

6220
Ser PM/

From: Executive Secretary, Navy Epidemiology Board
To: Commanding Officer, Navy Environmental Health Center
Via: President, Navy Epidemiology Board

Subj: MINUTES OF THE NAVY EPIDEMIOLOGY BOARD (NEB) MEETING OF
26-28 JUNE, 2002

Ref: (a) NAVENVIRHLTHCENINST 6220.1F

Encl: (1) List of Attendees
(2) Navy Epidemiology Board Meeting Agenda
(3) EPI-RAP 02-003 Validation of Medical Event Reports – Ms. Riegodedios
(4) EPI-RAP 02-004 Public Health Surveillance Using Laboratory and Pharmacy Data – Ms. Riegodedios
(5) EPI-RAP 02-005 Tuberculin Skin Test Competency and Refresher Training– CAPT Hayashi
(6) EPI-RAP 02-006 Notifying Gaining Commands of TST Reactors and TB Patients on Treatment - CAPT Hayashi

1. The subject meeting was held at the Navy Environmental Health Center, 26-28 June, 2002, in accordance with reference (a). CDR Sherman welcomed the attendees (listed in enclosure (1)); the Minutes from the previous meeting were reviewed. CAPT Sack, NEHC Commanding Officer, addressed the NEB members, and explained the new position of NEHC as M11 under the BUMED realignment. He sees a big role for the command in Population Health improvement, which appears to be one of the Surgeon General's main interests.

2. **Old Business** (Previous EPI-RAPs still pending).

a. EPI-RAP 00-008: Preventive Medicine Physician Credentials and Privileges.

NEB Recommendation: CAPT Brawley informed the NEB that a final draft of the PAR privileging form for 'Population Health Medicine' is being reviewed by prevention specialty leaders, and BUMED is updating the relevant instruction; progress is slow currently. A draft NEHC Instruction for Credentialing and Privileging is being reviewed.

Action Required: CAPT Bohnker will provide an update at the next NEB meeting on status of credentials and privileges.

Status: Closed.

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b. EPI-RAP 00-013: Individual Medical Readiness Categories.

NEB Recommendation: A universal needs statement was developed by II MEF and is now being reviewed by MCCDC.

Action required: CDR Hendrick to update the Board on any action taken, at next NEB meeting.

Status: Closed.

c. EPI-RAP 00-014: Monitoring for syphilis Eradication in USN/MC.

NEB Recommendation: A paper was published by Navy authors, describing Navy and Marine Corps syphilis rates, progress towards elimination, and future plans.

Action Required: None.

Status: Closed.

d. EPI-RAP 00-015: Report of Thermal Stress Injuries.

NEB Recommendation: A new Marine Corps Order on Heat Stress has been released, incorporating all the medical requirements recommended by Preventive Medicine.

Action Required: None by NEB.

Status: Closed.

e. EPI-RAP 01-005: STD Interviews and Patient Confidentiality

NEB Recommendation: Obtain further legal guidance from JAG Corps, regarding duty to report violation of the UCMJ disclosed during epi/STD contact interviews.

Action required: Mr. Calvert will pursue further clarification from the JAG.

Status: Closed.

f. EPI-RAP 01-006: Epidemiology Software Standardization

NEB Recommendation: Do not recommend a specific software package for NEPMUs or FDPMPUs – individual PMOs have their own preferences, and there is not agreement on any one statistical software program

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Action required: None

Status: Closed.

g. EPI-RAP 01-007: PM Physician Billets – Changing The Infrastructure

NEB Recommendation: It was proposed to Commanding Officer, NEHC, that he convene a committee to carefully examine Navy PM manning and unfulfilled needs/ related issues, and to make recommendations for the future manning levels of Preventive Medicine/public health in Navy Medicine. It was suggested this committee include CAPTs Brawley and Thomas, among others.

Action Required: None by NEB.

Status: Closed.

h. EPI-RAP 01-008: Reservists for Backfill During Deployments, enclosure (6).

NEB Recommendation: CO NEHC has for action to pursue or not, whether it is feasible to implement an organizational structure to assure appropriate specialty backfill at the NEPMUs.

Action Required: None.

Status: Closed.

3. New Business

a. EPI-RAP 02-002: MRSA – Recommend Addition to List of Reportable Diseases

NEB Recommendation: The outbreak investigation at Parris Island is still producing prevalence figures. CAPT Mark Wallace, Infectious Diseases, thought it would be good to make Community Acquired MRSA a reportable event. NEB would like more data on prevalence, scope of problem.

