

STANDARDIZED TUBERCULOSIS (“TB”) GUIDELINES

Contractor acknowledges and certifies that it will implement the following procedures as recommended by the County of Los Angeles Department of Public Health Tuberculosis Control Program:

1. Screen all employees and all volunteers in direct contact with Clients
2. Appoint a shelter TB Liaison
3. Screen Clients for Infectious TB symptoms at Intake
4. In addition to screening Clients for TB symptoms at Intake, asymptomatic Clients seeking admission to the shelter must show evidence of TB clearance by a healthcare provider within seven (7) days after initial admission to the shelter
5. Establish a Cough Alert Protocol (“CAP”)
6. Refer any employee, volunteer or Clients with Infectious TB symptoms for immediate medical evaluation.

Contractor additionally acknowledges and certifies that, pursuant to this Agreement’s HMIS Compliance Certification, it will report each and any event as defined in that Certification.

1. Screen All Employees and Volunteers In Direct Contact with Clients

Contractor shall ensure that within 7 days after staff/ volunteer start date:

- A. All staff can be referred to their private healthcare provider or a community-based clinic in order to get tested for latent TB infection. A community based clinic may be found at <http://publichealth.lacounty.gov/tb/index.htm>
- B. New employees who report a prior test showing latent TB infection (baseline) must have a chest x-ray or provide written documentation that a chest x-ray was performed within the previous six months. Such individuals must also receive a medical evaluation by a healthcare provider to determine the need for further evaluation or treatment.
- C. All employees and volunteers should receive annual TB clearance

2. Appoint A Shelter TB Liaison*

Contractor shall appoint a TB Liaison whose primary responsibilities shall be:

- A. Ensure that TB symptoms review is performed and documented for all new Clients following SAMPLE FORM C, as well as annually for all Clients. Individuals with symptoms of active TB disease should be referred to a medical provider using a **Referral for Tuberculosis Evaluation** form. A sample of a form is attached hereto as **SAMPLE FORM A**; and

- B. Contractor shall ensure that if a Client is cleared for TB at intake, this clearance should expire one year from the date of the healthcare provider evaluation on the **Referral for Tuberculosis Screening**. **Even before the date of expiration, if the Client has symptoms suggestive of active TB disease (as outlined below) they should be referred to a medical provider for further evaluation.**

Note: When assessing the likelihood a Client with TB-related symptoms or risk factors might have TB, specific questions to ask the Client privately include:

- Do you have a cough that has lasted longer than 3 weeks?
- Have you recently lost weight without explanation during the past month?
- Have you had frequent night sweats during the past month, soaking your sheets or clothing?
- Have you coughed up blood in the past month?
- Have you been feeling much more tired than usual over the past month?
- Have you had fevers almost daily for more than one week?

- C. Contractor shall ensure that a Client who has prolonged cough (> 3 weeks) plus any other TB symptoms shall be promptly referred to an appropriate health care provider for evaluation.
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4. Screen Clients For Latent TB Infection at Intake

- A. Contractor shall ensure that in addition to screening Clients for TB symptoms at Intake, asymptomatic Clients seeking admission to the shelter must show evidence of TB clearance by a healthcare provider within seven (7) days after initial admission to the shelter. A comprehensive TB evaluation by a licensed healthcare provider should include:

- i. A review of symptoms
- ii. Test for latent TB infection: tuberculin skin test ("TST") or I blood test
- iii. Chest radiograph or additional tests as necessary

- B. Contractor shall use a form similar to **SAMPLE FORM D** for this purpose. If onsite healthcare services are available, this evaluation can occur at the shelter, otherwise, the Client must be referred to a healthcare provider.
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5. Establish a Cough Alert Protocol (CAP)

Contractor shall ensure that after Intake, shelter staff working closely with Clients during the day or monitoring the sleeping rooms at night should be continually alert for any Clients persistently coughing. When a coughing Client is identified, shelter staff must:

- A. Complete a CAP and provide it to the TB Liaison immediately after the Client has been identified.
- B. Upon receiving the CAP, the TB Liaison will fax the **Referral for Tuberculosis Evaluation** form to the healthcare provided to which the Client is referred to.

Clients with active TB disease can return to the shelter only upon providing written documentation by a licensed healthcare provider that they are no longer contagious.

ANNUAL SCREENING FOR EMPLOYEES AND VOLUNTEERS

California law requires annual screening for employees and volunteers who have direct Client exposure. Below is a summary of recommendations from the Los Angeles County Department of Public Health for shelters:

- A. All persons (employees or volunteers) with a new positive skin or blood test must also have a chest x-ray.
- B. Staff who have a documented previous positive skin or blood test and are coughing (possible active TB disease) must be excluded from work until medically evaluated.
- C. The medical evaluation will include an examination by a healthcare provider, a test for latent TB, a chest x-ray and possibly other diagnostic tests.
- D. Clearance to return to work must be obtained from an appropriately licensed healthcare provider.
- E. Results of TB screening for employees and volunteers are considered protected health information and must be kept confidential.
- F. Homeless shelters must maintain employee TB screening documentation in the employee's medical file. Documentation regarding compliance with required medical screening may be kept in the employees personnel file, however screening results may never be kept in the employee personnel file.
- G. Shelter employees and volunteers should receive TB prevention training annually, with a curriculum that has been developed by the Los Angeles County, Department of Public Health – Tuberculosis Control Program, and documentation of this training should be placed in the employee's personnel file.

