Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-93-126

October 14, 1993

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

ATTN: COS/EC; Medical Directors, VA Nursing Home Care Units; Chief, Domiciliary Programs

SUBJ: Surveillance, Containment, and Prevention of Tuberculosis in VA Nursing Homes and Domiciliaries

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) directive is to assure that each NHCU (Nursing Home Care Unit) and Domiciliary in the VA (Department of Veterans Affairs) system has an effective program for the surveillance, containment and prevention of TB (tuberculosis) among patients and staff.

2. POLICY: It is the policy of VHA that every VA NHCU and domiciliary will have an on-going program of surveillance for the purpose of identifying those patients and/or staff members who test positive for *Mycobacterium tuberculosis*. In addition, policies and procedures will be in place that address containment and prevention of TB among this population. Treatment protocols should follow guidelines established by the ATS (American Thoracic Society) and the CDC (Centers for Disease Control and Prevention). On-going assessment is required to evaluate the effectiveness of the program in each facility.

3. BACKGROUND

a. TB is a clinical disease caused by *M. tuberculosis*. *Active* (and usually infectious) TB is when clinical manifestations are present and viable organisms are identified. *Inactive* TB represents either successfully treated TB or past evidence of TB in a person who is asymptomatic. *Tuberculous infection* or infection with *M. tuberculosis* may cause tuberculosis or simply a positive skin test with no clinical disease.

b. The incidence of TB is on the rise in the United States. The mortality rate for untreated TB is up to 60% in 5 years. Elderly persons have a higher death rate from TB than do younger persons; approximately ten times higher in those 65+ compared to those age 25-44.

c. Tuberculosis case rates are high among the elderly. In the period 1986-1988, of approximately 22,500 reported cases, 27%-28% were in persons 65+ although this age group made up only 12% of the U.S. population. Although 80% of TB cases in the elderly occur in community dwellers, nursing home residents are at higher risk for TB than those living in the community with an annual incidence of 39.2 cases/100,000 population in nursing homes versus 21.5/100,000 older adults in the community.

d. Others at increased risk for TB are those who test positive for HIV (human immunodeficiency virus; highest risk group), substance

THIS VHA DIRECTIVE WILL EXPIRE OCTOBER 14, 1994

abusers, the homeless, persons with certain medical conditions (e.g., diabetes mellitus, immunosuppression, renal failure, severe weight loss, leukemia), and the medically underserved low-income populations. Patients in VA NHCUs and domiciliaries draw heavily from these high risk groups.

4. ACTION

a. Surveillance. Identifying and reporting all cases of active TB in the facility and identifying all patients and staff with M. tuberculosis infection:

(1) All admissions to the NHCU or domiciliary should have a recent chest x-ray.

(2) All new patients on admission should receive a two-step tuberculin skin test using 5 units of PPD (purified protein derivative) antigen, employing the Mantoux method of application. Results will be recorded in the patient's medical record. Two-step method is used to check for booster effect.

(3) All patients who test positive with PPD should receive a chest x-ray to identify active or inactive pulmonary TB or tuberculous infection.

(4) Sputum smear and culture should also be performed on patients with abnormal chest x-ray consistent with TB and those with symptoms and/or signs such as chronic cough, "bronchitis", weight loss, or unexplained fever, regardless of chest x-ray findings.

(5) Skin test-negative patients, should periodically have repeat skin tests with the frequency depending on the risk of TB infection in that facility. Repeat skin tests should be provided for tuberculin-negative patients after any suspected exposure to a documented case of active TB.

(6) Skin-test converters (10mm or more induration for persons under 35 years and 15mm or more induration for persons 35 years and older) should receive a chest x-ray. Management of skin-test converters will depend on chest x-ray findings, need for sputum evaluation and presence or absence of clinical symptoms.

(7) Similarly, management of patients with positive skin tests on initial testing will depend on further evaluation. PPD-positive patients should be evaluated annually for clinical symptoms of TB.

(8) Suspected or confirmed cases of TB among patients should be recorded and reported to local or state health departments as required by state and local laws or regulations. (Refer to VA Directive 10-93-063)

(9) When indicated, patients with TB or past TB infection should be assessed for HIV infection with proper pre-test counselling, post-test counselling, and signed informed consent.

b. Containment. Promptly prohibiting the transmission of tuberculosis.