Action required: LCDR McDonald will update prevalence data and related information.

Status: Closed.

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b. EPI-RAP 02-003: Validation of Medical Event Reports

NEB Recommendation: NEHC PM should pursue a pilot study for validation of MERs, wherein MTF laboratories reportable dz lab reports are compared with the MERs submitted to the NDRS. In the future, may include in the MER Instruction the requirement for MER QA and validation by MTFs.

Action required: Ms. Riegodedios and NEHC PM to draft SOP for validation of MERs, and pursue pilot study.

Status: Open.

c. EPI-RAP 02-004: PH Surveillance Using Lab and Pharmacy Data

NEB Recommendation: Endorses concept of making reporting of reportable diseases mandatory for MTF laboratories.

Action required: NEHC PM to draft addition to BUMED Instruction 6220.12A Medical Event Reports

Status: Open.

d. EPI-RAP 02-005: TST Competency and Refresher Training

NEB Recommendation: Enclosure (1) of the BUMED TB Instruction states that the SMDR must document that personnel are qualified to perform TST. NEB endorses having more detailed requirements for personnel who administer and read TSTs.

Action required: CAPT Hayashi will take lead on developing appropriate guidelines, and submitting them to BUMED Prev Med.

Status: Open.

e. EPI-RAP 02-006: Notifying Gaining Commands of TST Reactors and TB Patients on Treatment

NEB Recommendation: If medical personnel executed the TB program as currently instructed, LTBI and active TB patients would not be lost from the program during PCS moves. Patient tracking may improve by adding to the TB Instruction that relevant TST and INH treatment information must be thoroughly documented on the DD 2766 Adult Preventive and Chronic Care Flowsheet.

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Action required: CAPT Hayashi will take lead on drafting appropriate input for BUMEDINST 6224.8, and submitting to BUMED Prev Med

Status: Open.

4. Administrative Business

a. Presentations to the Board.

1) CAPT Yund, MC, USN, presented the new BUMED realignment and discussed related issues. Also, the Navy IG has said that that BUMED should conduct a self-assessment for Preventive Medicine, “to establish and prioritize POA&Ms to address areas for improvement.” NEB discussion included a possible ‘board of advisors’, and the desire to create something useful for Navy PM that is not burdensome. It was decided that the NEB will create a working group to address a Navy PM Self Assessment; members will include personnel from the NEB, NEHB, PMTs and other pertinent communities. CAPT Yund and CDR Sherman will take for action.

2) Mr. Paul Morgan and Mr. Paul Forshe, of NMIMC, presented a web-based DNBI reporting tool developed with input from NEHC PM. It now exists online and is ready for beta testing. Issues include obvious need for web access, not available on many smaller ships; and issue of Secret classification of certain data that would then require SIPRNET for access. SOUTHCOM is already doing web-based DNBI reporting out of GITMO.

3) Ms. Riegodedios briefed current activities in NEHC PM Epi. The MER instruction is in process of rewrite. CDR Sherman stated this is time to de-emphasize the NDRS software and make its use not mandatory. Recommended to add requirement for labs to report RMEs directly to NEHC. Suggestion to have added a notifiable disease category to the ESSENCE system. Look for RMEs using daily ADS searches for the ICD9 codes. SAMS has reportable disease module, but only useful for AD, and is not used by large MTFs.

4) LtCol Cox, MC, USAF, presented AFIERA epi update, influenza surveillance, and some new non-lethal weapon issues for consideration by PMOs. (see enclosure (7)).

5) NEPMU presentations: 7 and 5 have large amounts of DNBI data from 5th Fleet and 1 MarDiv respectively; now have good ship-specific data and baseline rates, 3.5-4.0 %/week, most common in order injury/derm/resp/gi/other. All Units reported very large CBRE training burden having to teach the 3-day course – suggested the teaching responsibility be transferred to CNET. Recommended gathering data to document burden, and present as future Epi-Rap.

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6) CDR Hendrick, MC, USN, reported on his experience as PMO for the JTF at Guantanamo Bay. Other than usual PM issues, big challenge was formulating and following public health policies in face of arguments with ID docs who were not experienced with medical issues in the field away from tertiary care centers. He said being able to reach experienced, well-placed contacts to provide objective external validation of policy and decisions was key to success.

