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SECRETARY OF THE AIR FORCE**



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Supplement**

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Aerospace Medicine

***SURVEILLANCE, PREVENTION, AND
CONTROL OF DISEASES AND
CONDITIONS OF PUBLIC HEALTH OR
MILITARY SIGNIFICANCE***

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFD 48-1, *Aerospace Medical Program*, and explains the procedures for surveillance, prevention, and control of diseases and conditions of public health or military significance. It applies to all Air Force military treatment facilities (MTFs) and other units responsible for public health activities. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974, 10 U.S.C., Chapter 55, *Medical and Dental Care*, 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force*, and Executive Order 9397 authorize collection and maintenance of information. Systems Record Notices F044 AF SG R, *Medical Records System*, and *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFD 37-1, *Information Management* and AFMAN 37-123, *Management of Records* and disposed of in accordance with the *Air Force Records Disposition Schedule (RDS)* located at <https://webrims.amc.af.mil>. Unless otherwise

directed, Air Force medical personnel follow the methods for controlling and preventing disease as described in the American Public Health Association publication, *Control of Communicable Diseases Manual*, and the Centers for Disease Control and Prevention (CDC) publication, *Morbidity and Mortality Weekly Report (MMWR)*, and its supplements. Where applicable, the most recent guidelines from these publications are utilized as the standard.

The following surveillance activities can be found elsewhere and are not included in this AFI: Human Immunodeficiency Virus (HIV) Program is found in AFI 48-135; occupational illness reporting, follow Title 29, Code of Federal Regulations, Part 1960, *Occupational Illness and Injury Reporting Guidelines for Federal Agencies*; AF injury prevention and surveillance are managed through the AF Safety Center (IAW AFI 91-204); instructions for suicide event reporting and surveillance are found in AFI 44-154, *Suicide and Violence Prevention, Education and Training*; alcohol and drug abuse reporting and substance use assessment tools are found in AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment Program*. Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels to HQ AF/SGOP, 110 Luke Avenue, Room 400, Bolling AFB DC 20032-7050.

(459ARW) PURPOSE

(459ARW) To provide methods for identifying, training, and testing of personnel with a potential high-risk occupational exposure to the *Mycobacterium Tuberculosis* (TB) in accordance with Air Force Standards and Centers for Disease Control and Prevention (CDC) guidelines.

(459ARW) Scope: This plan provides guidance to minimize the risk of transmission of TB. The 459 ARW TB program is a targeted program, except for an initial TB test upon accession (baseline test), the TB testing program for 459 ARW personnel will be limited to individuals with high-risk TB exposure or those with clinical indications for testing.

SUMMARY OF CHANGES

This interim change makes a deletion to reflect repeal of the Don't Ask Don't Tell policy. A margin bar (|) indicates newly revised material.

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1. ROLES AND RESPONSIBILITIES.

1. (459ARW)Responsibilities.

1.1. Headquarters, US Air Force Surgeon General (HQ USAF/SG).

1.1. (459ARW) The 459 ARW Commander must provide a safe and healthful environment for all 459 ARW personnel.

1.1.1. Provides policy guidance on the surveillance, prevention, control, treatment and reporting of diseases and conditions of public health or military significance affecting AF installations.

1.1.2. Ensures compliance with Department of Defense (DoD) directives and instructions and serves as the executive agent for the DoD Influenza Surveillance Program.

1.2. US Air Force Health Care Operations (AF/SGO).

1.2. (459ARW) The 459 AMDS Commander will:

1.2.1. Establishes Air Force policies and guidance for the surveillance, prevention, control and reporting of diseases and conditions of public health or military significance.

1.2.1. (459ARW) Ensure the implementation of an effective TB control program IAW current CDC guidelines.

1.2.2. Represents AF/SG for surveillance, prevention, and control of diseases and conditions of public health or military significance, or delegates representation for AF/SG involvement, including collaborative research, with other DoD or Federal agencies and organizations.

1.2.2. (459ARW) Ensure a written plan for prevention of TB transmission for health care workers is completed and reviewed annually.

1.2.3. (Added-459ARW) Establish a multi-disciplinary healthcare team (Infection Control Manager (ICM), Public Health (PH), Bioenvironmental Engineering (BE), etc.) to evaluate and conduct an annual TB risk assessment IAW AFI 48-105 and CDC guidelines.

1.3. Air Force Medical Support Agency (AFMSA).

1.3. (459ARW) Public Health/designee will:

1.3.1. Executes programs and policies on surveillance, reporting, and prevention and control of diseases and conditions of public health or military significance.

1.3.2. Reviews periodic reports of various disease surveillance, prevention, and control programs and makes recommendations to AF/SGO for improvement.

1.3.2. (459ARW) Review the Tuberculosis Exposure Control Plan annually and recommend risk-based procedures for screening, control and protection against TB IAW CDC guidelines ([Attachment 6](#)).

1.3.3. Utilizes evidence-based information and population health data to assist MTFs in optimizing population health through effective and efficient health care delivery and disease detection, prevention, and control.

1.3.3. (459ARW) Conduct a risk assessment of personnel, including re-deployers and beneficiaries returning from high-risk TB endemic countries, to determine the frequency of follow-up TB skin testing.

1.3.4. (Added-459ARW) Perform the initial Latent TB Infection (LTBI) patient interview IAW CDC guidelines, document interview on AF Form 2453, *Tuberculosis Detection and Control Data* ([Attachment 7](#)), and refer patients to physician for medical evaluation.

1.3.5. (Added-459ARW) Perform contact tracking IAW CDC guidelines and ensures contact personnel are screened for TB and/or referred to local health department.

1.3.6. (Added-459ARW) Report active TB cases within 24 hours to AFIOS/RSRH. Documents only if an active duty component or combatant command designee is not overseeing the facility.

1.3.7. (Added-459ARW) Direct member training, education, counseling and screening.

1.4. Air Reserve Component (ARC) Surgeons.

1.4. (459ARW) Bioenvironmental Engineering (BE) will:

1.4.1. Coordinate with AFMSA to provide their component's policies and guidance for prevention, control, surveillance, and reporting of diseases and conditions of public health or military significance.

1.4.1. (459ARW) Coordinate with the Infection Control Manager (ICM) and PH to perform occupational and environmental health surveillance activities including industrial health hygiene surveys when required.

1.4.2. Ensures Air National Guard (ANG) and AF Reserve (AFR) medical units and Public Health flights report cases of Tri-Service Reportable Events acquired while the member is on active duty status on federal installations to ANG Surgeon General, AFR Command Surgeon General, state/local health officials, and to AFIOH/RSRH, Epidemiology Services Branch.

1.4.2. **(459ARW)** Determine the appropriate respiratory protections requirements to protect 459 ARW personnel from potential exposure to TB and manages those requiring respiratory protection per AFOSH Standard 48-137, *Respiratory Protection Program*.

1.4.3. **(Added-459ARW)** Ensures procedures are in place for controlling the ordering and issuing of respirators as required.

1.4.4. **(Added-459ARW)** Maintain a roster of personnel of 459 ARW personnel assigned to the fit-testing program for medically cleared personnel.

1.5. Air Force Major Command (MAJCOM) and Air Forces Forward (AFFOR) Surgeons. References to MAJCOMs in this AFI include the Headquarters Air Force Reserve Command (HQ AFRC), Air National Guard (ANG) Readiness Center and other agencies that Headquarters, US Air Force (HQ USAF) designates as “Major Command equivalent.”

1.5. **(459ARW)** Immunization personnel will:

1.5.1. Provide specific Command policy and guidance to fixed and deployed MTFs for preventing, controlling, treating, and reporting diseases and conditions of public health and military operational significance.

1.5.1. **(459ARW)** Administer Tuberculin Skin Test (TST) per current CDC guidance and IAW AFI 48-105, Attachment 3, on testing procedures and interpretation of tests in identified at-risk personnel.

