

MSDH TUBERCULOSIS TESTING SUMMARY

Reporting Period From: _____ To: _____

Facility Name: _____

County: _____

Facility Address: _____

Facility Phone: _____

Reported by: _____

Date Completed: _____

Instructions	Employees		Residents/Patients/Inmates	
	A1	A2	B1	B2
	New	Continuing Employment From Previous Report Period	New	Continuing Residence From Previous Report Period
1. Total number of individuals employed/housed for reporting period [1 = (2 + 3)].	1. _____	1. _____	1. _____	1. _____
2. Total number not tested and reason for not testing: (a + b + c + d + e=2)	2. _____	2. _____	2. _____	2. _____
a. Number with documented previous positive.	a. _____	a. _____	a. _____	a. _____
b. Number refusing test.	b. _____	b. _____	b. _____	b. _____
c. Number individually medically excluded	c. _____	c. _____	c. _____	c. _____
d. Number terminating employment or residence prior to annual testing.	d. _____ N/A	d. _____	d. _____ N/A	d. _____
e. Continuing employment report period ONLY. Annual signs and symptoms assessment performed.	e. _____	e. _____	e. _____	e. _____
	Initial Test	2nd Step Skin Test	Initial Test	2nd Step Skin Test
3. Total number of individuals tested during the report period.	3. _____	3. _____	3. _____	3. _____
4. Total number of tests read and resulted	4. _____	4. _____	4. _____	4. _____
5. Total number of new reactors with skin test reading between 5-9 mm.	5. _____	5. _____	5. _____	5. _____
6. Total number of new reactors with skin test reading equal to 10mm or more or a positive IGRA.**	6. _____	6. _____	6. _____	6. _____
7. Total number of new reactors x-rayed.	7. _____	7. _____	7. _____	7. _____
8. Total number of new reactors placed on treatment for latent tuberculosis infection (LTBI).	8. _____	8. _____	8. _____	8. _____
9. Total number found to have active tuberculosis.	9. _____	9. _____	9. _____	9. _____

*TST – Tuberculin Skin Test

**IGRA – Interferon-Gamma Release Assay (Blood Test for TB Infection)

***LTBI – Latent Tuberculosis Infection

Approved by: _____

Administrator

TURN PAGE TO COMPLETE INDIVIDUAL NEW REACTOR DATA LIST

Mississippi State Department of Health Form Instructions

TUBERCULOSIS TESTING SUMMARY

FORM NUMBER F-181
REVISION DATE October 12, 2021
RETENTION PERIOD The submitter retains a copy for a period of not less than two (2) years.

PURPOSE

To provide a summary of tuberculosis surveillance and screening activities among designated high-risk groups of Mississippi's population. To provide the summary within a time-frame conducive to an analysis of epidemiological data that is most applicable to the elimination of tuberculosis in institutions and among healthcare workers.

The summary must be a **true and correct reflection** of tuberculosis surveillance activities: screening, screening omissions, TB epidemiology data, subsequent follow-up procedures, referrals, and outcomes. It is incumbent upon the licensee to ensure the form is accurate.

REPORTING TIME FRAME

Health Department Staff

Results of screening should be documented on a Tuberculosis Testing Summary Form #181 and sent to the TB Program. Annual testing shall be done in June of each year, and results reported to the TB Program by July 15. Employees in high-risk settings requiring semi-annual testing are also tested in December, with the report due January 15.

Prisons and Jails

Results of screening should be documented on a Tuberculin Testing Summary Form #181 and sent monthly to the TB Program. Monthly reports are due on the 15th of the following month. Annual testing shall be done in January each year and reported to the TB Program on or before February 15.

Regional TB Contract Hospitals

All contract hospitals are required to perform annual testing. Any regular 12-month timeframe is acceptable. The summary report is due within 15 days of the end of the 12-month period.

Exposure Management/Screening/Targeted Testing

The reporting timeframe is the same as for reporting contacts. The #181 may be used to summarize testing. Record all positive tests for Tuberculosis Infection in the electronic TB record.

Nursing Homes and Personal Care Homes

Annual reports are to be submitted to Licensure and Certification with the annual Licensure application package.

Mississippi State Department of Health Form Instructions

INSTRUCTIONS

(Type or print legibly)

- Report Period:** Period Beginning/Ending: Enter dates for reporting timeframe. The timeframe must be 12-month period if making an annual report. If monthly, enter the start and end of the month and year.
- Name of Facility:** Enter name of facility as listed on the license. If doing business under another name, list that name second. Do not use abbreviations or acronyms. Do not combine reports for different facilities.
- County:** Enter County in which the facility is located.
- Address:** Enter street and mailing address for the facility.
- Report Completed By:** PRINT/type the name and title of the person who completed the report.
- Phone Number:** Enter contact telephone number of person who completed the report.
- Date Completed:** Enter date report was completed.

