CORRECTIONAL TUBERCULOSIS SCREENING PLAN

INSTRUCTIONS

The Correctional Tuberculosis (TB) Screening Plan (TB-805) is required of all Chapter 89 facilities. 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 or the form will be returned. Do not leave questions blank (type N/A if needed). The 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. Download the plan from: http://dshs.texas.gov/disease/tb/forms.shtm#correctional. If assistance is needed, contact the Congregate Settings Team 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

Name **Credentials**

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)*
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 body?

☐ YES ☐ NO Regulatory body, if applicable: _____

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

7. Total number of inmate admissions 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 indicate counties with which you have a contract):* _____

☐ Out-of-State *(Please indicate states with which you have a contract):* _____

9. Does the facility maintain a health care team? 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: _____

10. Who is the service provider that provides medical care for inmates and oversees the health care team? *Please specify.*

Provider name(s): _____

_____

☐ County ☐ Hospital

☐ Private ☐ Other *(Specify):* _____

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

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

13. List names and credentials of all staff the medical director 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. Are chest x-rays done at the facility? 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

16. Are chest x-rays interpreted by the same x-ray facility listed in question 15? If NO, provide the information below.

☐ YES ☐ NO

Name (provider of x-rays): _____

Phone Number: _____

Address: _____

17. 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: _____

18. 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 generation monthly reports, maintain supplies and medications, and making necessary referrals.

Name: _____ Title: _____

Email Address: _____ Phone Number: _____

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19. Does your facility have an infection control plan (ICP)? *If YES, please attach a copy of the TB portion of the plan.*

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

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 is in charge of inspection and maintenance?

☐ YES ☐ NO ☐ N/A

Name: _____ Title: _____ Phone Number: _____

23. Provide name, mailing address, and phone number of local or regional health department (who your facility sends reports to) and the name of their contact person.

Health department: _____

Contact name and title: _____

Phone Number: _____

Address: _____

24. What is the name and title of the facility person who contacts the local or regional health department about TB suspects and/or cases in custody?

Name: _____

Title: _____

Phone Number: _____

25. What TB services, if any, does your local or regional health department provide to your facility?

☐ N/A ☐ Education and/or Training

☐ TB Testing at Intake ☐ Contact Investigation

☐ TB Annual Screenings ☐ Other (*Specify*): _____

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

☐ Pharmacy (*Specify name and address*)

_____

☐ Health Department (*Specify name and address*)

_____

☐ Other (*Specify name and address*)

_____

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

☐ Pharmacy (*Specify name and address*)

_____

☐ Health Department (*Specify name and address*)

_____

☐ Other (*Specify name and address*)

_____

C. INMATE SCREENING

1. On which days and shifts are TSTs or Interferon Gamma Release Assays (IGRAs) administered? *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. Do you offer treatment for TB infection?

☐ YES ☐ NO

If NO, please explain 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 continuity of care policy for inmates diagnosed with TB and scheduled for release into the community? *If YES, please attach a copy of the policy.*

☐ YES ☐ NO

9. Who maintains inmate screening records?

Name: _____

Title: _____

Phone Number: _____

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

Name: _____

Title: _____

Phone Number: _____

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.

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

☐ N/A ☐ Prisoner in Transit Medical Summary Form (USM-553)

☐ Texas Uniform Health Status Update (TDCJ) ☐ Other (*Please specify):* _____

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):* _____

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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 (10mm 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? If NO, please indicate "N/A" in the following questions for Section E.

☐ YES ☐ NO

2. Do volunteers in this facility work more than 30 hours a month? If NO, please indicate "N/A" in the following questions for Section E. 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 ☐ N/A

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 (10mm 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

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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

Facility Name			
Physical Address	**City**	**State**	**Zip Code**
Mailing Address *(if different from physical)*	**City**	**State**	**Zip Code**

Jail Administrator's Name	**Title**	**Phone Number**
Email Address	**Fax Number**	

Contact Person *(if different from jail administrator)*

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 must be 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

http://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