Department of
Mental Health &
Substance Abuse Services

STATE OF TENNESSEE

Tuberculosis (TB) Training and Examination

10/08/2015

TB Training and Examination

Welcome to the Division of Substance Abuse Services TB Training and Examination. Prior to beginning the training, please review the:

- Tuberculosis Control Guidelines for Alcohol and Drug Abuse Prevention Programs; and/or
- Tuberculosis Control Guidelines for Alcohol and Drug Abuse Treatment Programs.

The training will go into detail about the Tuberculosis (TB) Symptom Screening Tool. Once you have completed the training, click on the link to begin the examination.

Thank you!

TB Control Guidelines for Alcohol and Drug Abuse Prevention Programs

The Purpose:

- To identify and prevent tuberculosis (TB) disease and latent TB infection (TBI) among employees and volunteers who are providing direct prevention services (e.g. Tennessee Prevention Network).
- To provide procedures on administration of the Symptom Screening Tool, testing and education for employees and volunteers.
- To provide the timelines for baseline screening on employees and volunteers.
- To give direction if the symptoms suggested active TB disease.

TB Control Guidelines for Alcohol and Drug Abuse Treatment Programs

The Purpose:

- To identify and prevent tuberculosis (TB) disease and latent TB infection (TBI) among employees, volunteers, and service recipients in alcohol and drug treatment programs.
- To provide procedures on administration of the Symptom Screening Tool, testing and education for employees, volunteers and service recipients.
- To provide the timelines for baseline screening on employees, volunteers, and service recipients.
- To indicate which treatment levels of care are required to be tested for TB.
- To give direction if the symptoms suggested active TB disease.
- To document that the guidelines and procedures for TB Services (e.g., screening, testing, counseling and referral for treatment) were developed as statutorily required.

TB Symptom Screening Tool

The Purpose:

- To determine the presence or absence of active TB disease or TB Infection (TBI) in employees and volunteers of alcohol and drug prevention and treatment programs and recipients of alcohol and drug treatment services;
- To provide baseline screening for symptoms of active TB disease and appropriate testing for TBI all new employees and new volunteers prior to employment or provision of volunteer services;
- To ensure that all employees and volunteers who provide direct care services are screened and counseled annually for symptoms of active TB disease and appropriately tested for TBI;
- To ensure that all alcohol and drug prospective service recipients are screened and counseled for symptoms suggestive of active TB disease prior to each admission for alcohol and drug services and appropriately referred for medical assessment; and
- To serve as documentation that TB Services (e.g., screening, testing, counseling and referral for treatment) was provided to new employees and volunteers; annually for employees and volunteers; and service recipients.

Who should be assessed with the TB Symptom Screening Tool?

- New employees
- New volunteers
- All service recipients at each admission to an alcohol and drug treatment program
- Employees and volunteers annually

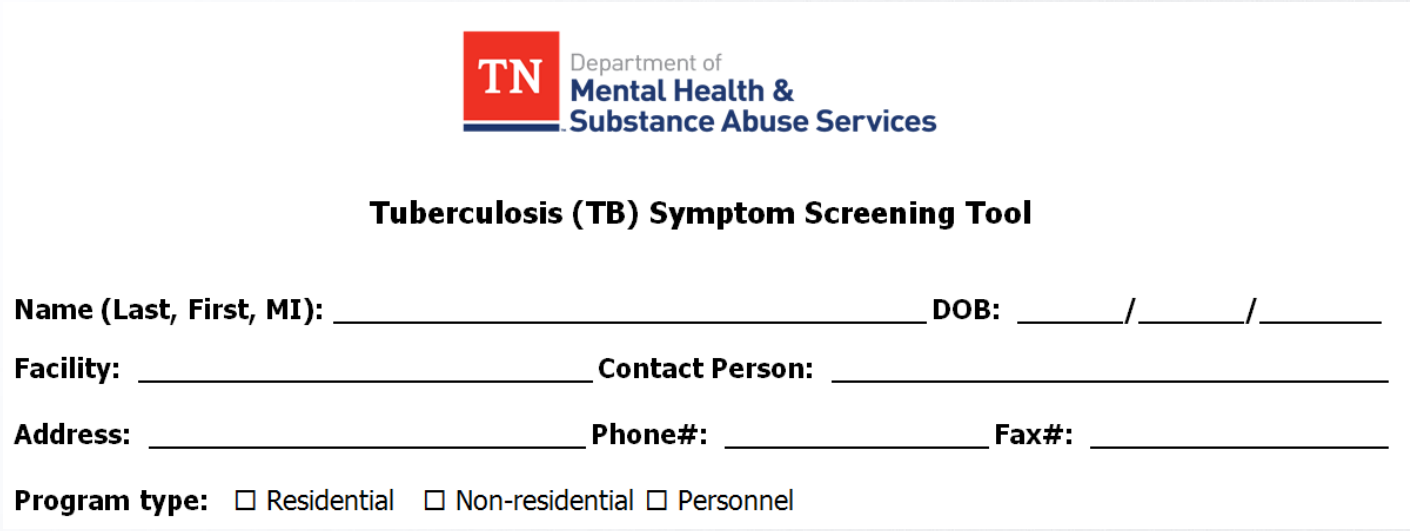
Who should complete the TB Symptom Screening Tool?

