BY ORDER OF THE COMMANDER
59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
48-107

3 DECEMBER 2019

Aerospace Medicine

CONTROL OF COMMUNICABLE AND OTHER REPORTABLE DISEASES

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: 559 AMDS/SGPM

Certified by: 559 MDG/CC
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Supersedes: 59 MDWI 48-107, 6 January 2017

Pages: 26

This instruction implements Air Force Policy Directive 48-1, *Aerospace Medicine Enterprise*, AFI 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*. It delineates responsibilities and procedures for the management and reporting of communicable and other conditions of public health significance to include sexually transmitted infections (STIs), Human Immunodeficiency Virus, rabies, and tuberculosis. This instruction applies to all personnel assigned, attached, or on contract to the 59th Medical Wing (MDW) with the exception of 959th Medical Group (MDG). This instruction does not apply to the Air National Guard or Air Force Reserve. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by 10 U.S.C. 55, *Medical and Dental Care*, and E.O. 9397 (SSN). The applicable SORN F044 AF SG D, and Automated Medical/Dental Record System is available at: **http://dpclo.defense.gov/Privacy/SORNs.aspx.** Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records created as a result of processes prescribed in this publication are IAW Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

SUMMARY OF CHANGES

This publication has been substantially revised. changes include updates to sexually transmitted infections.

Chapter 1

SEXUALLY TRANSMITTED INFECTIONS (STI)

1.1. Overview.

1.1.1. The purpose of the STI Program is to detect, treat and provide education to patients infected with STIs in order to break the chain of infection and prevent complications and/or chronic disease. STIs are identified in active duty and beneficiaries primarily through clinical encounters, whereas, female basic trainees are actively screened for Chlamydia and Gonococcal Infection (GC). Human Immunodeficiency Virus (HIV) is identified through the testing of basic trainees at the time of accession and through the routine screening of the active duty population every 2 years.

1.2. Responsibilities.

1.2.1. Healthcare Providers/teams/Family Emergency Center (FEC) will:

1.2.1.1. Diagnose and treat confirmed STI cases IAW the *Centers for Disease Control and Prevention Sexually Transmitted Infections Treatment Guidelines*, 2015 (or most recent version when superseded). **https://www.cdc.gov/std/tg2015/default.htm**

1.2.1.2. Centers for Disease Control (CDC) Summary of 2015 Treatment Guidelines (wall chart) **https://www.cdc.gov/std/tg2015/2015-wall-chart.pdf**

1.2.1.3. Clinically track pending laboratory tests and notify patients of positive STI results within 72 hours of the lab resulting.

1.2.1.4. Presumptively treat STIs when indicated by the disease specific criteria IAW CDC treatment guidelines.

1.2.1.5. Instruct patients to avoid intimate contact and/or sexual intercourse until 7 days after a single-dose regimen or after completion of a 7-day regimen for themselves AND for their contact(s).

1.2.1.6. Order initial HIV and other recommended screening tests based on risk and IAW CDC guidelines at every initial patient encounter for presumptive and/or confirmed STI cases.

1.2.1.7. Refer presumptive and confirmed STI cases immediately to Public Health (PH) for education and a contact investigation in order to prevent re-infection and to break the chain of infection

1.2.1.7.1. For Joint Base San Antonio (JBSA)-Lackland patients, notify Public Health by faxing most current version of 59 MDW Form 3520, *Provider Reportable Condition,* worksheet to (210) 292-9635.

1.2.1.7.2. For JBSA-Randolph patients please contact Public Health at 652-1876 or escort patient to the Public Health office.

1.2.1.8. Providers who diagnose and treat patients with an STI, as well as Public Health staff who provide follow-up counselling, will advise each patient of the need for follow-up testing 90 days later. Patients diagnosed outside of their PCM clinic will be advised to see their PCM team to obtain the lab testing and follow-up counselling. Primary care providers

informed of a patient's STI (to include FEC or PH notification) are responsible for ordering and addressing the 90-day post treatment labs with the patients.

1.2.1.9. For patients diagnosed with syphilis, consult with BAMC Infectious Disease at (210) 916-5554.

1.2.1.10. Test and treat STI *contacts* presumptively IAW CDC treatment guidelines. Non-beneficiary contacts will be referred to San Antonio Metro Health Department (210) 207-8807 for treatment.

1.2.1.10.1. All disclosures to local health departments or state agencies will be reported to the 59MDW Privacy Officer for Health Insurance Portability and Accountability Act (HIPAA) disclosure accounting purposed as required by DoDM 6025.18, 4.4.b.

1.2.2. Public Health Flights (559 AMDS/SGPM and 559 MDS/SGPM) will:

1.2.2.1. Conduct an epidemiological investigation to identify contacts of an STI case for testing and treatment IAW CDC treatment guidelines.