7) CAPT Schor, MC, USN, joined the meeting by teleconference call, and briefed HQ-USMC issues. The USMC Generals' 3 main areas of current interest are sports medicine and injury prevention, and they are asking for good injury data while considering a fundamental change in the way physical training is conducted throughout the MC; psych and stress counseling and other ways to reduce the 2nd most common cause of disability, mental health issues; and 'blue-green' integration to eliminate any barriers to care for the Marines at all Navy MTFs

5. Next Meeting. The next meeting is scheduled for 04-06 December, 2002.

(signed)
M. A. MALAKOOTI
CDR, MC, USN

Minutes reviewed and approved by President, Navy Epidemiology Board.

Date: 08OCT 2002

(signed)
S. S. SHERMAN
CDR, MC, USN

Minutes reviewed by Commanding Officer, NAVENVIRHLTHCEN.

Comments:

f. **EPI-RAP 01-006:** Epidemiology Software Standardization

CO COMMENT: I understand individual preferences. However, PMOs need to understand the data environment of the platform and ensure the ir preferred analysis software is compatible. We do NOT need surprises on deployment

g. **EPI-RAP 01-007:** PM Physician Billets – Changing The Infrastructure

CO COMMENT: I need more background. Not sure I understand why this could not be a NEB item.

h. EPI-RAP 01-008: Reservists for Backfill During Deployments

CO COMMENT: Concur. Referred to P&O (CAPT Mitchell) for action.

Approved/Disapproved

Date: 13SEPT2002

(signed)
D. M. SACK

**NAVY EPIDEMIOLOGY BOARD
NAVY ENVIRONMENTAL HEALTH CENTER
NORFOLK, VA**

**LIST OF ATTENDEES FOR NAVY EPIDEMIOLOGY BOARD
MEETING OF 26-28 JUNE, 2002**

MEMBERS PRESENT

CDR S. Sherman, MC, USN (**President**/NEPMU-5)
CAPT B. Bohnker, MC, USN (NEHC)
CAPT J. Yund, MC, USN (BUMED Med-24)
CAPT K. Hayashi, MC, USN (NEPMU-6)
CDR B. Hendrick, MC, USN (II MEF)
CDR M. Malakooti, MC, USN (**Executive Secretary**/NEHC)
LCDR T. Blankenship, MC, USN (NEPMU-2)
LCDR C. Clagett, MC, USN (NEPMU-7)
LCDR J. Howe, MC, USN (I MEF)

GUESTS

CAPT T. Sharp, MC, USN (PM Specialty Leader)
CAPT B. Mitchell (HSO)
LTCOL Cox, MC, USAF (AFIERA)
LCDR S. Wright, MSC, USN (MARFORLANT)
LCDR E. Kasowski, MC, USN (USUHS)
LCDR B. Conner, MC, USN (USUHS)
Mr. Paul Morgan
Mr. Joe Forshe
Ms. Lea Gilchrist (NEHC)
Mr. Bill Calvert (NEHC)
Ms. Asha Riegodedios (NEHC)

MEMBERS ABSENT

CAPT R Thomas, MC, USN (NEHC)
CAPT K. Schor, MC, USN (HQUSMC)
CAPT J. Beddard, MSC, USN (NEHC)
CDR M. McCarthy, MC, USN (NMRC)

AGENDA

NAVY EPIDEMIOLOGY BOARD MEETING 26-28 JUNE 2002

Wednesday, 26 June 2002

0800-0810 Welcome & Opening Remarks - CDR Sherman
0810-0830 Commanding Officer Remarks - CAPT Sack
0830-0915 BUMED MED-24/JPMPG - CAPT Yund
10 min break
0925-1000 NEHC PM Epi – Ms. Riegodedios
1000-1100 Web-based DNBI reporting – NMIMC
1100-1115 NEHC EPICENTER POM – CAPT Bohnker
1115-1130 SAMS CCB update – CAPT Bohnker

1130 - 1300 Lunch

1300-1320 NDRS/SAMS 8.02 update – Ms. Gilchrist
1320-1420 NEPMUs 15-min Briefs
Break
1430-1515 USAF Epi update, Flu surveillance, new non-lethal weapons issues - LtCol Cox
1515-1600 GITMO PM Experience – CDR Hendricks

