TB Infection Control in Health Care Settings

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Objectives

- TB incidence in community & hospitals decreasing but Risk to health care workers persists
- CDC Guidelines 2005 update reviewed
  - Administrative, Environmental, Respiratory Controls
  - Implementation
  - Extended to include many non-hospital settings
- Re-evaluation of TST screening
- New technology (eg, BAMT, IGRA)
TB Among Health Care Workers

- Occupational risk to HCW recognized in 1950s
  Resource-rich countries ⇒ Infection Control Measures that ↓ Nosocomial TB
- US: Resurgence of Nosocomial TB in 1990s
  - Poor implementation of Infection Control
  - HIV Epidemic
  - MDRTB
- Recent Public Health Threat will impact HCW: XDRTB
LTBI & TB Risk to HCW

Annual LTBI Incidence

- Overall: 4.6%
- Intermediate: 6.9%
- High: 8.4%
- Low TB Incidence: 3.8%

Relative Risk for TB

- Overall: 3.0
- Low & Intermediate Incidence: 2.4
- High: 3.7

Occupational Risk in HCW

- HCW at increased risk for LTBI & TB disease
  - Risk correlates directly to regional TB incidence
- TB infection control measures protect HCW
  - Protection magnitude ~ correlates directly with regional TB incidence
    - Up to 49% in Low TB Incidence Regions
    - Up to 27% in Intermediate
    - Up to 81% in High

What is the most dangerous type of TB to Health Care Workers?

The Unsuspected Case!!

What Factors Determine TB Infectiousness?
Transmission of Tuberculosis

- Aerosol (airborne droplet nuclei) **only** transmits infection
- 21-23% of close contacts become infected
- **Patient factors**
  - Disease in lung, airway, and/or larynx
  - Coughing or cough inducing procedure
  - Concentration of droplet nuclei (cavitary > non-cavitary)
    - Sputum smear:
      - Positive: transmission occurs
      - Negative, but culture positive: transmission less often (see Figure)
- **Environment factors**
  - Duration of contact
  - Small enclosed space
  - Poor ventilation or recirculation of room air
- **Other factors**
  - Susceptibility of the host
  - Partially understood bacteria characteristics
- **Infection rate drops rapidly with treatment initiation**
TB Transmission...Percent Infected
Smear-Positive vs. -Negative Source
Case Proximity to Source Case

*AFB smear negative cases account for 17% TB transmission

Behr MA et al: Lancet 1999
Transmission of Tuberculosis

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How long should patients be isolated?
Traditional CDC Isolation Recommendations

Patients are not considered infectious if they meet the following criteria:

• Adequate therapy for 2 or 3 weeks
• Favorable clinical response
• Sputum smear negative x 3…

Disconnect: Regulation vs. Reality
Prolonged Sputa/Culture Positivity = Reality
(Smear + correlates w/ culture + duration)

<table>
<thead>
<tr>
<th>Study</th>
<th>Culture Conversion</th>
<th>Rx Regimen</th>
<th>N</th>
<th>Cure Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohn et al: AIM 1990</td>
<td>1-19 wks</td>
<td>6 mos DOT (2x/wk)</td>
<td>125</td>
<td>98%</td>
</tr>
<tr>
<td>Combs et al: AIM 1990</td>
<td>50% (-) @ 7 wks</td>
<td>6 mos daily</td>
<td>1451</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td>90% (-) @ 16 wks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dutt et al: AJM 1984</td>
<td>50% (-) @ 6.5 wks</td>
<td>6 mos DOT (2x/wk)</td>
<td>751</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>90% (-) @ 13 wks</td>
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</tbody>
</table>

Data from studies in developed countries show:

- ~90% cases smear negative at 3 months
- Sputum persistently AFB positive more likely a/w negative culture results than with treatment failure (Al-Moamary et al, *Chest* 1999)

If smear & culture still positive at 2 months: Re-evaluate susceptibilities, Adherence to Rx, & Plan to prolong Rx by at least 3 months
Scientific/Common Sense Criteria for TB Non-Contagion