1.5.2. During deployments, ensure that AF medical components transmit reports on exposures, diseases, injuries and fatalities involving deployed personnel. After deployments, ensure that AF medical components forward copies of lessons learned and after action reports to the Joint Universal Lessons Learned System (JULLS) and the Armed Forces Medical Intelligence Center.

1.5.2. **(459ARW)** Document testing and results in the Air Force Completed Immunization Tracking System (AFCITA). AFCITA will be documented by the Immunization section on the date the TST is given.

1.5.3. **(Added-459ARW)** Trained personnel can place, read, and record the TST.

1.5.4. **(Added-459ARW)** Refer all individuals with TST indurations greater than 5mm to PH. If active TB is suspected then alert the ICM, Primary care team leader/provider, and PH to ensure appropriate precautionary infection control measures are applied.

1.6. Air Force Materiel Command (AFMC). Plans, programs, and provides appropriate resources to the AF Institute for Operational Health (AFIOH) to examine, analyze, report and respond to diseases and conditions that affect the health of AF personnel and their beneficiaries.

1.6. **(459ARW)** Physical Examination Section (PES) personnel will:

1.6.1. **(Added-459ARW)** Evaluate all individuals without a negative test.

1.6.2. **(Added-459ARW)** Record positive reactions, initial, and follow-up care on the AF Form 2453 and place in the patient's medical record upon completion of treatment.

1.6.3. **(Added-459ARW)** Document positive reactions on the SF Form 600, *Chronological Record of Medical Care*, in the patient's medical record.

1.6.4. **(Added-459ARW)** Ensure all patients with latent or active TB are referred to PH for contact tracking, education, and reporting then refer member to medical provider for evaluate on and document on SF 600 overprint, *TB and Detection Control Program Provider Initial Interview* (**Attachment 8.1 and 8.2**).

1.6.5. **(Added-459ARW)** Monitor patient compliance with clinical management and follow-up from the initial visit to completion of treatment IAW CDC guidelines.

1.6.6. **(Added-459ARW)** Ensure personnel on flying status are grounded for the first 7 days of treatment. If the services of the flyer are of a critical nature (e.g., in a combat zone or for alert force manning) and active TB has been ruled out, Isoniazid (INH) therapy can be delayed up to 18 months. During this time, the flight surgeon will continue to monitor the flyer closely until his services are no longer critical. At that point, the flight surgeon will initiate INH therapy.

1.7. **USAF School of Aerospace Medicine (USAFSAM).** Develops and conducts training on prevention, investigation, control, reporting requirements and applied epidemiology on diseases affecting USAF personnel.

1.8. **Air Force Institute for Operational Health (AFIOH).**

1.8.1. Provides worldwide consultation services to the AF and DoD in public health surveillance, epidemiology, preventive medicine, and outbreak response. Acts as the AF center of excellence for global emerging infections surveillance and response.

1.8.2. Manages, monitors and analyzes surveillance data and other AF-specific data (e.g., AFRESS) for disease trends and reports significant events to appropriate AF and DoD authorities.

1.8.3. Receives deployment health event data from deployed medical personnel, analyzes data for trends, and archives AF deployment surveillance data. Forwards required data elements to the Defense Medical Surveillance System (DMSS) and serum samples to the DoD Serum Repository IAW AF and DoD guidance.

1.8.4. Promotes standardization of laboratory data and information for surveillance, including identifying emerging pathogens and common sources of disease outbreaks.

1.8.5. Manages the DoD influenza surveillance program; coordinates with Service representatives and with the DoD Global Emerging Infections Surveillance and Response System (DoD-GEIS).

1.8.5.1. Identifies sentinel bases for etiology-based influenza surveillance in collaboration with Army, Navy, DoD-GEIS, and CDC POCs.

- 1.8.5.2. Provides viral collection materials to sentinel bases, and others upon request. Analyzes and reports positive influenza isolates to appropriate personnel at MTFs for notification and follow-up.
- 1.8.5.3. Generates regular reports during the influenza season and annual report at the end of each influenza season. Provides these reports to sentinel sites, AFMSA, DoD-GEIS, Service and Health Affairs POCs.
- 1.8.5.4. Coordinates findings in viral identification and typing with the CDC for consideration in the national influenza vaccine selection.
- 1.8.6. Air Force Mortality Registry (AFMR). Conducts data quality assurance and routinely analyzes mortality data for trends.
- 1.8.7. Provides clinical reference lab and diagnostic services for the AF and DoD, including performing requested AF accessions screening.
- 1.8.8. Provides medical entomological support to AF installations, including consultation services for vector/pest management, personal protection recommendations, and environmental entomology support (e.g., arthropod identification).
- 1.8.9. Provides tuberculosis (TB) risk assessment consultative support to AF activities, including guidance on TB risk assessment and prevention of TB transmission. Maintains a current list of countries/areas with high TB prevalence as well as other deployment-related TB policies and risk assessment procedures on the AFIOH website.
- 1.8.10. Provides on-site epidemiological response support to AF activities upon request.
- 1.9. HQ AETC and AF Training Centers.**
- 1.9.1. Collect, analyze, and disseminate information on significant events and mortality from the training populations, and participate in DoD efforts to reduce morbidity and mortality in training populations.
- 1.9.2. Perform population-based febrile respiratory illness (FRI) surveillance. The Naval Health Research Center (NHRC) in San Diego, California manages this population-based component of the DoD Influenza Surveillance program.
- 1.9.3. Provide health surveillance, health promotion, disease and injury prevention (including immunization and screening) for recruits and training populations based on the unique population risk characteristics (e.g., age, challenging physical activities, and close living quarters) IAW national recommendations, AF and DoD policies.
- 1.10. Installation Responsibilities.**
- 1.10.1. **Installation Commander.** Ensures all units/tenants comply with requirements for preventing and controlling diseases, injuries and other reportable conditions.
- 1.10.1.1. Designates in writing, a Public Health Emergency Officer (PHEO) IAW DoDD 6200.3, *Emergency Health Powers on Military Installations*, to provide medical or public health recommendations in response to public health emergencies.
- 1.10.1.2. When appropriate, declares a public health emergency and exercises special powers, in consultation with the PHEO, IAW DoDD 6200.3, *Emergency Health Powers on Military Installation*.

1.10.2. **Unit/Squadron Commander.** Ensures personnel report to the MTF for screening, immunizations and medical appointments, as required by the wing, MAJCOM, AF or DoD level directives.

1.10.2.1. Ensures that personnel processing to and arriving from overseas locations (e.g., PCS) report to the MTF for appropriate health assessments, screenings, immunizations and medical exams.

1.10.2.2. Ensures personnel complete appropriate pre- and post-deployment health assessments, screenings, immunizations and medical exams IAW with DoD and AF guidance.

1.10.2.3. Ensures that non-prescription public health countermeasures (e.g., mosquito netting, insect repellent) are available. Ensures personnel obtain required prescription products (e.g., malaria prophylaxis). Directs personnel to comply with recommendations for use.

1.10.3. **Base Civil Engineer.** Collaborates with Bioenvironmental Engineering (BE) and Public Health to ensure the base has a safe water supply, proper sewage and trash disposal, effective disease vector and reservoir control (e.g. insects, rodents), proper site selection, and any other environmental safeguards necessary to reduce illnesses/injuries on the base, taking into consideration operational priorities and resources.

1.10.4. Mission Support Squadron Commander.

1.10.4.1. Ensures that accurate monthly rosters of personnel deploying and returning from deployments are forwarded to the MTF.

1.10.4.2. At overseas bases where indicated, ensures that location-specific medical requirements are on the out-processing checklist (e.g., tuberculosis screening).

1.10.5. **Military Treatment Facility (MTF) Commander.**

1.10.5.1. Provides for the surveillance and control of diseases, injuries, and conditions that adversely impact the health of the base population, and recommends and takes actions to prevent or reduce their impact.