Thursday, 27 June 2002

0800-0805 Presidential Remarks – CDR Sherman
0805-0845 Specialty Leader Brief – CAPT Sharp
0845-0915 ADS Coding study – LT Elizabeth Haydon
0915-0925 Break
0925-1130 **Old Business (Review Previous Open EPI-RAPS)**
EPI-RAP 00-008 PM Physician Credentials and Privileges – CAPT Brawley
EPI-RAP 00-013 Individual Medical Readiness Categories – CDR Hendricks
EPI-RAP 00-014 Monitoring for Syphilis Eradication in USN/USMC – CAPT Thomas
EPI-RAP 00-015 Report of Thermal Stress Injuries – Ms. Nancy Craft OEM/PM
EPI-RAP 01-005 STD interviews and patient privacy/confidentiality – Mr. Bill Calvert
EPI-RAP 01-006 Epidemiology Software Standardization – CDR LaMar
EPI-RAP 01-007 PM Physician Billets – Changing the Infrastructure – CAPT Brawley
EPI-RAP 01-008 Designation of Reserve Assets for Backfill During Extended Deployments –

CDR

Sherman

1130–1300 Lunch

Enclosure (2)

Continued – Thursday

1300-1500 New EPI-RAPS

EPI-RAP 02-001 MRSA Surveillance in Recruits - LT Hankinson

EPI-RAP 02-002 MRSA – Recommend addition to reportable diseases list - LCDR McDonald

EPI-RAP 02-003 Validation of Medical Event Reports

EPI-RAP 02-004 PH Surveillance Using Laboratory and Pharmacy Data

EPI-RAP 02-005 TST Competency and Refresher Training

EPI-RAP 02-006 Notifying Gaining Commands of TST Reactors and TB Patients On Treatment

1500-1530 Request for NEB feedback on PM issues from MCCDC-lead WG, Marine Combat Assessment Team
– CDR Sherman

1530-1540 Break

1540-1610 Dietary Supplements Use/effects Survey – LCDR Byron Conner

Friday, 28 June 2002

0800-0805 Opening Remarks - CDR Sherman

0805-0930 CAPT Schor telephone conference

- HQ USMC

- HQMC/HS proposed Marine Corps Program for Sports Medicine and Injury Prevention

- PM AMAL/FDPMU doctrine, strategy, concepts, and employment

- Sick Cell issues at MWTC, AFEB re SCD/SCT; CAPT Schor, CDR Sherman, CAPT Yund

0930-0940 Break

0940-1000 NEB Membership Issues – Clinical Epi member; Great Lakes PMO for At-Large position; Army
guest rep

1000-1020 Selection of Date for Next Meeting and Closing Remarks

1030 **Adjourn**

Notes

Friday 1030 Retirement Ceremony CDR Mothershead, at MacArthur Memorial, Norfolk

Enclosure (2)

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (EPI-RAP)**

DATE: 6/17/02
EPI-RAP# 02-003

TITLE

Medical Event Reports Validation

ISSUE/PROBLEM STATEMENT

According to BUMED Instruction 6220.12A, NEPMUs shall "validate, on an annual basis, a sample of MERs as directed by NAVENVIRHLTHCEN." This direction has not been provided in the past. NEPMUs have conducted various validation tests at various times. However, this process is neither standardized nor routine.

PRIORITY

Routine

BACKGROUND

USACHPPM with the Army Surveillance Medical Activity (AMSA) conducted a study on the completeness of reporting of hospitalized reportable medical events the Army, Navy, and Air Force. Results showed that in 2001 the Navy had 18% completeness of reporting of hospitalized cases through the Naval Disease Reporting System (NDRS) while the Army had 45% completeness of reporting through their reportable diseases surveillance activities.

Surveillance data should be validated on a regular basis in order to understand: (1) whether reported cases are true cases and (2) the extent of under-reporting in the outpatient and inpatient setting. This would substantiate the need and possibly identify specific gaps in improving data surveillance and reporting. Data validation would also facilitate accurate interpretation and usefulness of reported data as it is used for outbreak identification and planning purposes.

ACTION NEEDED

- (1) Establish a need for this validation
- (2) Support the writing of a specific standard operating procedure
- (3) Review the enclosed proposed outline (Enclosure 1) as a feasible guide that NEPMUs may use for performing this validation.

