TUBERCULOSIS SURVEILLANCE PROCEDURES

SUBSTANCE ABUSE TREATMENT FACILITIES (SATFs)

INTRODUCTION

TB Problem among Substance Abusers

-- New Jersey reported 422 verified TB cases in CY2008. This was a decline of 9.9 percent from 467 cases in CY2007. Prior to CY2005, TB incidence had decreased or remained constant in the state every year since the most recent peak in CY1992. A 5.4 percent increase observed from CY2004 to CY2006 has been reversed with a decline in TB incidence in NJ since CY2004 (3.1 percent) is slower than the 4.25 percent annually over the previous 12 years (CY1992 to CY2004).

-- The TB case rate decreased in CY2008 to 4.9 per 100,000 in population, compared to 5.4 in CY2007, 5.8 in CY2006, 5.6 in CY2005, 5.5 in CY2004 and 5.7 in CY2003. The 2.7 percent annual decline in case rate since CY2004 does not compare favorably to the historic 4.6 percent annual decline from CY1992 to CY2004.

-- The number of individual TB cases self-reporting excess alcohol use, injecting drug use and/or non-injecting drug use was 42 or 10.0 percent of 422 cases in CY2008. This is up from 8.6 percent in CY2007. Of these 42 TB cases, 24 (57.1%) reported alcohol use from exclusively, 11 (26.2%) reported non-injection drug use exclusively, none reported injection drug use exclusively, one (2.4%) reported use of alcohol and non-injection drugs, two (4.8%) reported use of alcohol and injection drugs, one (2.4%) reported the use of injection and non-injection drugs and three (7.1%) reported use of alcohol, injection and non-injection drugs. Forty (95.2%) of the 42 cases reporting substance abuse in CY2008 were tested for HIV and 12 (30.0%) of these 40 were HIV co-infected.

-- Without treatment, approximately 20 percent of persons with latent TB infection (LTBI), and a history of injection drug use could be expected to develop active TB over the next 20 years. Over the same time period, approximately 70 percent of persons with HIV infection could be expected to develop active TB. HIV infection contributes most to an increased risk for progression of LTBI to active TB.

-- With the sustained decline of TB in the U.S. over the past decade, TB has been retreating into well-defined risk groups. Every effort should be made to test only those persons at highest risk for latent TB infection, interpret tuberculin skin reactions accurately, and ensure appropriate treatment and completion of the recommended regimen. Screening persons other than members of high-risk groups is not recommended.

Opportunity for Preventing TB Among Injecting Drug Users
-- Injection drug users have an increased risk for progressing to active TB (10 cases per 1000 person-years), and this risk is even greater for injection drug users co-infected with HIV and TB (76 cases per 1000 person-years). These higher rates may reflect increased transmission, more recent infection in this population, and the increased risk associated with injection drug use and HIV infection.

-- Most health department jurisdictions have been successful in achieving the highest priority TB objectives of identifying and ensuring completion of therapy among active cases and ensuring complete follow up and treatment of TB contacts. While maintaining these efforts, accelerated progress towards TB elimination will occur through testing and treatment of latent TB infection among groups at the highest risk of developing active TB.

-- Fortunately, latent TB infection, if discovered, is at a stage where progression to infectious TB disease is almost entirely preventable. Prevention requires identification of the infected individual and treatment for the latent infection with Isoniazid for 9 months. Studies have shown that persons who complete a full course of treatment for latent TB infection have more than a 90% reduction in the risk of developing active TB compared with persons who are not treated.

-- Adherence to Treatment for latent TB infection is greatly enhanced by the implementation of a directly observed therapy (DOT) program. Tuberculin skin testing should not be undertaken by a SATF unless DOT is provided by the facility staff.

-- As indicated in the table below, treatment for LTBI among injection drug users, with or without HIV infection, is a relatively efficient way to prevent active, infectious TB. Therefore, SATFs provide a unique setting in which to cost-effectively prevent TB in an otherwise difficult to reach high risk population.