NOTE: It is simpler to complete the form column by column (downward not left to right).

COLUMN A1 - NEW EMPLOYEES

Line 1: Enter the total number of new employees hired by your facility during this reporting time- frame.

Line 2: Enter the total number of new employees not tested for tuberculosis infection during the current reporting period. Sub-divide this total into the following categories, as applicable.
(Line 2 = 2a + 2b + 2c)

Line 2a: Enter the total number of new employees with documentation of a previous positive test for tuberculosis (IGRA or TST). These individuals must receive an annual pulmonary/symptom assessment.

Line 2b: Enter the total number of new employees refusing to be tested. NOTE: This section does not apply for long-term care facilities.

Line 2c: Enter the total number of new employees with a documented medical exclusion. (This would be an extraordinarily rare occurrence. Pregnancy is not an exclusion). A physician's statement must be kept in facility files citing the reason for the exclusion. List the individual on back of Form 181 and explain why the individual could not be tested with any of the available tests.

Line 2d: This does not apply to new employees.

Mississippi State Department of Health

Form Instructions

INITIAL TEST

Line 3: Enter the total number of new employees who were tested at your facility. Individuals that provided documentation of current testing at another facility may be listed here or listed in summary in the comments section. *If the number in #3 is different from the sum of #1 minus #2, explain the difference in the comments section on the back.*

Line 4: Enter the total number of those tested in #3 whose test was documented as read or resulted. *If the number in #4 is different than the number in #3, explain in the comments section on the back.*
Note: This number minus the total number of positive tests on initial testing and minus the number of persons receiving an IGRA on initial test will be the number that you should have in #3 on second step. If different, explain on back of form.

Line 5: Enter the total number of new employees with new skin test readings of 5-9 mm on initial or two-step skin test.

Line 6: Enter in the total number of new employees with a positive IGRA or new skin test readings of 10 mm or greater.

Note: New employees with new skin test readings of 5 mm or greater should be entered on the back of the form.

2ND STEP SKIN TEST

Line 3: Enter the total number of new employees who received a second-step test at your facility. **NOTE:** A two-step test is not required for individuals that received an IGRA as the initial test. Individuals that provided documentation of testing from another facility as their first- step are listed here when they received the second step. (This may be the first time they have been tested at your facility, but if you accepted documentation as the first step, your testing is the second step. (See Note under #4, initial step.)

Line 4: Enter the total number of those tested in #3 second step whose test was documented as read or resulted. *If the number in #4 is different than the number in #3, explain the difference in the comments section on the back.*

Line 5: Enter the total number of new employees with second step skin test readings of 5-9 mm on initial or two-step skin test.

Line 6: Enter the total number of new employees with second step skin test readings of 10 mm or greater.

Note: New employees with new skin test readings of 5mm or greater should be entered on the back of the form.

Line 7: Enter the total number of new employees that received a chest x-ray as a result of having a positive IGRA or new significant positive tuberculin skin test.

Line 8: Enter the total number of new employees that were placed on treatment for *M. tuberculosis* infection.

Line 9: Enter the total number of new employees that were found to have *M. tuberculosis* disease. (Active disease must be confirmed through the MSDH TB Program.)

Mississippi State Department of Health

Form Instructions

COLUMN A2 - CONTINUING EMPLOYEES

Line 1: Enter the total number of employees who were employed prior to the start of the current reporting date and who were included in the last annual report. A simple way to find this may be to get the total numbers on the payroll, January 1 of the reporting year. The number would include all employees, including but not limited to, full-time, part-time, and contract employees.

Line 2: Enter the total number of continuing employees who were not tested during the current reporting period; sub-divide this total into the following categories below, as applicable.
(Line 2 = 2a + 2b + 2c + 2d + 2e)

Line 2a: Enter the total number of continuing employees who were not tested because of documentation of a positive tuberculosis test (IGRA or TST) prior to this testing period.

Line 2b: Enter the total number of continuing employees refusing to be tested. NOTE: This does not apply to long-term care facilities.

Line 2c: Enter the total number of continuing employees with a documented medical exclusion. (This would be an extraordinarily rare occurrence. (A physician's statement must be kept in facility files citing the reason for the exclusion.) List the individual on back of Form 181 and explain why the individual could not be tested with any of the available tests.

