



Department of Health

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February 17, 2021

DAL: DHCBS 21-03
**Subject: Frequently Asked Questions
Regarding Annual TB Testing**

Dear Administrator:

This guidance is intended for Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), AIDS home care programs, Hospices and Licensed Home Care Services Agencies (LHCSAs). This guidance provides direction for interpreting and implementing the new regulations described in DHCBS DAL 20-14, “Annual TB Testing,” and reminds providers that policies and procedures must be updated, TB annual assessments must be in place for current personnel when their annual health assessments become due, and staff education regarding TB is required.

On December 16, 2020, the Department adopted regulatory changes to 10 NYCRR 763.13, 766.11, and 794.3 (among other regulatory sections) and issued DAL DHCBS 20-14, “Annual TB Testing,” announcing the changes in requirements for pre-employment tuberculosis (TB) testing and annual TB assessments of healthcare personnel in a variety of healthcare settings. The DAL outlined the updates to the requirements for pre-employment TB testing and annual TB assessment and advised that current, active employees are no longer required to have an annual TST or interferon-gamma release assay (IGRA) blood test, unless medically indicated, but must be screened by a Registered Nurse (RN) annually through an individual risk assessment.

The Division of Home and Community Based Services (DHCBS) has received numerous questions from home care and hospice providers regarding the new guidance. The attached “Frequently Asked Questions” (FAQs) addresses the questions DHCBS has received to date.

Providers are advised to carefully read through the FAQs and review the DHCBS 20-14 DAL prior to updating agency policies and procedures to ensure compliance with the baseline and annual TB assessments required. The regulatory amendments and related guidance became effective on December 16, 2020, and healthcare providers are expected to implement these regulatory changes as soon as it is practicable, and to have TB annual assessments in place for current personnel as annual health assessments become due based on the personnel’s date of hire.

Please note, however, that agencies must not unduly delay the creation of new policies and procedures to comply with the December 16, 2020 regulatory changes. Any unreasonable delays with coming into compliance will be reviewed by DHCBS and cited, if appropriate.

Questions related to TB testing should be directed to tbcontrol@health.ny.gov; other questions should be addressed to homecare@health.ny.gov.

Sincerely,

A handwritten signature in black ink that reads "Carol A. Rodat". The signature is written in a cursive style with a horizontal line at the end.

Carol A. Rodat
Director
Division of Home and Community Based Services

Tuberculosis Risk Assessment Frequently Asked Questions (FAQs)

Q.1. Please explain what an individual TB risk assessment must include.

A.1. A simplified, general risk checklist assessment for TB includes:

- 1) History of temporary or permanent residence (for >1 month) in a country with a high TB rate (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe);
- 2) Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15mg/day for >1 month) or other immunosuppressive medication;
- 3) Close contact with someone who has had TB disease;
- 4) Whether the individual has been treated for latent TB infection;
- 5) Symptom screening:
 - Productive cough for more than 3 weeks;
 - Coughing up blood;
 - Unexplained weight loss;
 - Fever, chills, or drenching night sweats for no known reason;
 - Persistent shortness of breath;
 - Unexplained fatigue for more than 3 weeks;
 - Chest pain.
- 6) Question as to prior diagnosis of active TB or latent TB infection or a positive skin test or positive blood test for TB; and
- 7) Question as to whether the individual has been treated with medication for TB or for a positive TB test.

Remember that DHCBS DAL 20-09 and amended regulations at 10 NYCRR 763.13, 766.11, and 794.3 require an annual TB risk assessment and education. A risk assessment is the primary screening tool, with follow-up TB tests when indicated.

Q.2. Does the TB risk assessment replace the TST?

A.2. Not necessarily. Even if there is no increased risk of TB, baseline testing with an IGRA or a two-step TST is indicated unless there's documentation of prior Latent TB Infection (LTBI) or TB disease.

Q.3. When is this change effective?

A.3. December 16, 2020. Policies should be developed to implement the changes as soon as feasible for the revised annual assessments as they become due.

Q.4. Please clarify that current active employees no longer are required to have an annual PPD skin test and/or quantiferon and are only required to fill out an annual PPD screening questionnaire reviewed by the RN?

A.4. Yes, such individual screening will satisfy the new regulatory requirements; in addition, staff must receive education regarding TB and follow-up tests, if medically indicated based on the screening.