- TB therapy rapidly reduces contagion
  - Viable TB bacilli w/in sputum reduced >90% in 1st 2 days
- Low likelihood of MDR TB
- Complete adherence to DOT multi-drug Rx x2-3 weeks
  - 5-7 days if AFB smear negative at onset
- Clinical improvement evident (eg, reduced cough frequency, ↓ AFB smear grade)
- Close contacts identified, evaluated, started on Rx (LTBI or even active TB)
- Most stringent criteria for congregate settings & suspect or proven MDR TB: 3 consecutive negative AFB smear results (8-24 hours apart)
Amended CDC Isolation Recommendations

Patients are not considered infectious if they meet the following criteria:

- Adequate therapy for 2 or 3 weeks (susceptibility data helpful)
- Favorable clinical response
- Mycobacteriologic response (↓Smear Grade)

Many patients released from strict isolation after 2 – 3 weeks (cough resolved, energy improved, smear grade↓, pan-susceptible organism)
Outpatient or Inpatient Therapy?

• Guiding principle: Minimize transmission risk
• Inpatient therapy guidelines:
  – Is it worth putting more people at risk?
  – Clinical indications (e.g., massive hemoptysis, concurrent disease complications)
  – High risk for poor adherence to therapy
What are the Fundamentals of TB Infection Control?

• Early identification and isolation

• Effective Airborne Infection Isolation (AII)

• Rapid institution of effective treatment
What Agencies Oversee Infection Control?

- **Advisory Recommendations (Toothless)**
  - Center for Disease Control (CDC)
  - National Institute for Occupational Safety & Health (NIOSH): Certifies respirator design

- **Regulatory (Teeth): Occupational Safety & Health Administration (OSHA)**
  - Private employers
  - Federal agencies (certain restrictions)
  - States choose to participate (Local/state agencies)
    - ~50% states so choose
    - Iowa does not, but Iowa OSHA follows federal agency regulations closely
2005 CDC Guidelines
Three Tier Control Hierarchy Continue

- **Administrative controls**: Decreases risk of exposure
- **Engineering controls**: Reduce [droplet nuclei]
- **Personal Respiratory protection**
  - Respirators, fit-testing
  - Last tier, back-up if 1 & 2 fail

Guidelines for Preventing the Transmission of TB in Health-Care Settings, 2005

*MMWR Recommendations & Reports 12/30/05*
Overview of Differences
2005 Compared to 1994 Guidelines

• Applies to entire health care setting rather than selected areas
• Scope of settings broader: laboratories, more outpatient & non-traditional settings
• Terminology & abbreviations
  – Tuberculin skin test (TST) replaces purified protein derivative (PPD)
  – Airborne infection isolation (AII)
  – New technology breeds new abbreviations:
    • Blood analysis for *Mycobacterium tuberculosis* (BAMT)
    • QuantiFERON-TB Gold (QFT-G) [IGRA] substitutes for TST in HCW screen
• TB screening for HCW
  – Criteria change
  – Decreased frequency
  – Clearer definitions for which HCW need serial testing
• Expanded information:
  – UV germicidal irradiation (UVGI) & room air circulation
  – Dealing w/ MDRTB & HIV
  – Respirator training
Administrative Controls

Infection Control strategy for reducing exposure risk

- Assess TB Risk
- Assigns responsibility for TB Infection Control
- Develops/installs written TB Infection Control plan
- Ensures timely lab availability
- Screen & Evaluate HCWs
- Train and educate HCWs
- Coordinate efforts w/ state/county public health departments
TB Risk Assessment
Worksheet…Appendix B

• Community rate of active TB
• Number of TB patients treated at your facility
• Screening for LTBI among workers
• TB infection control program in place
• Types of Environmental Controls in use
• Respiratory Protection Plan
• Level of laboratory support
• Annual risk re-assessment plan
Screening for TB among HCWs
Guidelines…Appendix C

- Baseline testing TST (two step) or BAMT (IGRA)
- Screen for LTBI (and active TB)
- Training & education about TB
- Serial testing with TST (or BAMT/IGRA)
IGRA (QFT-G) for Screening

