designated person or persons at each VA facility so they can determine when patients have become sputum negative. This information is also used to make important decisions regarding preventive therapy.

d. Transfer of Medical Information

(1) The disclosure of medical record information to state public health departments without patient consent is limited to that information that is required by the law which requires the reporting, and is consistent with the disclosure provisions of those statutes referenced in paragraph 3a. The disclosure of any additional information to the public health department requires the written consent of the patient which should be obtained on VA Form 70-3288, Request for and Consent to Release Information From Claimant's Records. If the medical record information being considered for disclosure includes information related to treatment for drug or alcohol abuse, infection with HIV or sickle cell anemia which is protected by the confidentiality provisions of 38 U.S.C. 7332, the patient's specific written consent must be obtained on VA Form 10-5345, Request for and Consent to Release Medical Records Protected By 38 U.S.C. 7332.

(2) Timely transfer of relevant medical information between VA facilities and the health department is essential, particularly in an era of controlled eligibility for long term outpatient VA care. Providing information about diagnostic tests performed and their results enhances the health department's ability to conduct appropriate epidemiologic follow-up and prevent unnecessary or duplicated services. With written patient consent, it is also important to provide to the health department information about other medical conditions, including substance use, which will influence patient management. For example, doses of antituberculosis drugs must sometimes be modified in the presence of other medical conditions or the concomitant administration of certain drugs; patients with alcohol or drug use must be monitored more closely for adverse drug reactions; directly-observed therapy must routinely be provided for patients with certain mental disorders; tuberculosis patients with HIV infection must be treated longer than patients without HIV infection. In addition, compliance with treatment is often affected by the patient's mental condition, or by drug or alcohol use; the prescription of antituberculosis medications may be influenced by the presence of alcohol-related liver disease, and more frequent monitoring for hepatotoxicity or modification of the drug regimen to include less hepatotoxic drugs may be necessary to safely treat such patients; in persons receiving methadone, the concurrent administration of rifampin may reduce the blood concentration of methadone to a degree sufficient to produce withdrawal symptoms. It would be prudent to counsel patients regarding these issues if patient written informed consent is denied.

(3) In many localities, health departments treat all TB cases including veterans. In other locations, VA facilities treat the veteran for TB, and in still other settings, VA facilities and health departments share in the

treatment plan. There are a variety of services available to the veteran for the diagnosis and treatment of suspected or confirmed tuberculosis. In any case, there should be a mutual and clear understanding about who is responsible for providing services to each patient.

(4) The health department is responsible for the control of TB in the community and must treat and monitor the treatment of suspects, cases and contacts. Notification of admission and discharge of a veteran with TB to or from a VA facility should be reported to the health department within 1 week; continuity of treatment and necessary follow-up can then efficiently take place. The timely transfer of hospital discharge summaries, outpatient clinic reports, laboratory findings and clinical follow-up information, is also critical for the health department to carry out its responsibilities to the veteran and the community. Similarly, the health department should provide health department medical records to the VA facility within 1 week when notified that VA needs these records for proper patient management.

e. Patient Management

(1) Under ordinary circumstances, dispensing of more than 1 month's supply of antituberculosis medications at a time to a patient is discouraged because it may allow adverse drug reactions to progress to a serious stage before they are recognized. Mailing of medications to the veteran is discouraged unless adequate monitoring for both adverse reactions and compliance can be done by a local, responsible health care worker.

(2) Because of the length of therapy required for TB treatment, non compliance with therapy is a common problem. Non-compliant individuals are more likely to experience treatment failure or relapse, often with drug resistant organisms, and they may continue to spread infection in the community. One solution to the problem of non-compliance with self-administered therapy is twice-weekly, directly-observed treatment given under the supervision of a health care worker. Many health departments now routinely provide this service to veterans free of charge. VA facilities are encouraged to investigate referrals of those who are non-compliant, or who are judged to be at high risk for becoming non-compliant, to the health department for directly-observed therapy.

(3) In most states, health departments also provide medications and TB-related services (such as laboratory tests and chest x-rays), at no charge. VA facilities are encouraged to utilize and promote these services to their clients. VA personnel should alert the veteran with newly diagnosed TB that the health department is responsible for the control of TB in the community and that they and their families and other close contacts should expect to be interviewed and examined. The veteran should be made aware that these services are available from the health department (as outlined) without loss of VA benefits based on standard eligibility criteria.

f. For further information, contact Dr. Gary Roselle, Program Director, Infectious Diseases, VA Central Office, Medical Service/VAMC Cincinnati, Ohio, FTS 700-773-5047.

5. REFERENCES

a. MMWR , A Strategic Plan for the Elimination of Tuberculosis in the United States, Vol. 38, No. S-3, April 21, 1989.

b. MMWR, Perspectives in Disease Prevention and Health Promotion: A Strategic Plan for the Elimination of Tuberculosis in the United States, Vol. 38, No. 16, April 28, 1989.

c. VA Manual M-2, part IV, chapter 6.

d. VA Manual M-1, part I, chapter 9.

e. MMWR, Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations and the Use of Preventive Therapy for Tuberculosis Infection in the United States, Vol. 39, No. RR-8, May 18, 1990.

f. MMWR, Nosocomial Transmission of Multi-Drug Resistant Tuberculosis Among HIV-Infected Persons - Florida and New York 1988-1991, Vol. 40, No. 34:585-591, August 30, 1991.

6. FOLLOW-UP RESPONSIBILITY: Associate Deputy Chief Medical Director for Clinical Programs (111A).

7. RESCISSIONS: VHA directive 10-92-063 is rescinded. This VHA directive will expire on August 8, 1994.

Signed 8/6/93 D.B. Mavridis for

James W. Holsinger, Jr., M.D.
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 8/6/93
FLD: RD, MA, DO, OC, OCRC and 200 - FAX 8/6/93
EX: Boxes 104, 88, 63, 60, 54, 52, 47 and 44 - FAX 8/6/93