BHS Policies and Procedures

City and County of San Francisco
Department of Public Health
Community Programs
BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE REGARDING: **Tuberculosis Screening & Testing for Residential Community Care Licensed Beds Excluding Substance Use Disorder Beds.**

Issued By:

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Director of Systems of Care

Effective Date: May 8, 2024

Manual Number: 3.02-12
References: California DSS Manual, Section 81069; SFDPH Shelter-Health Screening Guidelines

Technical revision; Last Reviewed: May 1, 2024. Replaces policy 3.02-12 of March 14 2019.

Equity Statement: The San Francisco Department of Public Health (SFDPH) Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, members, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse members. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our members' needs and lived experiences.

Purpose:
To standardize Tuberculosis Screening and Testing in Mental Health Residential Treatment (Social Rehabilitation) Programs.

Scope:
This policy is applicable to San Francisco County operated or contracted Mental Health Residential Treatment programs licensed by California Department of Social Services Community Care Licensing Division (CCLD) as Social Rehabilitation Facilities. This policy does not apply to Adult Residential Care Facilities or Residential Care Facilities for the Elderly (RCF/E), Skilled Nursing Facilities (SNF), or Department of Health Care Services licensed Alcoholism and Drug Abuse Residential Recovery or Treatment facilities.

Policy:
This policy applies to all clients admitted to a SFDPH funded Mental Health Residential Treatment program whose stay will be for more than three days (cumulative within a 30-day period).

1. Tuberculosis screening shall be part of the medical assessment required upon admission. (CCR Title 22, Sec 81069)
2. Documentation must include results of a tuberculosis screening examination from within the last three (3) months prior to or 72 hours after admission. (SFDPH Infection Control guidance)
3. Tuberculosis screening examination must follow the Tuberculosis screening protocol below.

Refer to the California Department of Public Health webpages for any updates.
TB Guidelines and Regulations (ca.gov)

Tuberculosis Screening Protocol:
All clients should be screened for Tuberculosis infection when staying at a residential facility and routinely thereafter.

Screening includes a Tuberculin Skin Test (TST) or QuantiFERON ®-TB blood test (QFT) or CXR with symptom review and a history of TB treatment and diagnosis. Documentation of prior TST results should be obtained whenever possible.

In addition, a baseline CXR (within one month prior to enrollment) is required for all newly enrolled HIV+ members regardless of prior or current TST results.

I. Initial Screening for New Clients

1. Review Symptoms: Any chronic cough (>3 weeks), weight loss, night sweats, fever, hemoptysis (coughing up blood)?
2. Past History: Assess prior TB disease and treatment for active or latent TB infection
3. Test: TST or QFT Testing; and/or a chest x-ray with physician's statement that the client does not have communicable tuberculosis
4. If the member is known HIV+ (regardless of skin/blood test result) or the client has symptoms of TB or has a TST $\geq$ 5mm or a + QFT result, the following is required:
    a. CXR
    b. Medical evaluation
5. All members with a negative initial TST or QFT will require routine repeat TSTs or QFTs, and TB symptom review annually.

The following types of clients require specific evaluations:

Member Type	Treatment Status/History	Evaluation Required
TST or QFT– and HIV– or HIV unknown	No prior treatment	Annual TST/QFT Annual symptom review
TST or QFT– and HIV+	No prior treatment	Annual TST/QFT/chest xray Biannual symptom review
TST or QFT+ and HIV– or HIV unknown	Completed preventive treatment	Annual symptom review

TST or QFT+ and HIV– or HIV unknown	No prior or incomplete treatment	Annual symptom review and medical risk assessment for diabetes, cancer, immune modulating medication intake, end-stage renal disease and HIV. If new risk present, repeat chest x-ray annually if patient remains untreated a physician's statement that he/she/they do not have communicable tuberculosis
TST or QFT+ and HIV+	Completed preventive treatment	Annual symptom review
TST or QFT+ and HIV+	No prior or incomplete treatment	Must be evaluated for treatment Biannual symptom review Annual CXR (if treatment contraindicated)

References:

- California DSS Manual CCL-Social Rehabilitation Facilities;
  CCR Title 22 Sec 81065: employee TB screening,
  Sec 81069: client TB screening: srfman3.docx (live.com)
- Shelter Client TB Screening Guidelines: https://www.sf.gov/information/shelter-client-tuberculosis-screening-guidelines
- Clinical Testing Guidance for TB: Health Care Personnel
  https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm
- State Residential Treatment for Behavioral Health Conditions: Regulation and Policy:
  https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-California.pdf
  (Scope: Definition of Social Rehabilitation Facility vs other facilities)

Contact Person:
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Director of Residential System of Care, (628) 754-9263

