2019 CDC/NTCA Recommendations for Health Care Personnel (HCP): What TB Programs Need to Know

National Webinar: August 28, 2019

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This webinar is a collaborative training between the National TB Controllers Association (NTCA), the Centers for Disease Control and Prevention (CDC), the Rutgers Global TB Institute, and the Curry International TB Center (CITC) at UCSF.
Project Funding

The Curry Center is funded by the Centers for Disease Control and Prevention's Cooperative Agreement NU52PS910163-02 and is a project of the University of California, San Francisco (UCSF).

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Declaration of Disclosure

The following presenters and panelists have indicated that they do not have a financial relationship or conflict of interest with any commercial interest that may have a direct bearing on the subject matter. In addition, information on investigational or off-label use of pharmaceutical or medical devices will not be included:

- Lisa Chen, MD
- Lynn Sosa, MD
- Robert Belknap, MD
- Gibril Njie, MPH
- Neela Goswami, MD, MPH

The following faculty member has indicated that within the past 12 months, they have had a relevant financial relationship with a commercial interest which has direct interest in the subject matter:

- Wendy Thanassi, MD, MA, MRO (Grant/Research Support from Qiagen Inc.)

Today’s Facilitator

Lisa Chen, MD

Principal Investigator/Medical Director
Curry International Tuberculosis Center

Professor
Pulmonary and Critical Care Division
University of California, San Francisco
Learning Objectives

By the end of this webinar, participants will be able to:

- State specific changes from the 2005 CDC TB screening and testing guidelines for healthcare personnel (HCP)\textsuperscript{[1]} that are addressed in the 2019 recommendations\textsuperscript{[2]} in order to determine updates to organizational TB screening policies and procedures
- Describe common questions that public health TB programs may be asked about the 2019 HCP recommendations in order to effectively support the local implementation of the new recommendations
- Strategize ways that TB programs can work with occupational health partners to address unique implementation challenges within the occupational health setting resulting in less testing and more LTBI treatment

Webinar Agenda

(\textit{times displayed using the Pacific time zone})

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<th>Time</th>
<th>Session</th>
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</table>
| 10:00 – 10:05 | Introduction and Overview  
Lisa Chen, MD |
| 10:05 – 10:25 | Updated Recommendations for Tuberculosis Screening, Testing and Treatment of Health Care Personnel  
Lynn Sosa, MD |
| 10:25 – 10:35 | Key Changes for Occupational Health  
Wendy Thanassi, MD, MA, MRO |
| 10:35 – 11:15 | Moderated Panel Discussion  
Robert Belknap, MD and Panelists |
| 11:15 – 11:25 | Q & A  
Faculty |
| 11:25 – 11:30 | Closing  
Lisa Chen, MD |
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TB/STD Control Programs Coordinator

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2019 CDC/NTCA Recommendations for Health Care Personnel (HCP): What TB Programs Need to Know

Lynn Sosa, MD
Health Care Personnel Screening Guidelines Working Group
National Tuberculosis Controller’s Association

UPDATED RECOMMENDATIONS FOR TUBERCULOSIS SCREENING, TESTING AND TREATMENT OF HEALTH CARE PERSONNEL

Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

The 2005 CDC guidelines for preventing Mycobacterium tuberculosis transmission in health care settings include recommendations for baseline tuberculosis (TB) screening of all U.S. health care personnel and annual testing for health care personnel working in medium-risk settings or settings with and TSTs have well-documented limitations for serial testing of health care personnel at low risk for LTBI and TB disease (9,10).