Line 2d: Enter the total number of continuing employees who were terminated prior to annual testing.

Line 2e: Enter the total number of continuing employees who completed the S/SX assessment

Note: *Line a + b + c + d + e must equal the total in Line 2*

Line 3: Enter the total number of continuing employees who received an IGRA or TST during the reporting period. (Two-step testing is not necessary if the annual screening is current.)

Line 4: Enter in the total number of continuing employees who had their IGRA resulted or TST read. If this number is different than the total in #3 above, explain the difference in the comments section.

Line 5: Enter the total number of continuing employees with **new** skin test reading between 5-9 mm. (If recently exposed, symptomatic, or has risk factors, refer for x-ray and medical evaluation.)

Line 6: Enter the total number of continuing employees with a positive IGRA or **new** skin test reading of 10 mm; (*Note: If follow-up IGRA is negative, repeat IGRA annually; do not TST.*)

Note: *Continuing employees with new skin test readings of 5mm or greater, or positive IGRA results should be entered in Section 2 on the back of the form.*

Line 7: Enter the total number of continuing employees who received an x-ray as a result of a **new** positive skin test or IGRA.

Line 8: Enter the total number of continuing employees who were placed on treatment for *M. tuberculosis* infection.

Line 9: Enter the total number of continuing employees who were found to have *M. tuberculosis* disease. (*M. TB* disease must be confirmed through the MSDH TB Program.)

Mississippi State Department of Health Form Instructions

COLUMN B1 - NEW RESIDENTS/PATIENTS/INMATES

Line 1: Enter the total number of new residents/patients/inmates hired by your facility during this reporting timeframe.

Line 2: Enter the total number of new residents/patients/inmates not tested for tuberculosis infection during the current reporting period. Sub-divide this total into the following categories, as applicable. (Line 2 = 2a + 2b + 2c)

Line 2a: Enter the total number of new residents/patients/inmates with documentation of a previous positive test for tuberculosis (IGRA or TST). These individuals must receive an annual pulmonary/symptom assessment.

Line 2b: Enter the total number of new residents/patients/inmates refusing to be tested. NOTE: This section does not apply for long-term care facilities.

Line 2c: Enter the total number of new residents/patients/inmates with a documented medical exclusion. (This would be an extraordinarily rare occurrence. (Pregnancy is not an exclusion). A physician's statement must be kept in facility files citing the reason for the exclusion. List the individual on back of Form 181 and explain why the individual could not be tested with any of the available tests.

Line 2d: This does not apply to new residents/patients/inmates.

INITIAL TEST

Line 3: Enter the total number of new residents/patients/inmates who were tested at your facility. Individuals that provided documentation of current testing at another facility may be listed here or listed in summary in the comments section. *If the number in #3 is different from the sum of #1 + #2, explain the difference in the comments section on the back.*

Line 4: Enter the total number of those tested in #3; whose test was documented as read or resulted. *If the number in #4 is different than the number in #3, explain in the comments section on the back.*

Line 5: Enter the total number of new residents/patients/inmates with new skin test readings of 5-9 mm on initial or two-step skin test.

Line 6: Enter in the total number of new residents/patients/inmates with a positive IGRA or new skin test readings of 10 mm or greater.

Note: *New residents/patients/inmates with new skin test readings of 5mm or greater should be entered on the back of the form.*

Mississippi State Department of Health

Form Instructions

2ND STEP SKIN TEST

Line 3: Enter the total number of new residents/patients/inmates who received a second-step test at your facility. NOTE: (A two-step test is not required for individuals that received an IGRA as the initial test.) Individuals that provided documentation of testing from another facility as their first step are listed here when they received the second step. (This may be the first time they have been tested at your facility, but if you accepted documentation as the first step, your testing is the second step. *If the number in #3 second step is different from the number listed in #4 initial-step, plus the number from the comment section for #3 initial-step, that came to your facility with documentation of a first step and minus those that received an IGRA as the initial test, explain the difference in the comments section.*

Line 4: Enter the total number of those tested in #3 second step whose test was documented as read or resulted. *If the number in #4 is different than the number in #3, explain the difference in the comments section on the back.*

Line 5: Enter the total number of new residents/patients/inmates with second step skin test readings of 5-9 mm on initial or two-step skin test.

Line 6: Enter in the total number of new residents/patients/inmates with a second step skin test readings of 10 mm or greater.

Note: *New residents/patients/inmates with new skin test readings of 5mm or greater should be entered on the back of the form.*

Line 7: Enter the total number of new residents/patients/inmates that received a chest x-ray as a result of having a positive IGRA or new significant positive tuberculin skin test.

