TEXAS Health and Human Services | Texas Department of State Health Services

CORRECTIONAL TUBERCULOSIS SCREENING PLAN (TB-805)

INSTRUCTIONS

The Correctional Tuberculosis (TB) Screening Plan (TB-805) is required of all jails designated as Texas Health and Safety Chapter 89. **Refer to publication #TB-805-I for instructions on filling out this form.** Type in each box using the fillable electronic form. **All sections of the plan must be filled out completely and must be legible or the form will be returned.** Do not leave questions blank (type N/A if needed). The electronically signed original plan must be **emailed to Texas Department of State Health Services (DSHS) Tuberculosis and Hansen's Disease Unit at CongregateSettings@dshs.texas.gov.**

A. CONTACT INFORMATION

1. Facility Name

2. Physical Address (*list additional sites in Section F*) **City** **State** **Zip Code**

3. Mailing Address *(if different from physical)* **City** **State** **Zip Code**

4. Jail Administrator's Name	**5. Title**	**6. Phone Number**

7. Email Address	**8. Fax Number**

9. Medical Director (MD, DO, NP, or PA-C)

Name **Credentials (MD, DO, NP, or PA-C)**

National Provider Identifier (NPI) **Email Address**

Phone Number **Address**

City **State** **Zip Code**

10. Is the contact person the same as the jail administrator?

☐ YES ☐ NO If NO, complete question 11 below.

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11. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.

Name: **Title:**

Phone Number: **Email Address:**

Name: **Title:**

Phone Number: **Email Address:**

B. FACILITY INFORMATION

1. Facility operated by:

☐ County ☐ Private ☐ Other (*Specify):* _____

2. Name of the operating agency/company:

3. Is this facility regulated by Texas Commission on Jail Standards (TCJS)? If NO, who is the regulatory agency?

☐ YES ☐ NO Regulatory agency, if applicable: _____

4. Total number of employees:	**5. Facility bed capacity:**	**6. Current population:**

7. Total number of inmate admissions to the facility in the past calendar year:

8. Which category of inmate is the facility authorized to hold? *(Select all that apply)*

☐ Federal (*Select all that apply*): ☐ Immigration and Customs Enforcement ☐ Bureau of Prisons ☐ U.S. Marshals

☐ County

☐ Out-of-County *(Please list the counties that you have a contract, memorandum of agreement (MOA), or memorandum of understanding (MOU) with):*

_____

_____

☐ Out-of-State *(Please list the states that you have a contract, memorandum of agreement (MOA), and/or memorandum of understanding (MOU) with):*

_____

_____

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9. Does the facility maintain a health care team (RN, LVN, MA)?

☐ YES ☐ NO

Is the health care team contracted? If contracted, please indicate who employs the health care team in the space below and *attach a copy of the contract.*

☐ YES ☐ NO Contracted entity, if applicable: _____

Who is the health care team employed by?

☐ County ☐ Hospital

☐ Private ☐ Other (*please specify*): _____

10. Does the Medical Director, listed in A9, provide TB medical care services for inmates? If no, please provide the name of the treating physician and their National Provider Identifier (NPI). *Note: A TB medical provider must have a valid and current license to practice in Texas with one of the following credentials: MD, DO, NP, or PA-C.*

☐ YES ☐ NO

Provider name(s): _____

National Provider Identifier (NPI): _____

Does the facility maintain a contract with the TB medical provider? If contracted, please indicate the contracted entity in the space below and *attach a copy of the contract.*

☐ YES ☐ NO Contracted entity, if applicable: _____

Who is the medical provider employed by?

