Correctional TB Training: Correctional Tuberculosis Screening Plan (TB-805)

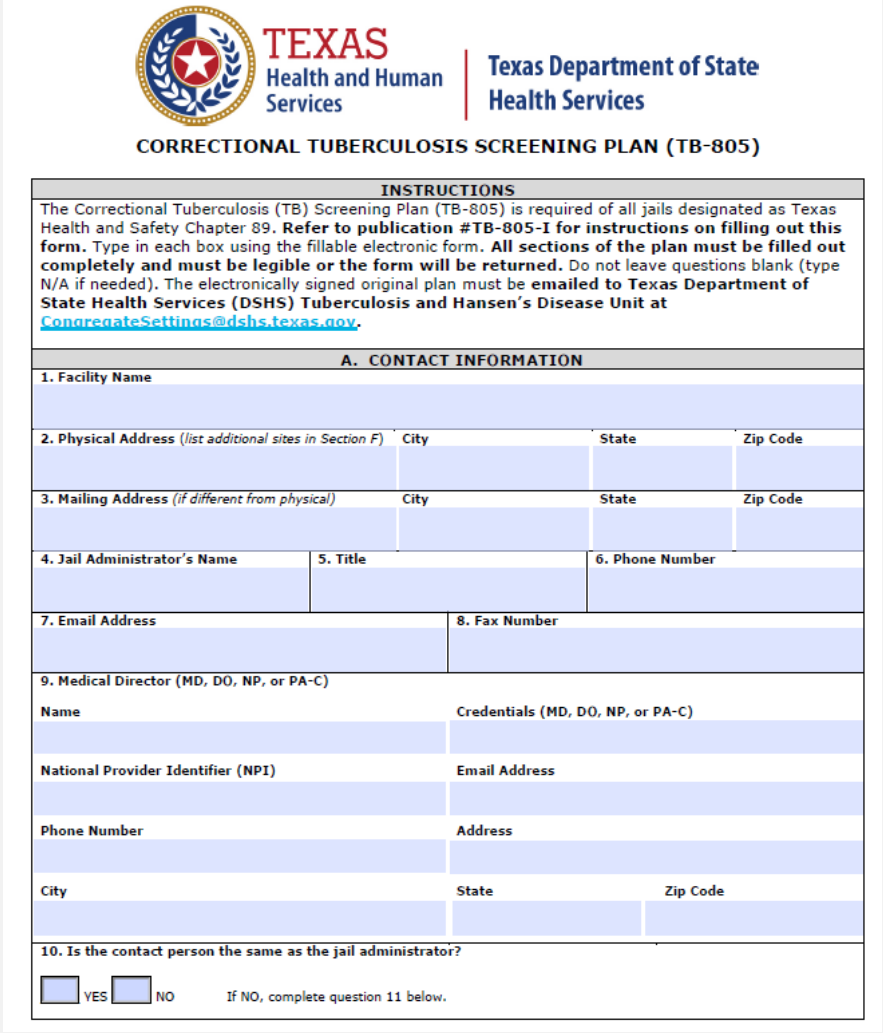
Continuing Quality Improvement (CQI) Group
Tuberculosis and Hansen's Disease Unit

LEARNING OBJECTIVES

- ❑ Understand the purpose of the Correctional Tuberculosis Screening Plan (TB-805)
- ❑ Understand the process for screening plan renewal and approval
- ❑ Recognize key information listed in each section
- ❑ Understand the new changes to the TB-805

Purpose of the Correctional Tuberculosis Screening Plan (TB-805)

- Framework for the implementation and monitoring of legally required TB prevention and care standards for Chapter 89-designated facilities
- Requirement of the Texas Administrative Code (TAC)
  - Title 25, Part 1, Chapter 97, Subchapter H
  - Title 37, Part 9, Chapter 273
- Determine compliance with the Health and Safety Code (HSC) and TAC



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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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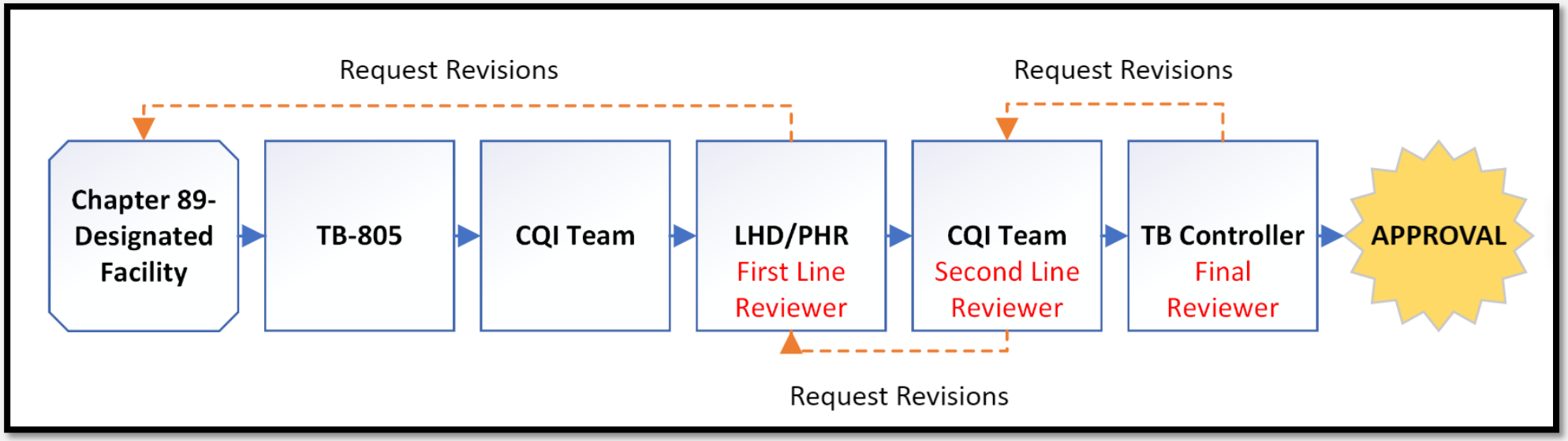
Renewal Process for TB-805

- All Chapter 89-designated facilities will receive a 120-day renewal notification and reminders at 90-day, and 60-day intervals, if not received
    - Note: Effective January 2024, all approval periods will be from January 1 to December 31 each year
- Screening plans will be submitted to CongregateSettings@dshs.texas.gov
- CQI will forward the TB-805 to the local or regional TB program for **first-line review**



Expectations of Local and Regional TB Programs

- Ensure that Chapter 89-designated facilities submit their screening plan for review early, to allow quality assurance
- Ensure an accurate and complete screening plan **prior** to submitting to CQI team
- Submit the screening plan to CongregateSettings@dshs.texas.gov for Central Office approval 60 **days** prior to the expiration to ensure time for review
- Communicate any concerns or questions to the Program Evaluation Consultant (PEC) in a timely manner
- Ensure that medical contracts are current during the approval period

LHD/PHR Notification of TB-805

LHD/PHR Notification of a TB Screening Plan for a Chapter 89 Facility in Jurisdiction

Send from CongregateSettings@dshs.texas.gov

To: Correctional Liaison
Cc: Jail Administrators, Jail Administrator POC, CQIteam@dshs.texas.gov, PEC, LHD/PHR Program Manager

SUBJECT: [Facility] Notification of Receipt: Correctional TB Screening Plan (TB-805)

Dear Correctional Liaison:

The DSHS Continuing Quality Improvement Team received a Correctional TB Screening Plan (TB-805) for Facility Name on date. As this facility falls in your jurisdiction, we are forwarding to you as first-line reviewers. Please use the checklist on the website (link) to assist with your quality assurance.