TB Risk	Annual Risk of TB - Without TX	# Completing TX to Prevent 1 Case of TB Over a 20 –Year Period
IDU & HIV Positive	.0760	1
HIV Positive	.0450	2
IDU & HIV Neg or Unk	.0100	6
No Risk	.0007	77

Objectives

For Clients

1. All clients will receive TB counseling and education before admission to a SATF.
2. All clients will receive a symptom assessment for pulmonary tuberculosis before admission to a SATF. Past history of treatment for TB disease, tuberculin skin tests (TST) or adequate treatment for latent TB infection (LTBI) will be obtained. An efficient and feasible screening tool to identify those persons in need of evaluation for active tuberculosis disease attending SATFs is the implementation of a Pulmonary Tuberculosis Symptom Assessment.

(See Attachment 2)

3. All clients with symptoms consistent with pulmonary tuberculosis will promptly be referred for a chest X-ray and medical evaluation for active tuberculosis.
4. Using the 2-step method, the Mantoux TST status will be known on those clients with a history of intravenous drug use and/or clients with a history of HIV who are in treatment plans consisting of 9 months or longer that are enrolled in long term care-residential SATFs or methadone maintenance-

opioid pharmacotherapy facilities within 30 days of admission.
5. Clients with newly identified positive TSTs will receive a chest X-ray and be evaluated for active TB within 10 days of the TST.

-- At least 90% of clients with a positive TST will be started on treatment for LTBI, unless medically contraindicated, within 10 days of the evaluation for TB.

6. Directly observed therapy (DOT) will be provided by the SATF for clients receiving treatment for latent TB infection or TB disease.
7. At least 85% of clients placed on treatment will complete the recommended regimen within 12 months.
For Employees
1. All employees will receive TB counseling and education at time of employment.
2. All employees will receive a symptom assessment for pulmonary TB at the time of employment. (See Attachment 2) Past history of previous treatment for TB disease, tuberculin skin tests (TST), or adequate treatment for latent TB infection (LTBI) will be documented.
3. All employees with symptoms consistent with tuberculosis will promptly be referred for a chest X-ray and medical evaluation for active tuberculosis.
4. Using the two-step method, the Mantoux TST status will be known on all employees within 30 days of employment at the SATF.
5. All employees with a newly identified positive TST will receive a chest X-ray and be evaluated for active TB within 10 days of the TST.
6. At least 90% of employees with a positive TST will be started on treatment for LTBI, unless medically contraindicated, within 10 days of the evaluation for TB.
7. At least 85% of employees placed on treatment will complete the recommended regimen within 12 months.
Federal and State Requirements for TB Testing

Federal: The Substance Abuse and Mental Health Services Administration (SAMHSA), through its Center for Substance Abuse Treatment (CSAT), stipulates that facilities receiving Block Grant funds provide, or arrange for, TB services for each individual receiving substance abuse services. TB services may include:

-- Counseling the individual with respect to TB, testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment for the individual, and

-- Providing for or referring the individuals infected by mycobacterium tuberculosis for appropriate medical evaluation and treatment.

Source: Public Law 102-321 45 CFR 96 - Rules and regulations; Section 96.121 - Definitions and Section 96.127 - Requirements Regarding Tuberculosis

State: The Standards for Licensure include requirements for TB testing and follow up (if indicated). The TB Surveillance Procedures provide more specific guidance in carrying out the requirements and are based on recent scientific findings and on newly published recommendations. Therefore, SATFs should be guided by the TB Surveillance Procedures in developing and updating their TB-related policies and procedures.

Purpose of Tuberculosis Surveillance Procedures
Each year, over 50,000 substance abusers are admitted to SATFs in New Jersey. In 2003, there were 54,543 individuals admitted to substance abuse centers and 10,827 were injecting drug users. Since injection drug users and/or clients with a history of HIV are at high risk for progressing to active infectious TB once infected and since TB is feasibly preventable among these individuals with

LTBI, the purpose of the Tuberculosis Surveillance Procedures is to:
-- Identify and treat persons with active, infectious TB and

-- Identify and treat, with the initiation of DOT, high risk persons with LTBI to prevent the development of active, infectious TB

These Procedures will cover the following:
-- Initial examination, follow up, and treatment procedures for both clients and employees.

-- Annual examination requirements for employees.

-- Procedures following exposure to infectious TB.

-- Documentation of results and reporting requirements.

At the end of this document is a list of resources to assist SATFs in implementing these Procedures.

