

THE TUBERCULOSIS DETECTION AND CONTROL PROGRAM

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AFI 48-115, dated 29 June 1994, is supplemented as follows:

Purpose Statement. This publication applies to Air National Guard (ANG) Medical Squadrons, Medical Flights, and (as appropriate) Aeromedical Evacuation Squadrons. AFI 48-115, *The Tuberculosis Detection and Control Program*, is applicable to all ANG medical units unless otherwise noted. Additionally, this publication outlines ANG policy and guidance for compliance with Occupational Safety and Health Administration (OSHA) guidelines for tuberculosis (TB) exposure control in medical facilities. It should be implemented in consideration of related policy and guidance provided in AFI 48-101, *Aerospace Medical Operations*, AFI 44-108, *Infection Control Program*.

Summarizing noteworthy items, this publication: (a) requires the development and implementation of a wing tuberculosis detection and control instruction outlining local TB program policy and procedure specifics; (b) authorizes locally-determined annual TB screening for selected cohorts; (c) outlines ANG policy for compliance with OSHA guidelines for TB exposure control; and (d) authorizes local implementation of standardized "self-read" policy and procedures. **NOTE:** Any reference to "Military Public Health" in AFI 48-115 should be amended to read "Public Health".

1.2. (Changed to read) (ANG) Commanders.

1.2.1. (Added) (ANG) The Wing Commander approves and ensures execution of the local (wing) tuberculosis detection and control instruction, and provides appropriate level of emphasis and support to the associated program.

1.2.2. (Added) (ANG) Group/Squadron Commanders ensure that personnel report to the medical unit for tuberculin screening, chest radiographs, and follow-up visits as required by this instruction.

1.3. Not applicable to ANG units.

1.4. (Changed to read) (ANG) The Medical Squadron/Flight Commander:

- (Added) (ANG) Ensures developing of a wing instruction outlining local policy and procedures for tuberculosis detection and control, as well as occupational exposure to TB, IAW the guidelines provided in this instruction.
- (Added) (ANG) Ensures that medical unit personnel administer tuberculin skin tests (TSTs) to all individuals requiring them.
- (Added) (ANG) Ensures that active cases of TB are promptly and appropriately evaluated, treated, and followed up IAW eligibility status, as well as appropriately reported.
- (Added) (ANG) Properly manages positive reactors and recent converters IAW eligibility status.

1.5. (Changed to read) (ANG) Public Health (PH):

- (Added) (ANG) Manages education and epidemiology for the Tuberculosis Detection and Control Program.
- (Added) (ANG) Coordinates with the Aerospace Medicine Council (AMC) and Infection Control Function (ICF) to ensure compliance with relevant OSHA guidelines for control of occupational exposure to TB.
- (Added) (ANG) Conducts baseline histories and interviews for positive reactors IAW eligibility status; reviews histories and interviews (to the greatest possible extent) when conducted by private health care providers and captures appropriate documentation in either circumstance.

3.1. (Changed to read) (ANG) Scope of Testing. ANG wings will employ the Mantoux IPPD (intermediate [strength] purified protein derivative) method for *all* TB skin testing. ANG wings will order TSTs for:

3.1.1. (Changed to read) (ANG) Each member entering active duty for the period of time specified by law that renders them eligible for medical care.

3.1.2. (Changed to read) (ANG) Albeit a rare circumstance, each member and their dependents returning from an overseas statutory tour, or moving from one overseas statutory tour to another (upon notification of reassignment).

3.1.3. (Changed to read) (ANG) Each member testing positive for human immunodeficiency virus.

3.1.4. (Changed to read) (ANG) Eligible members and family members in close contact with active TB patients.

3.1.5. (Changed to read) (ANG) Occupationally exposed personnel, as determined by the local AMC in coordination with the local ICF. This includes the requirement for all ANG medical units to comply with OSHA guidelines for occupational exposure to TB in medical facilities, as well as potential work-related exposures in non-medical personnel.

3.1.5.1. (Added) (ANG) The AMC-ICF (interaction) will serve as the multi-disciplinary working group required by OSHA. The AMC is responsible for overall program management; the specific OPR is locally determined.

3.1.5.2. (Added) (ANG) ANG medical unit facilities will generally be characterized as having a lower level of risk for occupational exposure to TB.