Annually UI screens 300-500 students from high TB incidence nations (eg, SE Asia, Africa)

- TST positive 2002-2007: 31-49% positive
- 2006 (N=313): 49% TST+, 149 CXRs, INH Rx 20%
- 2007 (N=470): 37% TST+, 7% QFT-G+, 33 CXRs (↓ by 76%), INH Rx 50%
- Other Big 10 Universities similar results using QFT-G (N > 3000 screened in 2007)
  - Several have switched from TST to QFT-G (CDC recommendation w/ little data)
  - LTBI infection rate reduced to 6-8% from 25-45%
  - One institution found 3 early active pulmonary cases
Serial Testing of HCWs for LTBI

• Serial testing: administer, read & interpret TST according to guidelines...
• Rationale for decreased emphasis on serial testing:
  – Most hospitals: transmission of TB infection approaches a level (< 2%) which predicts that TST less likely to detect disease & more likely to be false positive
  – UIHC: TST screening data review suggests TST conversion rate (0.05%) most likely false positive rather than indicating TB transmission
• No serial testing for Low Risk classification (Appendix C).
• Exempt those HCWs w/ LTBI & Rx completed
  – Consider annual TB assessment in lieu of TST
• BAMT (eg, IGRA) substitute for TST in serial testing...
Serial Testing-IGRA

• Significant variation in IFN-\(\gamma\) release over time w/in same individual

• Questions:
  – What do you do w/ those who start near positive cut point? (analogous sitn: HCW w/ baseline TST = 12 mm…Risk Factors for TB?)
  – What magnitude of change represents new infection vs “routine” IFN-\(\gamma\) variation? (eg, above case returns following year w/ TST = 18 mm)
  – Should there be criteria for judging IGRA conversion analogous to TST?
Environmental Controls
Second Level

Control source of infection:

• Removing contaminated air by ventilation

• Preventing contamination in areas adjacent to source case (All rooms)

• Cleaning air by use of HEPA filtration (min efficiency: 99.97% ≥ 0.3 µm particle)

• UV germicidal irradiation only w/ simultaneous use of HEPA filters & high rate of purge airflow
General Ventilation Issues

Air Flow Patterns for Mixing & Preventing Short Circuit Circulation

- Single pass (preferred)
- Recirculation (use of HEPA/UVGI)
- All: negative pressure
  (New facilities: 12 ACH; Existing facilities: 6ACH)
General Ventilation Issues (2)

• Ante room preferred for All rooms
  – Helps maintain negative pressure
  – Limits impact of opening door/traffic in/out

• Monitoring room airflow recommended
Confucius Says…

Speak no evil. See no evil. Hear no evil.

…But NIOSH & OSHA say…

Breathe no evil!
Personal Respiratory Protection
Level Three

- Use in high risk situations
- Most of the benefit: Administrative & Environmental controls
- Epidemiologic data lacks power to support respiratory protection /fit-testing of minimal import
- Respiratory protection & particularly fit-testing remains contentious issue
Evidence for Effectiveness of Respiratory Protection

Administrative and Engineering Measures Effectively Control Outbreaks of Nosocomial TB Transmission

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Control Measure(s) Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administrative Control</td>
</tr>
<tr>
<td>Jackson Memorial, Miami</td>
<td>Extensive</td>
</tr>
<tr>
<td>Cabrini, NYC</td>
<td>Extensive</td>
</tr>
<tr>
<td>Grady Memorial, Atlanta</td>
<td>Extensive</td>
</tr>
</tbody>
</table>

RPD = Respiratory protective device
Exhaust fans were placed in windows to produce negative pressure rooms
No fit-testing performed in any institution (predated 1994 CDC/NIOSH)

From: McGowan et al, JID 1995
Evidence for Effectiveness of Respiratory Protection