I. CLIENTS

A. INITIAL EXAMINATION

1. Counseling and Evaluation for Signs and Symptoms of TB

All newly admitted clients to a SATF will be counseled about tuberculosis infection and disease. All clients will also be evaluated for signs and symptoms of tuberculosis. The symptoms of pulmonary tuberculosis may include productive, prolonged cough, chest pain, and/or hemoptysis. Systemic symptoms of tuberculosis may include fever, unexplained appetite loss, unexplained weight loss (10 pounds or greater), night sweats (regardless of room temperature), chills and/or persistent fatigue. If the client is determined to have symptoms and/or clinical evidence suggestive of active TB (regardless of the results of the TST), the SATF will immediately isolate the client in a separate area of the facility away from other clients, until the need for hospitalization has been determined. Local hospitals can be used for inpatient care when necessary. The SAFT should contact the NJDHSS, TB Program at (609)-826-4878 for consultation and referral.

2. Mantoux Tuberculin Skin Test (TST)

-- Purpose: The purpose of the TST is to identify clients who have been infected with TB so that these persons can be (a) evaluated for active, infectious TB and (b) if active TB is ruled out, placed on treatment to prevent the future development of active TB.
-- Who Will Be Tested

Clients with a history of intravenous injection drug use and/or clients with a history of HIV infection who are in treatment plans consisting of 9 months or longer that are enrolled in long term care-residential SATFs or methadone maintenance-opiod pharmacotherapy facilities, where DOT is feasible. The provision of a DOT program by SATF staff is an essential component of the tuberculin testing procedure.

Exceptions: Clients presenting written documentation of a (a) prior positive Mantoux TST reaction, (b) prior or present TB disease, or (c) adequate treatment for latent TB infection (LTBI).

Note: A verbal history from the client of prior testing or treatment results is not sufficient to exclude testing. Unless written documentation can be provided, the TST shall be performed.

Note: Tuberculin testing is not contraindicated for persons who have been vaccinated with BCG. These persons should receive a TST without regard to the history of BCG.

Administration of the Mantoux TST
The Mantoux TST is performed by the intradermal injection of 0.1 ml of Purified Protein Derivative (PPD) tuberculin containing 5 TU (tuberculin units) into either the volar or dorsal surface of the forearm. The injection should be made with a disposable safety tuberculin syringe with a short (one-

quarter to one-half inch), bluntly beveled, platinum (26-gauge) or steel (27-gauge) needle. The injection will be made just beneath the surface of the skin, with the needle bevel facing upward to produce a discrete, pale elevation of the skin (a wheal) 6 mm to 10 mm in diameter.

To prevent needle stick injuries, needles will not be recapped, purposely bent or broken, removed from disposable syringes, or otherwise manipulated by hand. After use, syringes and needles will be placed in puncture-resistant containers for disposal. Institutional guidelines regarding universal precautions for infection control will be followed.

Reading the Mantoux TST
The Mantoux test is read between 48 to 72 hours after administration by a trained health care provider. Positive reactions (see Interpretation of TST Results section for definition of positive) tend to persist for several days and can be read up to 7 days from the date of testing. However, if an individual fails to return within 48 to 72 hours and has a negative test, the TST shall be repeated.

Readings should be made in good light, with the forearm slightly flexed at the elbow. The basis of the reading is the presence or absence of induration, which may be determined by inspection (from a side view against the light as well as direct light) and by palpation. The diameter of induration (raised, hardened area) should be measured using a tuberculin ruler. Erythema (redness) or bruise without induration should not be measured. The reaction is measured transversely to the long axis of the forearm and recorded in millimeters of induration. If no induration is found 00 mm will be recorded.

Documentation in the medical record should include date of administration, date of the reading, measurement in millimeters of induration, name of administrator and/or reader, site of placement, brand name of the PPD solution, lot# and expiration date of PPD solution.

Interpretation of TST Results
A Positive TST indicates the probable presence of TB organisms in the body. Persons with a positive TST shall receive follow up evaluation (including a chest X-ray) to rule out active TB and will be considered for treatment of LTBI if active TB is ruled out.

A Negative TST indicates the probable absence of TB organisms in the body. Persons with a negative TST do not require further evaluation unless symptoms compatible with active TB are present (see Section I.A.1.)