Their current TB-805 will expire on December 31, 2023.

Per the FY24 DSHS TB Work Plan, please ensure the following:

- Review correctional TB screening plans for completion and accuracy and provide technical assistance and guidance to the Chapter 89-designated facilities for any identified errors.
- Submit the corrected TB-805 and supporting documents to CongregateSettings@dshs.texas.gov for final review and approval before the current expiration date.

The completed screening plan with the original signature must be received within **30** days from the date of this email.

Plans submitted on an outdated form will be returned.

If assistance is needed, contact the Congregate Settings Team at CongregateSettings@dshs.texas.gov.

Thank you for your continued cooperation.

Section A. Contact Information

Section A. Contact Information

NEW! National Provider Identifier and Email Address of the medical director

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.			

Credential must be MD, DO, NP, or PA-C

Section A. Contact Information (continued)

NEW! Up to two contact persons can be listed.

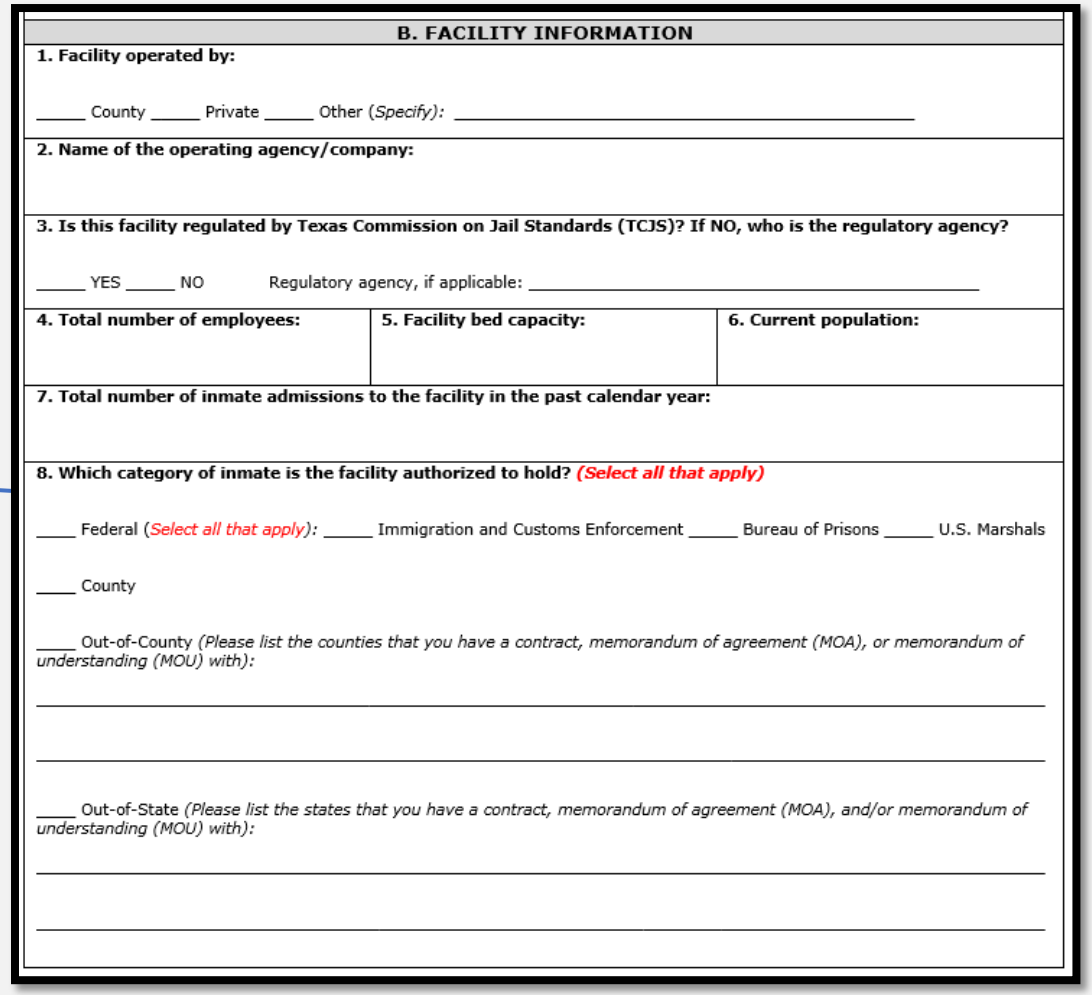
11. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.

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

Section B. Facility Information

Section B. Facility Information

Facility should check all applicable federal inmates that they house



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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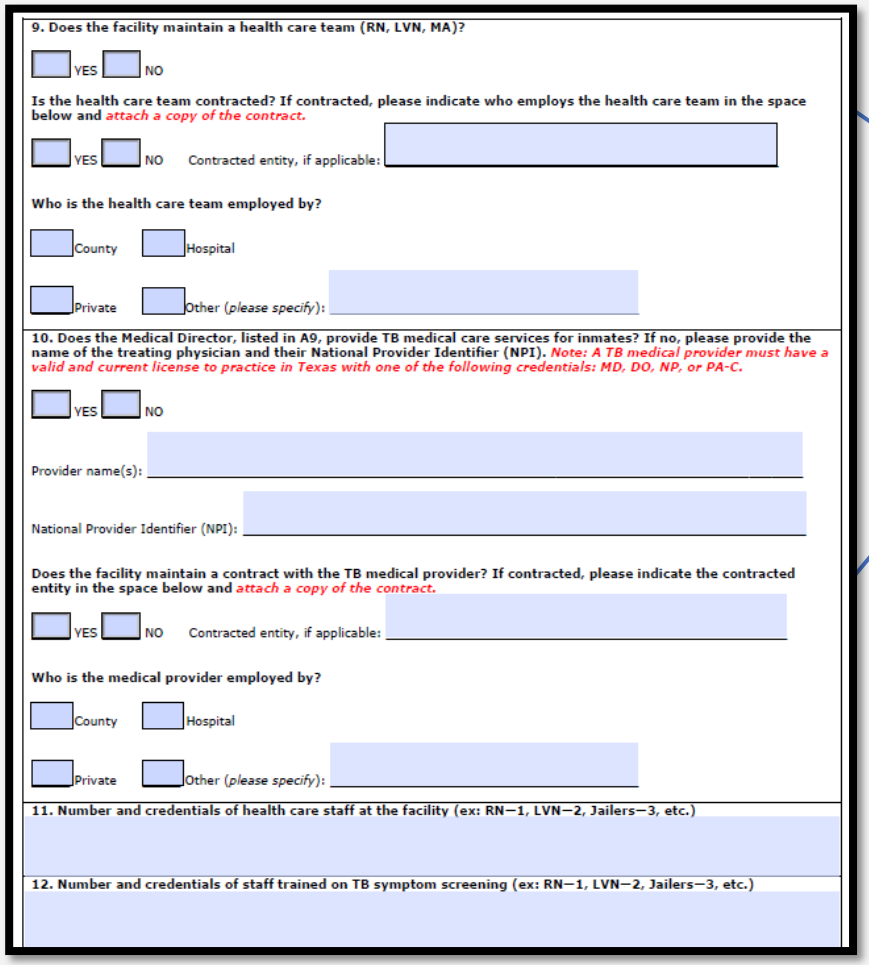
Section B. Facility Information (continued)



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.)