The TB Symptom Screening Tool should be completed by persons **TRAINED** to **Counsel** and **Screen** the individual concerning TB/TBI and related issues. ***The individual should NOT be asked or allowed to complete this form.***

TB Symptom Screening Tool Instructions

The TB Symptom Screening Tool is organized into three sections. It is very important that you ask the individual all the questions on the Tool and then fill out the disposition section for documentation. **Please complete all sections.**

If you using the electronic version of the tool, it was created utilizing the Microsoft Word Check Box Control feature. To enable a check box, double click the box you want to check. The Check Box Form Field Options box will open. Go to Default Value and click "Checked". Click Okay. If the box is not checked, go back to the Check Box Form Field Options box and look at the Field Settings to make sure that "Check box enabled" is marked.



Department of Mental Health & Substance Abuse Services

Tuberculosis (TB) Symptom Screening Tool

Name (Last, First, MI): _____ **DOB:** _____/_____/_____

Facility: _____ **Contact Person:** _____

Address: _____ **Phone#:** _____ **Fax#:** _____

Program type: ☐ Residential ☐ Non-residential ☐ Personnel

DEMOGRAPHICS:

1. **NAME:** Emphasize to each individual the importance of using the same name for all health visits. Assure confidentiality and remind the individual that their names are recorded for medical. records only;

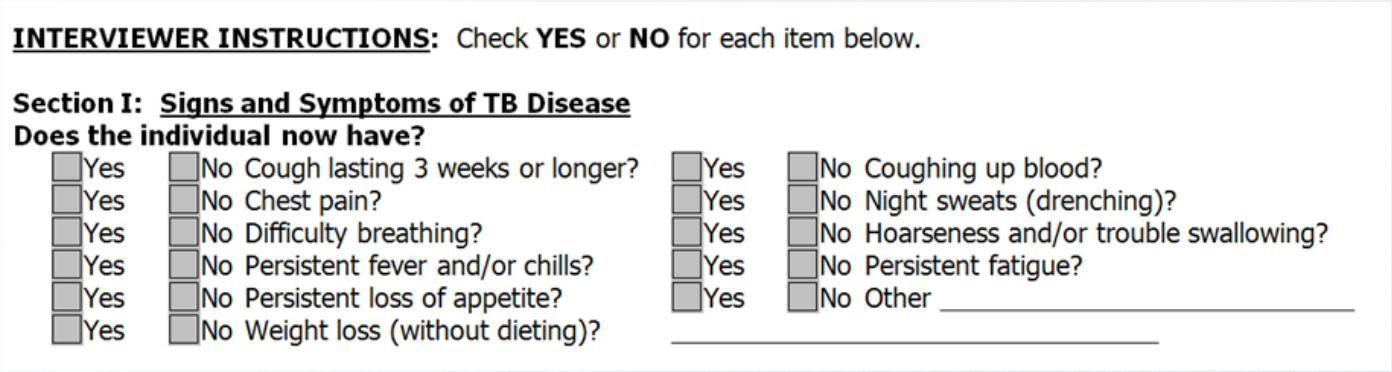
2. **DATE OF BIRTH:** Encourage individual to give- an accurate date. Be sure to capture the month, day and year the individual was born;

3. **FACILITY/ADDRESS:** The official name of the site and location;

4. **CONTACT PERSON/PHONE #/FAX #:** This should be the person who can answer questions regarding the information on the screening tool;

5. **PROGRAM TYPE:** Select the type of program that the individual is being admitted into for services. If the individual is an Employee or Volunteer, check Personnel.

Signs and Symptoms of TB Disease



INTERVIEWER INSTRUCTIONS: Check **YES** or **NO** for each item below.

Section I: Signs and Symptoms of TB Disease
Does the individual now have?