1.2.2.1.1. All STI contacts (Active duty, beneficiaries, or civilians) are notified by PH and advised to seek immediate medical evaluation. All source and contact information is forwarded to the San Antonio Metropolitan Health District for State reporting and follow-up if necessary.

1.2.2.1.2. All disclosures to local health departments or state agencies will be reported to the 59MDW Privacy Officer for HIPAA disclosure accounting purposed as required by DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs* (2019), 4.4.b.

1.2.2.2. Conduct active and passive surveillance for STIs and other communicable diseases to identify cases that may not have been referred/reported. Maintain a database of STIs and conduct an annual program review to include a trend analysis. Present findings to the Aerospace Medicine Council.

1.2.2.3. Report STIs in accordance with Air Force and State regulations and educate professional staff on program requirements such as current treatment guidelines, follow-up testing requirements, program changes, and trends as needed.

1.2.3. Laboratory will:

1.2.3.1. Conduct testing in accordance with the College of American Pathologist guidelines and make results available to providers and Public Health.

1.2.3.2. Notify PH of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the most current version of the Armed Forces Reportable Medical Events Guidelines and Case Definitions.

1.2.3.2.1. Notify PH of any unusual pattern of laboratory testing or significant increase in incidence of a disease.

1.2.4. Chief of the Medical Staff (SGH) will:

1.2.4.1. STI review of appropriate treatment, counselling and follow-up testing will be conducted by Public Health personnel. The results of the clinical review by provider name and patient identification number will be shared with the Infection Control Committee and group Chief of the Medical Staff (SGH) for clinic/provider feedback to improve clinical outcomes. This is a form of peer review that may be placed in a Provider Activity Folder.

Chapter 2

RABIES EXPOSURE CONTROL PROGRAM

2.1. Overview.

2.2.1. To outline responsibilities and post-exposure procedures in order to prevent human rabies that may result from bite and non-bite exposures.

2.2.1.1. Responsibilities.

2.2.1.2. Healthcare Providers will:

2.2.1.3. JBSA-Lackland. Refer all potential rabies exposures to include scratches, bites, contact of saliva or central nervous system (CNS) tissue with the mucous membranes (eye, mouth, or nose) or non-intact skin (open wounds), etc. to the Wilford Hall Ambulatory Surgical Center (WHASC) FEC for wound management, rabies risk assessment, and initiation of post-exposure prophylaxis (PEP) when indicated.

2.2.1.4. JBSA-Randolph (559 MDS). Will provide care, wound management rabies risk assessment and initiation of PEP when indicated for potential rabies exposures to include scratches, bites, contact of saliva with mucous membranes or non-intact skin, etc. at the medical clinic if during normal duty hours. If outside of normal duty hours, members will be referred to the FEC or Brooke Army Medical Center (BAMC).

2.2.2. Treating Provider Will:

2.2.2.1. Clinically manage all potential rabies exposures (bite and non-bite) to include scratches, bites, contact of saliva with mucous membranes or non-intact skin, etc.

2.2.2.2. Render first aid to include cleansing the wound with soap and water due to the lipophilic nature of the rabies virus; when available, irrigates the wound with a virucidal agent such as a povidone-iodine solution.

2.2.2.3. Complete the DD Form 2341, *Report of Animal Bite - Potential Rabies Exposure*, Part I and II and assesses the initial risk for rabies exposure. Risk for rabies exposure is based on the type of animal involved, type of contact, circumstances of the exposure, health status of the animal, the animal's vaccination status, whether the animal is a stray, and in the case of dogs and cats, whether the animal is available for 10-day quarantine. In Texas, animals considered to be high risk for transmitting rabies include bats, skunks, foxes, coyotes, and raccoons; bats and skunks are the primary reservoirs. Additional local information on rabies cases, epidemiology, and statistics can be found published at **https://www.dshs.texas.gov/IDCU/disease/rabies/Cases.aspx**.

Risk classifications are as follows:

2.2.2.3.1. *Low Risk*: Incident (bite, scratch, mucous membrane exposure) involves healthy dog or cat (not a stray) where the owner is known and the dog or cat is available for 10-day quarantine. According to the CDC, squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice, and other small rodents, rabbits, and hares are generally considered minimal risk and almost never require rabies post-exposure prophylaxis. **Note:** these animals can carry rabies, though it is infrequent and unusual. For additional information visit:

https://www.cdc.gov/rabies/exposure/animals/index.html. The SGP, other designated healthcare provider, or Public Health Officer will conduct a final review of DD Form 2341 and sign (block 26) prior to filing the completed report in the patient's medical record.

2.2.2.3.2. *Moderate Risk*: Incident (bite, scratch, mucous membrane exposure) involves dog or cat with bites or injuries to the face, head and neck, **OR** bites from dogs or cats too young for vaccination, **OR** bites from STRAY dogs or cats AVAILABLE for 10-day quarantine (**Note:** 10-day quarantine is only valid for dogs, cats and domestic ferrets). The SGP or designated healthcare provider will conduct a final review of DD Form 2341 and sign prior to filing the completed report in the patient's medical record.