Ensure that medical contracts are current until 12/31/24 or automatically renewed and attached to the screening plan.

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Sample Contracts

Automatic Renewal

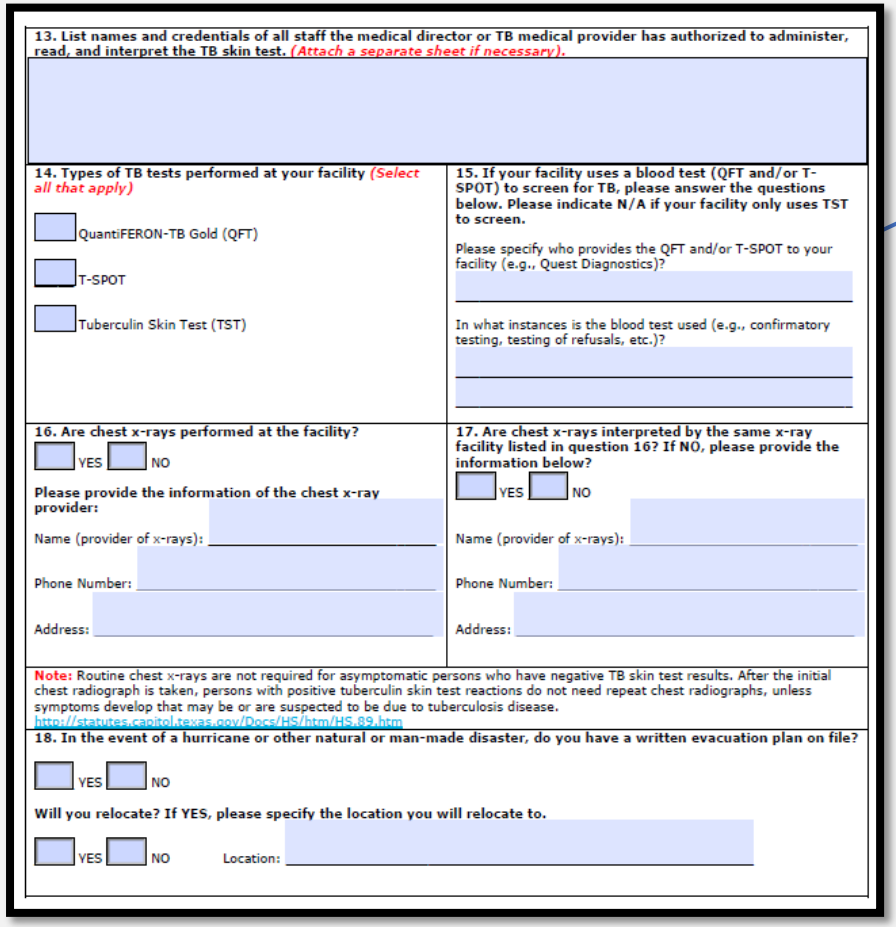
ARTICLE VI: TERM AND TERMINATION OF AGREEMENT

6.1 Term. This Agreement shall commence on October 1, 2021. The initial term of this Agreement shall end on September 30, 2022, and this Agreement shall thereafter be automatically extended for additional periods of twelve months each, beginning on October 1 of each year, subject to County funding availability, unless either party provides written notice to the other of its intent to terminate, or non-renew, in accordance with the provisions of Section No. 6.2 of this Agreement.

Expires Mid-Year

Contract Period: October 1, 2022, through September 30, 2023	
Base annualized fee:	$221,335.92 ($18,444.66 per month)
Per diem greater than 130 inmates:	$1.57
Annual outside cost pool limit:	$40,000.00 (includes 100% pool refund provision)

Section B. Facility Information (continued)



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:

NEW! Ensure that there is no confirmatory testing

Reminders:

- DSHS-distributed tubersol and/or syringes are to be used for inmate screening only and cannot be used for employees or volunteers
- DSHS-purchased IGRAs cannot be distributed to Chapter 89 designated facilities

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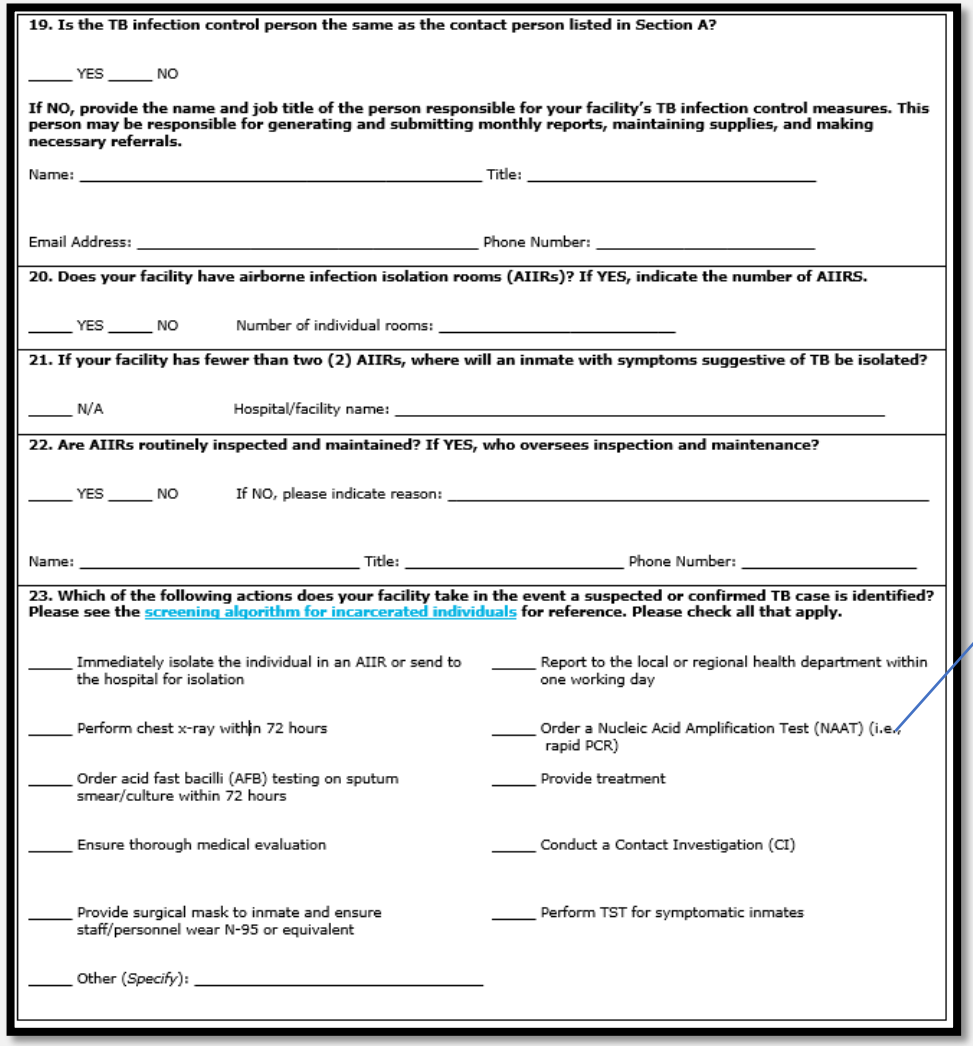
Section B. Facility Information (continued)