1.10.5.1.1. Requests consultative epidemiological or laboratory services (e.g., from AFIOH), as needed, to control disease outbreaks, or to investigate unusual health-related conditions.

1.10.5.1.2. Ensures that the designated PHEO has adequate experience and resources to provide assistance to installation commanders in the event of a public health emergency.

1.10.5.2. Ensures Force Health Protection Prescription Products (FHPPP) (e.g., malaria prophylaxis or PB tablets) are appropriately prescribed by a credentialed health care provider. Ensures providers issue FHPPP with a prescription, appropriate education, and documentation on the SF 600.

1.10.5.3. Appoints physician(s) as clinical consultant for TB, HIV, and other communicable disease control measures.

- 1.10.5.4. Ensures collection, surveillance, prevention and public health activities adhere to AF, DoD, CDC guidelines, and applicable state/local or host nation requirements, and that they are integrated with population health functions.
- 1.10.5.5. Maintains tuberculosis screening and immunization functions and ensures complete documentation in the current AF immunization tracking system.
- 1.10.5.6. Ensures collection and surveillance of communicable, environmental, and other reportable disease/conditions (IAW *Tri-Services Reportable Events Guidelines & Cases Definitions* document, see [Attachment 1](#) for URL) and ensures reporting to AFIOH/RSRH and state/local or host nation officials, as appropriate.
- 1.10.5.7. Ensures contracts involving employee health screening services, provided by the MTF, clearly specify what medical support the MTF can provide.
- 1.10.5.8. Ensures that health care providers and clinical laboratory personnel notify PH of those patients with reportable diseases or other unusual diseases/conditions.
- 1.10.5.9. Ensures reportable diseases diagnosed at clinical visits are correctly coded, using the International Classification of Disease (ICD), and entered into current information systems. ICD Codes for reportable events are listed in the *Tri-Service Reportable Events Guidelines and Case Definitions* document (see [Attachment 1](#) for URL).
- 1.10.5.10. Maintains and supports MTF functions to ensure adequate resources and training for surveillance, prevention and control of diseases and conditions of public health or military significance. Ensures current clinical management guidelines are available to MTF providers.
- 1.10.5.11. Ensures compliance with the requirements of the DoD Influenza Surveillance Program.
- 1.10.5.12. Ensures the MTF uses AF and CDC guidance for disease surveillance, prevention, detection, treatment, and control.
- 1.10.5.13. Ensures MTF complies with rabies prevention and control program requirements IAW current state/local and CDC guidelines.
- 1.10.6. Public Health (PH) (Active Component Only).**
- 1.10.6.1. Conducts community or location-specific public health surveillance, which includes chemical, biological, radiological, and nuclear (CBRN) terrorism and syndromic surveillance. Provides information to the MTF commander and medical staff as necessary.
- 1.10.6.2. Conducts and manages epidemiological surveillance and contact interviews, and serves as a non-clinical consultant on disease prevention, education and control programs. In the event of a suspected or declared public health emergency, these activities (including reporting) shall be conducted in coordination with the PHEO, as appropriate.
- 1.10.6.3. Informs the MTF Commander, providers, the PHEO, AFIOH/RSRH, and, if deployed, the Joint Task Force/Theater Surgeon of the incidence, prevalence, modes

of transmission, and recommended control measures for diseases/conditions of PH or military significance.

1.10.6.4. Maintains a surveillance system that tracks incidence and trends of reportable diseases and conditions of public health significance. Assistance for establishing a local program is available from AFIOH/RSRH.

1.10.6.5. Establishes a program to evaluate risks for vector-borne and zoonotic disease in the local geographical area and establishes a risk mitigation program. Assistance for establishing a local program is available from AFIOH/RSRH.

1.10.6.6. Establishes liaisons with the state/local or host nation public health officials. Maintains awareness of local epidemiological activities, including local surveillance, prevention, and control capabilities.

1.10.6.7. Completes disease-specific case investigation forms as mandated by state/local or host nation health officials. Ensures reportable diseases (including conditions of public health or military significance), are reported to appropriate authorities and entered into the Air Force Reportable Events Surveillance System (AFRESS).

1.10.6.8. Reviews test results provided by the laboratory and other electronic data sources to ensure timely identification and investigation of reportable and communicable infections, including disease/conditions of PH or military significance not identified in the *Tri-Service Reportable Events Guidelines and Case Definitions* document (See [Attachment 1](#) for URL).

1.10.6.9. Disseminates information derived from PH surveillance in a timely manner. This includes periodic feedback to health care providers and to appropriate MTF committees (e.g., aerospace medicine council, population health working group, professional staff, occupational health working group, and infection control) regarding incidence or prevalence of diseases and conditions of interest or importance.

1.10.6.10. Reviews MTF surveillance data and conducts investigations as appropriate. At a minimum, this syndromic surveillance will include respiratory (influenza-like illness), gastrointestinal, febrile illness (fever), and dermatologic conditions.

1.10.6.11. Conducts special surveillance not specified by this directive as appropriate. Conditions not identified as reportable in the *Tri-Service Reportable Events Guidelines and Case Definitions* document (See [Attachment 1](#) for URL) may require special surveillance activities when the local risk is significant. Such decisions are based on the local threat assessment from civilian and installation morbidity and mortality reports and military medical intelligence.

1.10.6.12. Transmits to AFIOH/RSRH, within 24 hours, conditions determined to be *Urgently Reportable* (list of *Urgently Reportable Conditions* is available at the AFIOH website, see [Attachment 1](#) for URL)

1.10.6.13. At sentinel influenza surveillance sites, provides the PCM team with program instructions and updates, including the case definition for influenza-like

illness. Coordinates with the PCM team to ensure the influenza questionnaire is sent to AFIOH/RSRH using the prescribed mechanism.

1.10.6.14. Interviews individuals with communicable infections that require contact tracing IAW CDC guidelines.

1.10.6.15. Refers contacts of patients with reportable diseases or diseases/conditions of PH or military significance, if eligible, for medical care and counseling within the MTF; refers non-beneficiaries to the health department in their area of residence. Air Reserve Component (ARC) PH will ensure that reportable disease information is sent to AFIOH and to the state/ local public health officials.

1.10.6.16. Epidemiologically monitors and communicates rabies risk in the local area to MTF providers and reports exposures (potential or confirmed cases) IAW state/local, Federal, or AF.

1.10.6.17. **(DELETED)**

1.10.6.18. Performs disease outbreak investigations and works with the Chief, Aerospace Medicine Services to advise the MTF Commander on the management and control of disease outbreaks.

1.10.6.19. Consults with the Epidemiology Services Branch (AFIOH/RSRH), and state/local public health authorities to control and report outbreak investigations.

1.10.7. **Public Health Emergency Officer (PHEO).**

1.10.7.1. Coordinates public health emergency planning and response with the Medical Defense Officer or bioenvironmental engineer, casualty management officer, public health officer, and public affairs personnel, as appropriate.

1.10.7.2. Verifies the existence of cases suggesting a possible public health emergency, which includes identifying and investigating cases for sources of exposure and defining the distribution of the illness or health condition.

1.10.7.3. When a public health emergency is declared, the PHEO shall advise the installation commander of appropriate actions IAW DoDD 6200.3.

1.10.8. **Clinical Laboratory.**

1.10.8.1. Notifies providers and PH of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the *Tri-Service Reportable Events Guidelines and Case Definitions* document (see [Attachment 1](#) for URL). Notifies PH of any unusual pattern of laboratory testing or significant increase in incidence of a disease.

1.10.8.2. Participates in the CDC Laboratory Response Network for Bioterrorism and Chemical Terrorism. Identifies potential offensive biological and chemical agents and reports IAW CDC-DoD notification protocols. Facilitates process for forwarding clinical and environmental specimens (e.g., unusual pathogens, antibiotic-resistant strains, chemical and radiological exposures), where appropriate or required, to DoD or civilian reference labs.

