Tuberculosis Prevention & Control Program

Frequently Asked Questions

TB Testing for Health Care Workers

Our mission is to improve the health and safety of people in Kentucky through prevention, promotion, and protection.

Kentucky Public Health

Prevent. Promote. Protect.

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Regulation Updates

TB Testing for Health Care Workers (902 KAR 20:205)

Effective March 4, 2016 (Updated 12/20/2022)

https://apps.legislature.ky.gov/law/kar/titles/902/020/205

Section 1: Definitions

Are there any new definitions?

The following new terms were incorporated into the definition section to provide standardization and correspond directly with updated CDC guidelines and emerging technology: Airborne Infection Isolation Room (AII), BAMT conversion, Blood Assay for Mycobacterium tuberculosis (BAMT), Health Care Setting, Healthcare workers (HCW), Multidrug-resistant tuberculosis (MDR TB), Nucleic Acid Amplification (NAA), Polymerase Chain Reaction (PCR), Staggered Tuberculosis Testing, and Tuberculosis Risk Assessment.

Section 2: TB Infection Control Program

Who must implement a TB Infection Control Program?

Employers who fall within the scope of federal or state OSHA TB compliance requirements and this Regulation must establish and comply with an effective written TB Infection Control Plan.

What criteria should be included in an Infection Control Plan?

Infection Control Plans should include a three-level hierarchy of control measures:

A. Administrative Controls: precautions to minimize the number of areas where exposure to Mycobacterium tuberculosis may occur

B. Environmental Controls: precautions to reduce the concentration of airborne M. tuberculosis

C. Respiratory Protection: identifies protective equipment in situations that pose a high risk for exposure

The first and most important level of the hierarchy, administrative measures, impacts the largest number of people. It is intended primarily to reduce the risk of uninfected people from being exposed to people who have active TB disease.

The second level of the hierarchy is the use of environmental controls to reduce the amount of TB in the air. The first two control levels of the hierarchy also minimize the number of areas in the health care setting where exposure to TB may occur.

The third level of the hierarchy is the use of respiratory protective equipment in situations that pose a high risk of exposure to TB. Use of respiratory protection equipment can further reduce the risk for exposure of health care workers.

Who should be included in the facility TB screening program?

It is at the discretion of the facility as to who should be screened and defined in the TB Exposure Control Plan. At a minimum, a HCW should be included if they are at risk of TB exposure in the workplace. (See section 1: Definition of a HCW, and Section 2: TB Infection Control Plan)

Which is the preferred method of screening, TST or BAMT?

Facilities may elect to use a single or preferred testing method, and should describe the method in the TB Exposure Control Plan, and review annually. If facilities elect to do a hybrid with both methods, or accept testing method results from an outside source, this should also be stated in the Plan.

For optimal occupational health programs and to avoid discordance in results, it is recommended to select one method of testing and adhere to that method for serial testing unless special situations occur.

Sources

CDC Fact Sheet for Respiratory Protection in Health-Care Settings
https://www.cdc.gov/tb/publications/factsheets/prevention/rphcs.htm

Curry International TB Center, 2011: Tuberculosis Infection Control: A Practical Manual for Preventing TB, pp. 54, 66, & 71

Section 3: Tuberculosis Testing Requirements for Tuberculin skin testing (TST)

Is two-step TST testing done for both initial hire and annual testing?

Two-step testing is useful only for the initial skin testing of adults who are going to be retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection. (http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm)

Is staggered employee testing a requirement or suggestion?

Staggered testing is a requirement as stated in the new regulations.

How should I determine when to begin staggered testing for each employee?

Staggered screening of HCWs (e.g., on the anniversary of their employment or on their birthdays) increases opportunities for early recognition of infection control problems that can lead to conversions in test results for M. tuberculosis infection. (http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf [page 30].)

Facilities may stagger testing at their discretion (i.e. monthly, quarterly, or semi-annually). For your facility to meet this new requirement, it may require testing some employees early (i.e. twice within a calendar year). Testing for each individual should not go beyond 12 months from the last test done.

Is it necessary for new staff to have two-step TST testing if they have already had the first-step while employed at another facility?

The initial TST at the new facility shall count as the second-step if the individual provides medical documentation that the one-step at another facility occurred within one year prior and the result was interpreted as negative.

Is it ok to begin testing using one method and then switching to another (i.e. TST to BAMT)?

Settings that use TST as part of TB screening and want to adopt BAMT can do so directly (without any overlapping TST) or in conjunction with a period of evaluation (e.g., 1 or 2 years) during which time both TST and BAMT are used. Baseline testing for BAMT would be established as a single step test. As with the TST, BAMT results should be recorded in detail. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm). Serial testing relies on the comparison of future test results with prior baseline test results, so a facility should plan to serially use the same test method for each healthcare worker once the baseline has been established with either TSTs or BAMTs.

