TB Nurse Certification Course

TB Testing
Requirements for Licensed Facilities

Bureau of Community & Health Systems (BCHS)

Presenters

Teri Dyke, RN, MSN, CIC
Tom Bissonnette, MS, RN

Regulatory Oversight

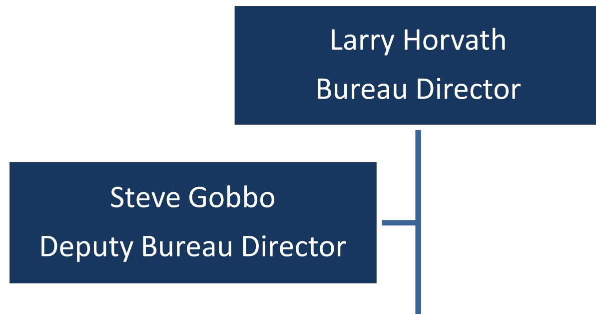
Bureau of Community & Health Systems (BCHS) Provides State Licensing of:

- State Licensing
  - Health Facilities & Agencies (including Homes for the Aged)
  - Substance Use Disorder Programs
  - Child Care Homes & Centers
  - Adult Foster Care Homes

BCHS Also Provides:

- Federal Certification of Providers and Suppliers on Behalf of the Centers for Medicare and Medicaid Services (CMS)
- Life Safety Code Inspection of Long Term Care Facilities
- Plan Review/Construction Permits for State Licensed Health Facilities
- Workforce Background Checks
- Nurse Aide Training Program Review
- Certified Nurse Aide (CNA) Registry

BCHS Organizational Overview



Mark Jansen, Director
Child Care Licensing Division

State Licensed
- Child Care Group Homes/Centers

Jay Calewarts, Director
Adult Foster Care & Camps Division

State Licensed
- Adult Foster Care Homes
- Adult Foster Care/Child Camps
- Homes for the Aged
- Complaint Intake (AFC, HFA, Child Care, Camps)
- Application Processing (AFC, HFA, Child Care, Camps)

Teri Dyke, Director
Health Facility Licensing, Permits, and Support Division

State Licensed
- Freestanding Surgical Outpatient Facilities
- Hospice Agencies & Residences
- Hospitals
- Nursing Homes
- Substance Use Disorder Programs

Other Functions
- Complaint Intake (Health)
- Construction Permits
- Fire Safety (LTC)
- Nurse Aide Training Program
- Nurse Aide Registry
- FOIA
- Workforce Background Checks
- Enforcement/Compliance

Michelle Roepke, Director
Federal Survey & Certification Division

Federal Certification
- Ambulatory Surgical Centers
- Clinical Laboratory Services
- Comprehensive Outpatient Rehabilitation Facilities
- Dialysis Centers
- Home Health Agencies
- Hospice Agencies & Residences
- Hospitals
- Nursing Homes
- Outpatient Physical Therapy (OPT)/Speech Pathology Providers
- Portable X-Ray Suppliers
- Rural Health Clinics

Michigan Covered Providers

(As of December 29, 2015)

No. of Providers	Type
9,876	Child Care Homes & Centers
8,445	Clinical Laboratory Services (CLIA)
4,248	Adult Foster Care Homes
1,300	Substance Use Disorder Programs
1,061	Adult Foster Care/Child Care Camps
616	Home Health Agencies
460	Nursing Homes/LTC Facilities
234	Homes for the Aged
196	Dialysis Centers (ESRD)
169	Hospitals
168	Rural Health Clinics
160	Outpatient Physical Therapy (OPT)/Speech Pathology
141	Hospice Agencies
136	Freestanding Surgical Outpatient Facilities/ASC
58	Inpatient Psychiatric Hospitals/Units
18	Hospice Residences
9	Organ Transplant Facilities
9	Portable X-Ray Providers
5	Community Mental Health Centers
4	Comprehensive Outpatient Rehab Facilities (CORF)

** Some federal oversight for organ procurement organizations (1) and federally qualified health centers (215).*

BCHS State/Federal Oversight by Covered Providers

State	Federal	Type
YES	NO	Adult Foster Care Homes
YES	NO	Adult Foster Care/Child Care Camps
YES	NO	Child Care Centers
YES	NO	Homes for the Aged
YES	NO	Substance Use Disorder Programs
YES	YES	Freestanding Surgical Outpatient Facilities/ASC
YES	YES	Hospice Agencies
YES	YES	Hospice Residences
YES	YES	Hospitals
YES	YES	Inpatient Psychiatric Hospitals/Units
YES	YES	Nursing Homes/LTC Facilities
NO	YES	Clinical Laboratory Services (CLIA)
NO	YES	Community Mental Health Centers
NO	YES	Comprehensive Outpatient Rehab Facilities (CORF)
NO	YES	Dialysis Centers (ESRD)
NO	YES	Home Health Agencies
NO	YES	Organ Transplant Facilities
NO	YES	Outpatient Physical Therapy (OPT)/Speech Pathology
NO	YES	Portable X-Ray Providers
NO	YES	Rural Health Clinics (RHC)