- Published surveys of hospitals (Columbia, St. Clares, UVa, SHEA) show that TST conversion rates fall or remain low more as a result of administrative & engineering controls vs. respiratory protection (Bangsberg et al: *ICHE* 1997; Fella et al: *AJIC* 1995, Jernigan et al: *AJIC* 1994; Fridkin et al: *ICHE* 1995)
- No data regarding effect of fit-testing
- No study that isolates and evaluates impact of respiratory protection program in the hierarchy of controls
Respiratory Protection Sequence of Events

- Respirator for entering isolation: N95 since 1995
- CDC/NIOSH: 1994, recommend initial fit-testing, periodic re-assessment, but annual fit-testing not mentioned
- OSHA: initial & annual assessment & fit-testing (qualitative & quantitative)
  - Must conform to 1987 OSHA respiratory protection standard (no annual fit-testing)...No more!!!
  - OSHA revised respiratory standard in 1998 (29 CFR 110.134) (requires annual fit-testing), but excluded TB...until 12/30/03
  - Wicker amendment to 2005 Omnibus Spending Bill: OSHA can’t use tax dollars to enforce respiratory standard for TB
Respiratory Protection Measures

• Respiratory Protection Program
  – Select respirators
  – Write SOP
  – Medically screen users
  – Provide training: user seal-check
  – Fit testing
  – Evaluate program

• Training HCWs about respiratory protection & TB

• Use Respiratory Protection:
  – Entering All room
  – During cough/aerosol inducing procedures
  – Where Administrative &/or Environmental controls insufficient to protect you from inhaling droplet nuclei

• Training patients on respiratory hygiene & cough etiquette

What mask should patient wear in room with visitors?
Coughing propels & disperses a plume of TB droplet nuclei ~1-2 m outward
Wearing any mask blocks forward momentum of cough plume
Respiratory Protection Devices

- NIOSH certifies respirator design
- Types of devices:
  - N95: inexpensive, simple, disposable (e.g., duck bill)
  - APR/PAPR: greater protection; ([Powered] Air Purifying Resp)
  - Others: Air hood/helmet; Cartridge respirator; body suit
  - Surgical, DM; DMF vs. HEPA respirators... no longer in use
Fit-Testing

- **Quantitative**: concentration of a marker material measured inside & outside; requires trained personnel & complex equipment
- **Qualitative**: pass/fail (saccharin, NaCl, irritant smoke)
- **Seal-check**: performed by user each time respirator put on (positive/negative).
Special Situation: TB Infection Control in Resource Poor Setting (esp. ↑ HIV Incidence)

Administrative Controls
• Proactive Planning
• Select individual responsible & encourage creative implementation (eg, change attitudes/stigma, eliminate cohorting in TB wards, ↓ LOS)

Environmental Controls
• Open-Window Ventilation & Fans
• Inexpensive ceiling UV light/shield/fan set-up
• Continuous teaching patients proper cough hygiene

Personal Respiratory Protection
• N95 respirator availability
• Model/teach proper use

TB Control in Health-Care Setting

- Review of TB contagion
- TB incidence in community & hospitals is decreasing
- Risk to health care workers is decreasing (…Risk for increased complacency!)
- CDC Guidelines 2005 update reviewed
  - Applies to traditional & non-traditional settings
  - Implementation of 3 tiers of control: Administrative, Environmental & Respiratory
- Re-evaluation of TST screening
- New technology (eg, BAMT…IGRA)
Almost The End...
Pop Quiz #1

What is the recommended sequence for application of control measures in TB exposure program?

1. Administrative, Environmental, Respiratory Protection
2. Respiratory Protection, Administrative, Environmental
3. Environmental, Respiratory Protection, Administrative
4. It doesn’t matter
5. None of the above

Answer: 1
Pop Quiz #2

Appropriate Administrative Measures include:

1. Conducting a TB risk assessment
2. Testing & evaluating HCWs who are at risk for TB or may be exposed to TB
3. Controlling the source of infection by use of general ventilation systems
4. Installing HEPA/UVGI for All rooms

Answer: 1 & 2
Pop Quiz #3

N95 respirators should be used in settings where Administrative & Environmental controls may not fully protect HCW from airborne droplet nuclei.

• True
• False

Answer: True