3.1.5.3. (Added) (ANG) Tuberculosis Exposure Control Plan. **NOTE:** See the sample TB exposure control plan, Atch 5. Each ANG medical unit must develop and implement *written* guidelines for:

- Characterization of the medical unit TB risk assessment (see para 3.1.5.2 above).
- Listing of activities which place workers at potential risk of TB exposure.
- Protocols for early detection of patients who may have infectious TB.
- Education and training of health care and other occupationally exposed workers as to the signs/symptoms of TB, their risk of occupational exposure, methods of personal protection (including personal protective equipment, PPE, as appropriate), and the purpose and significance of annual screening.
 - Annual screening for all medical personnel (AFSC 4XXX).
 - Procedures for the evaluation, treatment, and follow-up (as appropriate) of TST positive workers (IAW eligibility status).
 - Additional considerations for emergency medical services and dental health care workers.

3.1.5.4. (Added) (ANG) Consideration must be afforded to non-medical workers potentially exposed to TB on-the-job, in light of the “reasonably anticipated” precept.

3.1.6. (Changed to read) (ANG) Pre- and post-deployment for members participating in operational, exercise, or temporary duty events as determined from threat assessment or as required by higher headquarters policy.

3.1.6.1. (Added) (ANG) However, in lieu of pre- and post-deployment TB screening, ANG wings are authorized to annually screen flyers and frequent deployers, all personnel “on mobility”, or all wing personnel per local discretion. All related decisions must be made on the recommendation of the local AMC—and approved by the medical unit commander—in thoughtful consideration of wing mission requirements, resource limitations, epidemiology-based cost-effectiveness analysis, and impact on line of duty determination (i.e., generally, this means LOD “yes” for an affirmative TST if deployed since the last screening and LOD “no” if not; there may be exceptions). **NOTE:** Related decisions regarding annual screening must be included in the wing instruction, thereby gaining the approval of the wing commander.

3.2. (Changed to read) (ANG) Interpreting TSTs and Recording of Results.

3.2.1. (Changed to read) (ANG) ANG wings may employ any (or a combination) of the following methods to read TSTs. Any related decision must be made on the recommendation of the local AMC, approved by the medical unit commander, and included in the wing instruction. The TST may be read by:

3.2.1.1. (Added) (ANG) Qualified military medical personnel (i.e., those having successfully completed recognized military or civilian sponsored TST interpretation training, or sufficient OJT overseen by a qualified health care provider).

3.2.1.2. (Added) (ANG) Qualified public or private sector health care personnel (i.e., a licensed physician, physician assistant, nurse, or nurse practitioner).

3.2.1.3. (Added) (ANG) The tested individual (i.e., “self-read”), but ONLY if each of the following criteria are met. Detailed guidance is provided in Atch 4.

- The self-read procedure is based on the two-choice approach, raised versus not raised.
- Tested individuals receive appropriate education on the self-read process.
- Reliable mechanisms are in place for prompt reporting and documenting of all results.
- Individuals reporting *raised* self-read results will have their TST promptly assessed by qualified personnel as described in paras 3.2.1.1.-3.2.1.2.

3.2.2. (Changed to read) (ANG) Regardless of the reader, all TST results—positive or negative—must be recorded on the PHS 731 (i.e., “shot record”) and in the Military Immunizations Tracking System (MITS) database. All positive results must also be documented on the AF Form 2453 and on AF Form 1480 (or equivalent) in the personal medical record.

3.2.3. (Added) (ANG) All confirmed cases of active tuberculosis must be promptly reported to ANG/SG and IAW local and state guidelines.

4. Not applicable to ANG units.

5. (Added) (ANG) **Non-compliance.** It is the responsibility of the medical unit to notify the member’s immediate commander of any non-compliance concerning tuberculin screening, evaluation, or follow-up appointments. It is the commander’s responsibility to ensure that the member complies in a timely manner.

Attachment 2. Not applicable to ANG units.

PAUL A. WEAVER, JR.
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3 Attachments
3. References and Bibliography (Added)
ANG)
4. Self-Assessment (“Self-Read”) Guidance
(Added) (ANG)
5. Sample Tuberculosis Exposure Control
Plan (Added) (ANG)

Attachment 3 (Added ANG)**References and Bibliography*****References***

AFI 44-108	<i>Infection Control Program</i>
AFI 48-101	<i>Aerospace Medical Operations</i>
AFI 48-115	<i>The Tuberculosis Detection and Control Program</i>
AFI 48-115/ANGSUP 1	<i>The Tuberculosis Detection and Control Program</i>

Bibliography

ANGRC/SG Log Letter SG-94-30, "Occupational Exposure to Tuberculosis," 9 May 94.

