Since the early 1990s, the rates of tuberculosis (TB) in the United States have declined. In addition, a systematic review conducted by the Centers for Disease Control and Prevention (CDC) found a low percentage of healthcare workers with a positive TB test at baseline and during serial testing. For these reasons, the CDC updated its recommendations for TB screening, testing, treatment, and education of all paid and unpaid persons who have the potential for exposure to M. tuberculosis. Home care and hospice agencies need to implement the updated CDC guidelines by conducting an individual TB risk assessment and TB symptom evaluation, perform testing for TB for staff with no documented evidence of prior latent tuberculosis infection (LTBI) or TB disease, encourage treatment for staff with LTBI, and provide TB education (Sosa et al., 2019).

An individual TB risk assessment needs to be conducted on hire for all staff to determine if the staff member is at increased risk for TB. The results of the individual TB risk assessment may be useful when interpreting positive TB test results. To conduct the individual TB risk assessment, require each staff member to minimally answer all three questions listed in Figure 1 and document their responses (Sosa et al., 2019). If the staff member answers “yes” to one or more of the individual risk assessment questions, they may still provide patient care if their TB symptom evaluation and baseline TB test results were both negative (McGoldrick, 2019).

A TB symptom evaluation needs to be conducted on hire (and prior to patient contact) for all staff to determine if the staff member has signs and symptoms compatible with TB disease. Symptoms of TB disease in the lung, pleura, airways, or larynx include coughing for ≥3 weeks, loss of appetite, unexplained weight loss, night sweats, bloody sputum or hemoptysis, hoarseness, fever, fatigue, or chest pain (CDC, 2005). To conduct the TB symptom evaluation, require each staff member to self-identify and document if he/she has signs or symptoms of TB disease. If the staff member has unexplained answers of “yes” to one or more of the signs or symptoms of TB disease, do not schedule the staff to make home visits until he/she has received a medical evaluation by a physician knowledgeable and experienced in managing TB disease and the physician determines the staff member to be noninfectious (McGoldrick, 2019).

For staff who are TB test negative and TB symptom evaluation negative on hire, the TB symptom evaluation does not have to be repeated ongoing (e.g., annually), unless required by other authorities. For staff who are TB test positive, the TB symptom evaluation needs to be conducted annually to identify symptoms of active TB disease (Sosa et al., 2019).

Staff with no documented evidence of prior LTBI or TB disease need to have a TB test

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**Figure 1. Indicators of Risk for Tuberculosis (TB)**

Consider home care and hospice staff at increased risk for TB if they answer “yes” to any of the following statements.

1. 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); or
2. Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a tumor necrosis factor (TNF)-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication; or
3. Close contact with someone who has had infectious TB disease since the last TB test.

Source: Sosa et al. (2019)
conducted by either blood or two-step skin testing and the results documented. LTBI is infection with \textit{M. tuberculosis} with no signs or symptoms of TB and is not infectious. Refer to McGoldrick (2017) for additional information regarding methods of testing for TB. Refer to CDC (2005) for information on actions to take for staff with documented prior TB disease or LTBI. Additional medical follow-up and evaluation for TB disease will need to be conducted if a staff member has a new positive TB test result or has TB symptoms compatible with TB disease.

After the initial TB testing is conducted on hire (for staff who had a negative TB test and a negative TB symptom evaluation), routine, serial TB testing (e.g., annually) does not have to be conducted unless:

- There are state regulations requiring ongoing, routine TB testing (e.g., annually); or
- There is evidence of ongoing transmission of \textit{M. tuberculosis}; or
- There has been a known occupational exposure to TB where a staff member was exposed to a person with suspected or confirmed infectious TB disease (or to air containing \textit{M. tuberculosis}) for a sufficient amount of time to allow possible transmission of \textit{M. tuberculosis}, without the benefit of effective infection-control measures (CDC 2005; Sosa et al., 2019).

On an annual basis, staff should receive education about TB, including risk factors, signs, and symptoms of TB and the need to self-report any signs and symptoms to detect early evidence of TB disease.

The new guidelines in the updated CDC recommendations for conducting an individual TB risk assessment; not recommending routine serial screening and testing for staff without LTBI; encouraging treatment for all staff with untreated LTBI, unless medically contraindicated, and the new emphasis on educating all staff about TB exposure risks may further decrease the transmission of TB in healthcare settings, and will definitely streamline health screening activities. 

On an annual basis, staff should receive education about TB, including risk factors, signs, and symptoms of TB and the need to self-report any signs and symptoms to detect early evidence of TB disease.

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