2.2.2.3.3. *High Risk*: Incident (bite, scratch, mucous membrane exposure) involves a STRAY dog or cat NOT available for quarantine, OR a wild animal likely to carry rabies such as a bat, raccoon, skunk, fox, coyote, etc. OR an animal exhibiting signs of rabies. In incidents involving bats, PEP may be appropriate even in the absence of demonstrable bite, scratch, or mucous membrane exposure such as when a sleeping individual awakes to find a bat in their room, or an intoxicated individual or small child, or someone who otherwise can't give an accurate account, or if a bat flies up and brushes against an individual. The SGP or designated healthcare provider will conduct a final review of DD Form 2341 and sign prior to filing the completed report in the patient's medical record.

2.2.2.4. The provider may telephonically convene the Rabies Advisory Board (RAB) (Flight Surgeon, Base Veterinarian, PH Officer) on Moderate or High Risk bites to discuss the need for PEP. Generally, the recommendation is to administer rabies post-exposure prophylaxis on all MODERATE (unless animal appears healthy and is available for 10-day quarantine) and HIGH RISK incidents as outlined in Table 2.1.

2.2.2.4.1. If the provider deviates from the RAB recommendations, they must clearly document the reason *why* in the patients Electronic Health Record (EHR) and communicate the risk assessment to the patient.

2.2.2.4.2. Will document all patient education and interventions (including attempts to contact member) in the EHR.

2.2.2.4.3. The Human Diploid Cell Rabies Vaccine (HDCV) series can be stopped if the source animal is found to be healthy at the end of the 10-day quarantine or the animal's rabies test is negative.

2.2.2.5. Provide patients the immunization schedule (Day 0 [the day the Human Rabies Immunoglobulin (HRIG) and 1st vaccine dose is given], 3, 7, 14,) as outlined in current CDC guidelines, and instruct/direct patients to follow-up with appropriate clinics to complete HDCV series on weekdays and/or weekends/holidays.
https://www.cdc.gov/rabies/medical_care/index.html

2.2.2.6. Assess the tetanus status of the patient and administers booster doses as indicated.

2.2.2.7. Assess immunocompromised, **asplenic**, and *Capnocytophaga canimorsus* risk. Document assessment and patient education on SF600, *Potential Rabies Exposure Case Management*.

2.2.2.8. Assess the risk for Dysgonic Fermentator-2 infection and administers antibiotics as indicated.

2.2.2.9. Provide a single point of contact (POC) to Public Health to correct and address discrepancies in completion of the DD Form 2341 and clinical management of patients.

2.2.2.10. Contact Civil Engineering Customer Service Center at 671-5555 or the 802 Security Forces Emergency Communications Center at (210) 671-3030 (Lackland) or Security Forces at (210) 652-5700 (Randolph) for animals involved in a bite that are loose on base and document contact on the DD Form 2341, block 20.b. (This can be accomplished by any administrative support person from the treating providers clinic.)

Table 2.1. Rabies Post-exposure Prophylaxis (PEP) for Persons Not Previously Vaccinated.

Treatment	Regimen
HRIG (Human Rabies Immunoglobulin)	Administer 20 IU/kg body weight. If anatomically feasible, **the full dose** should be infiltrated in and around the wounds and any remaining volume should be administered intramuscular (IM) in the closest muscle mass of suitable size to accommodate the remainder of the HRIG. The muscle mass selected for HRIG must differ from that selected for initial vaccine administration. HRIG is administered once on day 0 at the time PEP is initiated, in conjunction with human rabies vaccines. If HRIG is not administered when vaccination was begun on day 0, it can be administered up to and including day 7 as part of the PEP series. HRIG should not be administered in the same syringe as vaccine. Because HRIG might partially suppress active production of antibody, no more than the recommended dose should be given. **Note:** Administration of HRIG in the gluteal area is discouraged due to the increased risk of injection into adipose tissue. Persons who have been previously vaccinated for rabies, such as veterinarians, do not require HRIG, therefore consult CDC guidance for HCDV vaccination schedule
Human Diploid Cell Rabies Vaccine (HDCV)	HDCV, Rabies Vaccine Adsorbed, or Purified Chick Embryo Cell Culture Rabies Vaccine 1.0 mL, IM (deltoid area for adults; anterolateral thigh for infants and small children), one each on days 0, 3, 7, 14. Day 0 is the day the HRIG and 1st dose of vaccine is given. **Note:** Vaccine should NEVER be given in the gluteal muscle as this may result in lower neutralizing antibody titers.
Note: When a documented or likely exposure has occurred, post-exposure prophylaxis should be administered regardless of the length of the delay, provided that compatible clinical signs of rabies are not present in the exposed person. (Human Rabies Prevention - MMWR 57/(RR03);1-26,28).	