1.10.8.3. During epidemiological and outbreak investigations, coordinates with PH on appropriate sample collection protocols, test availability, and result reporting.

1.10.8.4. For influenza surveillance, etiology-based sentinel MTFs will send respiratory specimens weekly during influenza season (usually October to May or year-round if indicated), as directed by AFIOH.

1.10.9. **MTF Information Management Officer.** Maintains systems to support reporting and surveillance activities, including immunization tracking databases.

1.10.10. **MTF Medical and Dental Providers.**

1.10.10.1. Deliver effective disease prevention and control programs. Counsel individuals on communicable diseases, risk factor reduction, and early recognition of symptoms.

1.10.10.2. Refer patients to PH with reportable conditions listed in the *Tri-Service Reportable Events Guidelines and Case Definitions* (see [Attachment 1](#) for URL), Air Force specific reportable diseases (listed on the AFIOH website, see [Attachment 1](#) for URL), diseases that require contact tracing, or those required by state/local, or host nation directives. Diseases/ conditions that have PH impact or military significance are also reported to PH.

1.10.10.3. Use case definitions outlined in the *Tri-Service Reportable Events Guidelines and Case Definitions* document (see [Attachment 1](#) for URL). If a case definition is not available in the Tri-Service Guidelines, use CDC guidelines and case definitions.

1.10.10.4. Report to PH, within 24 hours, conditions determined to be *Urgently Reportable* (list of *Urgently Reportable* conditions available at AFIOH website, see [Attachment 1](#) for URL). Ensure appropriate reporting through chain of command.

1.10.10.5. At sentinel influenza surveillance sites, identifies patients meeting the case definition for influenza, collects respiratory specimen, and ensures completion of the influenza questionnaire.

1.10.10.6. Provide pre- and post-exposure prophylaxis, including vaccines, IAW AF, DoD, COCOM policies and CDC guidelines or the Advisory Committee on Immunization Practices (ACIP) recommendations.

1.10.10.7. Screen, treat, and follow up with personnel with communicable infections IAW AF, DoD, CDC and the US Preventive Services Task Force recommendations, taking into account the local epidemiology and high-risk groups.

1.10.10.8. Initiate and complete DD Form 2341, Report of Animal Bite—Potential Rabies Exposure, for all patients presenting with animal bites or scratches and ensure that these patients are assessed, treated (to include tracking patients for completion of rabies prophylaxis when necessary), and educated IAW current CDC guidelines. This process must include coordination between MTF health care providers and the Army Veterinary Control Officer or local animal control officials to determine the rabies risk (and thus, appropriate patient rabies prophylaxis) in the biting/scratching animal using the information available from laboratory testing, quarantine, or local rabies prevalence in the particular species when laboratory testing or quarantine is not

possible. Providers may consult PH for local rabies prevalence and most current rabies prophylaxis recommendations/guidelines.

1.10.11. **Bioenvironmental Engineering (BE)**

1.10.11.1. Performs occupational and environmental health surveillance (e.g., toxic industrial materials, CBRN agents, etc).

1.10.11.2. Conducts sampling and identification of suspect substances. Coordinates sampling and identification plans with the base civil engineer and reports findings and results through appropriate command channels.

1.10.11.3. Provides recommendations for respiratory protection equipment, as necessary, and manages those requiring respiratory protection per AFOSH 48-137.

1.10.11.4. Provides expertise on engineering controls that provide protection against CBRN agents.

1.10.12. **Air Reserve Component Medical Units.** Report cases of Tri-Service Reportable Events (see [Attachment 1](#) for URL) acquired while the member is on a duty status on federal installations to Air National Guard Surgeon General or Headquarters Air Force Reserve Command Surgeon General; and to AFIOH/RSRH; and their respective local PH authorities.

2. SPECIFIC PROGRAM ATTACHMENTS.

2. (459ARW) Risk Assessment.

2.1. **Childhood Blood Lead Screening.** Instructions for MTFs to identify children who are at risk for lead exposure are found in [Attachment 2](#).

2.1. (459ARW) The 459 ARW TB testing program will be a TARGETED program.

2.2. **Tuberculosis (TB) Prevention and Control Program.** Specific components for effective TB prevention and control are in [Attachment 3](#).

2.2. (459ARW) Routine annual TST is not necessary unless an exposure to *Mycobacterium tuberculosis* occurs, except where indicated by other guidance.

2.2.1. (Added-459ARW) Perform TST at least 3 months (no later than 6 months) if member stationed in a high-prevalence overseas areas and who have direct and prolonged contact with high-risk population or have a high-risk known exposure after returning to CONUS or a low TB prevalence OCONUS location.

2.2.2. (Added-459ARW) Combatant Command may direct additional TB testing. If deferred to the Service, members deployed for 30 or more consecutive days to a high-prevalence area and had direct and prolonged contact with local populations or had high-risk known exposure to any active TB case should be tested 3 months but not more than 6 months post-deployment.

2.2.3. (Added-459ARW) Healthcare workers will receive a baseline two-step TST. Either a TST in the last 12 months or TST done on Air Force accession will be considered step one.

2.3. **(Added-459ARW)** An updated risk assessment will be done annually IAW CDC guidelines.

2.4. **(Added-459ARW)** For deployer, access the Air Force Institute for Operational Health (AFIOH) website to determine if a 90 day post-deployment TST is necessary ([Attachment 9](#)).

2.4.1. **(Added-459ARW)** Members of the 459 ARW who deploy for 30 days or more will complete a post deployment questionnaire. This questionnaire will be reviewed by the Medical ART and determine if a post TST is required based on responses to the questionnaire.

2.4.2. **(Added-459ARW)** If a TST is indicated it will be added to AFCITA for that individual to report 3 months from the time they returned from their deployment.

2.4.3. **(Added-459ARW)** The Medical ART will initiate AF Form 348, *Line of Duty Determination*, for any individual who converts following a deployment and submit to approving authorities for a Line of Duty (LOD) determination.

2.4.4. **(Added-459ARW)** Individuals who converted while on active duty must provide a copy of their active duty orders. All active duty members will be referred to the Veterans Affairs (VA) or their primary healthcare provider for treatment if it was found in the LOD.

2.5. **(Added-459ARW)** Members of the 459 ARW who perform Annual Tour in a location of higher risk will be assessed to determine if a post TST is required.

2.6. **(Added-459ARW)** The 459 ARW personnel presented to the 459 AMDS with clinical indications of TB will be referred to a collaborating facility or their personal healthcare provider as soon as possible. Personnel will be instructed to provide the 459 AMDS with the results of any TB testing conducted.

2.7. **(Added-459ARW)** If a TST is required, the results must be read 48-72 hours after administration. A qualified military technician, private physician, school nurse, local emergency room staff, or civilian public health officer can read the results. If given during a UTA, unit members must understand it is their responsibility to have the results read 48-72 hours after administration. The unit member must provide the results to the 459 AMDS during the next month's UTA.

3. Forms Adopted. AF Form 847, **Recommendation for Change of Publication**, Standard Form 600, DD Form 2341, **Report of Animal Bite-Potential Rabies Exposure**, DD Form 2766, **Adult Preventive** and Chronic Care Flowsheet, Public Health Service Form 731, International Certificates of Vaccination, AF Form 2453, Tuberculosis Detection and Control Data.

4. (Added-459ARW) Positive Reactors.

4.1. **(Added-459ARW)** Personnel with a positive TST (5mm or greater) will be referred to PH for an interview and history to identify possible risk factors, exposures, or disease. Country of birth and home of record must be considered when determining risk factors.

4.1.1. **(Added-459ARW)** The 459 AMDS is not a treatment facility. Any suspected or confirmed TB patient will be directed to go to Malcolm Grow Medical Center or their personal healthcare provider for evaluation and treatment ([Attachment 10](#)).

4.1.2. **(Added-459ARW)** The individual will be given a surgical mask and instructed not to remove it unless it becomes wet. If the mask becomes wet, it is to be replaced. Providers assessing will also wear a mask IAW AFI 48-105 and CDC guidelines.