General Overview

State Licensure

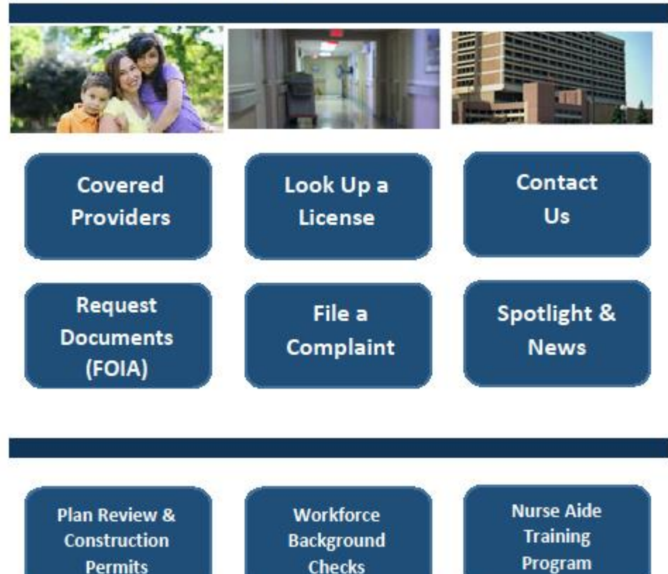
- Initial licensure
- Routine surveys/inspections
- Complaints
- Relicense
- Enforcement

Federal Certification

- Initial certification
- Routine recertification surveys
- Complaints
- Recertification
- Enforcement

Web Change

www.michigan.gov/bchs



Proposed Administrative Code - TB

- Long-Term Care
- MI Administrative Code
  - R 324.20402
  - R 325.20506
  - R 325.20602
  - R 325.21102
  - R 325.21105
- Hospice

R 324.20402

- Health of employees and other care providers
  - Eliminated requirement for annual TB skin testing
  - Included the need for baseline screening for communicable diseases/immunizations
- Facility adopts and implements educational program to ensure that care providers are aware of and practicing acceptable infection control measures

R 325.20506

- TB Testing
  - excluded routine annual skin test and requirement for chest x-ray on admission for residents
- Develop a communicable disease policy governing the assessment and baseline screening of employees and patients
- Use of TB risk assessment to drive testing frequency

R 325.20602

- Medical Examination of Patients
  - Excluded the requirement for a routine chest x-ray

R 325.21102

- Patient Clinical records
  - Eliminated the requirement for a chest x-ray to be in the record within 90 days of admission for each patient (unless indicated by H & P)

R 325.21105

- Employee records
  - Eliminated the requirement for baseline chest x-rays and skin tests for each employee
  - Included the need for baseline screening for communicable diseases for all staff

TB Risk Assessment - Steps

- One each for different locations
- Identify data sources for county, state and country statistics
- Identify data sources for suspect or confirmed TB cases
- The need for and frequency of screening for TB will be driven by the facility’s TB risk assessment

CDC Guidelines for Control of TB

Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005

Please note: *This report has been corrected and replaces the electronic PDF version that was published on December 30, 2005.*

Recommendations and Reports
December 30, 2005 / 54(RR17);1-141

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Summary

In 1994, CDC published the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities, 1994. The guidelines were issued in response to 1) a resurgence of tuberculosis (TB) disease that occurred in the United States in the mid-1980s and early 1990s, 2) the documentation of several high-profile health-care–associated (previously termed "nosocomial") outbreaks related to an increase in the prevalence of TB disease and human immunodeficiency virus (HIV) coinfection, 3) lapses in infection-control practices, 4) delays in the diagnosis and treatment of persons with infectious TB disease, and 5) the appearance and transmission of multidrug-resistant (MDR) TB strains. The 1994 guidelines, which followed statements issued in 1982 and 1990, presented recommendations for TB-infection control based on a risk assessment process that classified health-care facilities according to categories of TB risk, with a corresponding series of administrative, environmental, and respiratory-protection control measures.