Table 2.2. Rabies Post-exposure Prophylaxis (PEP) for Persons Previously Vaccinated.

Treatment	Regimen
HRIG (Human Rabies Immunoglobulin)	HRIG should not be administered.
Human Diploid Cell Rabies Vaccine (HDCV)	HDCV or Purified Chick Embryo Cell Culture Rabies Vaccine 1.0 mL, IM (deltoid area for adults), one immediately on day 0 and one on day 3.
Note: For persons with immunosuppression, rabies PEP should be administered using all five doses of vaccine on days 0, 3, 7, 14, and 28.	

2.2.2.10.1. For bites occurring Off-Base:

2.2.2.10.1.1. Bite occurred near Randolph, contact Schertz Animal Control (210) 619-1550. 2.2.2.10.1.2. Bite occurred near Lackland, contact Animal Care Services at (210) 207-6000.

Note: The phone number listed is not a direct number to Animal Care Services. It is linked to the city's 311 number then calls are transferred to Animal Care Services.

2.2.2.11. Document immunizations administered in the Aeromedical Services Information Management System (ASIMS). This can be accomplished by any admin support function from the treating provider's clinic.

2.2.3. Public Health Flights will:

2.2.3.1. Provide sequential animal bite packets to the FEC (at JBSA-Lackland) or the treating providers, which includes the following documents:

2.2.3.1.1. DD Form 2341, *Report of Animal Bite - Potential Rabies Exposure and checklist*, SF 600 59 MDW Overprint *Potential Rabies Exposure Case Management*, program instructions, and the MMWR PEP schedule (US, 2010) to the Rabies Program designee and/or designated clinical location.

2.2.3.2. Conduct quality reviews of animal bite forms for accuracy. Return incomplete or inaccurate forms to medical provider and/or Veterinary Treatment Facility (VTF) (and/or their designee) for correction.

2.2.3.3. Monitor patients for whom PEP was initiated to ensure HRIG and HDCV were administered IAW with CDC guidelines or provider's documented treatment regimen.

2.2.3.4. Serves as a member of the Rabies Advisory Board.

2.2.3.5. Educate professional staff on program requirements and trends at least annually.

2.2.3.6. Upon receipt of the completed DD Form 2341 from the VTF, review for case closure. Bring form to Public Health Officer for review and designated health care provider for final review and signature prior to filing report in the patient's EHR.

2.2.3.7. Report all animal bite/exposure cases and post-exposure prophylaxis administration to AMC at least annually.

2.2.4. Immunizations Clinic will:

2.2.4.1. Administer rabies vaccine in accordance with the CDC regimen.

Note: For JBSA-Randolph. If post-exposure treatment is administered and a scheduled vaccination occurs after normal duty hours, weekends or holidays, advise the patient to report to the medical clinic on the next duty day for vaccine administration.

2.2.4.2. Document series in ASIMS and print a copy out for the patient. Provide the patient with a schedule of the series.

2.2.4.3. Maintain HRIG and HDCV inventory IAW historic usage rates.

2.2.5. Base Veterinarian will:

2.2.5.1. DD Form 2341:

2.2.5.1.1. At JBSA-Lackland: PH Technician will pick up completed animal bite packets and refer cases to Army Veterinary Technicians.

2.2.5.1.2. At JBSA-Randolph clinic: PH Technician will scan and email DD Form 2341s to the Fort Sam Houston Animal Bite POC.

2.2.5.2. Verify rabies vaccination status of source animal.

2.2.5.3. Arrange the 10-day quarantine of source animal involved in bite/non-bite exposures and verify the health status of the source animal at the end of quarantine. *The 10-day quarantine starts at the time of the exposure*. Immediately notify PH if an animal being quarantined dies or its health condition changes.

2.2.5.4. Complete Part III of the DD Form 2341 and return the completed form to PH once the quarantine is complete.

2.2.5.5. Serve as a member of the Rabies Advisory Board and report rabies trends in animal species to the Aerospace Medicine Council (AMC) annually or to PH to report to the AMC.

Chapter 3

TUBERCULOSIS DETECTION AND CONTROL PROGRAM

3.1. Overview. The purpose of this plan is to outline procedures for the testing and treatment of latent tuberculosis infection (LTBI) in active duty Air Force personnel, military beneficiaries, basic trainees, civilians at Defense Language Institute, medical employees, and child care employees.

3.2. General.

3.2.1. Tuberculosis (TB) screening is conducted as follows:

3.2.1.1. Active duty Air Force personnel, basic trainees, and military dependents are screened for TB based on exposure risk and clinical symptoms. Screening may be conducted using a screening questionnaire or an approved testing method [i.e. Tuberculin skin test (TST) or interferon-gamma release assays (IGRA) such as QuantiFERON-TB Gold®, T-*SPOT*®.