☐ Yes	☐ No	Cough lasting 3 weeks or longer?	☐ Yes	☐ No	Coughing up blood?
☐ Yes	☐ No	Chest pain?	☐ Yes	☐ No	Night sweats (drenching)?
☐ Yes	☐ No	Difficulty breathing?	☐ Yes	☐ No	Hoarseness and/or trouble swallowing?
☐ Yes	☐ No	Persistent fever and/or chills?	☐ Yes	☐ No	Persistent fatigue?
☐ Yes	☐ No	Persistent loss of appetite?	☐ Yes	☐ No	Other _____
☐ Yes	☐ No	Weight loss (without dieting)?	_____		

SECTION I:

Section I identifies individuals with active TB who should be immediately isolated and referred for further evaluation. If a person other than a doctor or nurse is performing the symptom screening, they must be trained to notify the doctor or nurse if any of these symptoms are present. It is then up to that medical provider to determine if the symptom is truly suggestive of TB or represents a minor complaint, such as a cold.

When completing Section I, *you will check **yes** or **no** to each* symptom *according to the individual's answer.* If the individual answers "**yes**" to any of the symptoms, the interviewer should obtain detailed and descriptive information regarding the symptom. Use open-ended questions in a conversation type discussion to gather the information.

Signs and Symptoms of TB Disease

Cough/Coughing Up Blood: Prolonged, productive cough that lasts 3 weeks or longer. It may be accompanied by thick, cloudy and sometimes bloody phlegm (thick mucus) also called hemoptysis (coughing up blood). This cough is usually worse in the morning.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. Tell me about the last time you remember having a cough?
2. How long have you had this cough?
3. When do you have this cough (morning, night, all day long, etc.)?
4. What type of cough is it…dry, hacking, nagging, croupy, productive;
5. What color is the phlegm that you produce?
6. Have you noticed blood or pink tinged sputum/phlegm?
7. Have you seen a doctor about this cough?

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Signs and Symptoms of TB Disease

Chest Pain: Pain with breathing or coughing, which may be sharp pain as in pleurisy; or dull ache.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. Describe this pain. Is it a sharp pain or dull, aching type of pain?
2. How long have you been having this pain?
3. How long does the pain last?
4. Does it mainly occur with breathing or coughing?
5. What makes the pain stop?
6. Have you seen a doctor about this pain?

Signs and Symptoms of TB Disease

Difficulty Breathing: Short of breath; unable to do activities of daily living, due to breathlessness. Symptoms of breathlessness are usually mild to begin with before gradually getting worse.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. When did this shortness of breath start?
2. How often are you short of breath?
3. Does anything trigger this shortness of breath?
4. Are you able to do your activities of daily living with this shortness of breath?
5. Have you seen a doctor about this shortness of breath?

Signs and Symptoms of TB Disease

Persistent Fever and/or Chills: Fever: temperature of 100.4°F or above, chills: shaking body type chills.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. What degree has your temperature been registering?
2. How long have you been running fevers?
3. Are your fevers also causing chills?
4. How many times per day are you having chills/fevers?
5. Have you seen a doctor about these fevers/chills?

Signs and Symptoms of TB Disease

Persistent Loss of Appetite: A decreased appetite, a reduced desire to eat, unable to tolerate the thought of food.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. How long have you had a loss of appetite? Is this something unusual for you?
2. Have you lost any weight? Are your clothes still fitting?
3. Have you seen a doctor about this?

Signs and Symptoms of TB Disease

Weight Loss (without dieting): Loss of body weight without dieting or exercising, not intending to lose weight. (Usually a gradual weight loss over several weeks or months)

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. How much weight have you lost;
2. Over what period of time have you lost this weight;
3. Are you eating routine meals and the usual amounts; and
4. Have you seen a doctor about this weight loss?

Signs and Symptoms of TB Disease

Night Sweats (drenching): Severe hot flashes which occur at night and result in a drenching sweat, that soak your nightclothes or bedding, even when your bedroom is not excessively hot.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. How long have you been having these night sweats?
2. Do you have these night sweats every night?
3. Do you have to change your nightclothes or sheets?
4. Is anyone else in the home having night sweats?
5. Do you have air conditioning?
6. What temperature is your home at night?
7. Have you seen a doctor about these night sweats?

Signs and Symptoms of TB Disease

Hoarseness and/or Trouble Swallowing: Refers to abnormal voice changes. Hoarseness may be manifested as a voice that sounds breathy, strained, raspy, or a voice that has higher or lower pitch. Difficulty swallowing may range from mild discomfort during swallowing, to inability to swallow due to complaints of pain or sore throat.