Methods

In 2015, an NTCA-CDC work group comprising experts in...
CDC Guidelines for Preventing TB Transmission in Health Care Settings - 2005

Summary of Recommendations

• At hire - symptom screen and IGRA or tuberculin skin test (TST) testing in those without prior history of TB or LTBI
• Post exposure – symptom evaluation and IGRA or TST testing for those with a negative test at baseline and without TB history
• Serial Screening and Testing – Recommended for health care personnel (HCP) in medium risk setting and setting with potential ongoing transmission
• Follow up of LTBI positive – treatment referral and annual symptom review

http://www.currytbcenter.ucsf.edu
Background

• Concerns about the efficacy of serial TB testing with declining TB incidence were amplified by the PPD shortage in 2013 and multiple articles reporting on IGRA poor performance in low risk persons

• Joint NSTC-NTNC session at 2015 National Tuberculosis Conference to discuss issue

• Working group created in Summer 2015

• Systematic review commenced in January 2017

• Updated recommendations to be published in 2019

Review Focused on TB Screening and Testing of Health Care Personnel

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Systematic Review

- A process by which a body of literature is reviewed and assessed using systematic methods which are intended to reduce bias in the review process and improve understandability.
- Used to inform research, policy, and practice
- Evidence base for guideline development


Research Questions

- What is the prevalence and incidence of LTBI among health care personnel in the United States?
- What is the incidence of TB disease among health care personnel in the United States?
- Does annual or serial testing (via TST or IGRA) of U.S. health care personnel reduce the risk of TB transmission in U.S. healthcare settings?
- Does annual or serial testing (via TST or IGRA) of U.S. health care personnel increase the detection of occult TB transmission in U.S. healthcare settings?
- Are certain individuals who work within health care facilities at higher risk of TB than others based on occupational and non-occupational factors?
Methodology

- Community Guide systematic review methods used to evaluate and summarize available evidence
- Two reviewers independently screened and abstracted data for each included study
- Disagreements were resolved by consensus
- Data analyzed using “metafor” and “meta” packages in R (v3.3.2)

Search for Evidence

- We conducted a search for studies that screened and/or tested health care personnel (HCP) for LTBI
- Electronic databases included:
  - MEDLINE, EMBASE, and Scopus
- Search period:
  - Original search: January 2006–February 2017
  - Update search: February 2017–November 2017 (MEDLINE only)
- Language restriction:
  - English only
Inclusion/Exclusion Criteria

- **Inclusion Criteria**
  - Study designs
    - Randomized controlled trial (RCT), quasi-experimental, observational studies, cross-sectional surveys, other designs with concurrent comparison groups
  - Target population
    - Paid or volunteer health care workers
  - Outcomes of interest
    - Prevalence, conversion, and reversion rates; TB transmission rates; TB disease
  - Setting
    - High-income, low TB-incidence countries

- **Exclusion Criteria**
  - Study designs: case reports, editorials, commentaries, descriptive articles on nosocomial outbreaks

Search Results

Original Search Period
Jan. 2006 - Feb. 2017
(n = 1,129)

- Duplicates (n=2)
- Not relevant (n=212)

Ordered Full Text (n=908)

- Did not meet inclusion criteria (n=37)
- Unable to retrieve full text (n=6)

TB Screening & Testing in HCP Articles (n=35)

- Limited quality of execution (n=5)

Included in Analysis (n=34)

Total Included in Meta-analysis (n=33)

Update Search Period
Feb. 2017 - Nov. 2017
(n = 18)

- Not relevant (n=14)

Ordered Full Text (n=4)

- Modeling study (n=1)
- Type of QFT test used (n=1)

TB Screening & Testing in HCP Articles (n=2)

- Limited quality of execution (n=2)

Included in Analysis (n=2)

Total Included in Meta-analysis (n=36)
Summary of Findings

- Relatively low proportion (3%–5%) of U.S. HCP test positive for *M. tuberculosis* at baseline
- <1% of U.S. HCP previously testing negative convert to a positive test result during serial testing
- Nearly 50% of U.S. HCP previously testing positive revert to a negative test result during serial testing
- Insufficient evidence to assess incidence and transmission of TB disease among HCP
  - No cases of TB disease reported among the ~64,000 U.S. HCP included in the studies reviewed

So what does this all mean?