Note: **http://www.stoptb.org/countries/tbdata.asp**

3.2.1.1.1. Individuals who deployed to high-prevalence areas for greater than or equal to 30 consecutive days and who had direct prolonged contact with the local population or had high-risk or known exposure to an active TB case should be screened to see if TB test at 3 months (no later than 6 months) post-deployment is required. *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.*

3.2.1.1.2. Baseline TB testing is indicated for individuals who are permanent change of station (PCS)ing to a high TB prevalence country and who have no verification of having been previously tested. Testing should be completed prior to departure.

3.2.1.1.3. 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.

3.2.1.2. All newly assigned Medical personnel will be tested IAW AFI 48-105 and the CDC guidelines for Mycobacterium tuberculosis: *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings.*

3.2.1.3. Personnel working in base child care facilities are tested **initially** IAW the Department of Defense's (DoD) accrediting body for DoD Child Development Centers, the National Association for the Education of Young Children and whenever clinically indicated.

Note: Annual TST is not required for childcare centers in Bexar County.

3.2.1.4. Basic trainees are screened for tuberculosis upon arrival to JBSA-Lackland.

3.2.1.4.1. Screening is conducted with the most current version of 59 MDW Form 16 and results are documented in ASIMS.

3.2.1.4.2. All 59 MDW Form 16 with positive screening results are additionally documented in the trainees EHR.

3.2.1.5. Personnel should be questioned to determine if they have received the BCG vaccine or are from a country listed on the most current TB high-burden country list. If yes or unknown, an approved blood test should be ordered. Results will be documented in ASIMS accordingly (TB Blood Assay with reaction).

3.2.1.5.1. Lab may be ordered under the assigned Primary Care Manger.

3.2.1.5.2. Current BCG Country Vaccine policies may be found at: **http://www.bcgatlas.org/**

3.2.1.6. Patients who are suspected of having active TB should be immediately referred to an MTF appropriately equipped to rule-out active disease, (i.e., Brooke Army Medical Center) prior to patient arriving for appointment at the facility. Suspected cases will be handled IAW the facility's respective Respiratory Exposure Control Plan.

3.3. Responsibilities.

3.3.1. The Immunizations Clinic will:

3.3.1.1. Administer and read all TSTs.

3.3.1.2. Schedule follow-up appointments and brief patients on the importance of returning to have the TST read and result documented. **Note:** TSTs can only be documented as "negative" 48-72 hours after test is administered. *Negative tests not read within this time frame must be repeated on the opposite arm.*

3.3.1.2.1. Contact personnel who "No Show" for TST readings.

3.3.1.3. Enter all TST and/or blood test results into ASIMS and print a DD Form 2766C, *Adult Preventive and Chronic Care Flowsheet (Continuation Sheet)*, for the patient's personal records. **Note:** Basic Trainees are not provided a hard copy of the DD Form 2766C.

3.3.1.4. Document reactive TSTs in ASIMS with millimeter indurations to prevent repeat testing of individuals with (LTBI) and to identify skin-test converters.

3.3.1.5. Refer all persons with a reaction of greater than or equal to 5mm indurations to PH (with their shot records/medical record if necessary) for interview and counseling.

3.3.2. Public Health Flights will:

3.3.2.1. Conduct initial patient interview and education of patients with reactions of 5 mm or greater induration and refer patients to the healthcare provider for LTBI "positive" determination and treatment.

Note: Contractors will be instructed to seek follow-up care as appropriate with their civilian provider or as otherwise stated in the terms of their contract and provide proof of treatment/evaluation to PH.

3.3.2.2. Re-enforce education regarding LTBI, signs and symptoms of active tuberculosis, treatment to include importance of strict adherence to treatment protocol, and potential side effects of isoniazid (INH) medication. Discuss the importance of notifying their provider of potential problems related to the INH (or other approved CDC treatment regimen) medication adherence, signs and symptoms of active TB, and potential medication side effects.

Note: Patients will be instructed to contact their provider prior to running out of their medication and to schedule their appointments.

3.3.2.3. Conduct epidemiological investigations for active cases of TB in workplaces/BMT and TST conversion clusters.

3.3.2.4. Report active TB cases to USAFSAM/PH via Air Force Disease Reporting System internet (AFDRSi) within 24 hours and to San Antonio Metropolitan Health District.

3.3.2.4.1. All disclosures to local health departments or state agencies will be reported to the 59 MDW Privacy Officer for HIPAA disclosure, as required by DoDM 6025.18, 4.4.b.

3.3.3. The Healthcare Provider will:

3.3.3.1. Order baseline chest x-ray and alanine aminotransferase (ALT), HIV (unless documented HIV risk assessment indicates low risk) and aspartate aminotransferase (AST) as indicated. Baseline ALT and AST are indicated for persons infected with HIV, pregnant women, women in the immediate postpartum period (usually within 3 months of delivery), persons with a history of liver disease, persons who use alcohol regularly, and those who have or are at risk for chronic liver disease.