29 CFR, 1910 series, *Occupational Exposure to TB; proposed rule of 17 Oct 97*

Core Curriculum on Tuberculosis: What the Clinician Should Know. 3rd edition, CDC, 1994.

Essential Components of a Tuberculosis Prevention and Control Program. Morbidity and Mortality Weekly Report, vol 44, RR-11, 8 Sep 95.

Guidelines for Preventing the Transmission of M. tuberculosis in Health Care Facilities. CDC, 1994.

Howard, T.P. et al.. "Reading the Tuberculin Skin Test: Who, When, and How?" *Arch Intern Med*, vol 148, 2457-2459, 1988.

HQ AMC/SG. "Tuberculosis (TB) Testing," policy letter, 3 Jul 96..

Prezant, D.J. et al. "Self-Assessment of Tuberculin Skin Test Reactions by New York City Firefighters: Reliability and Cost-Effectiveness in an Occupational Health Care Setting," *Annals of Internal Medicine*, vol 124, 280-283, 1996.

Risser, N.L. et al. "The Accuracy of Tuberculin Skin Tests: Self-Assessment by Adult Outpatients," *Public Health Reports*. vol 100, 439-445, 1985.

Attachment 4 (Added) (ANG)**SELF-ASSESSMENT (“SELF-READ”) GUIDANCE**

A4.1. Background. While interpretation of Tuberculin Skin Test (TST) results by qualified medical personnel is preferred by ANG/SG, ANG units may employ the following self-read process, as locally deemed necessary and appropriate. The ANG’s decision to promulgate TST self-read policy is based on consideration of multiple factors, including: (a) the 48-72 hour nature of the test in relation to availability of Guardsmen; (b) the potential costs associated with seeking “professional read” (administrative processes/orders, travel, liability, provider fees, time away from work/employer relations, etc.) versus potential cost savings of self-read; (c) perceptions by ANG units that historically utilized interpretation processes are unreliable, inefficient, and ineffective; (d) the need for standardization of diverse self-read processes locally implemented across the ANG; and (e) a literature review of related scientific studies¹.

A4.2. Concept. The ANG self-read strategy is founded upon a two-choice methodology designed to focus only on TST results suspected of being positive, resulting in improved compliance, increased efficiency, and reduced costs. Methods requiring the tested individual to measure induration size (e.g., in millimeters) or otherwise quantitatively interpret their TST result (e.g., negative versus doubtful versus positive) are not authorized. Using the simple two-choice design, an individual needs only be able to describe and report the test result as *raised* or *not raised*. Despite increasing the likelihood of false positives, this strategy virtually eliminates the more important false negative result. Erythema (i.e., redness) is ignored, and the self-assessment limited to the area of induration. Reliable mechanisms must be in place to ensure timely reporting of any result—*raised* or *not raised*—to appropriate ANG medical unit personnel; reporting of *raised* results is particularly time-sensitive. Any *raised* result requires timely assessment by qualified medical personnel, IAW paras 3.2.1.1.-3.2.1.2. All results are documented IAW para 3.2.2.

1. D.J. Prezant et al, “Self-Assessment of Tuberculin Skin Test Reactions by New York City Firefighters: Reliability and Cost-Effectiveness in an Occupational Health Care Setting,” *Annals of Internal Medicine*, vol 124: 280-283.

A4.3. Procedures. ANG medical units opting to employ a self-read strategy, must, at least, adhere to the following implementation protocol.

A4.3.1. Provide self-read education for each TST recipient. Instructions must be simple and clear. They must be provided in writing as well as fully briefed to each recipient, with ample interactive opportunity to address questions or concerns. The instructions will be contained in an acknowledgment form which the individual will sign, and must, at least, address the following (see sample form in Appendix 1 to this attachment):

- Importance of the TST to individual and unit health; importance of careful interpretation of results and prompt reporting; non-relationship of the test result to ANG employment status.
- Location of the test (injection) site and date/time administered.
- When to read the test result.
- Meaning and description (signs) of induration (swelling), in terms of *raised* versus *not raised*.
- Insignificance of Erythema (redness) to test interpretation.
- How and when to report results.
- Acknowledgment statement and member signature.