- Updated recommendations are based primarily on expert opinion
### Definitions

- **Health Care Personnel (HCP)**
  - Replaces Healthcare Worker (HCW) to be consistent with current HHS and CDC preferred language
  - Definition unchanged from 2005 recommendations

- **TB screening**
  - Broad process that includes a risk assessment, symptom evaluation, a test for LTBI (either a TST or IGRA), and additional work-up for TB disease as needed

- **TB Testing**
  - IGRA or TST

### 2019 Recommendations – Key changes

- **Pre-placement** – IGRA or TST with symptom assessment and individual TB risk assessment added (new)
- **Post-exposure** – Symptom evaluation and IGRA or TST testing for those with a negative test at baseline and without TB history (unchanged)
- **Serial Screening and Testing** (new)
  - Screening / testing not routinely recommended; can be considered for certain HCP groups
  - Annual TB education of all HCP including TB exposure risks
- **Follow up** of LTBI positive HCP – LTBI treatment strongly recommended unless contraindication exists (new)
**Baseline (Pre-Placement) Screening and Testing**

- Baseline screening on hire should include:
  - TB risk assessment
  - Symptom evaluation
  - TST or IGRA (not both)
- Low risk HCP testing positive should have second test
  - Consistent with TB Diagnostic Guidelines (Lewinsohn CID 1/15/2017)

**Postexposure Screening and Testing**

- Known exposure without adequate personal protection

- No history of positive TB test
  - Symptom assessment and TB test
  - Retest 8–10 weeks after last exposure

- History of positive TB test regardless of treatment
  - Symptom assessment, no test
Serial Screening and Testing Based on Occupational Risk

- No routine testing of HCP at any interval in the absence of known exposure or ongoing transmission
- Health care facilities can choose to conduct routine testing of specific HCP
  - Most health care facilities don’t need to!
  - This decision should be individualized to each facility and may be made in consultation with state/local health department

Serial Screening and Testing Based on Non-Occupational Risk

- Important to recognize non-occupational exposures to TB and risk factors for TB progression
- Facilities should educate HCP annually about TB
  - Include risk factors
  - Signs and symptoms
  - Encourage HCP to discuss any new exposures both occupational and non-occupational
- Decision to test HCP based on individual risk identified
Follow-Up of Positive Test Results

- HCP with positive TB test result:
  - Chest imaging
  - Symptom assessment
  - Further evaluation for TB disease if warranted

- All HCP with LTBI should be offered and encouraged to complete LTBI treatment unless a contraindication exists

Summary of Recommendation Changes

<table>
<thead>
<tr>
<th>Category</th>
<th>2005 Recommendation</th>
<th>2019 Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (replacement) screening and testing</td>
<td>TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI.</td>
<td>TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI (unchanged).</td>
</tr>
<tr>
<td>Postexposure screening and testing</td>
<td>Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8-10 weeks after the last exposure.</td>
<td>Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8-10 weeks after the last exposure (unchanged).</td>
</tr>
<tr>
<td>Serial screening and testing for HCP without LTBI</td>
<td>Not recommended for HCP working in low-risk health care settings. Recommended for HCP working in high-risk health care settings with potential ongoing transmission.</td>
<td>Not routinely recommended (new); consider for selected HCP groups (unchanged); recommend annual TB education for all HCP (unchanged), including information about TB exposure risks for all HCP (new emphasis).</td>
</tr>
<tr>
<td>Evaluation and treatment of positive test results</td>
<td>Referral to determine whether LTBI treatment is indicated.</td>
<td>Treatment is encouraged for all HCP with untreated LTBI, unless medically contraindicated (new).</td>
</tr>
</tbody>
</table>
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THE 2019 MMWR TB SCREENING AND TESTING FOR HEALTH CARE PERSONNEL: KEY CHANGES FOR OCCUPATIONAL HEALTH

CURRY CENTER WEBINAR
AUGUST 28, 2019

WENDY THANASSI MA, MD
CHIEF, OCCUPATIONAL HEALTH, PALO ALTO VA HEALTH CARE SYSTEM
ASSOCIATE PROFESSOR, STANFORD MEDICAL CENTER AND HOSPITAL
Pre-placement

...“all U.S. Health care personnel should have baseline TB screening, including an individual risk assessment”
**Individual Risk Assessment**

- Why = interpretation of test results
- Who = GINA, privacy, equality
- How often = once

**Pre-placement prior positives**

When to repeat a previously positive test:

- The HCP had a positive TST many years ago and did not have a confirmatory IGRA, particularly if BCG-vaccinated
- An older generation IGRA with poorer quality control and reliability was used
- The TST was positive in an HCP without TB risk factors

**Serial Testing**

Healthcare personnel should not undergo routine serial TB screening or testing at any interval after baseline unless there is known exposure or evidence of ongoing TB transmission.
2019 CDC/NTCA Recommendations for Health Care Personnel (HCP): What TB Programs Need to Know

August 28th, 2019

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Where TB Isn’t:

2016 CDC Table 47. Primary Occupation for the Past Year

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>8,654</td>
</tr>
<tr>
<td>HCP</td>
<td>3.4%  (-96.6%)</td>
</tr>
</tbody>
</table>

Table 1. Mean Annual Number of Active TB Cases and Rates per 100,000 Health Care Personnel (HCP) by Country of Birth Compared to All United States Residents: 2003-2007 and 2010-2016

<table>
<thead>
<tr>
<th>Study Period</th>
<th>HCP US-born</th>
<th>HCP Non-US-born</th>
<th>U.S. Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003-2007</td>
<td>1.7</td>
<td>17.9</td>
<td>4.2</td>
</tr>
<tr>
<td>No. (%)</td>
<td>153 (36)</td>
<td>268 (64)</td>
<td>421 (100)</td>
</tr>
<tr>
<td>Rate</td>
<td>0.8</td>
<td>10.8</td>
<td>2.5</td>
</tr>
<tr>
<td>2010-2016</td>
<td>0.8</td>
<td>10.8</td>
<td>3.0</td>
</tr>
<tr>
<td>No. (%)</td>
<td>90 (28)</td>
<td>262 (72)</td>
<td>352 (100)</td>
</tr>
</tbody>
</table>

*The U.S. total number of cases (not shown) is 14,065 from 2003-2007 and 9,561 from 2010-2016. Sources: Lambert, et al. 2012(14) and Mongkolrattanathai, et al. 2019(15)

Facility Risk Assessment Appendix C Update (DRAFT)

<table>
<thead>
<tr>
<th>SETTING</th>
<th>LOW</th>
<th>MEDIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic or &lt; 200 beds</td>
<td>&lt; 3 TB pts/year</td>
<td>≥ 3 TB pts/year</td>
</tr>
<tr>
<td>&gt; 200 beds</td>
<td>&lt; 6 TB pts/year</td>
<td>≥ 6 TB pts/year</td>
</tr>
</tbody>
</table>

http://www.currytbcenter.ucsf.edu
Post-exposure

“...after known exposure to a person with potentially infectious TB without adequate personal protection, HCP should have a symptom evaluation and additional timely testing.”

LTBI: When Reactivation Occurs

Loma Linda VA warns veterans of possible TB exposure

Employee, Patient Test Positive for Tuberculosis at VA Medical Center in Mather

http://www.currytbcenter.ucsf.edu
Contact Investigation/Post-exposure prior positives

Examples of when to repeat a positive baseline test:

- When required by the Worker’s Compensation insurance carrier
- The HCP had a positive TST many years ago and did not have a confirmatory IGRA, particularly if BCG-vaccinated
- An older generation IGRA with poorer quality control and reliability was used
- The TST was positive in an HCP without TB risk factors

Education and Treatment/Prevention

Healthcare personnel should receive annual TB education. Education should include information on TB risk factors, the signs and symptoms of TB disease, treatment options and facility infection control policies and procedures.
Elimination: Next steps

“Elimination is the containment of exposure.” E. Frenzel

- **Testing**
  - Does not prevent disease
  - Does not treat disease
  - Does not eliminate disease

- **Treatment**
  - Prevents disease (spread)
  - Treats disease
  - Eliminates disease

The final 10% is tougher than the first 90%.

"Elimination is the containment of exposure." E. Frenzel

Companion Doc. 3HP - NTCA
LTBI Treatment Options, 2019 (Companion Doc.)