3.3.3.2. Evaluate patients with a 5 mm or greater TST to determine if the skin test is "positive" based on their risk for infection and in accordance with Air Force and CDC guidelines. Determine the patient's disease status (latent or active TB), initiate and document appropriate treatment IAW CDC guidelines. Specifically, discuss the benefits and risks of treatment, review possible medication side effects or drug interactions, emphasize importance of adherence and identify potential barriers to adherence, and establish a plan with the patient to ensure adherence.

3.3.3.3. Clearly document the EHR with rationale if patient is not started on medication (examples: liver disease, previous reaction to INH therapy, or suspended due to short-notice PCS, pregnancy, etc.). **Note:** PCS is not a valid reason to delay treatment unless there is insufficient time to evaluate the patient's tolerance of the medication.

3.3.3.4. Document positive TB screening test results, the medication administered and dates completed in the medical record and on AF Form 2453, *Tuberculosis Detection and Control Data*.

3.3.3.5. Monitor personnel on the TB Detection and Control Program monthly and schedule follow-up appointments and laboratory testing as necessary. Maintain a confidential log listing or other tracking system of pertinent patient information, dates for follow-up testing and results of laboratory tests.

Note: All initial and follow-up appointments will be scheduled through Flight Medicine and will serve as the appointed physicians for patients on the TB program at JBSA-Randolph.

3.3.3.6. Ensure personnel on flying status are grounded for the first 7 days of treatment.

Note: Recent converters who do not have active TB but who are on flying status, have flying status handled IAW current AFMRA 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 unable to be in Duties Not

Involving Flying status for three days) and active TB has been ruled out, INH therapy can be delayed for up to 18 months with the approval of the base SGP documented in the clinical record. 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.

3.3.3.7. Conduct and document in the patient's medical record monthly follow-ups to ensure appropriate documentation includes:

3.3.3.7.1. Patient's adherence to treatment protocol by tracking/documenting the number of doses completed and the number of doses missed in their treatment regimen.

3.3.3.7.2. Potential signs and symptoms of active tuberculosis.

3.3.3.7.3. Potential medication side effects. Research suggests evaluation for medical side effects is a better indicator of potential hepatotoxicity than reliance on liver function tests. In general, studies have shown that persons 35 years of age or older tend to develop hepatotoxicity at a greater frequency. Therefore, 59 MDW policy is to initially conduct monthly AST/ALT for persons 35 years of age or older to establish a trend in the patient's Liver Function Tests and then either continue or stop testing at the clinician's discretion. Educate patients to stop taking medication if they experience medication side effects and to immediately contact their provider to determine if treatment should continue.

3.3.3.8. Order INH medication refills. Ensure patients obtain medications from the Pharmacy.

3.3.3.9. Close out the AF Form 2453 when the patient completes, is unable to complete or discontinues INH or other prophylaxis and files this in their electronic health record.

3.3.3.10. Will coordinate with the appropriate health care providers of patients requiring follow-up: PCS, retire, or separate from military.

3.3.4. The Pharmacy will:

3.3.4.1. Issue patients their INH or accepted alternative medication in accordance with the primary care manager's directions.

3.3.5. Dental Clinic Personnel will:

3.3.5.1. Dental Health Care Workers should routinely screen all patients for a past history of TB, current signs and symptoms consistent with active TB.

3.3.5.2. Follow the Facility's Tuberculosis Exposure Control Plan should a patient be suspected of having Active TB.

3.3.6. Laboratory Will:

3.3.6.1. Conduct testing in accordance with the College of American Pathologist guidelines and make results available to providers and Public Health.

3.3.6.2. Notify PH of reportable diseases/conditions meeting laboratory criteria for diagnosis as listed in the Armed Forces Reportable Medical Events Guidelines and Case Definitions **http://www.afhsc.mil/Home/ReportableEvents**.

3.3.6.2.1. Notify PH of any unusual pattern of laboratory testing or significant increase in incidence of a disease.

3.4. Treatment Considerations.

3.4.1. Members will be treated IAW the most current CDC Guidance and provider's clinical discretion.

3.4.2. Annual routine chest x-rays are not required, nor recommended for the asymptomatic positive TSTs. X-rays will be repeated only if the individual becomes symptomatic or per provider discretion.

Chapter 4

OTHER REPORTABLE CONDITIONS

4.1. Purpose. To provide early identification and intervention for communicable diseases and other diseases/conditions of significance to the health of the public.