☐ County ☐ Hospital

☐ Private ☐ Other (*please specify*): _____

11. Number and credentials of health care staff at the facility (ex: RN—1, LVN—2, Jailers—3, etc.)

12. Number and credentials of staff trained on TB symptom screening (ex: RN—1, LVN—2, Jailers—3, etc.)

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13. List names and credentials of all staff the medical director or TB medical provider has authorized to administer, read, and interpret the TB skin test. ***(Attach a separate sheet if necessary).***

14. Types of TB tests performed at your facility ***(Select all that apply)***

☐ QuantiFERON-TB Gold (QFT)

☐ T-SPOT

☐ Tuberculin Skin Test (TST)

15. If your facility uses a blood test (QFT and/or T-SPOT) to screen for TB, please answer the questions below. Please indicate N/A if your facility only uses TST to screen.

Please specify who provides the QFT and/or T-SPOT to your facility (e.g., Quest Diagnostics)?

_____

In what instances is the blood test used (e.g., confirmatory testing, testing of refusals, etc.)?

_____

_____

16. Are chest x-rays performed at the facility?

☐ YES ☐ NO

Please provide the information of the chest x-ray provider:

Name (provider of x-rays): _____

Phone Number: _____

Address: _____

17. Are chest x-rays interpreted by the same x-ray facility listed in question 16? If NO, please provide the information below?

☐ YES ☐ NO

Name (provider of x-rays): _____

Phone Number: _____

Address: _____

Note: Routine chest x-rays are not required for asymptomatic persons who have negative TB skin test results. After the initial chest radiograph is taken, persons with positive tuberculin skin test reactions do not need repeat chest radiographs, unless symptoms develop that may be or are suspected to be due to tuberculosis disease.
http://statutes.capitol.texas.gov/Docs/HS/htm/HS.89.htm

18. In the event of a hurricane or other natural or man-made disaster, do you have a written evacuation plan on file?

☐ YES ☐ NO

Will you relocate? If YES, please specify the location you will relocate to.

☐ YES ☐ NO Location: _____

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19. Is the TB infection control person the same as the contact person listed in Section A?

☐ YES ☐ NO

If NO, provide the name and job title of the person responsible for your facility's TB infection control measures. This person may be responsible for generating and submitting monthly reports, maintaining supplies, and making necessary referrals.

Name: _____ Title: _____

Email Address: _____ Phone Number: _____

20. Does your facility have airborne infection isolation rooms (AIIRs)? If YES, indicate the number of AIIRS.

☐ YES ☐ NO Number of individual rooms: _____

21. If your facility has fewer than two (2) AIIRs, where will an inmate with symptoms suggestive of TB be isolated?

☐ N/A Hospital/facility name: _____

22. Are AIIRs routinely inspected and maintained? If YES, who oversees inspection and maintenance?

☐ YES ☐ NO If NO, please indicate the reason: _____

Name: _____ Title: _____ Phone Number: _____

23. Which of the following actions does your facility take in the event a suspected or confirmed TB case is identified? Please see the screening algorithm for incarcerated individuals for reference. Please check all that apply.

☐ Immediately isolate the individual in an AIIR or send them to the hospital for isolation

☐ Perform chest x-ray within 72 hours

☐ Order acid-fast bacilli (AFB) testing on sputum smear/culture within 72 hours

☐ Ensure thorough medical evaluation

☐ Provide surgical mask to the inmate and ensure staff/personnel wear N-95 or equivalent

☐ Other (*Specify*): _____

☐ Report to the local or regional health department within one working day

☐ Order a Nucleic Acid Amplification Test (NAAT) (i.e., rapid PCR)

☐ Provide treatment for TB

☐ Conduct a Contact Investigation (CI)

☐ Perform TST for symptomatic inmates

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24. Provide name, mailing address, and phone number of local or regional health department (who your facility reports to) and the name of the contact person(s). You may list up to two individuals.

Health department name:

_____

Contact name and title: _____

Phone Number: _____

Email Address: _____

Address: _____

Contact name and title: _____

Phone Number: _____

Email Address: _____

Address: _____

25. What is the name and title of the person at your facility who informs the local or regional health department about TB suspects and/or cases in custody? You may list up to two individuals.