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 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 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 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

_____ Conduct a Contact Investigation (CI)

_____ Perform TST for symptomatic inmates

NEW! Opportunity for TB Programs to work closely with the jail to ensure an action plan in the event of a suspected TB case or confirmed TB case

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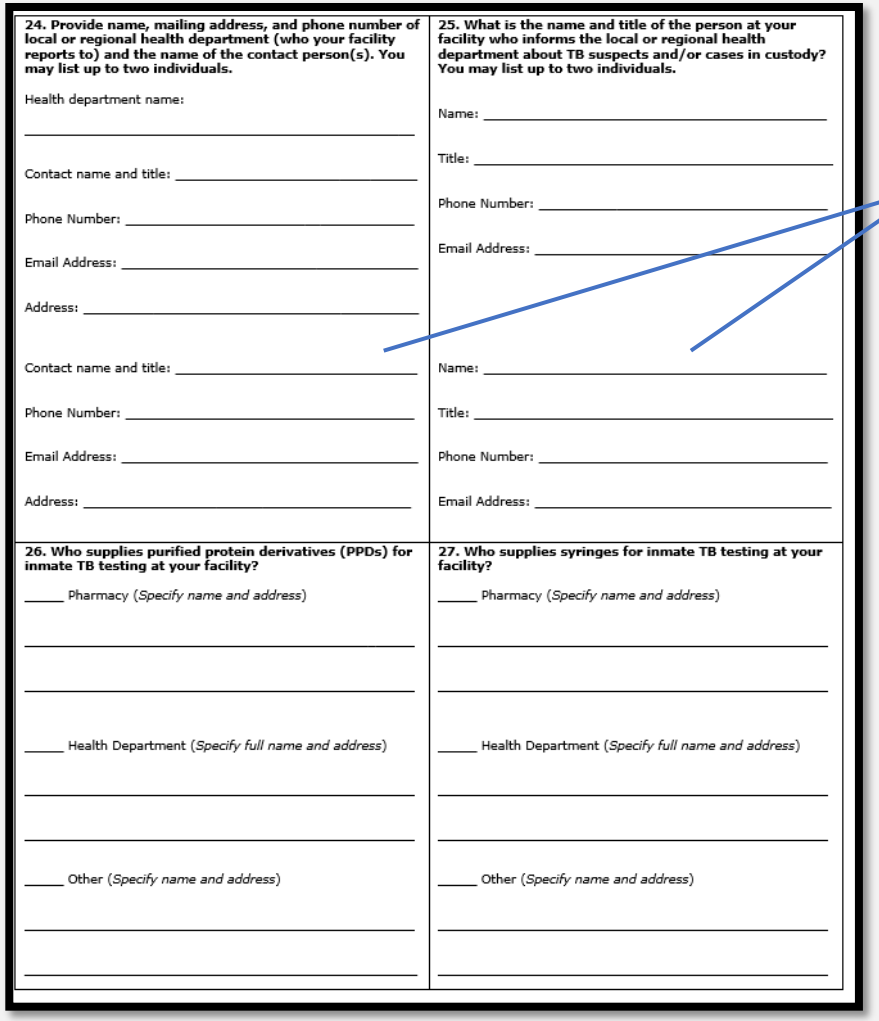
Section B. Facility Information (continued)



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*)

NEW! List up to two individuals

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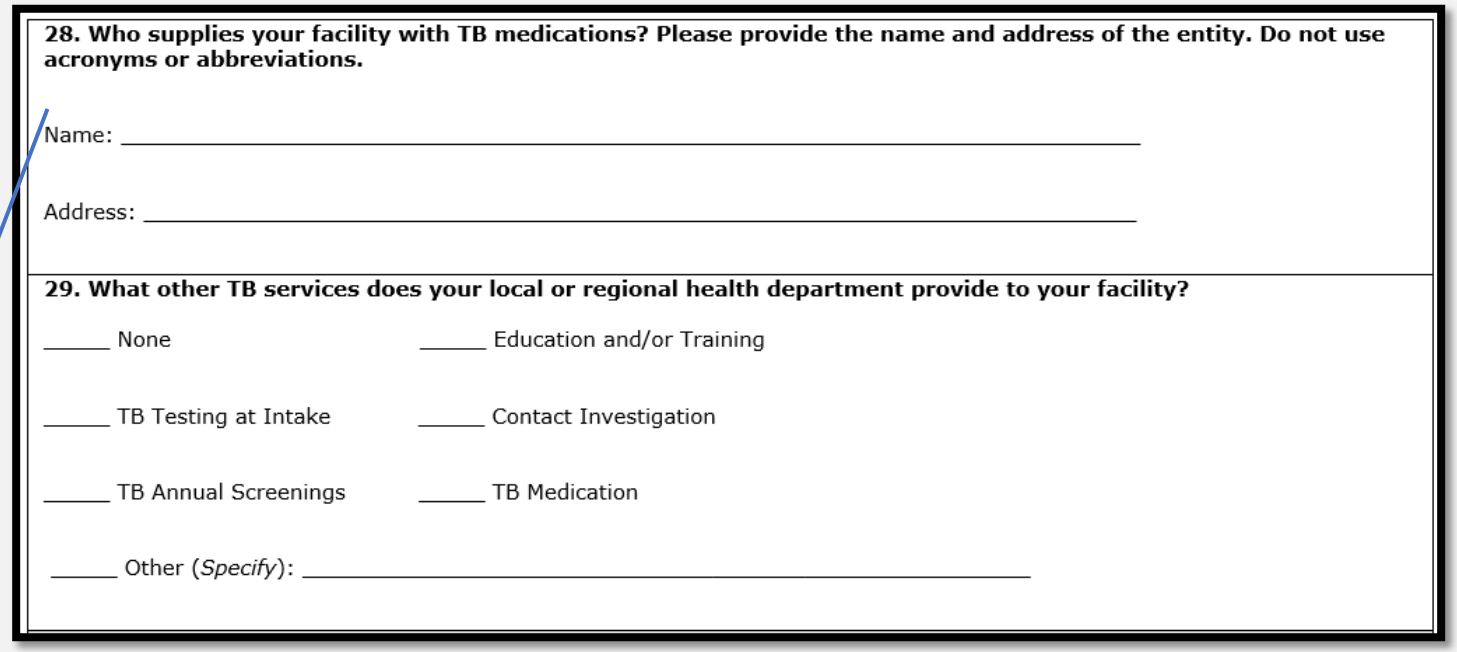
Section B. Facility Information (continued)

NEW! TB programs cannot distribute DSHS purchased medications to the jail unless they serve as the medical provider.