A4.3.2. Results reporting. Methodology is locally determined; however, reliability and timeliness are essential. Suggestions include: (a) a pre-addressed postcard, form, or letter; (b) fax; (c) telephone; (d) email; (e) secure web site. Only the more prompt methods of reporting (e.g., telephone) will be utilized in light of *raised* results. Self-readers experiencing a *raised* result must first contact host unit medical personnel to receive follow-up instructions (see para A4.3.5.).

A4.3.3. Suspense system. Medical units must establish a “suspense system” for ensuring complete and timely tracking of pending test results. Suggestion: the medical unit retains the member’s shot record and attaches a copy of the acknowledgment/instructions form to it, until results are recorded.

A4.3.4. Documentation. Reference para 3.2.2.

A4.3.5. Disposition of individuals reporting *raised* results. These individuals must be instructed to promptly report to a qualified health care provider (based on established member health care eligibility criteria) to have their test professionally read (IAW paras 3.2.1.1-3.2.1.2). Document results of the professional interpretation (IAW para 3.2.2), as well as additional follow-up (i.e., treatment, counseling/education, etc.) received/required.

A4.3.6. Dealing with non-compliance. When individuals fail to report the results of their self-read TST, notify their commander of the non-compliance and re-test the individual. **NOTE-1:** Compliance with all medical testing is a commander (and individual) responsibility. Include this important notion in your wing TB instruction. **NOTE-2:** The Centers for Disease Control and Prevention (CDC) does not specify a limitation on the frequency of tuberculin skin testing; however, consideration of the “booster effect” is prudent.

Appendix 1 to Attachment 4

This appendix provides a sample acknowledgment form and written instructions to report “self read” tuberculin skin test results. **NOTE:** When intended for return by mail, self-addressing is prudent. Local adaptation is authorized.

TUBERCULIN SKIN TEST “SELF-READ” INSTRUCTIONS AND MEMBER ACKNOWLEDGMENT

“ _____ (enter name) _____ (enter rank) _____ (enter last 4 of SSAN), you just received Part 1 of your tuberculin skin test today, _____ (enter date) at _____ hrs (enter time).

This two-part test screens you for evidence of exposure to tuberculosis (TB). It is a vital tool for detecting and controlling TB before it can make you, your family, or your unit sick. We need your help with Part 2 of the test, “reading” the results. **Here’s what YOU need to do:**

On _____ (enter date), please run your finger over the skin test placed on your arm. If you feel absolutely no swelling in this area (redness is not important), or in other words the area feels absolutely flat when you run your finger over it, check the box marked NOT RAISED. If you feel any swelling *whatsoever* in this area (again, redness is not important), or in other words the area feels raised or not flat when you run your finger over it, check the box marked RAISED **and call the medical unit at _____ (enter phone number)**”.

NOT RAISED

RAISED

Please call the Medical Squadron at _____ (enter phone number) if you have any questions or concerns about how to interpret (“read”) your TB skin test, or if you would like to report your RAISED results by phone.

I understand the purpose of my tuberculin skin test and my responsibility to assess my test results and promptly report them to the medical unit at my ANG base. I also understand that failure to do so will result in notification of my commander and re-testing.

Member’s Signature

(Enter the following)

Medical unit address: _____

Medical unit phone number: _____. Medical unit fax number: _____.

Medical unit E-mail address: _____

Attachment 5 (Added) (ANG)**SAMPLE TUBERCULOSIS EXPOSURE CONTROL PLAN**

**BY ORDER OF THE
COMMANDER**

[*unit designation*] **INSTRUCTION OI 48-XX**
[*date*]
[*unit designation*] **MEDICAL SQUADRON**

TUBERCULOSIS EXPOSURE CONTROL PLAN

PURPOSE. To establish guidelines for preventing the transmission of Tuberculosis (TB) to wing personnel with potential occupational exposures.

SCOPE. This plan, in conjunction with Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), Air Force (AF), and Air National Guard (ANG) guidelines, provides guidance to minimize the risk of transmission of TB in the workplace. This Tuberculosis Exposure Control Plan (TB-ECP) is applicable to medical and selected non-medical personnel that may have the potential to come in contact with an individual infected with TB while performing routine duties in a military duty status.