TB Risk Assessment

09/27/2006

Centers for Disease Control and Prevention
Division of Tuberculosis Elimination

Appendix B. Tuberculosis (TB) risk assessment worksheet

This model worksheet should be considered for use in performing TB risk assessments for health-care facilities and nontraditional facility-based settings. Facilities with more than one type of setting will need to apply this table to each setting.

Scoring	**√ or Y = Yes**	**X or N = No**	**NA = Not Applicable**

1. Incidence of TB

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.	Community rate________ State rate ____________ National rate __________ Facility rate ___________ Department 1 rate ________ Department 2 rate ________ Department 3 rate ________
Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?	Yes No
If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Year No. patients Suspected Confirmed 1 year ago _____ _____ 2 years ago _____ _____ 5 years ago _____ _____
If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?	Yes No

Michigan Case Rate

- http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5281_46528_59091---,00.html

MDHHS / KEEPING MICHIGAN HEALTHY / COMMUNICABLE & CHRONIC DISEASES

Tuberculosis Epidemiology & Statistics

- Michigan TB Cases and Rates 2011-2015 (includes county data)
- 2013 Michigan Tuberculosis Epidemiologic Trends
- 2014 CDC TB Surveillance Report
- National TB Program Objectives and Performance Targets for 2020

TUBERCULOSIS CASES & RATES[†]
MICHIGAN 2011 - 2015

	Cases 2015	Case Rates 2015[a]	Cases 2014	Case Rates 2014[a]	Cases 2013	Case Rates 2013[b]	Cases 2012	Case Rates 2012[b]	Cases 2011	Case Rates 2011[b]
MICHIGAN	130	1.3	105	1.1	141	1.4	149	1.5	170	1.7
Alcona	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Alger	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Allegan	0	0.0	<5	**	0	0.0	0	0.0	0	0.0
Alpena	0	0.0	0	0.0	0	0.0	<5	**	0	0.0
Antrim	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Arenac	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Baraga	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Barry	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Bay	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Benzie	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Berrien	<5	**	<5	**	<5	**	<5	**	<5	**
Branch	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Calhoun	<5	**	<5	**	<5	**	<5	**	0	0.0
Cass	<5	**	0	0.0	0	0.0	0	0.0	0	0.0
Charlevoix	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Cheboygan	0	0.0	0	0.0	<5	**	0	0.0	0	0.0
Chippewa	<5	**	0	0.0	0	0.0	0	0.0	0	0.0
Clare	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Clinton	0	0.0	0	0.0	0	0.0	0	0.0	<5	**
Crawford	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Delta	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Dickinson	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Eaton	<5	**	0	0.0	<5	**	<5	**	<5	**

http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5281_46528_59091---,00.html

Marquette	<5	**	0	0.0	0	0.0	0	0.0	0	0.0
Mason	0	0.0	0	0.0	<5	**	0	0.0	0	0.0
Mecosta	<5	**	0	0.0	0	0.0	0	0.0	0	0.0
Menominee	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Midland	0	0.0	0	0.0	0	0.0	<5	**	0	0.0
Missaukee	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Monroe	<5	**	<5	**	0	0.0	<5	**	0	0.0
Montcalm	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Montmorency	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Muskegon	0	0.0	<5	**	<5	**	<5	**	<5	**
Newaygo	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Oakland	17	1.4	17	1.4	26	2.2	22	1.8	22	1.8
Oceana	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ogemaw	0	0.0	<5	**	<5	**	0	0.0	0	0.0
Ontonagon	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Osceola	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Oscoda	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Otsego	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Ottawa	<5	**	<5	**	<5	**	<5	**	<5	**
Presque Isle	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Roscommon	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Saginaw	<5	**	0	0.0	<5	**	<5	**	<5	**
St. Clair	0	0.0	0	0.0	0	0.0	<5	**	0	0.0
St. Joseph	<5	**	0	0.0	0	0.0	0	0.0	<5	**
Sanilac	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Schoolcraft	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Shiawassee	<5	**	0	0.0	0	0.0	0	0.0	0	0.0
Tuscola	0	0.0	0	0.0	0	0.0	<5	**	<5	**
Van Buren	<5	**	<5	**	<5	**	0	0.0	<5	**
Washtenaw	6	1.7	7	2.0	<5	**	6	1.7	8	2.3
Wayne	43	2.4	41	2.3	69	3.8	61	3.4	77	4.2

National Statistics

- http://www.cdc.gov/tb/statistics/default.htm

Morbidity and Mortality Weekly Report (*MMWR*)