Depending on the HIV status, the TST reaction size should be interpreted as follows:

HIV Status	TST Reaction	Interpretation
Positive	0- 4 mm	Negative
	5 + mm	Positive
Negative or Unknown	0 - 9 mm	Negative
	10 + mm	Positive

Anergy Testing
Because results of anergy testing in HIV infected populations in the US do not seem useful to clinicians making decisions about treatment for latent TB infection, anergy testing is no longer recommended as a routine component of TB screening among HIV-infected persons.
B. FOLLOW UP EVALUATION OF CLIENTS WITH A POSITIVE TST
Any individual whose TST is positive shall promptly be referred for a chest X-ray in order to rule out the presence of active TB.
A posterior-anterior chest X-ray is the standard view used for the detection and description of chest abnormalities. In some instances, other views or additional studies may be necessary.
Abnormalities on chest X-rays may be suggestive of, but are never diagnostic of, TB. However,

chest X-rays may be used to rule out the possibility of pulmonary TB in an individual who has a positive reaction to the tuberculin skin test and no symptoms of disease. Note: In HIV- infected individuals, pulmonary TB may present atypically on chest X-ray.
Further diagnostic evaluation and/or treatment will depend on the results of the chest X-ray:
-- X-ray Abnormal - Compatible with Tuberculosis.
These individuals will be considered TB suspects and will be immediately referred to a local chest clinic or regional chest clinic that has the capability of collecting sputum and performing a clinical evaluation to confirm or rule out the presence of active TB. Referral for consultation is available by contacting the NJDHSS, TB Program at (609)-826-4878.
-- X-ray Normal or X-Ray Abnormal - Not Compatible with Tuberculosis.
These individuals can be evaluated by the local chest clinic, regional chest clinic or private medical doctor, and considered for treatment of LTBI. Referral for consultation is available by contacting the NJDHSS, TB Program at (609)-826-4878.
C. TREATMENT FOR LATENT TB INFECTION (LTBI)
-- Rationale: Unless treated, persons with LTBI who have a history of injection drug use and/or HIV infection are at an increased risk for progressing to clinically active TB disease and infecting staff members and other clients. Treatment of LTBI substantially reduces the risk of developing clinically active tuberculosis in infected persons. Therefore, all clients with a positive TST in whom active TB has been ruled out should be placed on treatment for LTBI unless medically contraindicated. SATFs provide a unique setting in which to efficiently use DOT to reach high risk populations and ensure completion of treatment for LTBI.
Treatment Regimens for LTBI
The recommended treatment regimen for LTBI in adults is isoniaid (INH) 5 mg/kg (maximum 300 mg) given daily in a single dose for 9 months (total of 270 doses). Completion of therapy is based on total number of doses administered not on duration of therapy alone. Allowing for minor interruptions in therapy, the regimen is considered complete when the client has taken all 270 doses within a 9 to 12 month period. For persons who complete this regimen, the risk of developing active TB is reduced by over 90 percent. This regimen can be given twice weekly by increasing the dosage to 15 mg/kg (maximum 900 mg).

A 6 month regimen of INH is also acceptable, but not as effective as the 9-month regimen. The six-month regimen of INH should consist of at least 180 doses administered within 9 months. Completion of a 6-month regimen of INH reduces the risk of developing active TB by approximately 65 percent.

Twice-weekly INH regimens should consist of at least 76 doses administered within 12 months for the 9- month regimen and 52 doses within 9 months for the 6-month regimen. Directly observed therapy (DOT) shall always be used with twice-weekly dosing.

Recommendations for HIV-infected adults largely parallel those for HIV-uninfected adults. However, when INH is chosen for treatment of LTBI in persons with HIV infection, 9-month regimens rather than 6-month regimens are recommended.

Other alternative treatment regimens for LTBI are available for individuals who cannot tolerate INH or who may have been exposed to INH-resistant TB. Referral for consultation is available by contacting the NJDOH, TB Program at (609)-826-4878.