Line 8: Enter the total number of new residents/patients/inmates that were placed on treatment for *M. tuberculosis* infection.

Line 9: Enter the total number of new residents/patients/inmates that were found to have *M. tuberculosis* disease. (Active disease must be confirmed through the MSDH TB Program.)

Mississippi State Department of Health

Form Instructions

COLUMN B2 - CONTINUING RESIDENTS/PATIENTS/INMATES

Line 1: Enter the total number of residents/patients/inmates who were housed in your facility prior to the start of the current reporting date and who were included in the last annual report. A simple way to find this may be to get the total number on the facility bed roster on January 1 of the reporting year.

Line 2: Enter the total number of continuing residents/patients/inmates who were not tested during the current reporting period. Sub-divide this total into the following categories below, as applicable. (Line 2 = 2a + 2b + 2c + 2d).

Line 2a: Enter the total number of continuing residents/patients/inmates who were not tested because of documentation of a positive tuberculosis test (IGRA or TST) prior to this testing period.

Line 2b: Enter the total number of continuing residents/patients/inmates refusing to be tested. NOTE: This does not apply to long-term care facilities.

Line 2c: Enter the total number of continuing residents/patients/inmates with a documented medical exclusion. (This would be an extraordinarily rare occurrence. A physician's statement must be kept in facility files citing the reason for the exclusion.) List the individual on back of Form 181 and explain why the individual could not be tested with any of the available tests.

Line 2d: Enter the total number of continuing residents/patients/inmates who terminated prior to annual testing

Note: *Line a + b + c + d must equal the total in Line 2.*

Line 3: Enter the total number of continuing residents/patients/inmates who received an IGRA or TST during the reporting period. (Two-step testing is not necessary if the annual screening is current.)

Line 4: Enter the total number of continuing residents/patients/inmates who had their IGRA result or TST read. If this number is different than the total in #3 above, explain the difference in the comments section.

Line 5: Enter the total number of continuing residents/patients/inmates with **new** skin test reading between 5-9 mm. (If recently exposed, symptomatic, or has risk factors, refer for x-ray and medical evaluation.)

Line 6: Enter the total number of continuing residents/patients/inmates with a positive IGRA or **new** skin test reading of 10 mm or greater. (Note: *If follow-up IGRA is negative, repeat IGRA annually, do not TST.*)

Note: *Continuing employees with new skin test readings of 5 mm or greater or positive IGRA should be entered in Section 2 on the back of the form.*

Line 7: Enter the total number of continuing residents/patients/inmates who received an x-ray as a result of a **new** positive skin test or IGRA.

Line 8: Enter the total number of continuing residents/patients/inmates who were placed on treatment for *M. tuberculosis* infection.

Line 9: Enter the total number of continuing residents/patients/inmates who were found to have *M. tuberculosis* disease. (*M. TB* disease must be confirmed through the MSDH TB Program.)

Approved by: Signature of the facility administrator indicating review, accuracy, and approval for submission.

Mississippi State Department of Health Form Instructions

PAGE 2: List all positive reactors (5 mm or greater) and IGRA positives counted in lines 5 and 6:

<u>Name:</u>	Enter last name, first name, and middle initial
<u>Date of Birth:</u>	In dd/mm/yy format.
<u>Race:</u>	Enter code W=White B=Black AI-American Indian AN=Alaskan, PI=Pacific Islander As=Asian.
<u>Sex:</u>	M=Male F=Female.
<u>Date of Test:</u>	Enter dates tuberculin test was placed and read or IGRA collected.
<u>Induration/Result:</u>	Enter test measurement in millimeters or IGRA (+).
<u>Date of Hire/Admission:</u>	Enter date of hire/admission to the facility.
<u>Position/Status/Room:</u>	Enter status (employee/resident/patient/inmate).
<u>X-ray date/results:</u>	Enter chest x-rays result (normal/abnormal).
<u>Treatment:</u>	Enter physician's written order (medicine ordered, start date, duration of therapy).
<u>Symptom Assessment:</u>	Enter date and "+" if symptoms present and "-" if no symptoms.

OFFICE MECHANICS AND FILING

The licensee or designee shall complete the form according to the schedules explained in the instructions; the completed form is to be routed as follows:

Nursing Homes and Personal Care Homes submit the original with licensure packet. Others route original to the Regional TB Nurse for verification of completion and accuracy. The Regional TB Nurse will forward the original to the Tuberculosis Program. The submitter will retain a copy for a period of not less than two (2) years. Questions regarding this form should be directed to the MSDH Tuberculosis Program, (601) 576-7700.