4.1.3. **(Added-459ARW)** The patient may transport himself to the appropriate facility.

4.1.4. **(Added-459ARW)** ICRF, ICM, and PH will be notified of any suspected or confirmed TB patient.

4.2. **(Added-459ARW)** Personnel previously identified with a positive TST **will not** be tested again. An AF Form 422, *Notification of Air Force Member's Qualification Status*, P2 will be generated stating "Positive TST no further testing" and placed in the medical record. The positive test reaction must also be documented in AFCITA. Individuals who have been tested at another facility must provide the 459 AMDS with documentation showing a positive or negative test result.

4.3. **(Added-459ARW)** Personnel will be directed by provider of enrollment into the TB Detection and Control Program for monthly follow-up for LTBI.

4.4. **(Added-459ARW)** Personnel will be required to visit PH monthly during UTA's for assessment. During the interview, PH will imitate and document on the SF 600, *TB Detection and Control Data* and *TB Detection and Control Program-Monthly Medication Refill Evaluation*. Both forms will be forwarded to a provider for review and/or signature as required, and then filed in the member's medical record.

5. (Added-459ARW) Respiratory Protection.

5.1. **(Added-459ARW)** Disposable N-95 respirators are approved by BE and will be available for personnel should the need arise. The need for respiratory protection will be based on a risk assessment for occupational task, including deployments or other mission essential tasks that may expose personnel of TB. Respiratory protection during deployments will be based upon risk of the gaining facility. BE will provide just in time qualitative respirator fit testing and training for identified personnel.

5.2. **(Added-459ARW)** Respiratory questionnaires will be completed and fit testing conducted before deployment to an area where the risk of TB exposure warrants it.

6. (Added-459ARW) Personal Protective Equipment (PPE).

6.1. **(Added-459ARW)** The 459 ARW home station clinical work areas are considered to be low risk areas. Therefore, no additional PPE specifically targeted for TB protection is required for most members.

6.2. **(Added-459ARW)** The 459 AES will have approved N-95 respirators available during operational flights. The 459 AES will have a Respiratory Protection Program to annually fit test those members that require it.

7. (Added-459ARW) Training.

7.1. **(Added-459ARW)** Initial and annual training will be provided by the individual unit ICO or other qualified medical personnel.

7.2. **(Added-459ARW)** The 459 AES will have a program for annual fit-testing of required medical flight crew members.

THOMAS J. LOFTUS, Major General, USAF, MC,
CFS
Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

(459ARW)

RUSSELL A. MUNCY, Colonel, USAFR
Commander, 459 ARW

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

(Added-459ARW) AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance, Attachment 3*, 1 March 2005

AFPD 37-1, *Records Management Programs*

AFPD 48-1, *Aerospace Medicine Program*

AFI 32-1067, *Water Systems*

AFI 44-102, *Community Health Management*

AFI 44-108, *Infection Control Program*

AFI 48-102, *The Medical Entomology Program*

AFJI 48-110, *Immunizations and Chemoprophylaxis*

AFI 48-116, *Food Safety Program*

AFI 48-119, *Medical Service Environmental Quality Programs*

AFJI 48-131, *Veterinary Health Services (Joint AFI)*

AFI 48-135, *Human Immunodeficiency Virus (HIV) Program*

AFI 91-204, *Safety Investigations and Reports* AF Institute for Operational Health (AFIOH) website: <http://www.brooks.af.mil/afioh/>

AFMAN 37-123, *Information Management*

AFMAN 37-139, *Records Disposition Schedule*

(Added-459ARW) AFOSH Standard 48-137, *Respiratory Protection Program*,

ASD (HA) Memo 95009, 26 June 95, *Modification of Pediatric Blood Lead Screening Program*

(Added-459ARW) CDC, *Essential Components of a Tuberculosis Prevention and Control Program/Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations of the Advisory Council for the Elimination of Tuberculosis*, MMWR 1995;44 (No. RR-11)

CJCS Memo MCM-0006-02, *Updated Procedures for Deployment Health Surveillance and Readiness*, 1 February 2002

DoDD 6200.3, *Emergency Health Powers on Military Installations*

DoDD 6490.2, *Joint Medical Surveillance*

DoDI 6490.3, *Implementation and Application of Joint Medical Surveillance for Deployments Control of Communicable Diseases Manual*, (most current edition) American Public Health Association, 1015 15 Street NW Washington DC 20005.

CDC. *Sexually Transmitted Diseases Treatment Guidelines 2002*. MMWR 2002; 51 (RR-6).

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- CDC. *Essential Components of a Tuberculosis Prevention and Control Program*. MMWR 1995;44 (No. RR-11).
- CDC. *Immunization of Health-Care Workers: Recommendation of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)*. MMWR Dec 26, 1997;46(No. RR-18). *Guidelines for Infection Control in Health Care Personnel*. Am J Inf Cont. Jun 1998, Vol. 26, Num. 3.
- CDC. *Core Curriculum on Tuberculosis, What the Clinician Should Know*, Fourth Edition, 2000.
- CDC. *Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection*. MMWR 2000; 49 (No. RR-6).
- CDC. *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities*, MMWR 1994;43 (No. RR-13).
- CDC. *Human Rabies Prevention - United States, 1999, Recommendations of the Advisory Committee on Immunization Practices (ACIP)*. MMWR 1999; 48 (No. RR-1).
- CDC. *Recommendations for the Prevention and Management of Chlamydia trachomatis Infections*, MMWR 1993;42 (No. RR-12).
- CDC. *Guidelines for Infection Control in Dental Health-care Settings*. MMWR 2003; 52(No. RR-17): 1-61.
- Federal Register 29 CFR Part 1910.1030, *Occupational Exposure to Blood Pathogens; Final Rule*.
- Federal Register 29 CFR 1960, *Occupational Illness and Injury Reporting Guidelines for Federal Agencies*.
- OSHA CPL 2.106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*
- TB Respiratory Protection Program in Health Care Facilities, Administrator's Guide*, NIOSH, CDC, (1999, September) publication 99-143.
- The "Red Book," 26th edition, June 2003 or most recent version, American Academy of Pediatrics Title 10, United States Code (USC), Section 8013, Medical Records System. 10 U.S.C., Chapter 55, Medical and Dental Care*
- 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force*, and Executive Order 9397 *Systems Record Notices F044 AF SG E, Medical Records System, and Reporting of Medical Conditions of Public Health and Military Significance*
- National Fire Protection Association (NFPA) Standard 1582
- Tri-Service Reportable Events, Guidelines and Case Definitions* document, Army Medical Surveillance Activity. Available at

http://amsa.army.mil/documents/DoD_PDFs/May04TriServREGuide.pdf *American Academy of Pediatrics*. In: Peter G, ed. *2003 Red book: Report of the Committee on Infectious Diseases*. 26th ed. Elk Grove Village, IL. US Preventive Services Task Force, *Screening Tuberculosis Infection, Guide to Clinical Preventive Services*, 2nd edition, 1996 or most recent update.