Adherence To Treatment for LTBI
For maximum benefit, every effort should be made to ensure adherence to treatment for LTBI until the client completes the regimen. Since clients will likely have difficulty adhering to the regimen on a self-administered basis, SATFs should not initiate a tuberculin testing program unless the medication can be administered by directly observed therapy (DOT) in the SATF. DOT is defined as "observation of the patient by a health care provider or other responsible person as the patient ingests TB medication." All clients on the twice-weekly regimen shall receive each dose on a DOT basis.

Referral for consultation on this matter is available by contacting the NJDOH, TB Program at (609)-826-4878.

Site for Providing INH Medication

Treatment for LTBI can be administered at any of the SATFs, provided that they have a nurse and/or physician on staff who can monitor the patients adherence with medication, observe side effects, administer the medications, and counsel/educate the patients. On-site provision of treatment helps foster continuity of care and is more convenient for the client than referring the client to another site. For clients who routinely return to the SATF at least twice weekly, for example, to receive methadone, the SATF provides a unique setting in which to efficiently ensure completion of treatment for LTBI through DOT. Referral for consultation regarding the provision and monitoring of INH is available by contacting the NJDOH, TB Program at (609)-826-4878.

If the SATF is unable to carry out the functions noted above, a tuberculin skin testing program should not be initiated.

For clients with dual tuberculosis and HIV infection (without disease), treatment may be provided at a state or federally funded HIV Early Intervention Program, where both conditions can be treated simultaneously.

Monitoring Patients On Treatment for LTBI

Baseline Evaluation

Baseline laboratory testing is not routinely indicated for all persons at the start of treatment for LTBI, even in older persons. Persons with the following high-risk conditions should have baseline laboratory testing:

-- HIV infection treated with HAART.

-- History of, or at risk for, chronic liver disease (for example, hepatitis B or C, alcoholic hepatitis, or cirrhosis).

-- Pregnancy and immediate postpartum period (within 3 months of delivery).

-- Alcohol abuse

-- Concomitant hepatoxic medication(s).

-- In these persons taking isoniazid, baseline and routine hepatic measurements of serum AST (SGOT), ALT (SGPT) and total bilirubin are indicated.

Evaluation During Treatment

Clinical Evaluation: Clients receiving treatment for LTBI should be questioned carefully, at least monthly, for signs and symptoms consistent with liver damage or other adverse effects, These include any of the following: unexplained anorexia, nausea, vomiting, dark urine, jaundice, rash and/or itching, persistent parenthesis of the hands and feet, persistent fatigue, weakness or fever of greater than 3 days duration, and/or abdominal tenderness (especially right upper quadrant discomfort), easy bruising or bleeding, and arthralgia. Clients should be instructed that if any of these or other signs occur during treatment for LTBI, they should report immediately to the treating physician for evaluation, including biochemical tests for hepatitis.

Laboratory Monitoring: The frequency of routine monitoring may be monthly, every other month or at 1, 3 and 6 months for patients prescribed a 9 month treatment regimen depending on perceived hepatotoxicity risk and the stability of ALT. Laboratory testing should be used to evaluate possible adverse effects that occur during the course of treatment whether baseline testing was done or not.

Medication should be withheld if the patient’s transaminase level exceeds 3 times the upper limit of normal in the presence of symptoms and 5 times the upper limit of normal if the patient is

asymptomatic.

D. TREATMENT OF TUBERCULOSIS DISEASE
Persons with suspected or confirmed TB disease should be started on a drug regimen recommended by CDC/ATS (see reference Treatment of Tuberculosis, MMWR, June 20, 2003, (99-7490)).
Clients with suspected or confirmed active TB disease must be referred to the local chest clinic or the regional chest clinic for treatment and management of their disease, since:
-- TB treatment is complex and requires experience and expertise to manage effectively.

-- TB Clinics have access to TB experts and other resources to deal with the major problems associated with curing TB patients, such as non-adherence to treatment regimens, drug resistance, adverse reactions to medication, and HIV infection.

-- TB Clinics are ultimately responsible for ensuring that persons with TB in the community are promptly started on and complete an appropriate drug regimen and for conducting a thorough contact investigation.