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

26. Who supplies purified protein derivatives (PPDs) for inmate TB testing at your facility?

☐ Pharmacy (*Specify name and address*)

_____

_____

☐ Health Department (*Specify full name and address*)

_____

_____

☐ Other (*Specify name and address*)

_____

_____

27. Who supplies syringes for inmate TB testing at your facility?

☐ Pharmacy (*Specify name and address*)

_____

_____

☐ Health Department (*Specify full name and address*)

_____

_____

☐ Other (*Specify name and address*)

_____

_____

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28. Who supplies your facility with TB medications? Please provide the name and address of the entity. Do not use acronyms or abbreviations.

Name: _____

Address: _____

29. What other TB services does your local or regional health department provide to your facility?

☐ None ☐ Education and/or Training

☐ TB Testing at Intake ☐ Contact Investigation

☐ TB Annual Screenings ☐ TB Medication

☐ Other (*Specify*): _____

C. INMATE SCREENING

1. On which days and shifts are TSTs administered, or Interferon Gamma Release Assays (IGRAs) drawn? *Select all that apply.*

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Facility shift hours when tests are done: from _____ to _____

2. How soon after incarceration are inmates given a TST or IGRA?

Within _____ hours *or* _____ days

3. How long after placing a TST is it read? *Please indicate a range.*

Within _____ to _____ hours

4. Are symptom screenings conducted? ***If YES, attach a copy of your facility's TB symptom screening form.***

☐ YES ☐ NO If YES, when are symptom screenings conducted? _____

5. For inmates with <u>newly positive</u> IGRA/TST results, when are chest x-rays done? *Select all that apply.*

☐ Within 24 hours ☐ Within 4-7 days

☐ Within 48 hours ☐ Other (*Please specify below):*

☐ Within 72 hours _____

6. Does your facility offer treatment for TB infection?

☐ YES ☐ NO

If NO, please explain the circumstances why.

_____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

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7. When do annual screenings of long-term inmates take place?

☐ 12 months after the last test

☐ On a designated month (*Please specify):* _____

☐ Other (*Please specify):* _____

8. Do you have a written continuity of care plan for inmates diagnosed or suspected with TB scheduled for release into the community or transferred? *If YES, please attach a copy of the plan*.

☐ YES ☐ NO

9. Who maintains inmate screening records?

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

10. Who is responsible for sending transfer records to Texas Department of Criminal Justice (TDCJ) or other correctional facilities on inmates with TB infection or suspected/confirmed TB disease?

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

11. Who is responsible for notifying the local or regional health department when an inmate with TB infection or suspected/confirmed TB disease is transferred or released?

Name: _____ Title: _____

Phone Number: _____ Email Address: _____

Note: All inmates shall be evaluated for TB infection and disease. All treatment must be documented. A record of treatment (TB-400A and TB-400B) must be completed and submitted to the local or regional health department TB program located in the county of the facility. Form TB-400A, TB-400B, and other forms are available at dshs.texas.gov/disease/tb/forms.shtm.

12. Which form(s) are used to transfer inmate records? *Select all that apply.* ***Please attach a copy of the form(s).***

☐ Texas Uniform Health Status Update ☐ Prisoner in Transit Medical Summary Form (USM-553)

☐ Other (*Please specify):* _____

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D. EMPLOYEE SCREENING

1. Does your facility perform initial employee screenings?

☐ YES ☐ NO

If YES, when do initial screenings take place?

☐ Prior to employment

☐ Within 7 days of starting

☐ Other (*Please specify):* _____

2. Does your facility perform annual employee screenings?

☐ YES ☐ NO

If YES, when do annual screenings take place?

☐ 12 months from date of hire

☐ On a designated month (Please specify): _____

☐ Other (*Please specify):* _____

3. Are employee screenings performed onsite or through referral?

☐ Onsite at facility ☐ Referral (*Please specify):* _____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

4. If an employee has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The employee must provide a physician certification indicating "no active disease" before returning to work.