This plan will provide guidelines for engineering controls, work practices, personal protective equipment (PPE), testing and training. The TB-ECP will also provide practices and procedures for housekeeping, medical evaluation, hazard communication, and record keeping. If an occupationally related exposure incident occurs, a post-exposure plan has been outlined.

This document must be reviewed, and appropriately updated, annually.

REFERENCES.

AFI 48-101, *Aerospace Medical Operations*

AFI 48-115, *The Tuberculosis Detection and Control Program*

AFI 48-115/ANGSUP-1, *The Tuberculosis Detection and Control Program*

Current OSHA rule, *Occupational Exposure to TB*.

Current Control of Communicable Diseases Manual, Benenson.

Current Morbidity and Mortality Weekly Reports (MMWR)

[*Enter applicable state and local policy/guidance references*].

TUBERCULOSIS EXPOSURE CONTROL PLAN

1.0. Purpose. The Tuberculosis Exposure Control Plan (TB-ECP) describes the coordinated efforts of all wing agencies involved in providing a safe and healthful environment for any individual identified to have a “reasonably anticipated” risk of contact with an individual with bacterial infection caused by microorganism, *Mycobacterium tuberculosis*. The TB-ECP is provided to eliminate or minimize occupational exposure to tuberculosis and provide evaluations and follow-up of personnel should such an exposure occur.

2.0. Responsibilities.

2.1. The ANG Wing Commander must provide a safe and healthful environment for all ANG workers.

2.2. The MDS Commander is responsible for development, implementation, and oversight of the TB-ECP.

2.3. The Aerospace Medicine Council (AMC), in coordination with the Infection Control Function (ICF), reviews, updates, and approves the TB-ECP on an annual basis and as necessary, to reflect new or modified tasks and procedures which affect occupational exposure. The AMC identifies the job classifications and tasks that have a potential occupational exposure and approves worker protection methods, including engineering controls and personal protective equipment (PPE).

2.4. The Infection Control Officer (ICO), through the ICF, approves applicable disinfectants and methods of infection control.

2.5. Public Health (PH) oversees education and training programs. PH conducts and documents training, and assists supervisors in training workers; coordinates program components with supervisors and the AMC; coordinates with the ICF as appropriate; and with bioenvironmental engineering, assesses adequacy of engineering controls and PPE to protect worker health.

2.6. Bioenvironmental Engineering (BE) evaluates exposure potential of workers; assesses adequacy of engineering controls (including ventilation systems and any other pertinent environmental factors) and PPE to protect worker health; coordinates program data with supervisors and AMC.

2.7. Supervisors of identified personnel ensure compliance with provisions of the TB-ECP; administer and document worker training; ensure that workers employ appropriate engineering and work practice controls, PPE, and adequate personal hygiene.

2.8. All personnel determined to be at risk for occupational exposure to tuberculosis are required to comply with the procedures and work practices outlined in this plan.

3.0. Program Elements. The ANG is committed to providing a safe and healthful workplace for all members. At the minimum, the following measures are provided to eliminate or minimize transmission of tuberculosis in the work place. Risk assessment, consists of determining the level of risk to potentially exposed wing workers from the following:

3.1. The community TB profile.

3.2. The number of TB patients identified in each area of the facility. **NOTE:** TB patients are not treated at ANG medical facilities.

3.3. The drug-susceptibility patterns of the TB organism experienced within the community.

3.4. The purified protein derivative (PPD) tuberculin skin test (TST) results of wing personnel.

3.5. The infection control parameters within the facility or potential exposure area.

3.6. Listing of activities which place workers at potential risk of TB exposure.

3.7. Current facility maintenance procedures and the most recent environmental evaluation.

3.2. Definitions.

3.2.1. Active Case of Tuberculosis – a person who has a bacterial infection with *Mycobacterium tuberculosis* characterized by the formation of granulomas. A suspected case is a person who has clinical signs and symptoms characteristic of TB (e.g. chronic cough, abnormal chest radiograph).

3.2.2. Minimal Risk – Applies to an entire facility when there are no TB patients in the facility or the community.

3.2.3. Very Low Risk – Applies to an entire facility when there are TB patients in the community, but they are not admitted as inpatients to the facility; policy is in place for referring confirmed or suspected TB patients to a collaborating facility.