Asymptomatic patients with active pulmonary TB disease can resume receiving services at the SATF as soon as they are determined to be non-infectious. Patients are considered noninfectious when they are on effective therapy, are improving clinically, and they have had three consecutive sputum smears negative for AFB collected on different days.
E. ANNUAL TESTING
Clients with an Initially Negative TST:
-- Annual tuberculin skin testing is required.
Clients with an Initially Positive TST:
-- For clients in whom active TB has been ruled out (for example, no TB symptoms and a negative X-ray) following an initially positive TST, repeat skin tests and chest X-rays are not recommended, even in clients who did not complete treatment for LTBI. These persons should be instructed to seek medical attention, including a chest X-ray, as soon as they experience signs and symptoms suggestive of active TB disease.
Note: Periodic monitoring for TB-like symptoms may be considered for clients with a positive TST who are at increased risk for developing TB (for example, clients with HIV-infection, clients who are otherwise severely immunocomprised or clients whose TST has converted from negative to positive within the last 2 years.)
II. EMPLOYEES
A. INITIAL EXAMINATION
Basis for Testing: These guidelines are based Public Employees Occupational Safety and Health Program (PEOSH) standards and/or recommendations and are recommended by the Centers for Disease Control and Prevention (CDC).
Testing Requirement: All employees will receive a twostep base-line Mantoux tuberculin skin test upon employment. If the result of the initial test is negative, administer a second test one to three weeks later. If the second test is positive, the person is classified as infected; if the second test is negative, the person is classified as uninfected. If a new employee has documentation of having received a single negative TST within the past year, only a one-step Mantoux test is required upon employment. NOTE: See protocol under CLIENTS for information about administering, reading and interpreting the Mantoux tuberculin skin test.
Exception from Testing:Employees shall be exempt from any testing if they present written documentation of:
-- A prior positive Mantoux TST

-- Prior or present TB disease

-- Prior adequate treatment of LTBI

- A negative two-step Mantoux TST within the last year.

Note: A verbal history from the employee of prior testing or treatment results is not sufficient to exclude testing. Unless written documentation can be provided, the tuberculin skin test shall be performed.

Note: Tuberculin skin testing is not contraindicated for persons who have been vaccinated with BCG, and, if positive, should be considered to indicate TB infection.

B. FOLLOW UP EVALUATION AND TREATMENT
See protocol under CLIENTS for the required follow up medical evaluations, treatment, and monitoring of persons identified as having TB infection or disease.
C. ANNUAL TESTING
At minimum, an annual routine one-step Mantoux tuberculin skin test shall be required for all employees with an initially negative TST. For persons with a positive TST in whom active TB disease was initially ruled out, routine follow-up skin tests and chest radiographs are unnecessary. These persons should be instructed to seek medial attention if they experience signs and symptoms suggestive of active TB disease.

In addition, a Tuberculosis Control Program that includes an annual risk assessment of the SATF should be implemented. The frequency of follow-up Mantoux tuberculin skin tests will be based on this risk assessment.

III. POST-EXPOSURE
Employees or clients who were exposed to an individual with suspected or confirmed active infectious TB shall be managed according to CDC recommendations. The SATF should immediately report the possible TB exposure to the local chest clinic/regional chest clinic, which will provide consultation and assistance.
IV. REGIONAL CHEST CLINIC/LOCAL CHEST CLINICS ASSISTANCE WITH NON-ADHERENT CLIENTS
SATF clients with TB disease who are overdue for a medical evaluation or who are non-adherent with prescribed TB therapy should be referred to the local chest clinic/regional chest clinic where the patient resides. Action will be taken based upon the priority of the referral and the availability of resources.
V. DOCUMENTATION
A. IN MEDICAL CHARTS
The New Jersey Department of Health Symptom Assessment Form for Pulmonary Tuberculosis and the Mantoux Skin Test Documentation Sheet (when appropriate) are to be completed for client/employee and placed in the individual's medical record. (See attachment I & II).
B. PERIODIC REPORTING TO THE STATE TB PROGRAM
1. Results of Follow-up as a Result of Post-Exposure to Active TB Case
The Record of Contact Interview form (TB-41) shall be completed for a post-exposure episode to an infectious tuberculosis case by a representative of the local chest clinic/regional chest clinic (with input from appropriate SATF staff). Information about the clients and employees, as well as their initial screening, follow-up medical information, including therapy prescribed (as applicable) should be forwarded to the appropriate local or regional chest clinic, within three weeks after completion.