4.2. Responsibilities.

4.2.1. Pediatrics and other Healthcare Providers will:

4.2.1.1. Report all cases of elevated blood lead levels, communicable diseases such as meningitis, West Nile Virus, and other diseases of public health and military significance to Public Health using the 59 MDW Form 3520 or via other secure methods. For JBSA-Randolph patients please notify Randolph PH immediately at (210) 652-1876 or fax the completed 59 MDW Form 3520 to (210) 652-6022

4.2.1.1.1. Reportable listings can be found:

State: **http://www.dshs.state.tx.us/idcu/investigation/conditions/**
Armed Forces Reportable: **https://health.mil/Military-Health-Topics/Combat-Support/Armed-Forces-Health-Surveillance-Branch/Reports-and-Publications**

4.2.2. Public Health Flights will:

4.2.2.1. Conduct community public health surveillance IAW AFI 48-105. This may include but not limited to: daily spools for reportable conditions and reviewing the Electronic Surveillance System for Early Notification of Community based Epidemics (ESSENCE v5) for warnings and alerts on specified syndromes. Surveillance tracking logs will be maintained.

4.2.2.1.1. Inform chain of command, MDG/CCs, Public Health Emergency Officers (PHEO) and providers on disease prevention, and on education and control programs for diseases/ conditions of public health or military significance as necessary.

4.2.2.2. Report all child or adult blood lead at any levels immediately to Texas Department of State Health Services (DSHS) IAW Texas regulations.

4.2.2.3. Report in AFDRSi all child blood lead levels greater than or equal to 5 ug/dL and adult blood lead levels of great than or equal to 40 ug/dL or IAW current CDC reporting guidelines.

4.2.2.4. Conduct epidemiological investigations and implement prevention measures as outlined in CDC/State guidelines and the *Control of Communicable Diseases Manual* as necessary.

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Chief of the Medical Staff, 59th Medical Wing

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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DoDI 6200.3, *Public Health Emergency Management Within the Department of Defense*, 5 March 2010

AFPD 48-1, *Aerospace & Operational Medicine Enterprise (AOME),* 7 June 2019

AFI 44-108, *Infection Control Program*, 5 June 2019

AFI 48-101, *Aerospace Medicine Enterprise,* 8 December, 2014

AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health and Military Significance,* 15 July 2014

AFI 48-123, *Medical Examinations and Standards*, 5 November 2013

Armed Forces Reportable Medial Events Guidelines & Case Definitions, July 2017

Morbidity and Mortality Weekly Report (MMWR), Vol 64, RR-3, 5 June, 2015 *Sexually Transmitted Diseases Treatment Guidelines*, 2015

MMWR, Vol 54, RR, 30 December 2005, *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings*

Control of Communicable Disease Manual, 20th Edition, 2015

Texas Department of State Health Services

Prescribed Forms

59 MDW Form 16, *Recruit Initial Tuberculosis (TB) Risk Assessment Tool*

59 MDW Form 3520, *Provider Reportable Condition*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 2453, *Tuberculosis Detection and Control Data*

DD Form 2341, *Report of Animal Bite - Potential Rabies Exposure*

DD Form 2766C, *Adult Preventive and Chronic Care Flowsheet (Continuation Sheet)*

SF Form 600, *Chronological Record of Medical Care*

Abbreviations and Acronyms

AFDRSi—Air Force Disease Reporting System internet

ALT—Alanine Aminotransferase

AMC—Aeromedical Council

ASIMS—Aeromedical Services Information Management System

AST—Aspartate Aminotransferase

BAMC—Brooke Army Medical Center

CDC—Centers for Disease Control

DoD—Department of Defense

EHR—Electronic Health Record

FEC—Family Emergency Center

GC—Gonococcal Infection

HDCV—Human Diploid Cell Rabies Vaccine

HIPAA—Health Insurance Portability and Accountability Act

HIV—Human Immunodeficiency Virus

HRIG—Human Rabies Immune Globulin

IAW—In Accordance With

IGRA—Interferon-Gamma Release Assay

IM—Intramuscular

INH—Isoniazid

JBSA—Joint Base San Antonio

LTBI—Latent Tuberculosis Infection

MDG—Medical Group

MDW—Medical Wing

PCS—Permanent Change of Station

PEP—Post-Exposure Prophylaxis

PH—Public Health

POC—Point of Contact

STI—Sexually Transmitted Infections

TB—Tuberculosis

TST—Tuberculin Skin Test

WHASC—Wilford Hall Ambulatory Surgical Center

Terms

Active Tuberculosis (TB)—Persons exposed to Mycobacterium tuberculosis (TB) as evidenced by a positive tuberculin skin test and are symptomatic and clinically ill. The possibility of Pulmonary TB should be considered in persons who have a productive cough, prolonged cough (duration of ≥ 3 weeks) chest pain, hemoptysis, and the systemic symptoms of TB including fever,

chills, night sweats, appetite loss, weight loss, and easy fatigability. See the definition for latent tuberculosis below.

Latent Tuberculosis (TB)—Persons exposed to Mycobacterium TB as evidenced by a positive tuberculin skin test, but who are not sick or have symptoms of active TB disease are considered to have latent TB. Persons with latent TB infection are not infectious and cannot spread TB infection to others.