CDC > MMWR

Leveling of Tuberculosis Incidence — United States, 2013–2015

Weekly / March 25, 2016 / 65(11);273–278

Jorge L. Salinas, MD[1,2]; Godwin Mindra, MBChB[1,2]; Maryam B. Haddad, MSN[2]; Robert Pratt[2]; Sandy F. Price[2]; Adam J. Langer, DVM[2] (View author affiliations)

View suggested citation

After 2 decades of progress toward tuberculosis (TB) elimination with annual decreases of ≥0.2 cases per 100,000 persons (*1*), TB incidence in the United States remained approximately 3.0 cases per 100,000 persons during 2013–2015. Preliminary data reported to the National Tuberculosis Surveillance System indicate that TB incidence among foreign-born persons in the United States (15.1 cases per 100,000) has remained approximately 13 times the incidence among U.S.-born persons (1.2 cases per 100,000). Resuming progress toward TB elimination in the United States will require intensification of efforts both in the United States and globally, including increasing U.S. efforts to detect and treat latent TB infection, strengthening systems to interrupt TB transmission in the United States and globally, accelerating reductions in TB globally, particularly in the countries of origin for most U.S. cases.

TB Risk Assessment Cont.

2. Risk Classification

Inpatient settings	
How many inpatient beds are in your inpatient setting?	
How many patients with TB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year ______ 5 years ago ______
Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.)	o Low risk o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Outpatient settings	
How many TB patients are evaluated at your outpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year ______ 5 years ago ______
Is your health-care setting a TB clinic? (If yes, a classification of at least medium risk is recommended.)	Yes No
Does evidence exist that a high incidence of TB disease has been observed in the community that the health-care setting serves?	Yes No
Does evidence exist of person-to-person transmission of *M. tuberculosis* in the health-care setting? (Use information from case reports. Determine if any tuberculin skin test [TST] or blood assay for *M. tuberculosis* [BAMT] conversions have occurred among health-care workers [HCWs]).	Yes No
Does evidence exist that ongoing or unresolved health-care–associated	Yes No

transmission has occurred in the health-care setting (based on case reports)?	
Is there a high incidence of immunocompromised patients or HCWs in the health-care setting?	Yes No
Have patients with drug-resistant TB disease been encountered in your health-care setting within the previous 5 years?	Yes No Year ________
When was the first time a risk classification was done for your health-care setting?	__________________
Considering the items above, would your health-care setting need a higher risk classification?	Yes No
Depending on the number of TB patients evaluated in 1 year, what is the risk classification for your outpatient setting? (See Appendix C)	o Low risk o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	Yes No
Nontraditional facility-based settings	

Appendix C Risk Classification

Appendix C. Risk classifications for various health-care settings and recommended frequency of screening for Mycobacterium tuberculosis infection among health-care workers (HCWs)*

Setting	Risk classification[†]: Low risk	Risk classification[†]: Medium risk	Risk classification[†]: Potential ongoing transmission[§]
Inpatient <200 beds	<3 TB patients/year	≥3 TB patients/year	Evidence of ongoing *M. tuberculosis* transmission, regardless of setting
Inpatient ≥200 beds	<6 TB patients/year	≥6 TB patients/year	
Outpatient; and nontraditional facility-based	<3 TB patients/year	≥3 TB patients/year	
TB treatment facilities	Settings in which • persons who will be treated have been demonstrated to have latent TB infection (LTBI) and not TB disease • a system is in place to promptly detect and triage persons who have signs or symptoms of TB disease to a setting in which persons with TB disease are treated • no cough-inducing or aerosol-generating procedures are performed	Settings in which • persons with TB disease are encountered • criteria for low risk are not otherwise met	
Laboratories	Laboratories in which clinical specimens that might contain *M. tuberculosis* are not manipulated	Laboratories in which clinical specimens that might contain *M. tuberculosis* might be manipulated	
Recommendations for Screening Frequency			
Baseline two-step TST or one BAMT[¶]	Yes, for all HCWs upon hire	Yes, for all HCWs upon hire	Yes, for all HCWs upon hire
Serial TST or BAMT screening of HCWs	No[**]	At least every 12 months[††]	As needed in the investigation of potential ongoing transmission[§§]
TST or BAMT for HCWs upon unprotected exposure to *M. tuberculosis*	Perform a contact investigation (i.e., administer one TST or BAMT as soon as possible at the time of exposure, and, if the result is negative, give a second test [TST or BAMT, whichever was used for the first test] 8–10 weeks after the end of exposure to *M. tuberculosis*)[¶¶]		

* The term Health-care workers (HCWs) refers to all paid and unpaid persons working in health-care settings who have the potential for exposure to *M. tuberculosis* through air space shared with persons with TB disease.

Frequently Asked Questions

How often to screen employees and patients?