*Examples of open-ended discussion questions to ask if individual's response to this question is "**yes**":*

1. How long have you had hoarseness and when did it start?
2. Do you also have pain or a sore throat or difficulty swallowing?
3. Describe your difficulty swallowing. When did you first notice this?
4. How long have you had difficulty swallowing?
5. How long have you had a sore/painful throat? When did it start?
6. Have you seen a doctor about these symptoms?

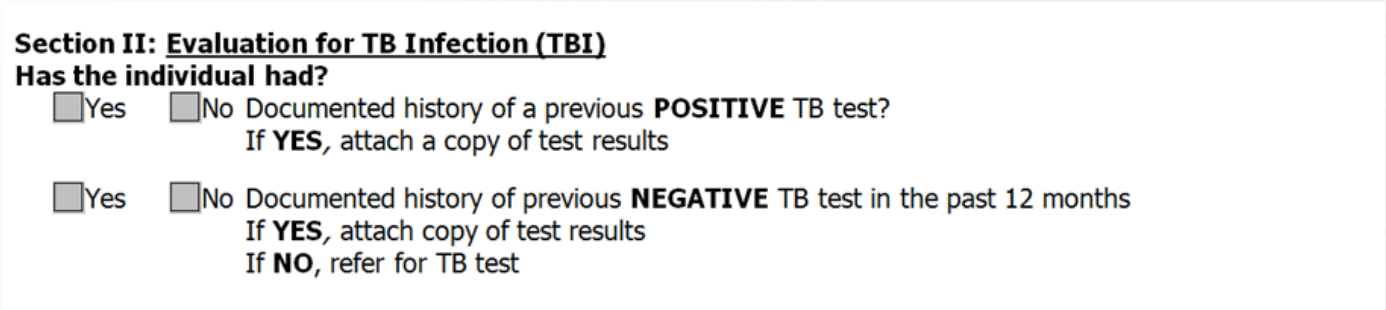
Signs and Symptoms of TB Disease

Persistent Fatigue: Characterized by a lessened capacity for work and reduced efficiency of accomplishment, weary or tired, difficulty performing activities of daily living

*Examples of open-ended discussion questions to ask if individual's response to this question is '**yes**":*

1. How long have you noticed being tired/weak?
2. When did this tiredness/weakness start?
3. Describe your day in relation-to work and activities of daily living?
4. Have you seen a doctor about this tiredness/weakness?

Evaluation for TB Infection (TBI)



Section II: Evaluation for TB Infection (TBI)
Has the individual had?

☐ Yes ☐ No Documented history of a previous **POSITIVE** TB test?
If **YES**, attach a copy of test results

☐ Yes ☐ No Documented history of previous **NEGATIVE** TB test in the past 12 months
If **YES**, attach copy of test results
If **NO**, refer for TB test

Section II:

Section II determines if the individual has documentation of a previous positive TB test or has been evaluated for TBI within the past 12 months with documentation of a negative TB test.

- There is no benefit in retesting individuals who have already been treated for TB or TBI. In general, individuals with documented positive test results, in millimeters, do not need to be retested.
- Retesting can safely be performed in most individuals for whom the test results are questionable if further evaluation for TB disease or possible TBI treatment is being considered.
- Questionable results include a history of a positive test without documented results, in millimeters, or when there is suspicion of improper testing technique or measurement.
- There is no contraindication to repeating the test for individuals with a prior positive result unless *a* significant adverse reaction to the test has previously occurred.

Evaluation for TB Infection (TBI)

The individual must provide written documentation of a past positive TB test with measurements recorded in millimeters or a negative TB test with measurements recorded in millimeters within the past 12 months.

1. Check **"yes"** if the individual has brought documentation of a previous positive TB test, recorded in millimeters. Attach a copy of test results to the screening tool.
2. Check **"no"** if the individual does not have a history of a previous positive TB in test or if he did not bring documentation in millimeters.
3. Check **"yes"** if the individual has brought documentation of a previous negative TB test, recorded in millimeters within the last 12 months. **If an individual has documentation of a previous negative chest X-ray (CXR) the individual does not need another CXR at the time or in the future unless the individual develops symptoms consistent with active TB.**
4. Check **"no"** if the individual did not bring documentation, in millimeters, of a TB test within the past 12 months.