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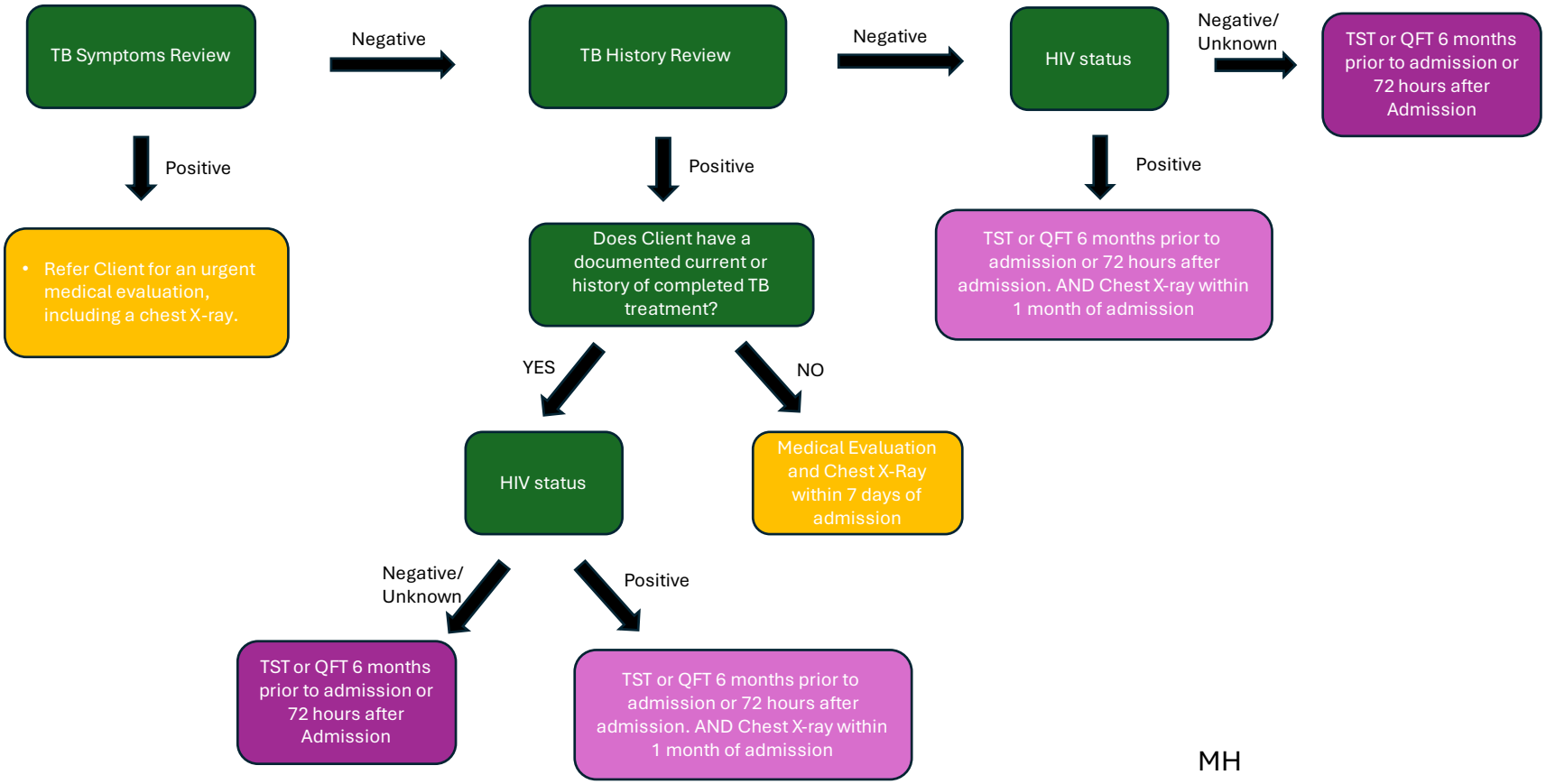

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APPENDIX 1

APPENDIX 2

Tuberculosis Symptom Screen

Do you have any of the following symptoms?

1. A cough lasting for 3 weeks or longer Yes ___ No ___
2. Coughing up blood Yes ___ No ___
3. Fever or night sweats Yes ___ No ___
4. Unexplained weight loss Yes ___ No ___

If the answer to question 1, is Yes AND the answer to any of the other questions is YES, refer for an urgent medical evaluation, including a chest radiograph (CXR). The client needs to wear a mask and may not participate in the program until determined not to have active tuberculosis (TB) disease in an infectious state, as certified in writing by a medical provider.

TB History Review

1.) Do you have a history of a positive tuberculosis test or have you ever been told you have tuberculosis? Yes ___ No ___

2.) Have you ever received treatment for tuberculosis? Yes ___ No ___

If the answer is yes to either question, assess for documentation of TB treatment history in the medical record or current engagement with a medical provider for tuberculosis. If the member has not received treatment for latent or active tuberculosis, proceed with medical evaluation with Chest Xray within 7 days of admission.