These forms will be used by the local or regional chest clinic to report to the NJDOH, TB Program as required by regulation.

2. Case and Status Reporting of Cases and Suspects
The Tuberculosis Case, Suspect and Status Report (TB-70) form is to be used to report individuals with suspected or confirmed tuberculosis disease. It is also used to report, at minimum, the current status of a person with tuberculosis disease on a quarterly basis. Changes in medication, laboratory

results, changes in status, or termination from follow up are to be reported as they occur.

These forms will be used by the local or regional chest clinic to report to the NJDOH, TB Program as required by regulation.

ATTACHMENT I

MANTOUX SKIN TESTING DOCUMENTATION SHEET

SUBSTANCE ABUSE TREATMENT FACILITY

FACILITY: _____ PERIOD: _____
NAME OF CLIENT: _____
MANTOUX SKIN TEST: DATE IMPLANTED _____ TIME: _____
LOCATION: _____
MANUFACTURER OF PPD.: _____ EXPIRATION DATE: _____
LOT NUMBER: _____
NURSE/MD SIGNATURE: _____
RESULTS: DATE READ: _____ TIME: _____
INDURATION/SIZE IN MM: _____
NURSE/MD SIGNATURE: _____
POSITIVE MANTOUX TEST, REFEREED FOR CHEST X-RAY
DATE OF CHEST X-RAY (MOBILE CHEST X-RAY UNIT): _____
RESULTS: _____
INTERVENTIONS TAKEN: _____
_____
SUBMITTED BY: _____ PHONE: _____

ATTACHMENT II

NEW JERSEY DEPARTMENT OF HEALTH

SYMPTOM ASSESSMENT FORM FOR PULMONARY TUBERCULOSIS (TB)

Name (Last, First, MI):_____
Birth date (mm/dd/yyyy): _____
Street Address:_____ Phone: ( ) _____
City: _____ State: _____ Zip: _____
Date of Symptom Assessment (mm/dd/yyyy):
Check all TB-like symptoms that apply:
( ) Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)
( ) Coughing Up Blood (Hemoptysis)
These are the primary symptoms of pulmonary TB. If either of the above symptoms is reported, a chest radiograph is warranted regardless of the results of a Mantoux tuberculin skin test.
( ) Unexplained Weight Loss (10 pounds or greater without dieting)
( ) Night Sweats (regardless of room temperature)
( ) Unexplained Loss of Appetite
( ) Very Easily Tired (Fatigability)
( ) Fever
( ) Chills
( ) Chest Pain
Above are secondary symptoms and if present, without prolonged productive cough or hemoptysis, warrant a Mantoux tuberculin skin test with further evaluation if a significant reaction (10mm or greater) is measured or the patient's medical history indicates a significant risk for active disease

(previous exposure to infectious TB, etc.).
( ) No TB-Like Symptoms Reported or Observed
Next Symptom Assessment Due (mm/dd/yyyy) _____
Person Completing Assessment (Print): _____ Date: _____

REFERENCES
1. CDC, Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection, 2000 MMWR Vol.49 (NO.RR6)
2. Model Tuberculosis Infection-Control Program, New Jersey Department of Health and Senior Services, Public Employees Occupational Safety and Health Program, February 1998
3. American Thoracic Society, CDC, Disease Society of America, Treatment of Tuberculosis, 2003, MMWR Vol.52 (No. RR-11)
4. CDC, 1998. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: principles of therapy and revised recommendations. M.M.W.R. 47(No.RR-11):36-42.
5. CDC. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 MMWR Vol.54 (No.RR-17).
RESOURCES
-- New Jersey Department of Health and the New Jersey Department of Human Services, Division of Mental Health and Addiction Services

-- Questions about federal and state requirements for TB testing in SATFs

-- New Jersey Department of Health, Tuberculosis Program 609-826-4878.

-- Questions on the content of the TB Surveillance Procedures.

-- Contact and referral information (local or regional chest clinics).

-- Reporting of persons with suspected or confirmed TB.

-- Mantoux TST testing material and Isoniazid to treat LTBI.

-- NJDOH, TB forms.