(1) Generally, patients with suspected or known active TB should be transferred to an acute care facility for evaluation where:

(a) The need for and type of therapy can be determined;

(b) Chemotherapy can begin promptly;

(c) Follow-up plans are established;

(d) Recent and current contacts are evaluated and placed on appropriate therapy, and;

(e) New contacts can be prevented for a 1-to-2 week period.

(2) Patients with suspected or known infection must be placed in tuberculosis isolation in a properly vented room and monitored until the patient is not infectious to others.

(3) Tuberculosis isolation, if necessary, generally cannot be accomplished in the nursing home or domiciliary setting. Patients requiring tuberculosis isolation should be transferred to the acute care setting.

(4) Initiation or completion of treatment of patients with suspected or known active TB infection should follow the recommendations published by the CDC and the ATS.

c. Prevention. Persons at high risk who have a positive tuberculin skin test should be considered for preventive therapy with isoniazid. The most current recommendation for preventive therapy by CDC and ATS should be followed.

d. Personnel. Screening and follow-up for TB in personnel should comply with VHA directives, manuals, and various regulatory requirements.

9. REFERENCES

a. VHA Directive 10-93-063.

b. VHA Directive 10-93-064.

c. Manual M-2, Part I, Chapters 23 and 24.

d. American Thoracic Society: Control of tuberculosis in the United States. Am Rev Respir Dis 1992; 146:1623-1633.

e. Centers for Disease Control: Prevention and control of tuberculosis in facilities providing long-term care to the elderly. MMWR 39 (No. RR-10): 7-20, 1990.

f. Yoshikawa, T., Tuberculosis in aging adults. JAGS 1992; 40:178-187.

g. Centers for Disease Control: 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 (ACET). MMWR 39 (No. RR-8): 1-12, 1990.

h. Centers for Disease Control: Tuberculosis and human immunodeficiency virus infection: Recommendation of the Advisory Committee for the Elimination of Tuberculosis (ACET). MMWR 38 (14): 238-250, 1989.

i. Centers for Disease Control: National action plan to combat multidrug- resistant tuberculosis. MMWR 41 (No.RR-11): 1-48, 1992.

j. Centers for Disease Control: Management of persons exposed to multidrug-resistant tuberculosis. MMWR 41 (No. RR-11): 61-71, 1992.

k. Centers for Disease Control: Initial therapy for tuberculosis in the era of multidrug resistance. Recommendation of The Advisory Council for the Elimination of Tuberculosis. MMWR 42 (RR-7): 1993.

l. VHA Program and Facility Planning Guidance for Tuberculosis Programs, April 6, 1993.

6. FOLLOW UP RESPONSIBILITY: ACMD for Geriatrics and Extended Care (114).

7. RESCISSIONS: None. This VHA directive will expire October 14, 1994.

Signed 10/14/93 Dennis Smith for

John T. Farrar, M.D.
Acting Under Secretary for
Health

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Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA Directive 10-93-126
Supplement 1
September 13, 1994

SURVEILLANCE, CONTAINMENT, AND PREVENTION OF TUBERCULOSIS IN VA NURSING HOMES AND DOMICILIARIES

1. **PURPOSE**: The purpose of this Veterans Health Administration (VHA) Supplement is to extend VHA Directive 10-93-126, to October 16, 1995, with minor changes.

2. **ACTION**. In the basic VHA Directive 10-93-126, make the following changes:

a. In paragraph 7. RESCISSIONS, at the bottom of page 4, change the rescission date to October 16, 1995.

b. In paragraph 4 a.(6), change (Refer to VA Directive 10-93-063) to (Refer to VHA Directive 10-93-094 Supplement 1, dated July 25, 1994)

c. In paragraph 5 a change "VHA Directive 10-93-063 " to "VHA Directive 10-93-094, Supplement 1, dated July 25, 1994

d. In paragraph 5.d. delete the reference and replace it with "American Thoracic Society Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children". Am J Respir Crit Care Med: 1994; Vol 149:1359-13374.

3. **FOLLOW-UP RESPONSIBILITY** The ACMD for Geriatrics and Extended Care (114) is responsible for this VHA Directive.

4. **RESCISSIONS** VHA Directive 10-93 126 and this Supplement will expire October 16, 1995

S/by Dennis Smith for

John T. Farrar, M.D.
Acting Under Secretary for Health

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THIS VHA DIRECTIVE EXPIRES OCTOBER 16, 1995