Q.5. New hires will continue to follow compliance by receiving PPD testing as this regulation is changed, is this accurate?

A.5. Yes, until new policies and procedures are implemented in the workplace, compliance with previous procedures is acceptable. However, agencies must not unduly delay the creation of new policies and procedures to comply with the December 16, 2020 regulatory changes; any unreasonable delays with coming into compliance will be reviewed and cited, if appropriate.

Q.6. Can the TB risk assessment and evaluation of symptoms be incorporated into the Employee Physical Examination Report which is done for the annual health assessment or should it be completed on a separate form?

A.6. The TB risk assessment and evaluation can be incorporated into the annual health assessment; however, providers who choose not to incorporate the TB risk assessment into the annual health assessment will need to ensure that it is documented and maintained in the employee file.

Q.7. Were home care and hospice providers required to complete the TB risk assessment and evaluation by December 31, 2020? If not, when will the assessment and evaluation be required?

A.7. Annual TB screening begins one year after the employee was hired.

Q.8. If a separate TB screening is required, what are the credentials required of the health care provider to conduct the questionnaire and examination? Can an RN with an associate degree perform the examination or does it need to be a RN with a BSN? Can a PA and NP complete the questionnaire

and examination?

A.8. A licensed practitioner can complete the questionnaire and examination, including an MD, RN, PA and NP.

Q.9. Unless the RN feels there is reason for further follow up by a physician, would the assessment suffice for compliance with annual TB screening?

A.9. Yes, in addition to staff education regarding TB.

Q.10. Can the TB risk assessment questions be answered by the caregiver themselves on the application?

A.10. No, the TB screen and evaluation should be done by a licensed practitioner and should not be part of the job application.

Q.11. A large percentage of our caregivers originate from outside the U.S. Haiti and would that mean that they need to do an annual TST or IGRA test since they originate from a country with a high TB rate?

A.11. The provider needs to assess the amount of time spent in the high-risk country at baseline and as part of annual risk assessment. The provider will need a baseline IGRA or two-step TST for these employees.

Q.12. If a caregiver responds “yes” to “history of temporary or permanent residence in a country with high TB rate”, will this caregiver need an IGRA or TST?

A.12. Yes.

Q.13. Please confirm that an annual TB test is not required for home care and hospice staff for 2020.

A.13. TB tests are required for **new** personnel hired in 2020, as well as any staff whose individual risk assessment for TB indicates a follow-up TB test is medically indicated.

Q.14. Can the TST be done anytime within the previous 12 months prior to hire?

A.14. Yes, a TST done within the last twelve months of hire would be considered the

first test of the two-step process, the second step being the repeat test.

Q.15. Must a TB risk assessment be completed for all home care and hospice staff for 2020 since this change was effective on 12/16/20?

A.15. As the guidance for TB risk assessment was not available before December 16, 2020, providers are not required to have completed the risk assessment by December 31, 2020; however, providers should make every attempt to complete the assessment as soon as practicable.

DHCBS DAL 20-11 requires the annual health assessment and TB test to be completed by December 31, 2020. The TB risk assessment guidance in DHCBS DAL 20-14 replace the prior legal requirement for an annual TB test for all staff. As the new regulations went into effect December 16, 2020, providers are advised to complete the risk assessment and education as soon as possible to comply with the amended regulations; any unreasonable delays with coming into compliance with the amended regulations will be reviewed by the Department and cited, if appropriate.

Q.16. Please confirm that a TB risk assessment can be done remotely by a nurse.

A.16. The TB risk assessment can be done remotely at this time by personnel described above.

Q.17. Please clarify whether the change from an annual TB test to an annual TB risk assessment applies to CDPAP personal assistants.

A.17. This guidance applies to Personal Assistants but remains subject to the suspensions of any annual health screening requirements, which we have not yet reinstated.

Q.18. What type of TB education is acceptable for our workforce and will the education be required as a component of the in-service?

A.18. The education should include information on TB risk factors, the signs and symptoms of TB disease, TB infection control policies and procedures, and regimen options for LTBI treatment. If the in-services for the past or current year have not been provided, TB education can be delivered as a component of in-service training requirement.

Q.19. Can you clarify the meaning of the following sentence in the TB DAL, DHCBS DAL 20-14: “Even if there is no increased risk for TB, baseline testing with IGRA blood test or TST is indicated unless there is documentation of prior latent TB infection or TB disease?”