Encl (3)

ISSUE ORIGINATOR

Asha Riegodedios, MSPH
Preventive Medicine Directorate
Navy Environmental Health Center
620 John Paul Jones Circle Ste 1100
Portsmouth, VA 23708-2103
(757) 953-0708

PERTINENT REFERENCES

1. BUMED INST 6220.12A
2. "Completeness and Timeliness of Reporting Hospitalized Notifiable Active Duty Cases, US Navy Medical Treatment Facilities", January 1995-June 2001, Medical Surveillance Monthly Report, AMSA. Vol. 7, No.9. 2001. pp. 16-19.

PERTINENT PERSONNEL

None

Medical Event Reports Validation, Proposed Outline

Validity provides a crucial element to determining the accuracy of a surveillance system. A measure of validity describes whether a medical event as reported reflects the true medical event occurrence in a population.

For the purposes of the Naval medical event reporting system, validity can be evaluated in two ways: (1) are the cases that are reported true cases (data integrity) and (2) how complete is reporting.

A three-fold approach is proposed. One is an ongoing assessment of reported cases as they are received at the NEPMU to ensure integrity of data. Two are annual efforts to estimate validity:

- (1) Ongoing assessment of conditions that may not be reported accurately (Hepatitis B that is not acute or cases reported as not confirmed but are actually confirmed for example). NEPMUs can confer with the reporting unit and make changes to inaccurate submissions as needed before data is transmitted to NEHC.
- (2) Annual assessment of select laboratory confirmed reportable medical events. Labs have certain ad hoc reports that are already created and can be run with a fair amount of ease depending on workload and computer load. One hospital or clinic lab with a large workload for that particular disease can be selected by each NEPMU, an ad hoc report can be requested for all lab positive results of a particular condition for that year. Then these
- (3) cases could be matched with the local NDRS database at the NEPMU. Measures such as # cases reported and not reported through NDRS could be calculated. Accuracy of certain NDRS fields such as "case confirmed" or "lab confirmed" as well as completeness of speciation reporting may also be determined.

- (4) Annual assessment of diagnosed reportable medical events. This is two-fold:
- a. Select two clinics - the highest and lowest reporter of MERs. Review sick call logs for that year, get distribution of reportable events by diagnosis, compare these numbers to the local NDRS database at the NEPMU. Note for further inquiry: Do clinics keep sick call logs that contain ICD-9 codes and would those logs have the diagnosis of medical events (since many medical events would be diagnosed several days after a visit and a subsequent visit might not have taken place)?
 - b. Formulate, if possible, a strategy for review of reporting on large decks, maybe through the Preventive Medicine Partnerships.
 - i. The following would be ideal, but is it possible: Select two large-deck ships in port (as applicable) - the highest and lowest reporter of MERs. Review sick call logs for that year (this should not be time consuming as most, if not all, of these ships have some sort of electronic log), get distribution of reportable events by diagnosis, compare these numbers to the local NDRS database at the NEPMU.
 - ii. Another possibility: The vast majority of what is seen on ships is STDs. Maybe a distribution of reportable events could be captured through the lab logs if sick call logs are not feasible.

**NAVY EPIDEMIOLOGY BOARD
REQUEST FOR ACTION PAPER (EPI-RAP)**

DATE: 6/17/02
EPI-RAP# 02-004

TITLE

Creating a Robust Public Health Surveillance System Using Laboratories and Pharmacies

ISSUE/PROBLEM STATEMENT

Civilian public health surveillance and response systems integrate the resources of providers, hospitals, and laboratories. In some states or local health departments, other infrastructures such as pharmacies are integrated in the surveillance systems. However, Navy public health surveillance utilizes only provider feedback for diagnosis of reportable diseases, which is mediocre at best. In addition, sensitivity and speciation surveillance of isolates is not routinely conducted or reported by military labs.

PRIORITY

Routine

BACKGROUND

Public health surveillance is facing a huge wall in the tracking and monitoring of reportable diseases. It is believed that completeness of reporting in the Navy is below 20%. This raises questions of validity and usefulness of reported data as well as the ability to identify and respond to disease threats among our forces and their families.

Including laboratories in disease surveillance is well practiced and common in the civilian sector. In addition, pharmacy data is becoming recognized as useful in public health surveillance.

It is apparent that new and innovative ideas and initiatives need to take place in order to improve disease surveillance. Integrating laboratory and pharmacies in the surveillance system may drastically improve the ability to protect our forces, especially during this time of War.