Abbreviations and Acronyms

(Added-459ARW) AES—Aeromedical Evacuation Squadron

AETC—Air Education and Training Command

(Added-459ARW) AFCITA—Air Force Complete Immunization Tracking Application

AFFOR—Air Force forces

AFI—Air Force instruction

AFIOH—Air Force Institute for Operational Health

AFIOH/RSRH—Epidemiology Services Branch

AFIOH/SDE—Epidemiological Surveillance Division

(Added-459ARW) AFIOSH—Air Force Institute for Operational Health

AFMC—Air Force Materiel Command

AFMIC—Armed Forces Medical Intelligence Center

AFMSA—Air Force Medical Support Agency

AFMR—Air Force Mortality Registry

AFOSH—Air Force Occupational Safety and Health

AFPD—Air Force Policy directive

AFR—Air Force Reserve

AFRESS—Air Force Reportable Events Surveillance System

(Added-459ARW) AMDS—Aerospace Medicine Squadron

(Added-459ARW) ARW—Air Refueling Wing

BE—bioenvironmental engineer

(459ARW) BE—Bioenvironmental Engineering

BLLS—blood lead levels

CBRN—chemical, biological, radiological, and nuclear

CDC—Centers for Disease Control and Prevention

(459ARW) CDC—Center for Disease Control

DMSS—Defense Medical Surveillance System

DOD—Department of Defense

DODD—Department of Defense Directive
DOD—GEIS—DoD Global Emerging Infections Surveillance and Response System
DODI—Department of Defense Instruction
ESSENCE—Electronic System for Early Notification of Community-based Epidemics
FHPPP—Force Health Protection Prescription Products
HIPAA—Health Insurance Portability and Accountability Act
HIV—Human Immunodeficiency Virus
(Added-459ARW) IAW—In Accordance With
ICD—International Classification of Disease
(Added-459ARW) ICM—Infection Control Manager
(Added-459ARW) ICO—Infection Control Officer
(Added-459ARW) ICRF—Infection Control Review Function
INH—Isoniazid
JULLS—Joint Universal Lessons Learned System
(Added-459ARW) LOD—Line of Duty
LTBI—latent tuberculosis infection
(459ARW) LTBI—Latent Tuberculosis Infection
MDO—medical defense officer
MAJCOM—major command
MMWR—Morbidity and Mortality Weekly Report
MTF—Medical Treatment Facility
OSHA—Occupational Safety and Health Administration
PB—Pyridostigmine Bromide
PCS—Permanent Change of Station
PH—Public Health
(459ARW) PH—Public Health
PHEO—Public Health Emergency Officer
(Added-459ARW) PPE—Personal Protective Equipment
SG—Surgeon General
SGH—Chief of Medical Staff
STI—Sexually Transmitted Infection
TB—Tuberculosis

(459ARW) **TB**—Tuberculosis

TST—Tuberculin Skin Test

(459ARW) **TST**—Tuberculin Skin Test

URL—Universal Resource Locate

USAFA—United States Air Force Academy

USC—United States Code

(Added-459ARW) **UTA**—Unit Training Assembly

(Added-459ARW) **VA**—Veterans Affairs

WHO—World Health Organization

Terms

Accessions—Service accessions include service members in recruit training, Officer Candidate School, Service Academy preparatory school, Service academy, Officer-indoctrination school, other officer accession programs, and officers that are directly commissioned.

Air Force Reserve Component (ARC)—Reserve forces that include the Air National Guard and the Air Force Reserve Command

Diseases and conditions of public health or military significance—These are diseases or health conditions that impact the health or readiness of Air Force personnel, their dependents, or other eligible personnel and which have a potential for substantial mission degradation, widespread morbidity, or significant adverse sequelae or mortality.

High—risk TB prevalence country/area—A country or geographical area with a high prevalence of tuberculosis as determined by the AFIOH in conjunction with the Armed Forces Medical Intelligence Center (AFMIC), World Health Organization (WHO) and other health agencies.

Nonreportable STIs—STIs that are not included on the list of *Tri-Service Reportable Events*. Patients with these diseases may be referred to PH for education, sexual contact identification, and follow-up, as appropriate.

Public Health Surveillance—The regular or repeated collection, analysis, and dissemination of uniform health information for monitoring the health of a population, and intervening in a timely manner when necessary.

Public Health Emergency Officer (PHEO)—A senior health professions military officer or DoD civilian employee, designated by the installation commander, with experience in preventive medicine/ emergency response who is responsible for advising the installation commander in the exercising of emergency health powers (as outlined in DoDD 6200.3) in the event of a suspected or confirmed public health emergency.

Reportable STIs—Patients with diseases identified as reportable in the *Tri-Service Reportable Events Guidelines and Case Definitions*. These patients should be referred to PH for sexual contact identification, evaluation, education, and annual reporting.

Screening—A method for early detection of disease or health problem before an individual would normally seek medical care. Screening tests are usually administered to individuals without current symptoms, but who may be at high-risk for certain adverse health outcomes.

STIs—These are infections commonly transmitted by sexual intercourse. The diseases specified in the CDC's *Sexually Transmitted Diseases Treatment Guidelines* will be considered STIs for this AFI.

Syndromic Surveillance—The surveillance of disease syndromes (groups of signs and symptoms), rather than specific, clinical, or laboratory-defined diseases. Surveillance of syndromes recorded at the time of patient visit, instead of specific diagnoses reported after laboratory or other diagnostic procedures, can greatly lessen the time it takes to determine that an outbreak is occurring (ESSENCE is an example of a syndromic surveillance system).

Attachment 2

CHILDHOOD BLOOD LEAD SCREENING

A2.1. The objective of this program is to identify children living on and off base who are at risk for environmental lead exposure IAW CDC guidelines and state/local regulations.

A2.1.1. Military Treatment Facility Commander ensures MTFs implement an effective Childhood Blood Lead Screening program IAW CDC guidelines and state/local regulations.

A2.1.2. Chief of Medical Staff (SGH) coordinates with PH to ensure the development of a risk assessment questionnaire for targeted lead screening (see paragraphs A1.3.2 and A1.3.3). This questionnaire supplements the CDC's standard lead exposure screening questions and reflects the community-specific lead exposure risk.

A2.1.3. Primary Care Management (PCM) Team

A2.1.3.1. Provides parents with educational materials about prevention and risk of childhood lead exposure.

A2.1.3.2. Conducts universal childhood blood lead testing when required by state/local regulations. Otherwise, PCM team will conduct targeted or risk-based screening IAW CDC guidelines.

A2.1.3.3. Conducts targeted screening through risk assessment questionnaire beginning at 9-12 months of age and periodically between 24 months to 6 years of age. Ensures completed questionnaires are placed in medical records.

A2.1.3.3.1. Children with one or more lead-exposure risk factors will receive blood lead testing. Uses CDC guidelines for instructions on blood lead sampling technique, treatment and follow-up of elevated blood lead levels (BLLs).

A2.1.3.3.2. Refers all children with BLLs $\geq 10\mu\text{g}/\text{dl}$ to public health.

A2.1.4. Public Health

A2.1.4.1. Initiates a lead toxicity investigation for any confirmed pediatric BLLs greater than or equal to $10\mu\text{g}/\text{dl}$. Coordinates with BE for lead sampling of the facility based on epidemiological data IAW CDC and OSHA guidelines.

A2.1.4.1.1. Reports all BLLs greater than or equal to $10\mu\text{g}/\text{dl}$ to AFIOH/RSRH using AFRESS.

A2.1.4.1.2. Submits periodic reports of blood-lead laboratory results to AFIOH/RSRH. Reports an elevated venous blood test once per patient (follow-up test results on the same patient are not counted again).

A2.1.4.1.3. Provides findings from lead toxicity investigation to the patient's PCM team.

A2.1.5. AFIOH/RSRH

A2.1.5.1. Provides surveillance and maintains a historical database of past pediatric blood lead screening results from each installation.

A2.1.5.2. Reports significant findings or unusual trends on blood lead results to AFMSA and submits an annual fiscal year summary of the Childhood Blood Lead Screening Program

Attachment 3

TUBERCULOSIS (TB) DETECTION AND CONTROL PROGRAM

A3.1. The objective of this program is to align the AF TB program with the national program to eliminate tuberculosis IAW current CDC guidelines. The AFMS uses current CDC guidelines for TB prevention and control. The following guidance is intended to cover areas where CDC guidance is vague or does not exist.

A3.2. The AF TB screening program will be a targeted program. Except for an initial TB test upon accession (baseline test), the TB testing program for Air Force personnel will be limited to individuals with high-risk TB exposure histories or those with clinical indications for testing.

A3.3. Military Treatment Facility Commanders.