**Short Course**
- INH - Rifapentine (3HP)
  - 3 months
  - 12 doses
  - Once weekly
  - INH: 15mg/kg, max 900mg
  - Rif: Varies, max 900mg

**Short Course**
- Rifampin (4R)
  - 4 months
  - 120 doses
  - Once daily
  - 10mg/kg, max 600mg

**Traditional**
- Isoniazid (INH)
  - 9 months
  - 270 doses
  - Once daily
  - 15mg/kg, max 900mg

**FUTURE?**
- Rifapentine
  - 6 weeks? (in trial)

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PSA: Much more than financial waste....

- 18M U.S. HCP
- + teachers, coaches, babysitters, bus drivers...
- Austria (plane)> L.A. (truck)> Palo Alto (truck)> Mountain View (truck)> Palo Alto (truck)> Valencia
- TSPOT adds (plane)> Memphis
- Tens of millions of tubes, needles and garbage
- Results: **Negative**
CDC Materials: For Organizations

- **MMWR: Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019**
- **Baseline Assessment Form**
- **FAQs**
- **Updated Web content**
  - Health Care Settings
  - HCP Testing

CDC Materials: General

- **Overview Video**
- **Medscape CDC Expert Commentary**
- **Infographic**

All materials can be found at [www.cdc.gov/tb](http://www.cdc.gov/tb)

Retweet or share social media content from Twitter (@CDC_TB) and Facebook (@CDCTB).
Panel Discussion

Case Scenario 1

A federally qualified health center that provides primary care to mostly uninsured patients, with over 50% who were born outside the U.S., asks if they should continue doing annual TB tests for their health care staff (they do not have an active contact investigation or evidence of ongoing transmission)
Discussion

- What additional information might be helpful?
- Do you need to know the TB incidence in the jurisdiction?
- Does it matter where the clinic is located (example near the US-Mexico border or not)?
- What if health care personnel had to be tested as part of a contact investigation the previous year?

Summary

Scenario 1: Should the federally qualified health center continue doing annual TB tests
- Best Answer is NO – focus on LTBI treatment and the administrative and environmental controls
- Additional information can be helpful to frame the discussion but it’s highly unlikely that a facility routinely detects unrecognized TB transmission through annual testing
- Most variability with annual testing is the known variability in the tests; <1% with TST vs 3-4% with IGRA (Dorman et al AJRCCM 2013).
Summary

• If a facility or area within a facility has consistently seen a high rate of annual conversions then the focus should be on identifying and fixing the administrative and environmental controls that are causing it.

• In that very rare scenario, it would be appropriate to continue annual testing until it was confirmed that occult TB transmission was no longer a problem.

Case Scenario 2

An Occupational Health provider calls and asks what they are supposed to do with the new individual risk assessment and can they can stop doing the facility risk assessment.
Discussion

• What is the purpose of the individual risk assessment?
• What are some challenges occupational health providers may face with the individual risk assessment?
• Is there still a need for the facility risk assessment and if so why?
• Why is treatment being emphasized?

Summary

Scenario 2: what to do with the individual risk assessment and can they can stop doing the facility risk assessment.

1. Best Answer is 1
   - The individual risk assessment is important for interpreting the TB tests
   - The facility risk assessment is important for determining environmental and administrative controls needed
Case Scenario 3

A friend who is a pulmonologist at a local hospital asks if she should continue to get an annual TB test because she regularly does bronchoscopies.

Discussion

• What does the 2019 Guideline say about which health care job categories/job classifications should still get serial testing?
• Can you think of any scenarios where you would recommend continued annual TB testing?
• What about correctional care workers who may be required to get an annual TB test?
Conclusion

2019 Guideline recommends focusing efforts on

- Baseline testing including an individual risk assessment
- Encourage health care personnel with LTBI to complete a course of treatment
- Educate all staff to recognize the symptoms of active TB and risks for potential non-occupational exposure (living, volunteering, and/or providing medical care in a country where TB is common).

Conclusion

- The guidelines do not override any local or state requirements
- They may be used to help change local requirements that are out of date relative to the actual risk for TB exposure and infection
- Companion Document focused on Implementation coming soon!
Questions?????

Options to ask questions during webinar:
1. Phone: Press *6 to unmute your phone line
2. Enter a question in Q & A field

Presenters

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