-- New Jersey Medical School National Tuberculosis Center

-- Call the TB Hotline 800-482-3627 for consultation on the clinical management (diagnosis, treatment, infection control) of persons with TB infection or disease.

-- Additional TB information available at the Center's website:
http://www.umdnj.edu/ntbcweb/tbsplash.html

-- Local Chest Clinic or Regional Chest Clinic List available from the State Tuberculosis Program.

-- Reporting of persons with suspected or confirmed TB.

-- Arranging for isolation of persons with suspected or confirmed TB.

-- Referral of persons with LTBI for a chest x-ray and evaluation for active TB.

-- Consultation on providing treatment for LTBI at the SATF, including directly observed therapy.

-- Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination (DTBE)

The CDC/DTBE website (http://www.cdc.gov/nchstp/tb/de fault.htm) contains a wealth of information on the prevention and control of TB. The website includes an on-line ordering system (https://www2.cdc.gov/nchstp_od/PIWeb/ TBorderform.asp) from which users can view, order, and download free of charge a variety of educational materials and current guidelines. Materials can also be ordered from a touch tone phone by calling (888) 232-3228, then press options 2, 5, 1, 2 (Note: You may select these options at any time without listening to the complete message). SATFs may find the following items especially useful:

-- Health Care Provider Educational Materials

-- Interactive Core Curriculum on Tuberculosis, 4th Edition(CD ROM) – 2004 (Order # 99-8049) training guide on clinical & public health aspects of TB control

-- TB Information CD ROM – Version 4.1, 12/04 (99- 6879)

-- TB materials, major TB guidelines, MMWRs, surveillance reports, and slide set

-- TB Facts for Health Care Workers – 1997 (99-5497)

14-page booklet for clinicians on diagnosis, treatment, and prevention of TB

-- Think TB!

Wall poster listing the symptoms of active TB.

-- In English – 1992 (00-6186)

-- In Spanish – 1993 (00-6406)

-- Mantoux Tuberculin Skin Testing

Visual aids and tools pertaining to the Mantoux test

-- Rulers – 2002 (99-7047)

-- Wall Chart – 2004 (New) (005564)

-- Videotape Training Kit – 2003 (00-5457)

-- Health Care Provider Guidelines

-- Targeted Tuberculin Testing and Treatment of Latent TB Infection. MMWR, April 2000 (99-6422)

-- Treatment of Tuberculosis, MMWR, June 20, 2003, (99-7490)

-- Prevention and Treatment of Tuberculosis Among Patients Infected with Human Immunodeficiency Virus: Principles of Therapy and Revised Recommendations. MMWR, October 30, 1998. (99-5879)

-- Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005 MMWR Vol.54 (No.RR-17).

-- Patient Education Materials

-- Tuberculosis - Get the Facts! – 1990: One-page pamphlet on basic facts about TB transmission, infection, and the tuberculin skin test

-- In English (00-5743)

-- In Spanish (00-5772)

-- Tuberculosis - The Connection Between TB and HIV (the AIDS Virus)–1990 One-page pamphlet on the risk of HIV-related TB, tuberculin skin testing, and preventive therapy (treatment of LTBI)

-- In English (00-5738)

-- In Spanish (00-5745)

-- Tuberculosis Fact Sheets (tear-off pads, 40 tear-off sheets per pad) - 1997

-- TB Facts - You Can Prevent TB (00-5981)

-- TB Facts - TB and HIV (The AIDS Virus) (00-5982)

-- TB Facts - Exposure to TB (00-5983)

-- TB Facts - The TB Skin Test (00-5984)

-- TB Facts - TB Can Be Cured (00-5985)

-- Stop TB! - 1994

-- Wall poster describing the transmission and pathogenesis of TB (00-6474)

-- Pad of 50 tear-off sheets duplicating the Stop TB! wall poster (00-6475)

-- Treatment of Latent Tuberculosis Infection (LTBI) Card and Poster Provides summary information on drug regimens, monitoring, and candidates for treatment of LTBI. Available in two formats:

-- Pocket Reference Card (5.5” X 4.25”)

-- Clinic Poster (13” X 19.5”)

These can be ordered free of charge from the Charles P. Felton National TB Center at Harlem Hospital website (http:// www.harlemtbcenter.org/products.htm) or by fax (212-939- 8259).