How many days are allowed for the employee to submit this certification? _____ days

5. Who is responsible for keeping employee certification records?

Name: _____ Title: _____ Phone Number: _____

E. VOLUNTEER SCREENING

1. Do volunteers provide services in your facility?

☐ YES ☐ NO (**If marking NO, please skip the rest of the section.)**

2. Do volunteers in this facility work more than 30 hours a month? Note: According to TAC §97.173, "All volunteers who share the same air space with inmates on a regular basis (more than 30 hours per month) shall be screened prior to becoming a volunteer and at least annually thereafter according to this section unless the volunteer is exempt as described in clauses (ii), (iii), or (iv) of this subparagraph."

☐ YES ☐ NO

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3. Does your facility perform initial volunteer screenings?

☐ YES ☐ NO ☐ N/A

If YES, when do initial screenings take place?

☐ Prior to becoming a volunteer

☐ Within 7 days of starting

☐ Other (*Please specify):* _____

4. Does your facility perform annual volunteer screenings?

☐ YES ☐ NO ☐ N/A

If YES, when do annual screenings take place?

☐ 12 months from date of hire

☐ On a designated month (Please specify): _____

☐ Other (*Please specify):* _____

5. Are volunteer screenings performed onsite or through referral?

☐ N/A ☐ Onsite at facility ☐ Referral (*Please specify):* _____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

6. If a volunteer has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The volunteer must provide a physician certification indicating "no active disease" before returning to work.

☐ N/A **How many days are allowed for the volunteer to submit this certification?** _____ days

7. Who is responsible for keeping volunteer certification records?

☐ N/A

Name: _____ Title: _____ Phone Number: _____

F. ADDITIONAL SITES (Refer to Section A2)

1. Does your facility have additional sites? If YES, enter the names and locations of additional sites. Use the "ADD" button at the bottom for additional facilities.

☐ YES ☐ NO

2. Facility Name

3. Physical Address	**City**	**State**	**Zip Code**

4. Mailing Address *(if different from physical)*	**City**	**State**	**Zip Code**

5. Jail Administrator's Name	**6. Title**	**7. Phone Number**

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8. Email Address	**9. Fax Number**

10. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.

Name:	**Title:**
Phone Number:	**Email Address:**
Name:	**Title:**
Phone Number:	**Email Address:**

ADD

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G. PLAN SUBMISSION AND ACKNOWLEDGEMENT

Submission type (*select one)*

☐ ANNUAL PLAN

☐ AMENDED PLAN (*Please specify date of original submission):* _____

Please read the following statement carefully and indicate your understanding and acceptance by signing in the space provided.

Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter H, Sec. 97.173, C, ii requires that every inmate shall have a screening test for tuberculosis on or before the seventh day of incarceration and at least annually thereafter if the inmate is not known to be a previous positive reactor. More frequent TB screening is recommended when a specific situation indicates an increased risk of transmission. Texas Health and Safety Code Chapter 89 Sec. 89.102 also requires corrections facilities to report to the local health department the release of an offender who is receiving treatment for tuberculosis. The local health department shall arrange for inmate continuity of care.

By signing this form, I acknowledge that I understand the above requirements. This plan may be electronically signed using Adobe Sign and may be locked after being signed.

_____ _____

ORIGINAL SIGNATURE – Jail Administrator Date

H. APPROVAL

Email the signed original plan to Texas Department of State Health Services, Tuberculosis and Hansen's Disease Unit, at **CongregateSettings@dshs.texas.gov** where the plan, once approved, will be maintained.

If any sections are left blank, are answered incorrectly, or required supporting documentation is missing, the form will be returned with requested revisions.

Texas Department of State Health Services
Tuberculosis and Hansen's Disease Unit

dshs.texas.gov/disease/tb/corrections.shtm

DSHS OFFICE USE ONLY

Approved by: _____ Effective Date: _____

ORIGINAL E-SIGNATURE – Tuberculosis and Hansen's Disease Unit Director

Name: _____ Expiration Date: _____

PRINT