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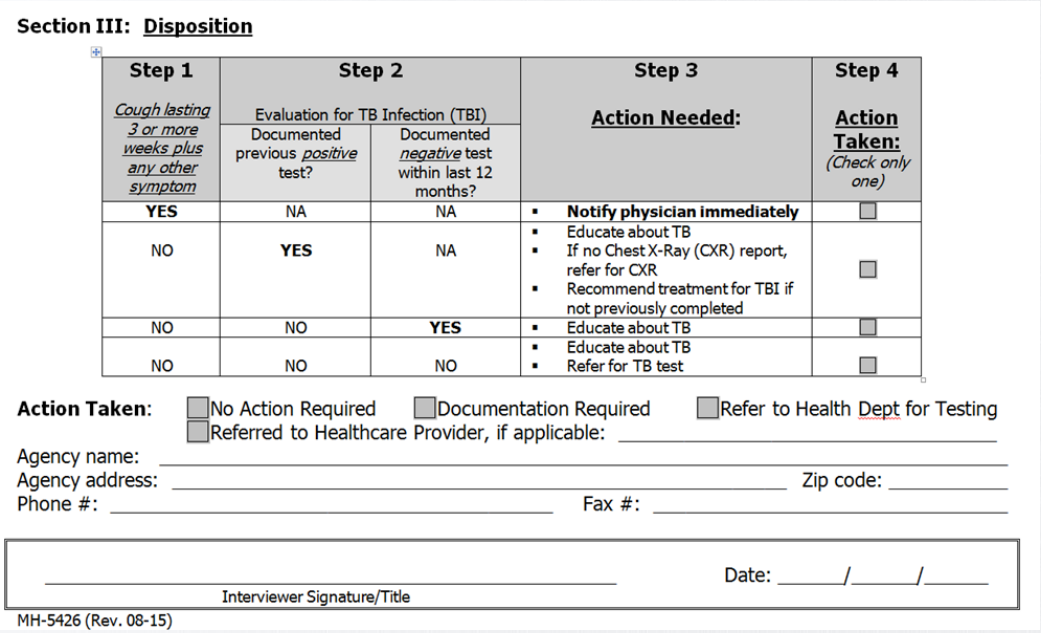
Disposition



Section III: Disposition

Step 1	Step 2		Step 3	Step 4
Cough lasting 3 or more weeks plus any other symptom	Evaluation for TB Infection (TBI): Documented previous *positive* test?	Documented *negative* test within last 12 months?	**Action Needed:**	**Action Taken:** *(Check only one)*
YES	NA	NA	▪ **Notify physician immediately**	☐
NO	**YES**	NA	▪ Educate about TB ▪ If no Chest X-Ray (CXR) report, refer for CXR ▪ Recommend treatment for TBI if not previously completed	☐
NO	NO	**YES**	▪ Educate about TB	☐
NO	NO	NO	▪ Educate about TB ▪ Refer for TB test	☐

Action Taken: ☐ No Action Required ☐ Documentation Required ☐ Refer to Health Dept for Testing
☐ Referred to Healthcare Provider, if applicable: _____

Agency name: _____
Agency address: _____ Zip code: _____
Phone #: _____ Fax #: _____

_____ Date: _____/_____/_____
Interviewer Signature/Title

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Section III:

Section III assists the interviewer with determining the **"Action Needed"** to be taken based upon the responses in Sections I and II; and to document the **"Action Taken".** The table is divided into four steps. To determine which action is to be taken, the interviewer must read the options listed horizontally across the table.

Disposition

For example:

Step 1: **Cough lasting 3 or more weeks plus any other symptom**. ***If yes***, then move to Step 2.

Step 2: **Evaluation for TB Infection (TBI)**. If the answer to Step 1 is yes, the answer to *Documented previous positive test* is NA and the answer to *Documented negative test within last 12 months* is NA. Next, move to Step 3.

Step 3: **Action Needed**. If the answer to Step 1 is yes and the answer to Step 2 is not applicable, then the action needed is to **notify physician immediately**. Move to Step 4.

Step 4: **Action Taken**: You should check the box that is adjacent to the response in Step 3.

Disposition

After you have determined what action needs to be taken, document your response below the table. If you determine that :

1. If all criteria have been met, check **No Action Required**.
2. If you are waiting on documentation from the individual, check **Documentation Required**
3. If you are referring the individual to the Health Department for TB testing, check **Refer to Health Dept for Testing**
4. If you are referring the individual to a healthcare provider, check **Referred to Healthcare Provider**. Please indicate reason and provide the name, address, phone and fax numbers.

After completing the screening tool, the interviewer must sign his or her name, title and date the form.

TB Training and Examination

Thank you for participating in the TB Training course. Please contact your Program Specialist at the Division of Substance Abuse Services if you have any questions or need additional information. Click below to proceed to the examination.

https://stateoftennessee.formstack.com/forms/tb_test