A.19. If the TST is used, two-step testing should be done for newly hired employees who have an initial TST result that is negative. The second test can be administered 1-3 weeks after the initial test. A second TST is not needed if an employee has had a documented negative TST during the previous 12 months. All TSTs must be done by trained staff, with documentation of the manufacturer, lot number, date placed, date read and names of persons placing, reading, and interpreting the test. Employees should not read or interpret their own TST results.

A single IGRA blood test (Quantiferon-TB or TSpot.TB) is also acceptable in place of the two-step TST. If there is a history of TB infection or TB disease, a TB test should not be done. If documentation of TB or LTIB treatment cannot be produced, the employee should have further evaluation by a provider.

Q.20. How do we handle employees with a positive IGRA/TST?

A.20. The employee should receive a TB medical evaluation including a chest x-ray and other tests as indicated. You will need documentation of a chest x-ray in the employee’s file. Documentation of treatment for LTBI or TB disease should also be in the file.

Q.21. How should providers handle caregivers with LTBI?

A.21. A person with latent TB is not infectious. If the person has a new positive TB test (either IGRA or TST) A chest x-ray should be done as close to the date of the positive test as possible.

Q.22. The TB DAL, DHCBS 20-14, refers to “date placed”; what does this mean?

A.22. The date the skin test was administered. If an IGRA is done, this would be the date of the blood test.

Q.23. On the CDC website it states that chest radiographs do not expire. Is this correct?

A.23. Yes, only one chest x-ray is needed. Chest X-rays are only repeated if clinically indicated.

Q.24. Is there a TB screening assessment form DOH can provide for Home Care Agencies to use universally for their employees?

A.24. NYS DOH is not requiring a specific form. DHCBS DAL 20-14 references the occupational health implementation guidance that provides helpful examples, including:

- Appendix 3. Integrated Tuberculosis (TB) Screening and Risk Assessment Form for Newly Hired HCP.
- Appendix 6. Educational Supplement on Tuberculosis (TB) infection.
- Appendix 7. Annual Tuberculosis Symptom Screen –(for persons with documented TB infection.)

These examples can be found at:

https://journals.lww.com/joem/Fulltext/2020/07000/Tuberculosis_Screening_Testing_and_Treatment_of.22.aspx

Q.25. Is there guidance for healthcare personnel regarding the COVID-19 vaccine and TB testing?

A.25. Yes, a CDC letter dated January 7, 2021, outlines that for healthcare personnel who require baseline TB testing (at onboarding or entry into facilities) at the same time they are to receive a COVID-19 mRNA vaccine, the CDC recommends:

- Perform TB symptom screening on all healthcare personnel;
- If using IGRA, draw blood prior to COVID-19 mRNA vaccination;
- If using TST, place prior to COVID-19 mRNA vaccination;
- If COVID-19 mRNA vaccination has already occurred, defer TST or IGRA until 4 weeks after completion of second dose of COVID-19 mRNA vaccination.

For healthcare personnel who require testing for other reasons, the CDC recommends:

- Perform TB symptom screening on all healthcare personnel;
- Test for TB infection before or during the same visit as COVID-19 mRNA vaccination. If this is not possible, prioritization of testing for TB infection needs to be weighed with the importance of receiving COVID-19 mRNA vaccination based on potential COVID-19 exposures and TB risk factors.
 - Healthcare personnel with high-risk conditions for TB progression should be fully evaluated as soon as possible;
 - Healthcare personnel without high-risk conditions for TB progression should proceed with contact tracing (symptom screening, chest

radiograph or other imaging, specimen for microbiologic evaluation) but delay being tested for TB infection (with either TST or IGRA) if prioritized for receiving COVID-19 mRNA vaccination.

All potential recipients of COVID-19 mRNA vaccination should weigh the risks and benefits of delaying TST/IGRA with their healthcare providers. Further information can be found at Interim “Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States” at:

<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html> , and “Understanding mRNA COVID-19 Vaccines” at: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html>

Q.26. Where do I send additional questions regarding TB testing?

A.26. TB testing questions should be directed to the NYS DOH Bureau of Tuberculosis Control at tbcontrol@health.ny.gov. Questions about employee or client screening should be directed to the OPCHSM unit which oversees the particular health setting.