ACTION NEEDED

- (1) Discuss the value and plausibility of pursuing laboratory and pharmaceutical surveillance.
- (2) Identify avenues for action to integrate labs and pharmacies in the surveillance infrastructure.
- (3) Discuss any barriers that may need to be addressed
- (4) Discuss the stakeholders that should be included.

ISSUE ORIGINATOR

Asha Riegodedios, MSPH
Preventive Medicine Directorate
Navy Environmental Health Center

PERTINENT REFERENCES None

PERTINENT PERSONNEL None

Enclosure (4)

EPI-RAP# 02-005 7 June 2002
Marienau, Hayashi, Slaten
NEPMU6 Pearl Harbor, HI

Tuberculin Skin Testing Competency and Refresher Training

Background: Tuberculin Skin Testing (TST) constitutes the backbone to check for infection with Mycobacterium tuberculosis (MTB), and thereby intervene before latent TB infection (LTBI) progresses to disease. Accuracy is dependent on the training and experience of individuals applying and interpreting the test. Placement and reading competence vary, with competency expected to be less in individuals who have spent significant periods of time away from performing and interpreting TSTs. There is no current refresher training requirement for TST for those who remain at a command for several years. NEPMU6 staff proposes a Navy-wide requirement for standardized refresher TST training and competency evaluation, having the requirements incorporated into the TB instruction NAVMED 6224.8 of 8 Feb 93 [The DRAFT is BUMEDINST 6224.8A] . NEPMU6 staff propose that this requirement be mandated.

Discussion: At least one major shipboard outbreak was aggravated by failure to recognize a TST that indicated infection in a service member with active pulmonary disease who spread TB to other deployed personnel. Observation of corpsmen attending class at NEPMU6 found significant variation in the competence of providers in applying the TST. Some of the performance variance many have resulted from personnel having been away from clinical care (i.e. assigned to administrative billets). Providers are expected to be able to perform TSTs whether or not they routinely perform them. The nature of deployments and independent duty demand high standards in performing and interpreting TSTs. The negative impacts on both operations and resources of marginal and substandard TST procedures can be significant, and should not be allowed to continue. Specific areas for TB testing program improvement include what training must be conducted at baseline, how often, and under what conditions TST training must be subsequently conducted (e.g. direct supervision by program managers and provider viewing of the CDC video on TST as part of any PCS process by clinicians, documentation of expertise in applying and reading a minimum number of TSTs). In addition, reinforcement of proper reporting procedures, documentation of TST and investigation results, monitoring of patients on INH, etc. are all important.

Recommendation: NEB solicit volunteers to work on standards responding to the above (NEPMU6 volunteers) to develop standard guidelines addressing the above concerns. Solicit members of the NEB for suggested guidelines for incorporation into the TB Instruction.

Enclosure (5)

Refresher Training (Provider scheduled to transfer)

Individual's whose current billet does not require them to routinely apply and interpret Tuberculin Skin Tests (TST) must, prior to their transfer to any billet where they will be required to apply and/or interpret TSTs, be certified by their department head to:

-be able to accurately apply TSTs, with a minimum of six TSTs properly applied (under direct supervision by a provider who regularly places TSTs) by the service member

-have seen the most current CDC video/DVD/internet bit stream on conducting and interpreting the TST

-be able to accurately interpret TSTs, with a minimum of six TSTs properly interpreted (under direct supervision by a provider who regularly interprets TST) by the service member

-be able to competently explain the procedures for reporting positive TST reactors (Latent TB Infection, LTBI), conducting follow-up investigations when there is an elevated rates of TST reactors to check for disease, conducting follow-up investigations when an active case is discovered, conducting and reporting contact/outbreak investigations, and obtaining additional assistance

-have their competency documented using the attached draft form with the competency certification forwarded with their service records, and kept in that service record until they are subsequently transferred from the gaining command to their next command

The sending command's department head is responsible for assuring that the above training is completed prior to transferring the service member.

Refresher Training (Provider not scheduled to transfer)

Individuals who provide clinical care be required to observe, annually, the most current version of the CDC video on TST placement and interpretation.

Documentation of Refresher Tuberculosis Skin Testing and
Program Management Competency

Day: _____ Command: _____

Month: _____ Mailing Street Address: _____

Year: 200__ City/State _____

Zip Code _____

Phone Number: Commercial: _____

DSN: _____

Name of Provider: Last _____ First _____ MI _____

Rate/Rank _____

Last 4 of Social Security: _____

Current Billet: _____

Below competencies are to be certified and dated prior to transfer of any medical provider not currently serving in a clinical care billet who has been assigned to, or is within three months of transferring to a billet where they will be working with the TB Control Program in a clinical role.