Attachment 2

SCREENING RECOMMENDATIONS

Table A2.1. Screening Recommendations.

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
Chlamydia	Sexually active women under 25 years of age USPSTF[1] Sexually active women aged 25 years and older if at increased risk2 USPSTF[1] Retest approximately 3 months after treatment CDC[3]	All pregnant women under 25 years of age USPSTF[1] Pregnant women, aged 25 years and older if at increased risk[2] USPSTF1 Retest during the 3rd trimester for women under 25 years of age or at risk[4] CDC[3] Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months USPSTF[1]	Consider screening young men in high prevalence clinical settings[5] or in populations with high burden of infection (e.g. MSM) CDC[6]	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use CDC[6] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first IV evaluation, and at least annually thereafter CDC[8] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology CDC[8]
Gonorrhea	Sexually active women under 25 years of age USPSTF[1] Sexually active women age 25 years and older if at increased risk[9] USPSTF[1] Retest 3 months after treatment CDC[10]	All pregnant women under 25 years of age and older women if at increased risk[11] USPSTF[1] Retest 3 months after treatment CDC[10]		At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use CDC[10] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter CDC[10] More frequent screening might be appropriate depending on individual risk

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
					behaviors and the local epidemiology CDC[10]
Syphilis		All pregnant women at the first prenatal visit USPSTF[11] Retest early in the third trimester and at delivery if at high risk AAP/ACOG[12]		At least annually for sexually active MSM CDC[13] Every 3 to 6 months if at increased risk[7] CDC[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter CDC, HRSA, IDSA, NIH[14,15,16] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology CDC[13]
Trichomonas	Consider for women receiving care in high prevalence settings (e.g., STD clinics and correctional facilities) and for women at high risk for infection (e.g., women with multiple sex partners, exchanging sex				Recommended for sexually active women at entry to care and at least annually thereafter CDC[14]

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
	for payment, illicit drug use, and a history of STD) CDC[17]				
Herpes	Type-specific HSV serologic testing should be considered for women presenting for an STD valuation (especially for women with multiple sex partners) CDC[17]	Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy CDC[17]	Type-specific HSV serologic testing should be considered for men presenting for an STD evaluation (especially for men with multiple sex partners) CDC[17]	Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection CDC[17]	Type-specific HSV serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition CDC[17]
HIV	All women aged 13-64 years (opt-out)** CDC[18] All women who seek evaluation and treatment for STDs CDC[19]	All pregnant women should be screened at first prenatal visit (opt-out) USPSTF[20] Retest in the third trimester if at high risk CDC[21]	All men aged 13-64 years (opt-out)** CDC[18] All men who seek evaluation and treatment for STDs CDC[19]	At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test CDC[22]	
Cervical Cancer	Women 21-29 years of age every 3 years with cytology	Pregnant women should be screened at same intervals as non-pregnant women			Women should be screened within 1 year of sexual

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
	Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing USPSTF[23], ACOG[24], ACS[25]	USPSTF [23], ACOG[24], ACS[25]			activity or initial HIV diagnosis using conventional or liquid based cytology; testing should be repeated 6 months later CDC, NIH, IDSA[26]
Hepatitis B Screening	Women at increased risk CDC[27]	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk CDC [27], USPSTF [28]	Men at increased risk CDC[27]	All MSM should be tested for HBsAg CDC[27]	Test for HBsAg and anti- HBc and/or anti-HBs. CDC[27]
Hepatitis C Screening	Women born between 1945-1965 CDC[29], USPSTF[30] Other women if risk factors are present[30] USPSTF[30]	Pregnant women born between 1945-1965 CDC[29] , USPSTF[30] Other pregnant women if risk factors are present[30] USPSTF[30]	Men born between 1945-1965 CDC [29] USPSTF[30] Other men if risk factors are present[30] USPSTF[30]	MSM born between 1945-1965 CDC[29] Other MSM if risk factors are present[30] USPSTF[30] Annual HCV testing in MSM with HIV infection CDC[31]	Serologic testing at initial evaluation CDC, NIH, IDSA[32,33] Annual HCV testing in MSM with HIV infection CDC[31]

Notes:
*Italics represent source of recommendations
** USPSTF recommends screening in adults and adolescents ages 15-65

1. LeFevre ML. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. September 23, 2014.
2. Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and

Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. September 23, 2014.
3. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
4. e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines (Special Populations), 2015.
5. Adolescent clinics, correctional facilities, and STD clinics. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
6. Increased rates of early syphilis (primary, secondary, or early latent), gonorrhea, and chlamydial infection and higher rates of sexual risk behaviors have been documented among MSM in the United States and virtually all industrialized countries. Sexually Transmitted Diseases Treatment Guidelines (Special Populations), 2015.
7. More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
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21. Women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
22. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.
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