A3.3.1. Ensure MTFs implement an effective TB control program IAW current CDC guidelines.

A3.3.2. Ensure a written plan on prevention of transmission and treatment of TB for the MTF is completed. The plan will include a multi-disciplinary healthcare team (e.g., Infection Control, PH, BEE, etc.) evaluation and a written TB risk assessment IAW CDC guidelines or in consultation with AFIOH. The plan will also include appropriate respiratory protection for potentially exposed health-care workers, effective engineering controls, education, counseling and evaluation of healthcare workers, and identification and treatment of individuals with active disease or latent tuberculosis infection (LTBI)

A3.4. Public Health.

A3.4.1. Coordinates with the Infection Control Committee and Bioenvironmental Engineers to ensure compliance with relevant Occupational Safety and Health Administration guidelines for the control of occupational exposure to tuberculosis.

A3.4.2. Reviews the plan for prevention of transmission and treatment of TB annually and recommends risk-based procedures for screening, control, and protection against TB IAW CDC guidelines. Coordinates the review with Infection Control Committee and Bioenvironmental Engineers.

A3.4.3. Conducts risk assessment of personnel, including re-deployers and beneficiaries returning from high-risk TB endemic locations and countries to determine the frequency of TB testing. Follow local city, county, and/or state recommendations if their guidance requires more frequent testing or inclusion of other individuals.

A3.4.4. Performs the initial LTBI patient interview IAW CDC guidelines and refers patient to PCM.

A3.4.5. Performs contact tracing IAW CDC guidelines and ensures these personnel are screened for TB.

A3.4.6. Monitors local TB risk and provides prevention and education messages for the installation population.

A3.4.7. Reports active TB cases within 24 hours to AFIOH/RSRH.

A3.5. Primary Care Management (PCM) team.

A3.5.1. Evaluates all individuals with non-negative tuberculosis tests. Non-negative tests include:

A3.5.1.1. Tuberculin skin test (TST) indurations greater than or equal to 5mm

A3.5.1.2. Indeterminate or positive blood assays for *M. tuberculosis* (BAMT)

A3.5.2. Records positive reactions, initial and follow-up care on AF Form 2453, *Tuberculosis Detection and Control Data*. Places AF Form 2453 in the patient's medical record upon completion of medical treatment.

A3.5.3. Ensures all patients with LTBI or active TB are referred to PH for contact tracing, education, and reporting.

A3.5.4. Evaluates patients for active disease. Provides clinical management and follow-up of patients with LTBI or active TB IAW CDC guidelines.

A3.5.5. Ensures recent converters who do not have active TB but who are on flying status, have flying status handled IAW current AFMOA LTBI prophylaxis policy. If the services of the flyer are of a critical nature, (e.g., in a combat zone or for alert force manning) and active TB has been ruled out, INH therapy can be delayed for up to 18 months. During this time the flight surgeon will continue to monitor the flyer closely until his/her services are no longer critical and INH can be initiated.

A3.6. Immunization Technician or Personnel Administering Tuberculosis Testing.

A3.6.1. Follow current CDC guidance on testing procedures and interpretation of tests.

A3.6.2. Immunization clinic personnel and other clinicians with experience or formal training can place, read, and record IPPD skin tests.

A3.7. Tuberculin Tests Administration.

A3.7.1. The AF TB testing program will be a targeted program. Except for an initial TB test upon accession, AF personnel (including deployers and other forward-based personnel) will only be tested when they have high-risk exposures, high-risk occupations, or are employees with clinical indications for testing as per local Aerospace Medicine Council recommendation.

A3.7.1.1. Persons at risk for developing TB disease fall into two categories: those who have been recently infected, and those with clinical conditions that increase the risk of progression from LTBI to TB disease.

A3.7.1.1.1. Recent infection should be suspected in close contacts of a person with infectious TB, persons who have immigrated from areas of the world with high rates of TB, children ≤ 5 years who have a positive TST result, recent converters, persons who work or reside with people who are at high risk for TB in facilities or institutions such as hospitals, homeless shelters, correctional facilities, nursing homes, and residential homes for those with HIV.

A3.7.1.1.2. Clinical conditions that increase the risk of progression from LTBI to TB disease include HIV infection, radiographic evidence of prior TB, low body weight ($\geq 10\%$ below ideal), silicosis, diabetes mellitus, chronic renal failure or being on

hemodialysis, gastrectomy, jejunal bypass, solid organ transplant, history of head and neck cancer, and prolonged use of immunosuppressive agents.

A3.8. Types of tuberculin tests.

A3.8.1. The Mantoux tuberculin skin test (TST) using Intermediate-strength Purified Protein Derivative (IPPD) has been the standard test for identifying LTBI.

A3.8.2. Blood assays for *M. tuberculosis* (BAMT) such as the enzyme-linked immunosorbent assay (ELISA) tests have been approved for diagnosing both LTBI and TB disease.

A3.8.2.1. Quantiferon[®]- TB Gold (QFT-G) is the first blood test of this type to obtain FDA approval. QTF-G can be used in all circumstances in which the TST is used, including contact investigations, evaluation of recent immigrants who have had BCG vaccination, and TB screening of healthcare workers and others undergoing serial evaluation for *M. tuberculosis* infection.

A3.8.2.2. BAMT tests usually can be used in place of (and not in addition to) the TST; however, the performance of the QFT-G test has not been evaluated in individuals with impaired immune function, e.g., HIV, individuals with a high likelihood of *M. tuberculosis* infection progressing to tuberculosis disease, patients who have been treated for either LTBI or tuberculosis disease, individuals younger than age 17 years, and pregnant women.

A3.9. Indications for TB Screening Tests.

A3.9.1. Test AD and ARC members during initial processing at officer or enlisted accession centers or at their first duty station.

A3.9.2. Perform annual testing for all individuals stationed in a high-prevalence overseas area and who have direct and prolonged contact with high-risk populations or have high-risk exposure. Perform another tuberculin test at 3 months (no later than 6 months) after returning to CONUS or a low TB prevalence OCONUS location.

A3.9.3. Combatant Command may direct additional TB testing. When the Combatant Command defers to Service policy for TB testing, then the following applies:

A3.9.3.1. Individuals who deployed to high-prevalence areas for greater than or equal to 30 consecutive days and who had direct and prolonged contact with the locals population or had high-risk or known exposure to an active TB case should receive a TB test at 3 months (no later than 6 months) post-deployment.

A3.9.3.2. Testing more frequently than every 12 months is not necessary for personnel who deploy regularly to high prevalence areas unless they have other risk factors for TB.

A3.9.4. Perform baseline two-step TST or one BAMT for healthcare workers (including civilians, contractors, and volunteers) upon employment/volunteer service if there is no verifiable history of being tested within the previous 12 months. A documented, initial TB test done on accession (baseline test) for Air Force personnel is considered the first step of the two-step TST. The second step should be completed within twelve months at either the first duty assignment or subsequent training program. Repeat or interval testing for healthcare workers is based on risk assessment for the setting IAW CDC guidelines or in

consultation with AFIOH. Healthcare workers transferring between healthcare settings or AFMS medical treatment facilities that are classified as low risk are not retested. Healthcare workers transferring between low and medium risk settings should be tested within 30 days of transfer to the medium risk setting location.

A3.9.5. Perform baseline and subsequent TB testing for family members and other beneficiaries IAW CDC guidelines.

A3.9.5.1. Baseline TB testing is indicated for individuals who are PCSing to a high TB prevalence country and who have no verification of having been previously tested. Testing should be completed prior to departure.

A3.9.5.2. Baseline TB testing is indicated prior to overseas travel if individuals anticipate prolonged contact with populations in settings at high-risk for transmission of infectious TB (e.g., hospital, prison, homeless shelters) and 3 months after returning.

A3.10. Tuberculin Skin Tests.

A3.10.1. Delay the TST at least four weeks *after* live-virus vaccine administration, unless operational or clinical circumstances require administration of TST on the same day.