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

_____ TB Testing at Intake

_____ TB Annual Screenings

_____ Other (*Specify*): _____

_____ Education and/or Training

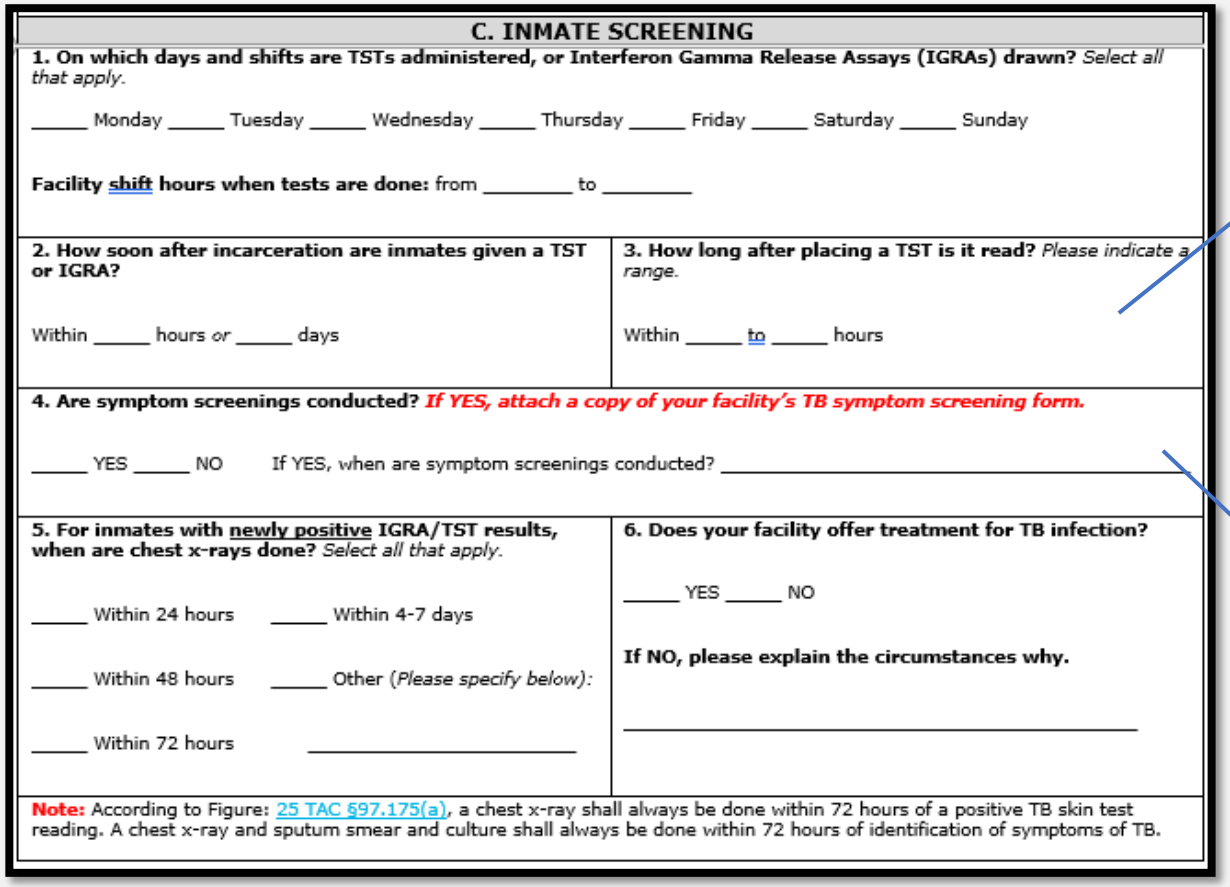
_____ Contact Investigation

_____ TB Medication

Ensure that the services checked are in alignment with the services provided by the TB program.

Section C. Inmate Screening

Section C. Inmate Screening



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 newly positive 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.

Ensure that TSTs are read 48 to 72 hours after placement

Ensure that if "YES" is selected that it is specified when symptom screening are performed AND the symptom screening form is attached

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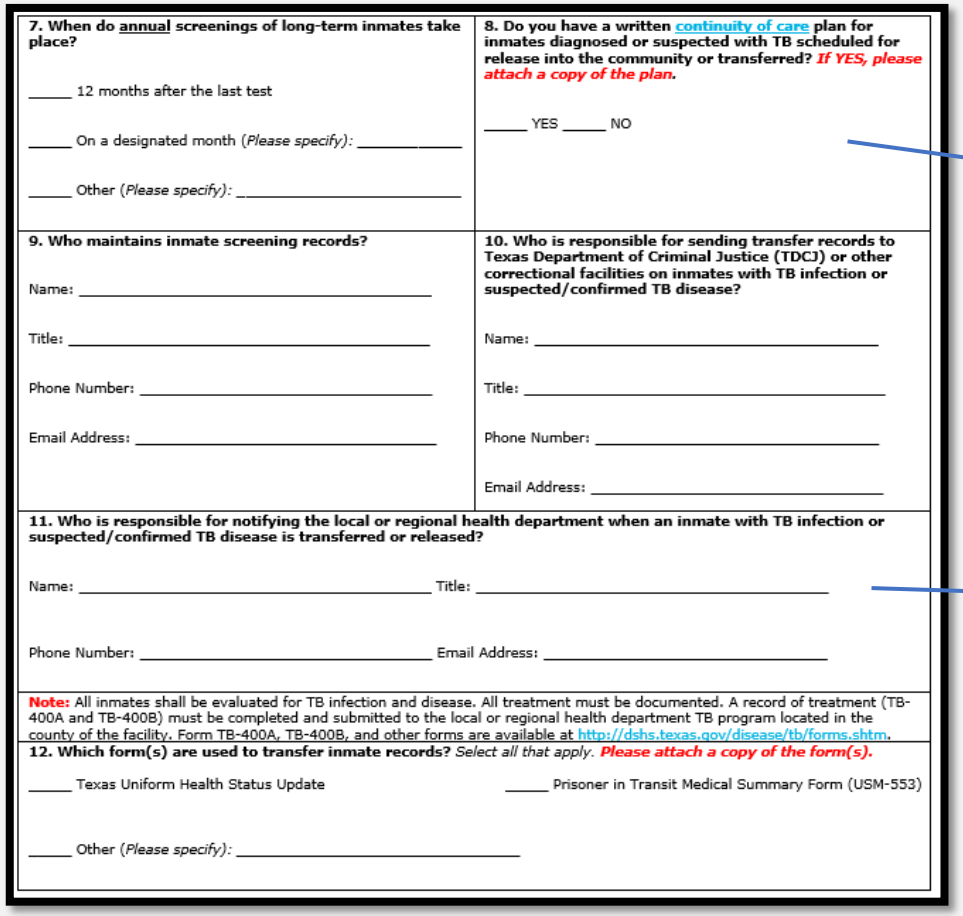
Section C. Inmate Screening (continued)



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 http://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*): _____

Ensure that the continuity of care plan is attached, when applicable

NEW!

