**DEFENSE HEALTH AGENCY**
WEED ARMY COMMUNITY HOSPITAL
P.O. BOX 105109
FORT IRWIN, CA 92310-5109

WACH Regulation
*No. 40-72

14 February 2025

Medical Services
**TUBERCULOSIS SURVEILLANCE AND CONTROL**

**1. Purpose.** To prevent new cases of Tuberculosis (TB) through prompt identification and treatment of both TB infection and disease. This regulation establishes policies and procedures IAW MEDCOM Regulation 40-64 for testing, evaluating, treating, surveillance, and documentation of Army personnel and Beneficiaries at risk for TB, and ensures a comprehensive TB Surveillance and Control Program at Weed Army Community Hospital (WACH) Fort Irwin.

**2. References.**

a. AR 40-5, Preventive Medicine, 25 May 2007.

b. Core Curriculum on Tuberculosis, Centers for Disease Control and Prevention, 6th ed., 2013.

c. DA PAM 40-11, Preventive Medicine, 22 July 2005.

d. Guidelines for the Investigation of Contact of Persons with Infectious Tuberculosis, MMWR Recommendations and Reports, 16 December2005, 54 (RR 15); 1-37.

e. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings,• MMWR 2005; 54(RR-17); 30 December 2005.

f. MEDCOM Regulation 40-64, Tuberculosis Surveillance and Control Program, 26 November 2013.

g. Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis infection, MMWR Recommendations and Reports, 25 June 2010, 59 (RR0S); 1-2 5.

**3. Background.** TB is a leading cause of death worldwide and is a public health concern for the U.S. Army. It poses a potential threat to Force Health Protection. TB is uncommon in the United States; the incidence of TB disease was 2.7 per 100,000 population in 2019. The risk of TB disease in the military is even lower, less than 1 per 100,000 population. The prevalence of Latent Tuberculosis Infection (LTBI) in the

United States is approximately 4 percent overall, but is one percent in military-age groups. In most military populations the prevalence of TB is low, which supports testing of high-risk individuals based on an individual risk assessment.

**4. Responsibilities**

a. The Chief, Public Health (PH), is responsible for oversight and program supervision of the TB Surveillance and Control Program including testing and treatment.

b. The Chief, Army Public Health Nursing (APHN), is responsible for TB program management and implementation, to include surveillance and reporting, quality assurance of testing, treatment, and case management.

(1) Nursing case management includes verification of cases, disease reporting, and coordination of treatment, contact investigations, supervision of therapy, and administration of directly observed therapy (DOT) when appropriate.

(2) Interview all newly confirmed/hospitalized cases to gather a complete history of prior exposure, travel in overseas areas, and close contacts. Contacts will be screened and tested as indicated per contact investigation recommendations.

c. Primary Care physicians will provide consultation and medical advice as indicated and will be responsible for initiation of appropriate therapy on all hospitalized adult patients with diagnosed active disease. Follow-up care will be coordinated between the physician and APHN. APHN will provide monthly follow-ups on all discharged active cases until treatment completion. Likewise, the Hospitalist or Primary Care physician will notify the APHN about any new or known outpatient cases among hospital employees, should they be the primary caregiver for these patients. Coordination of their care will then proceed between the provider, APHN, and the Infection Control Nurse.

d. The Infection Control Nurse (ICN) will:

(1) Identify those hospitalized individuals with a diagnosis of TB or suspected TB and report to the Chief, APHN who will notify the Chief, PH.

(2) Provide assistance in identifying and coordinating the testing of employees, and inpatient contacts of patients with TB. Of special concern are those employees, staff and patients who are exposed to TB before proper isolation technique was initiated.

(3) Remind outpatient clinics with a suspected TB patient to place a face mask on the patient to prevent transmission between other individuals. The clinic and/or ICN will notify the ED ahead of time that a patient suspected of TB disease is being escorted to the hospital. The ICN will inform Medical/Surgical staff and facilitate infection control measures.

f. The Occupational Health Clinic (OHC) will:

(1) Be responsible for completing MEDCOM Form 831 on hospital employees (military or civilian), per MEDCOM Regulation 40-64 and guidance in reference (e).

(2) Not administer tuberculin skin-tests on individuals who previously tested positive in past evaluations. These individuals do not require a chest x-ray unless symptomatic or it is indicated for some other reason.

h. The OIC, Immunization Clinic will ensure that the Immunization Clinic refers all persons with a skin test reaction of 5mm induration or greater to APHN for risk assessment.

i. The Chief, Obstetrics and Gynecology Service will:

(1) Ensure targeted testing of all obstetrical patients.

(2) Incorporate MEDCOM Form 829 into clinical practice to evaluate high risk patients.

(3) Administer TB testing as appropriate for patients, as it is both safe and reliable throughout pregnancy.

j. The Chief, Laboratory Services will ensure that APHN is notified when there are abnormal Quantiferon-Gold lab results.

**5. Procedures.**

a. Evaluation and Treatment of Active Cases:

(1) Evaluation and treatment of all new cases of active TB will be based on current clinical guidelines.

(2) It is essential that all strongly suspected or newly diagnosed cases of TB be hospitalized for immediate evaluation/ prompt treatment and coordination with APHN for contact investigation and reporting. Prompt notification is considered essential in order to ensure proper evaluation of all close contacts including family members.

b. Evaluation and Treatment of TST converters:

(1) TSTs should be targeted to individuals at high risk and discouraged in those at low risk. Only targeted testing will be performed during the periodic health assessment **(PHA).** There will be no testing in the pre-deployment setting and testing should not be routinely performed during deployment. There will be no testing during the

post-deployment health assessment or re-assessment. Post-deployment TB risk assessment will be performed at the time of the PHA.

(2) PHA - Soldiers will have an annual TB exposure risk assessment completed during the PHA using MEDCOM Form 830: Periodic TB Risk Assessment Tool (RAT}. Only those identified by the RAT will go on to receive TB testing.

(3) Converters or reactors will be referred to APHN. Personnel with evidence of skin test conversion will be considered for LTBI prophylaxis. IAW CDC guidelines, a baseline hepatic function test and chest x-ray may be obtained before beginning any treatment and referral to the Primary Care Manager (PCM}. The PCM will complete the medical evaluation and initiate preventive therapy for individuals referred with a positive TST.

c. Routine Surveillance Procedures:

(1) Inpatients: There is no requirement for routine surveillance of inpatients.

(2) Outpatients: There is no longer a requirement for routine surveillance of military personnel. Soldiers will have annual TB exposure risk assessment completed during the PHA using MEDCOM Form 830.

(3) Hospital Employees: Targeted testing among healthcare workers should occur based on the MTF's annual TB risk assessment and individual risk factors in accordance with current CDC guidelines.

**The proponent of this WACH Regulation is Chief, Public Health. Users are invited to send comments and suggested improvements on a DA Form 2028 (Recommended Changes to Publications and Blank Forms) to: Commander, WACH, ATTN: MCXK-PH, Box #105109 Fort Irwin, CA 92310-5109.**

FOR THE COMMANDER:

OFFICIAL:

F. CAMERON JACKSON
COL, MS
Director

DISTRIBUTION: A