3.2.4. Low Risk – Applies to areas or groups within a facility where: 1-5 TB patients have been admitted to the area during the preceding year; the healthcare PPD conversion rate is not significantly higher than rates for areas or groups in which occupational TB exposure is unlikely or higher than previous rates in the same area or group; there are no clusters of healthcare PPD conversions; and there is no evidence of person-to-person transmission.

3.2.5. Intermediate Risk – Applies to areas or groups within a facility when there: were 6 or more TB patients admitted to the area during the preceding year; the healthcare PPD conversion rate is not significantly higher than rates for areas or groups in which occupational TB exposure is unlikely or than previous rates in the same area or group; there are no clusters of healthcare PPD conversion; and there is no evidence of person-to-person transmission.

3.2.6. High Risk – Applies to areas or groups within a facility in which: the healthcare PPD conversion rate is significantly higher than rates for areas or groups in which occupational TB exposure is unlikely or more than previous rates in the same area or group; there are clusters of healthcare PPD conversions; or there is evidence of person-to-person transmission.

3.3. *[Enter unit designation]* Risk Assessment – *[Enter year]*. **[This represents an example only, whereby you can substitute your actual data points for the italicized entries.]**

3.3.1. *[Enter state]* TB Profile– The following table summarizes the incidence of TB (per 100,000 population) in Counties A and B during *[enter year]*:

The following are example incident rates, not intended to imply actual numbers for your locale

County A: 0.1-3.6/100,000

County B: 0.3-3.9/100,000

3.3.2. The incident rates in this example are small.

3.3.3. Assignment of Risk Level – The *[Enter unit designation]* Medical Squadron/Flight *[as appropriate]* is not a hospital and does not see inpatients. The baseline conversion rate in the facility has not shown any increase in conversions in personnel. There are TB cases in the community, though few. Therefore, our medical unit receives a Very Low Risk Rating *[This is only an example]*. The PPD testing of personnel will be conducted IAW the wing Tuberculosis Detection and Control Program instruction.

3.4. Very Low Risk Protocol *[as determined in the example Risk Assessment above]*.

3.4.1. Risk assessment/re-assessment – An updated risk assessment will be conducted annually during the review of this document.

3.4.2. Identifying, evaluating, and initiating treatment for suspected or confirmed TB patients.

3.4.2.1. No suspected or confirmed TB patient will be admitted to the facility; they will be referred to a collaborating facility or their personal physician as soon as possible.

3.4.2.2. Public Health and the ICO/ICF will be notified immediately of any suspected or confirmed TB patient.

3.5. Respiratory Protection.

3.5.1. Disposable N-95 respirators, approved by BE (based on NIOSH/OSHA Standards) will be available for personnel should the need be established. (Need will be based on a risk assessment for occupational tasks, including deployments or other mission essential tasks, that may expose personnel to TB.)

3.5.2. BE (or PH, as determined locally) will provide initial respirator fit-testing (qualitative will suffice) and training for personnel identified as requiring respirator wear. Respirator wearers must be medically qualified to do so. (In our example wing's case, this will be performed prior to a deployment to an area where the risk of exposure to TB warrants it.)

3.6. Training.

3.6.1. Initial TB training will be provided by PH (or other qualified agency as locally determined) for all determined to be at risk.

3.6.1.1. PH will educate and train workers as to the signs/symptoms of TB, their risk of occupational exposure, methods of personal protection (including PPE as appropriate), and the purpose and significance of annual screening.

3.6.1.2. Supervisors will ensure that personnel attend this training.

3.6.2. Annual TB training will be provided to supervisors by PH (or other qualified agency as locally determined). Supervisors will, in turn, train their personnel as appropriate. PH (or other qualified agency as locally determined) will assist supervisors as necessary.

3.6.3. All supervisors will document training for their personnel on AF Form 55, **Employee Safety and Health Record**, or approved substitute.

3.7. TB Screening.

3.7.1. TB screening (tuberculin skin testing) of personnel will be conducted IAW the wing Tuberculosis Detection and Control Program instruction. Follow AF and ANG guidance for the evaluation, treatment, and follow-up (as appropriate) of TST positive workers.

3.7.2. Epidemiological investigation of worker PPD conversion clusters and contacts will be conducted IAW wing, AF, and ANG policy, current CDC guidelines, and any OSHA standards that may be applicable.