– Baseline, and then according to the facility's TB risk assessment; Low, Medium and Ongoing transmission.

What to do if positive TB disease is identified ?

– Isolate the person in an airborne infection isolation room (AIIR), patient covers mouth and nose with a surgical mask, N-95 for staff, confirm it, identify the source, notify Local Health Department and initiate contact tracing/testing.

When to conduct TB risk assessments for your facility type?

– Annually, or when a cluster of conversions or an actual TB case is identified

Resources

- Guideline for Preventing Transmission of Mycobacterium Tuberculosis in Healthcare Setting http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e
- Prevention and control in Long-term care facilities http://www.cdc.gov/mmwr/preview/mmwrhtml/00001711.htm
- **TB Risk Assessment form Appendix B: http://www.cdc.gov/tb/publications/guidelines/AppendixB_092706.pdf
- TB Risk Assessment form Appendix C: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e#Appendixc

Resources continued

- State of Michigan Data and Statistics: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_5104_5281_46528_59091---,00.html
- National Statistics http://www.cdc.gov/tb/statistics/default.htm
- Local Hospital Infection Preventionist

Questions & Answers

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Lansing, MI 48909

Main Line: (517) 335-1980

www.michigan.gov/bchs

Thank you for your efforts to provide quality health care to Michigan residents!

Administrative Rules Revisions

Administrative Rules Process in a Nutshell

The process for creating, amending, and rescinding administrative rules is governed by the Administrative Procedures Act, PA 306 of 1969, MCL 24.201 to 24.328. (Note this is an overview and does not include all required provisions.) February 2015

Starting Out: Request for Rulemaking (RFR)	▲ A proposal for rulemaking can originate from professional boards or commissions, advisory committees, the department, or the public. ▲ The official Request for Rulemaking (RFR) must come from the department to the Office of Regulatory Reinvention (ORR) to begin. ▲ Within each department, the Regulatory Affairs Officer (RAO) works with staff to send an RFR to the ORR. The ORR approves or disapproves the RFR. If approved, the ORR notifies the Joint Committee on Rules (JCAR) of the approval.
Draft Rules: Prior to the Public Hearing	▲ Rules are drafted and approved by any necessary department, board or commission. The RAO submits the rules to the ORR to review for legal authority. ▲ The ORR approves the draft and notifies JCAR. The ORR sends the draft to the Legislative Service Bureau for editing according to format and style. ▲ The Legislative Service Bureau returns the edited draft to the ORR, and the ORR returns the draft to the department to add the new formatting edits.
Public Hearing & Public Comment	▲ A Regulatory Impact Statement & Cost-Benefit Analysis is prepared by the department and sent to ORR for approval 28 days prior to the public hearing. ▲ A public hearing notice, which includes the deadline for written comment, and the edited draft rules are sent by the RAO to ORR for approval. ▲ The notice is published in 3 newspapers including 1 in the UP, not less than 10 days but no more than 60 days prior to the hearing. ▲ The public hearing notice and edited draft rules are published in the *Michigan Register* by the ORR.
Post-Hearing Draft Rules	▲ Department RAO submits final draft of the rules and Joint Committee on Administrative Rules Report to ORR. ▲ ORR submits the final draft to the Legislative Service Bureau to certify the rules for form, classification, and arrangement. ▲ ORR legally certifies the rules and sends the JCAR Report, including the final draft of the rules, certifications, Regulatory Impact Statement, and RFR to JCAR.
Joint Committee on Administrative Rules (JCAR)	▲ The JCAR Report and rules must be submitted to JCAR within 1 year from the public hearing, or there must be a subsequent public hearing. ▲ The JCAR Report summarizes the purpose of the draft rules and any comments made at the public hearing or submitted in writing. ▲ The rules must be before JCAR for 15 session days. ▲ During those 15 days, JCAR may object to the rules, but then must pass legislation within another 15 session days to stop or delay the rules. ▲ JCAR may also waive the remaining of the required 15 session days. ▲ Rules can be filed by ORR with the Office of the Great Seal after 15 session days expire or JCAR has waived the 15 day requirement.
Department Adopts Rules ORR Files with Office of the Great Seal	▲ Department director, agency or commission (for type 1 agency) confirms the intent to adopt the rules by submitting a certificate of adoption to ORR. ▲ ORR enters the filing date at the top of the first page of the rules and sends an electronic and hard copy to the Office of the Great Seal. ▲ The rules may become effective immediately upon filing, or at a later date specified in the rules – selected by the department. ▲ On the effective date, ORR amends the state administrative code to reflect the new language of the rules.