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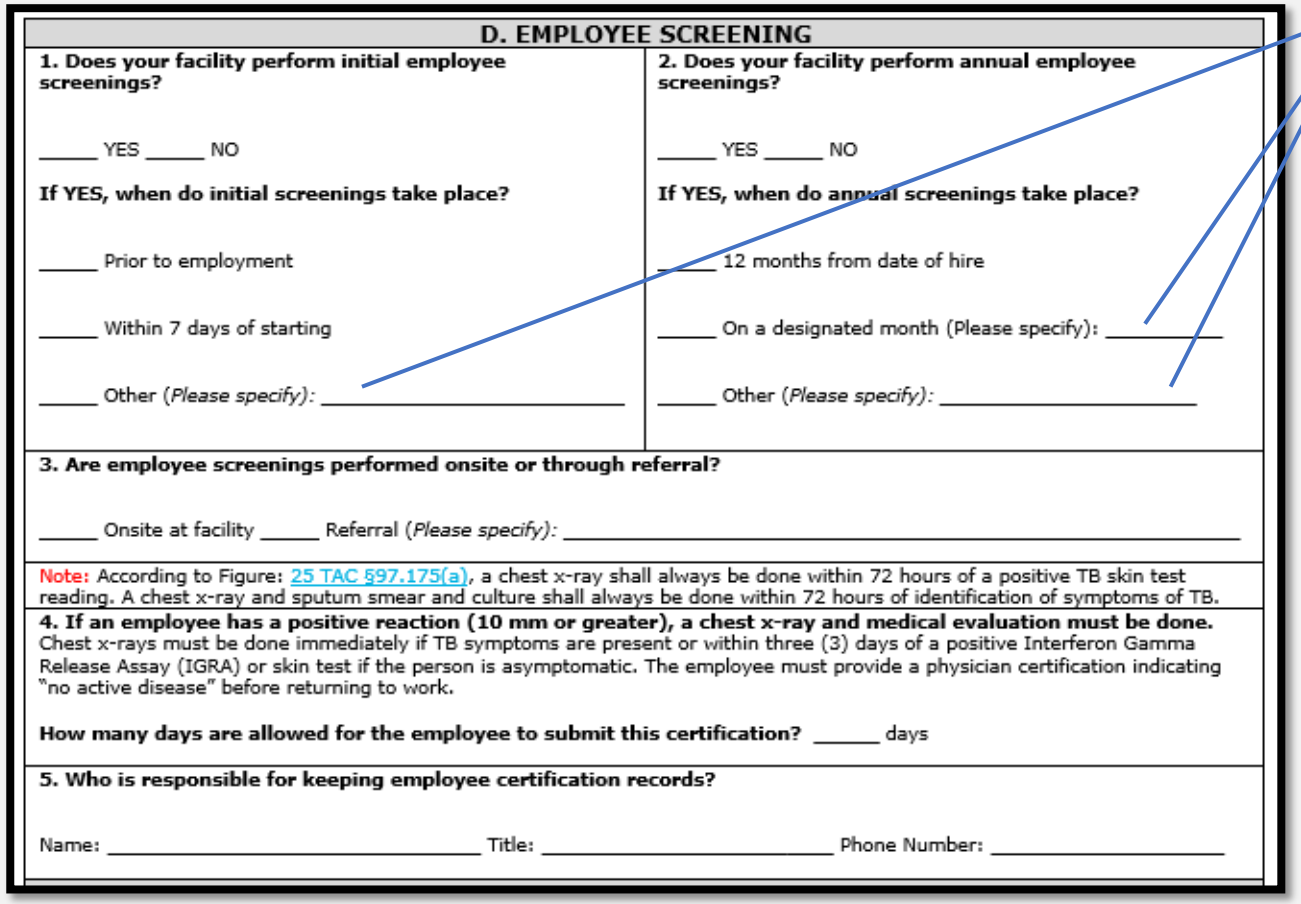
Section D. Employee Screening

Section D. Employee Screening

Ensure that the facility specifies if checked



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

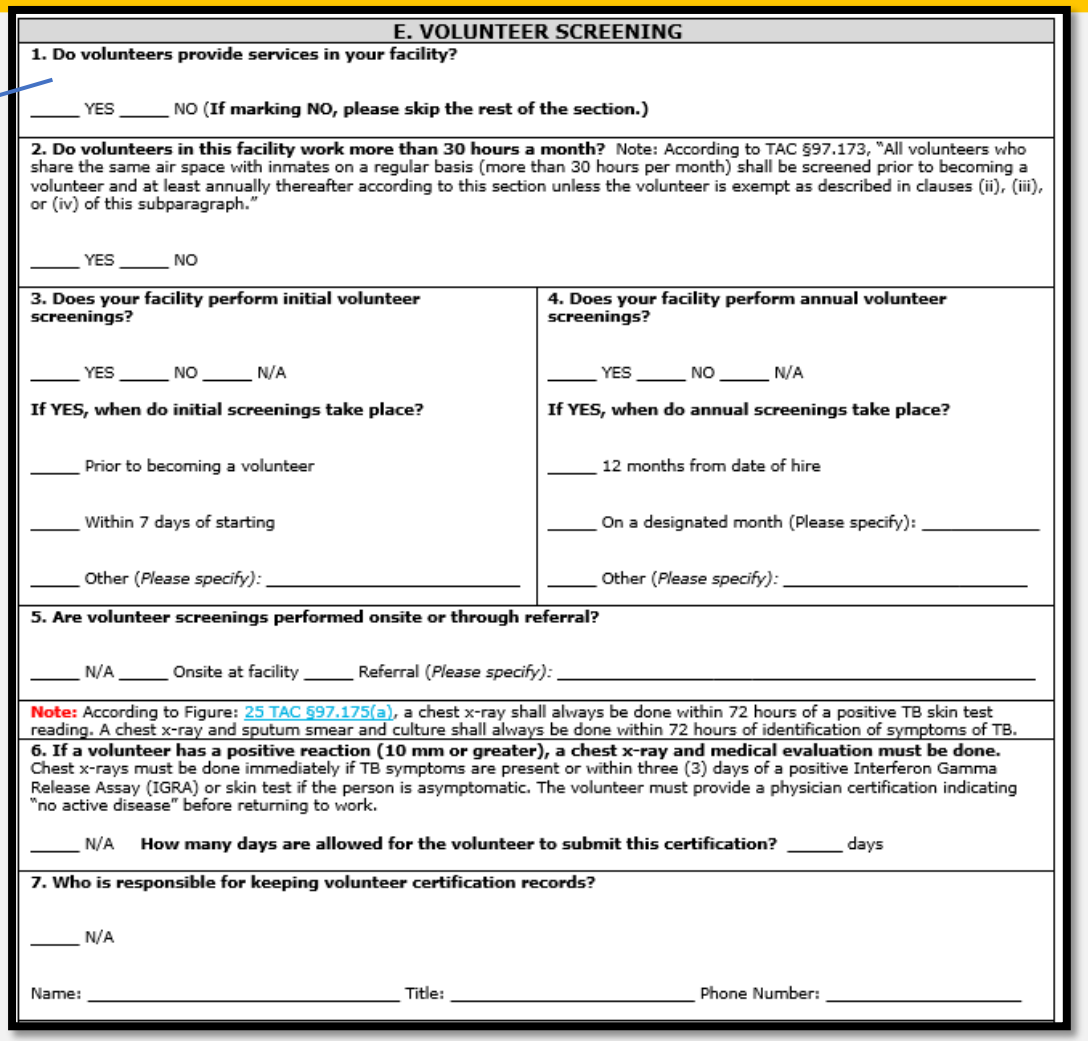
5. Who is responsible for keeping employee certification records?