A3.10.2. Measure TST reactions in millimeters of induration and record the results in the Air Force automated tracking system, on DD Form 2766, *Adult Preventive and Chronic Care Flowsheet* (or equivalent), on the Public Health Service Form 731, *International Certification of Vaccination*. Do not delete results of previous TB tests in the AF automated immunization tracking system.

A3.10.3. Refer all individuals with TST indurations greater than or equal to 5 mm to PH. If active TB is suspected, alert the infection Control Officer, the PCM team, and PH to ensure that appropriate precautionary infection control measures are applied.

Attachment 4 (Added-459ARW)

DECISION-ASSISTING ALGORITHM FOR DETERMINING HIGH-RISK EXPOSURE

A4.1. Deployers – Check combatant command preventive medicine requirements for deployed location and based on their risk assessment conduct TST if required. If no risk assessment has been performed for the deployed location then conduct a local risk assessment using the algorithm below

Table A4.1. Deployers.

Deployers	Deployed Location Incident Rate	High-Risk Exposure	TB Skin Testing
Individual deploying to high prevalence area for less than 30 days and no other risk factors for TB			No Testing Required
Individual deploying to high prevalence area for 30 consecutive days or more and will have prolonged contact with the local population	Determine if deployed high prevalence areas have a higher incident rate than the members home base or US incidence rate	If yes, then determine if the member will have prolonged contact with the local population (refugee camps, prisons, medical clinics, etc.)	If both the deployed location incident rate and high risk exposure is “YES”, then conduct TST before and 90 days after deployment.

A4.2. Healthcare Workers – Upon employment, if personnel have not been tested within the previous 12 months, perform TST. Baseline TST is recommended for all healthcare workers who will be retested periodically IAW CDC guidelines

Table A4.2. Healthcare Workers.

Healthcare Workers	Facility/Location	High-Risk Exposure	TB Skin Testing
Medical squadron personnel (including AES, ASTS) at home station	AMDS facility or satellite physical exam facility	No – Same as community incident rate	No testing required
		Yes – Higher than community incident rate	TST required if TB risk category prompts testing
Medical squadron personnel (including AES, ASTS) at locations other than home station	CONUS AD/civilian treatment facilities	No – Same as community incident rate	No testing required
	CONUS/AD civilian treatment facilities	Yes – Higher than community incident rate	Follow guidelines established by that facility

	Deployed facility	Yes – Higher than community incident rate	Follow guidelines established by deployed facility
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Attachment 5 (Added-459ARW)

TUBERCULOSIS DETECTION AND CONTROL DATA

TUBERCULOSIS DETECTION AND CONTROL DATA						
<i>(This form is affected by the Privacy Act of 1974 -- Use Blanket PAS DD Form 2005)</i>						
NAME OF PATIENT (Last, First, Middle Initial) Attachment #3			GRADE	SSAN	DOB	SEX
						MALE
						FEMALE
STATUS		ORGANIZATION AND DUTY PHONE			HOME ADDRESS AND PHONE NO.	
<input type="checkbox"/> MILITARY	<input type="checkbox"/> FOREIGN NATIONAL					
<input type="checkbox"/> FLYING						
<input type="checkbox"/> CIVILIAN	0-19					
NAME OF SPONSOR (If patient is a dependent)						
SKIN TEST INFORMATION			CLASSIFICATION OF PATIENT			
TYPE	DATE	RESULTS	<input type="checkbox"/>	POSITIVE REACTOR (No previous test or unknown)		
LAST NEGATIVE			<input type="checkbox"/>	INTIMATE CONTACT WITH ACTIVE TB CASE		
SCREENING (State type)			<input type="checkbox"/>	CASUAL CONTACT WITH ACTIVE TB CASE		
INTERMEDIATE PPD			<input type="checkbox"/>	CONVERTER		
			<input type="checkbox"/>	OTHER (Explain)		
MEDICAL HISTORY						
	DATE	RESULTS				
CHEST FILMS						
RECOMMENDED FOR INH CHEMOPROPHYLAXIS						
<input type="checkbox"/>	YES	DATE STARTED	<input type="checkbox"/>	NO	REASON	
CASE CLOSURE INFORMATION					DATE STARTED	
REASON (Check applicable block)						
<input type="checkbox"/>	COMPLETION OF ADEQUATE THERAPY					
<input type="checkbox"/>	SUPERVISION NO LONGER NEEDED					
<input type="checkbox"/>	DATE INH COMPLETED					
<input type="checkbox"/>	ALLERGIC REACTION					
<input type="checkbox"/>	REFUSED SUPERVISION					
<input type="checkbox"/>	ELEVATED SGOT'S					
<input type="checkbox"/>	OTHER (Explain in Remarks)					
REMARKS						
TYPED NAME OF CLOSING PHYSICIAN					SIGNATURE	

Attachment 8 (Added-459ARW)**MEMORANDUM FOR INFECTION CONTROL COMMITTEE****FROM: 459 AMDS/ICO**

3252 Oregon Circle

Joint Base Andrews, MD 20762

Subject: Tuberculosis Risk Assessment for the 459th Aerospace Medicine Squadron (459 AMDS)

1. CDC Guidelines require Medical Units to re-evaluate their Tuberculosis risk annually.
2. The following information was obtained from the Center for Disease Control Tuberculosis Prevention and Control Program website September 2011.

a. Area TB Profile: The following table summarizes the incidence of TB (per 100,000 population) for the year 2009:

Location of Residence	2008 Incident Rate (per 100,000)
District of Columbia	6.8
Maryland	3.8
Virginia	3.5
Combined	4.7

b. National TB Profile: The national average TB rate is 3.8 per 100,000 for the year 2009.

3. Assignment risk of the 459th Air Refueling Wing (459 ARW) does not contain any inpatient facilities. The 459 AMDS does not receive patients while at home station. The conversion rate at the 459 ARW has not shown an increased rate in personnel. There may be TB cases within the community and collectively, the State incidence is above the national average. Based on CDC guidelines, the 459 ARW and the Air Force remains Low Risk.

4. If you have any questions, please contact Maj Jo Ann Serafini, ICO, Infection Control, at (240) 857-3909 during Sunday of the UTA.

Attachment 9 (Added-459ARW)

DECISION-ASSISTING ALGORITHM FOR TB POSITIVE REACTORS

TST (+)	Deployment History	Treatment	Profile	Disposition
Documented positive TST. Refer person to PH and FS for evaluation and determination of treatment	Deployed to high-risk area anytime since Dec 1992. No history of BCG vaccination.	No treatment started	Member given a profile 3 (perform duty at home station only) pending evaluation.	LOD initiated and member sent to active duty medical treatment facility for evaluation and treatment.
		If member already under treatment and TB is inactive	Continue profile 3 restricted to CONUS for the first month of treatment. After 1st month, change to profile 2.	LOD initiated (if not already done) and member sent to active duty medical treatment facility for continued treatment.
		No treatment required	No profile action required	No further follow up required.
Active stage TB (Positive TST and CXR)	Deployed to high-risk area anytime since Dec 1992.	Under treatment	Profile 4 until completion of treatment, not worldwide qualified.	LOD initiate (if not already done) and member sent to active duty medical treatment facility for further treatment.
Documented positive TST	Not deployed since Dec 1992. No history of BCG vaccine.	No treatment started	Member is given a profile 3 (perform duty at home station only).	Since TB is not result of reserve military service, send to private MD or local health department at member's expense.
		Under treatment and TB is inactive	Continue profile 3 (restricted to CONUS) for the 1st month of treatment. After 1st month, change to profile 2.	Since TB is not result of reserve military service, send to private MD or local health department at member's expense.
Active TB (Positive TST and CXR)	Not deployed since Dec 1992. No history of BCG vaccine.	Under Treatment	Profile 4 until completion of treatment, not worldwide qualified.	Since TB is not result of reserve military service, send to private MD or local health department at member's expense.