1. Has been witnessed properly placing _____ (minimum of six required) tuberculin skin tests.

Observer: _____ Signature: _____
Date: Mo__ Day__

2. Has been witnessed properly interpreting _____ (minimum of six required) tuberculin skin tests.

Observer: _____ Signature: _____ Date: _____
Mo__ Day__

3. Has seen the most current version of the Centers for Disease Control and Prevention (CDC) videotape covering how to place and interpret the tuberculin skin test.

Observer: _____ Signature: _____ Date: _____
Mo__ Day__

4. Has been able to correctly explain procedures for reporting TST reactors (those with latent TB infection), active cases, contacts, and other populations as called for in the Annual Summary Record of Tuberculosis Screening.

Observer: _____ Signature: _____ Date: _____
Mo__ Day__

5. Is able to adequately describe procedures to investigate theoretical elevated TST reactor rates at a command in order to uncover any active cases of tuberculosis

Observer: Signature: Date:
Mo___Day___

6. Is able to describe how to investigate theoretical contact investigations when a case of active tuberculosis is discovered at a command.

Observer: Signature: Date:
Mo___Day___

7. Is able to describe additional resources for assistance in contact and outbreak investigations and indicators for calling on those resources.

Observer: Signature: Date:
Mo___Day___

8. Can accurately describe procedures for monitoring patients placed on Isoniazid (INH) to check for toxicity.

Observer: Signature: Date:
Mo___Day___

Verified by _____

Name of Department Head: _____

Signature: _____

Date: Month_____Day_____200__

[[Note: The number of six should be discussed as a minimum number. I have no metrics data that dictate a clear benefit of one number vice another for competency testing - Hayashi]]

Enclosure (5)

Upon completion: Place one copy of this form into service member's service record. Recommend service member retain one copy.

[[Note: Looking for inputs on the issue of a short examination that should supplement the annual viewing of the CDC video-hayashi]]

Enclosure (5)

EPI-RAP 02-006
10 June 2002
Marienau, Hayashi, Slaten
NEPMU6 Pearl Harbor, HI

EPIRAP-Notifying Gaining Commands of Known Tuberculin Skin Test Reactors and those under treatment for Active Tuberculosis

Background: Tuberculin Skin Testing (TST) converters and those who are under treatment for active tuberculosis (tuberculosis disease) require specific follow-up to maximize compliance with therapy. There is currently non mandate for commands to report TST reactors, or TB cases currently under treatment, to the medical departments of gaining commands. Thus, it is possible that those personnel who transfer to a gaining command will not have their medical condition noted on check-in, or that their medical records may never actually be checked in. This increases the risk those with latent TB infection (LTBI) will develop active TB as a result of failure to take Isoniazid, with disease spread. The risk of spread also applies to those under antibiotic treatment for active TB who are transferred. NEPMU6 staff proposes that a notification requirement be mandated in the NAVMED 6224.8 instruction for both conditions.

Discussion: Additional active TB case emerged in an individual who contracted infection with TB during a major amphibious combatant on the east coast approximately a year previously. The service member, properly identified as a TST converter, discarded their medication upon transfer from the ship some months after the initial outbreak. Their medical condition failed to be noted by their gaining command, and she did not renew her prescription for Isoniazid (INH). Reviews of medical records at a variety of commands found similar instances of INH having been inadvertently discontinued, without the concurrence of any medical authority. When a TST reactor is placed on INH, and the patient is subsequently transferred, there appears to be the systemic, enhanced opportunity for the service member to slip through the cracks of inprocessing, and not complete their chemoprophylaxis. This increases the risk of progression to active disease, and spread. In instances of active disease, under treatment, the opportunity for failure to complete therapy, and the emergence of multiple drug resistant therapy, are both increased when the patient "slips through". Failure to properly inprocess both TST reactors and those under treatment for active TB are unacceptable.

Recommendation: Require the command for any patient with LTBI notify, via Navy Message, the gaining command of any service personnel who have LTBI, and of any service personnel who are under treatment for active TB. This will lessen risk of those with LTBI and those with active TB under treatment, slipping through the cracks when transferring.

Enclosure (6)