Section 4: TB Risk Assessment and TSTs or Blood Assay for Mycobacterium tuberculosis (BAMT) for Health Care Workers on Initial Employment

Is self-reported documentation of a past previous positive TB screening sufficient?

A HCW must provide medical documentation from a licensed medical provider as part of the TB Risk Assessment. Verbal or written testimony from the individual is not sufficient. If a HCW cannot produce medical documentation, the preferred TB screening test must be administered.

Section 5: Annual TB Risk Assessments and Annual Tuberculin Skin Tests or BAMT for Health Care Workers

If a HCW has a previous TST or BAMT as positive, do they still have to be tested annually?

A health care worker, who has worked eleven (11) months or more in the facility and who has had a previous TST interpreted as positive, or a previously positive BAMT, shall:

1. Have an annual TB Risk Assessment in or before the same month as the anniversary date of his or her last TB Risk Assessment; and
2. Not be required to submit to an annual TST or BAMT.

Section 6: Medical Record or Electronic Medical Record Documentation for Health Care Workers

Where should an employee's TST or BAMT result(s) be documented? In the employee medical record?

The results should be made readily available. It is at the discretion of the facility as to the placement of the results (i.e. personnel records, employee medical record, central Occupational Health file, etc.).

Section 7: Medical Evaluations, Chest X-rays, and Monitoring of Health Care Workers with a Positive TST, a Positive BAMT, and Conversions

What is the difference between Section 7 and 8?

Section 7 refers to Latent TB Infection (LTBI) and Section 8 refers to suspected or active TB disease.

Section 8: Medical Evaluations, Chest X-rays, Lab Tests, Treatment, and Monitoring of Residents with Suspected TB Disease or Active TB Disease

When can an employee return to work if suspected to have TB?

An employee suspected of TB disease must remain off work until cleared as being noninfectious for TB by a licensed physician, advanced practice registered nurse, or physician assistant, in conjunction with the local and state health departments.

Section 9: Responsibility for Screening and Monitoring Requirements: Health Care Workers

Who is responsible for coordination and management of an Occupational Health Program (i.e. TB Infection Control Plan)?

A facility's administrator or administrator's designee shall be responsible for ensuring that all TB Risk Assessments, TSTs, BAMTs, chest x-rays, and sputum specimen submissions for health care workers comply with the requirements of Section 3 through Section 8.

If a facility does not employ licensed professional staff with the technical training to carry out the screening and monitoring requirements, the administrator shall arrange for training or professional assistance from the local health department or from a licensed medical provider.

Section 10: Reporting to Local Health Departments

If a facility suspects a false positive TB screening with no suspected active TB disease, should we wait to report to the health department after we have made our final determination after retesting?

HCWs identified to have one of the criteria listed in this section shall report to the local health department having jurisdiction within one business day of the result becoming known.

How should these results be reported to the local health department?

Facilities should complete the KY Reportable Disease form (EPID-200) and confirm with the local health department in their jurisdiction the preferred notification method.

Download an EPID-200 Form

https://www.chfs.ky.gov/agencies/dph/dehp/idb/Documents/EPID200.pdf

Section 11: Treatment for LTBI

For a recently infected person, is the medical evaluation and chest x-ray performed at the local health department?

It is the expectation that the healthcare facility will be responsible for developing an occupational health program that will include TB testing for HCWs.

A. A healthcare facility may choose to conduct medical evaluations, perform chest x-rays, diagnose, manage and treat LTBI in HCWs and internally pay for those occupational health services, or;

B. A healthcare facility may choose to collaborate with the LHD for medical evaluation, chest x-rays, diagnosis, management and treatment of LTBI or other TB-related occupational health

services. A written agreement should identify the roles of each organization and a payment schedule for any TB-related services provided by the LHD.

If a local healthcare facility desires for local health department staff to provide TB-related occupational health services, a contract, Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) should be developed defining the scope of services for each agency and a payment schedule.

Section 12: Compliance Date

What is the compliance date for this regulation?

All health care settings or health facilities subject to the tuberculosis testing requirements of this administrative regulation shall demonstrate compliance no later than 180 days (i.e. August 31, 2016) after the effective date of this administrative regulation.

Section 13: Supersede

Does this regulation replace all other regulations for healthcare settings?

This regulation only supersedes content mentioned in any other 902 KAR Chapter 20 regulations.

For additional information, contact:

Office of the Inspector General (OIG)

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https://www.chfs.ky.gov/agencies/os/oig/Pages/default.aspx

Tuberculosis Prevention & Control Program

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