Name: _____ Title: _____ Phone Number: _____

Section E. Volunteer Screening

Section E. Volunteer Screening

If volunteers do not provide services, please mark “NO” and skip the rest of the section



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

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: _____

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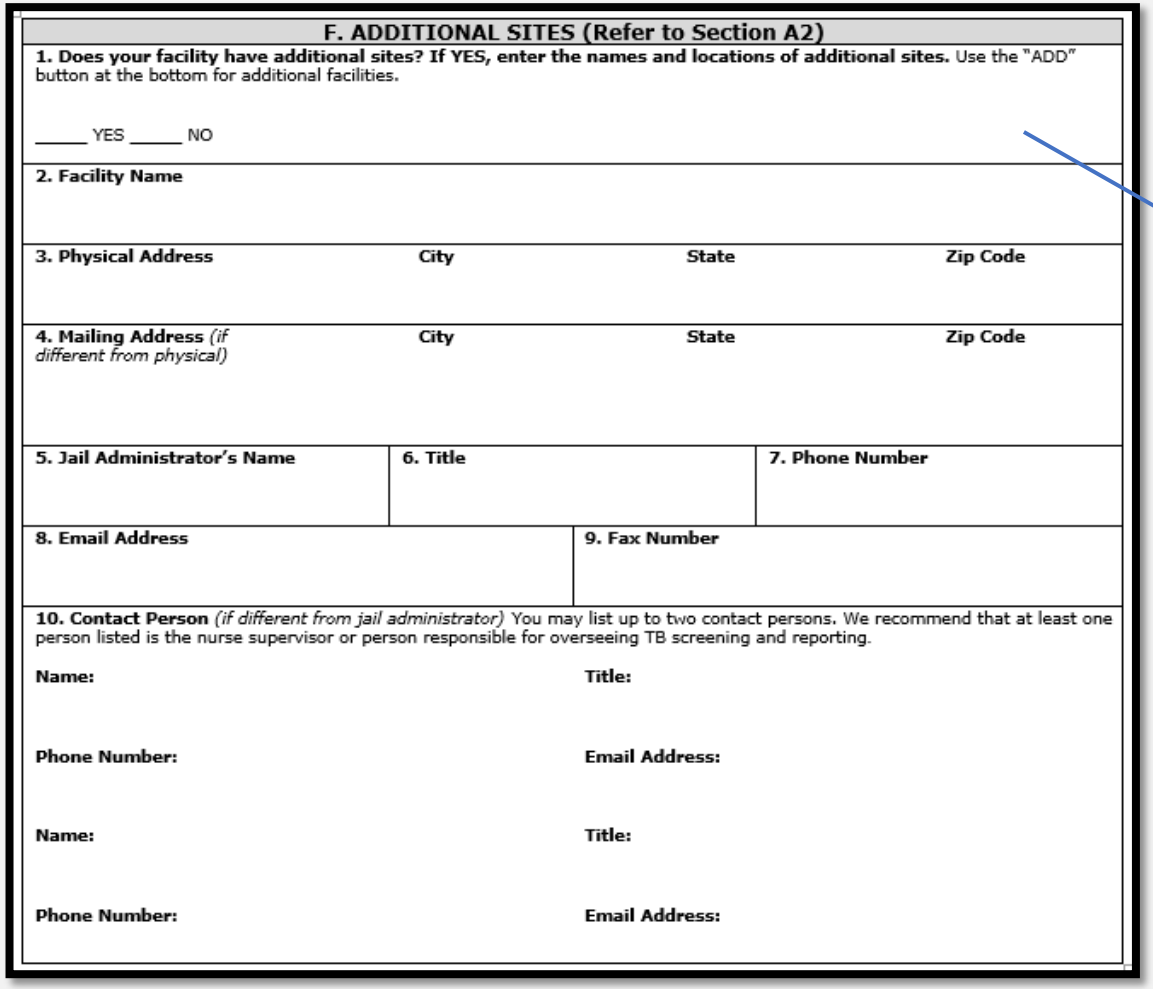
Section F. Additional Sites

Section F. Additional Sites



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**

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 information on additional sites

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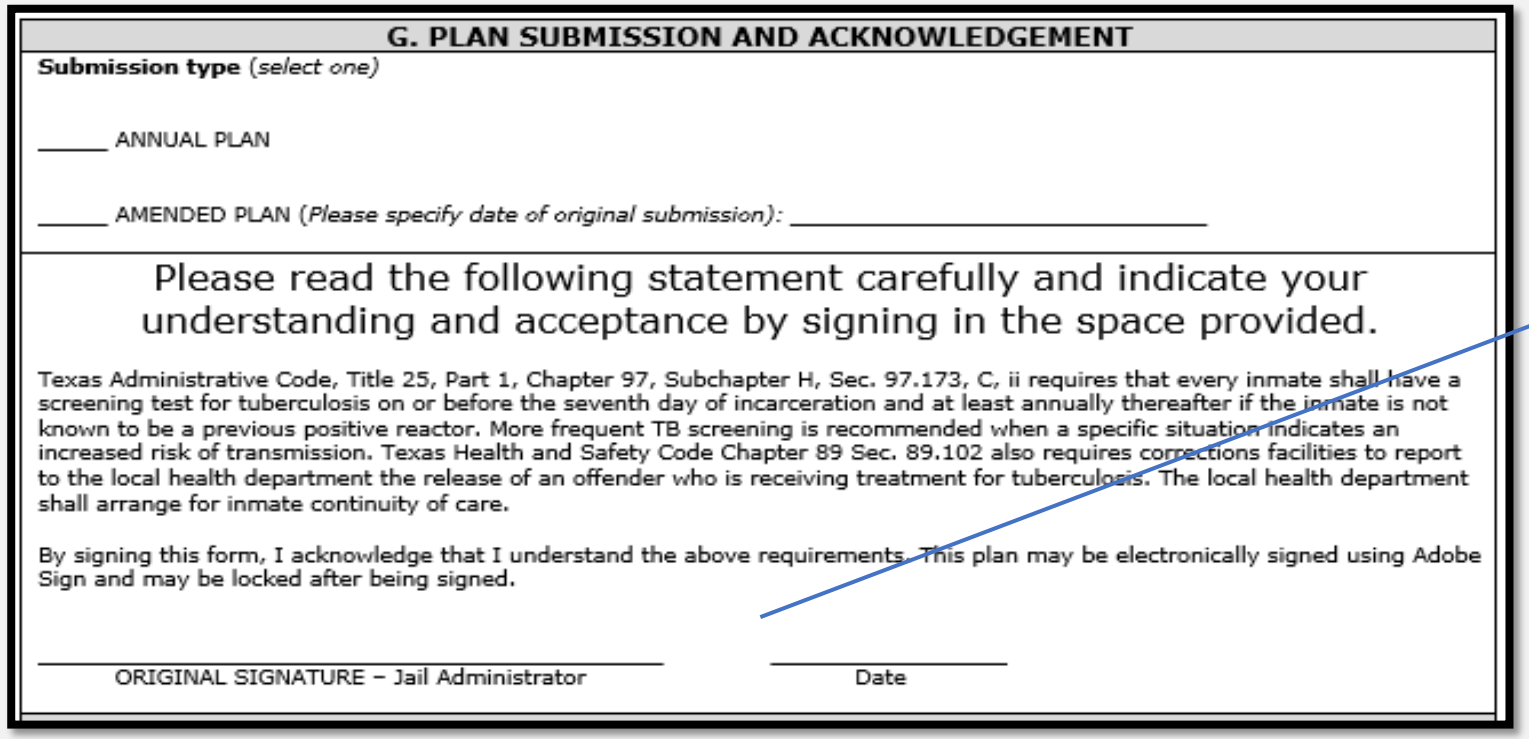
Section G. Plan Submission and Acknowledgement

Section G. Plan Submission and Acknowledgement



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

Ensure that the plan is signed and dated by the jail administrator

Amended plans are needed when there are administrative or operational changes that negate the information on the approved screening plan. Amended screening plans require the amended pages and the last page with the jail administrator's signature.