Contractor agrees that LAHSA may update this Exhibit from time to time as necessary to reflect any updates or changes to this TB Guidelines, Contractor shall accept renewals of this Exhibit through written confirmation without requiring a formal Amendment to this Agreement.

SAMPLE FORM A
Referral for Tuberculosis Evaluation
(for symptomatic Clients)

Name of referring shelter: _____

Name of contact person at shelter: _____ Telephone #: _____

Name of Client: _____ Date of birth: _____

Bed location: _____

Date of arrival at shelter: _____ Referral date: _____

Name of clinic/hospital to which Client was referred:

Comments/List reported or observed symptoms from **Early Detection of Tuberculosis Questionnaire**:

**Shelter staff: Hand this form to the Client to bring with them to the health care provider.
Attach a copy of the "Early Detection of Tuberculosis Questionnaire."**

To be completed by clinic physician or nurse (give a copy to Client)

Not a TB Suspect. This individual has been fully evaluated for active TB disease and it has been determined that he or she does not have active TB disease at this time. The Client may return to shelter. No infection control precautions are necessary. **Individual not reported to Los Angeles County TBC Program.**

TB Suspect. This individual is suspected of having active TB disease and he or she began taking an appropriately prescribed course of anti-TB medications on: _____, This individual is not considered contagious at this time and may return to (or seek admittance to) a congregate living situation such as a homeless shelter. No infection control precautions are necessary. **Clinic to report Suspect/Case to Los Angeles County TBC Program (213-745-0800)**

Name of physician or nurse at clinic: _____

Date of evaluation: _____ Name of clinic: _____

If the individual is not considered a TB suspect at this time, clearance to return to a congregate living setting such as a homeless shelter expires one year from the date of evaluation noted on the bottom half of this page.

(Note: Per California Health & Safety Code, providers are required to fax a Confidential Morbidity Report (CMR) for all TB Suspects and verified TB Cases to the LAC TB Control Program within seven (7) days. You may download a CMR at: <http://publichealth.lacounty.gov/tb/index.htm>).

SAMPLE FORM C
Early Detection of Tuberculosis Questionnaire

This questionnaire is designed for all Clients at the time of Intake. In addition, it can be used for any current Client with cough. It will help identify Clients who may have infectious TB so that appropriate precautions can be taken. **An individual with a prolonged cough (> 3 weeks) and at least one (1) other symptoms of TB should be referred to an appropriate health care provider for further evaluation.**

HISTORY/SYMPTOMS	Yes	No	Don't Know
<u>Do you have a cough that has lasted longer than 3 weeks?</u>			
Have you recently lost weight without explanation during the past month?			
Have you had frequent night sweats during the past month, soaking your sheets or clothing?			
Have you coughed up blood in the past month?			
Have you been feeling much more tired than usual over the past month?			
Have you had fevers almost daily for more than one week?			

Does the Client have prolonged cough (> 3 weeks) and answered "yes" to at least one other question above?

Yes No

If answered yes to a the Client should be referred immediately (or the next morning) to the nearest CHS public health center on week days and on weekends and holidays to a County Hospital Emergency Department (e.g., Los Angeles County+ USC Medical Center, Harbor-UCLA, or Olive View Medical Center).

Shelter Liaison COMMENTS

EXPOSURE CONTROL METHODS IMPLEMENTED

Surgical mask given to Client? _____

Instructed to cover mouth when coughing? _____

Was the Client separated from others and placed in a well-ventilated room? _____

Evaluator name: _____ Date: _____

Sample Form D
Referral for Tuberculosis Screening
(for asymptomatic Clients)

Shelter staff: Complete the top portion of this form and hand it to the Client.
Client: Bring this form with you to the clinic/hospital listed below.

Name of referring shelter: _____

Name of contact person at shelter: _____ Telephone #: _____

Name of Client: _____ Date of birth: _____

Bed location: _____

Date of arrival at shelter: _____ Referral date: _____

Name of clinic/hospital to which Client was referred: _____

Comments:

Dear Provider,

This Client was referred for a TB screening evaluation that is required of all persons staying at this facility. The form must be completed within **7 days** of arrival at the facility, or the Client will no longer be able to remain a part of the housing program.

To be completed by clinic/hospital physician or nurse (give a copy to Client)

1. Please perform a test for latent TB infection* for all individuals without history of previous positive test result.

TST result: mm TB Blood Test Result: Negative Positive

2. Please perform a chest radiograph for all individuals with a positive TST or TB blood test. Persons with a history of a positive test need to have an annual chest radiograph for repeat TB screening.

CXR result: Normal
 Abnormal, not consistent with active TB disease
 Abnormal, possibly representing active TB disease

Cleared for stay in congregate setting ****Date of clearance: _____
 Not cleared; pending additional testing

Name of physician or nurse at clinic/hospital: _____

Name of clinic/hospital _____

* Tests available include the tuberculin skin test (TST) or blood tests (Quantiferon and T-SPOT).