TEXAS Health and Human Services

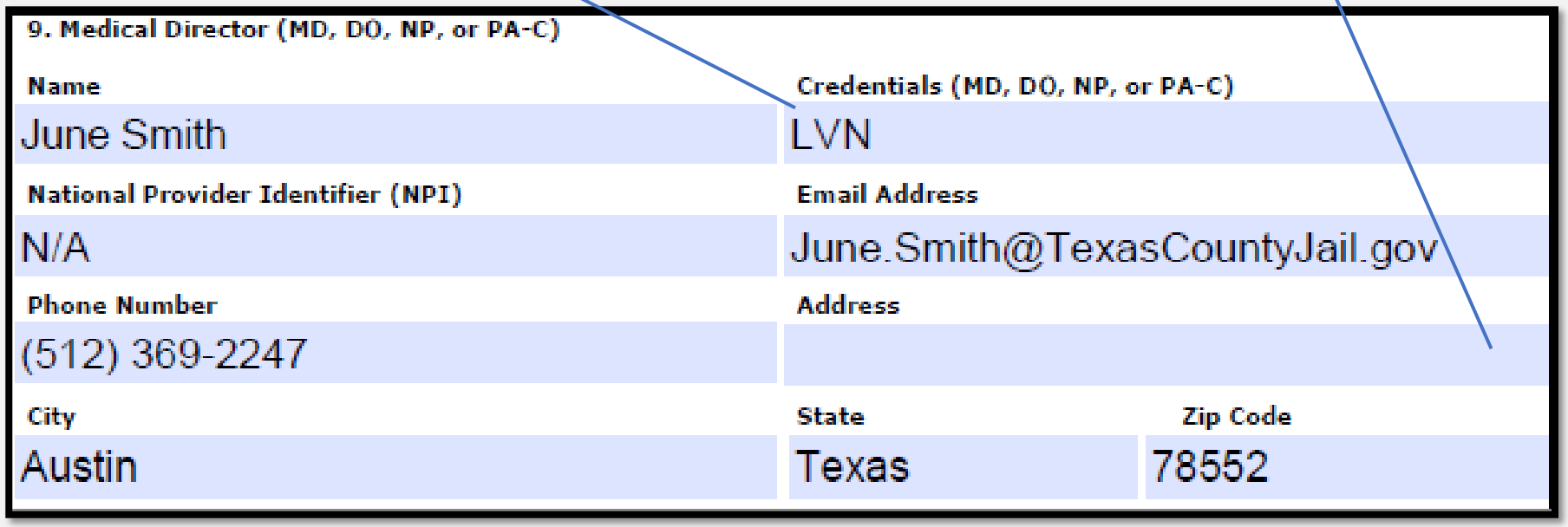
Texas Department of State Health Services

Check for Understanding

Check your Understanding: Question 1

Credential is not MD, DO, NP, or PA-C

Street address is not provided



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

Name	Credentials (MD, DO, NP, or PA-C)	
June Smith	LVN	
National Provider Identifier (NPI)	**Email Address**	
N/A	June.Smith@TexasCountyJail.gov	
Phone Number	**Address**	
(512) 369-2247		
City	**State**	**Zip Code**
Austin	Texas	78552

Check your Understanding: Question 2

Did not check the types

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):*

Garza, Trinity, Gonzales, Presidio, Van Zandt

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

Check your Understanding: Question 3

Did not specify whom the health care team is contracted by

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

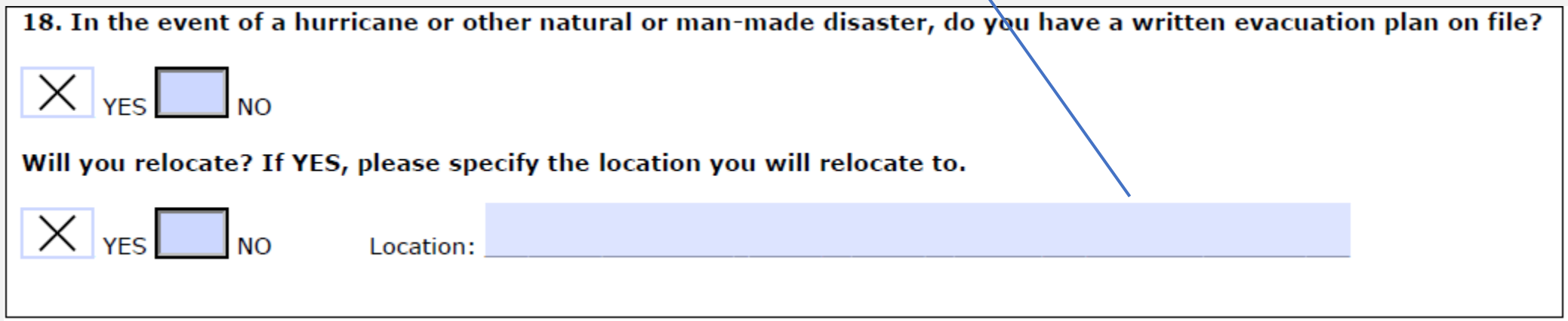
☒ Private ☐ Other (*please specify*): _____

TEXAS Health and Human Services

Texas Department of State Health Services

Check your Understanding: Question 4

Did not specify the location



Check your Understanding: Question 5

Did not specify the month

D. EMPLOYEE SCREENING	
1. Does your facility perform initial employee screenings?	**2. Does your facility perform annual employee screenings?**
[X] YES [ ] NO	[X] YES [ ] NO
If YES, when do initial screenings take place?	**If YES, when do annual screenings take place?**
[ ] Prior to employment	[ ] 12 months from date of hire
[X] Within 7 days of starting	[X] On a designated month (Please specify):
[ ] Other (*Please specify*):	[ ] Other (*Please specify*):

Supporting Documents (as applicable)

- Health care team provider contract (Question B9)
- Medical provider contract (Question B10)
- Facility's TB symptom screening form (Question C4)
- Facility's continuity of care plan (Question C8)
- Form(s) used to transfer inmate records (Question C12)

Helpful Tips

1. Use the TB-805 checklist to assist in your review of the screening plan
2. Communicate with the facility jail administrator and/or contact person for revisions or missing information/documents
3. Submit the plan at least **60 days** before expiration to ensure timely review and approval
4. Your assigned PEC is ready to assist if you need additional help!

Thank you!

Correctional TB Training:
Correctional Tuberculosis Screening Plan (TB-805)

CQITeam@dshs.texas.gov