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

Tuberculosis Action Plan to Minimize Exposure to COVID-19

The *Tuberculosis (TB) Action Plan to Minimize Exposure to COVID-19,* created March 20, 2020 and first updated on April 21, 2020, outlines recommended changes-in-practice for Department of State Health Services (DSHS) public health regions (PHRs) and local health department (LHD) TB programs during the COVID-19 outbreak. **This document reflects the most current recommendations for performing routine TB activities during the COVID-19 pandemic and remains in effect until further notice.**

Activity	Recommendations
Performing directly observed therapy (DOT) and directly observed preventive therapy (DOPT) services.	***Updated from March 20 and April 21st*** Options listed in order of preference: **Option 1:** Provide medications by Video-enabled DOT (VDOT) **Option 2:** Provide medications by DOT using clinic visit (CV) *or* home visit (HV) protocols (see Attachment 1), as determined locally **Option 3:** Provide medications by Enhanced Self-Administered Therapy (ESAT), *not preferred* • ESAT should be used only in extenuating circumstances when VDOT or DOT is not an option. This may include when a client is being actively treated for, or is on quarantine for exposure to, COVID-19, or where the medical director/Local Health Authority has advised that in-person medical visits are not recommended. • Direct observation of TB medications (in person or video) remains the standard of care for treatment of TB in Texas. Therefore, justification for counting any self-administered doses towards completion of therapy after one month (greater than 30 days) may only be made by the treating physician and documented in the medical record. • A current medical order is required for every patient who was originally prescribed DOT but qualifies for ESAT due to COVID-19 constraints.
Evaluating new patients suspected of having TB disease (American	***Unchanged from March 20 and April 21st:*** Prioritize new patients based on information gathered in the initial report:

Thoracic Society [ATS] Class V) based on any report (fax, phone call, walk in, etc.).	• **For the following high priority patients, *screen as usual at the CV or HV:***
	  ○ Acid Fast Bacilli (AFB) smear positive, Nucleic Acid Amplification Test (NAAT) positive or not done, abnormal chest x-ray (CXR) consistent with TB, negative or positive Tuberculin Skin Test (TST)/Interferon-Gamma Release Assay (IGRA), may be symptomatic.
	  ○ AFB smear negative, NAAT negative or not done, abnormal CXR consistent with TB, positive TST/IGRA, may be symptomatic.
	  ○ Anyone NAAT/Polymerase Chain Reaction (PCR) or culture positive for MTB.
	  ○ Anyone with signs or symptoms of TB with a positive TST/IGRA and/or abnormal CXR and need more diagnostics.
	  ○ Any other report that is consistent with suspicion for TB disease as determined by the PHR or LHD TB program.
	
	• **For the following low priority patients, *consider deferring CV/HV while further diagnostics are performed*.** PHR and LHD TB programs may mail sputum canisters, send CXR referrals or perform symptoms screening questionnaire over the phone to gather more diagnostic information before a classification is made.
	  ○ Any patient reported to the PHR or LHD and there is low suspicion of TB disease based on current diagnostics and as determined by the treating physician.

Evaluating new patients with known TB infection (ATS Class II).	***Updated from March 20 and April 21st*** • Referrals for TB infection should be evaluated based on the Texas TB Work Plan Prioritization chart (page 3 of the Texas TB Work Plan) and as local resources allow.
Evaluating patients reported through the Electronic Disease Notification (EDN) system.	***Updated from March 20 and April 21st*** • All patients reported to the local TB Program via the EDN system should be prioritized for evaluation and assessed by the TB program either via HV or CV. For initial information gathering, make phone contact where possible to minimize in-person interactions until assessments are needed. • During COVID-19 response, timelines for completing the EDN follow up worksheet may continue to be extended if local resources are limited.

Evaluating hospitalized patients in whom TB is suspected or known.	***Unchanged from March 20 and April 21st:*** • While visiting a newly diagnosed TB suspect or case in the hospital is ideal as this facilitates a clear discharge plan, this may not be possible in areas still experiencing high rates of COVID-19. Therefore, the Health Authority Warning Letters (HAWLs/TB 410s) can be deferred from being served in the hospital if patient is not a flight risk; coordinate with discharge hospital nurse. • When possible, the PHR/LHD may call the hospitalized patient to obtain address and notify patient of instructions upon discharge; document on the HAWL the date it was explained to the patient if over the phone. • After initial diagnosis, every effort should be made to coordinate a safe discharge plan; considerations as to where the patient is being discharged to (i.e. homeless shelter, young children in the home, etc.) can be weighed and the decision made to remain hospitalized in airborne infection isolation (AII) or recommend discharge. Hospital beds should be made available *where possible* if currently held by patients with TB who do not require acute care and for whom the health department has developed a safe discharge plan. • If a hospital visit is deemed necessary, adhere to hospital policy for COVID-19.
Performing monthly assessments on patients with probable or confirmed TB disease.	***Unchanged from March 20 and April 21st:*** • Monthly toxicity exams may be performed over the phone by the nurse case manager asking toxicity screening questions to minimize patient interaction prior to the in-person assessment via a CV/HV. • Refer to sections regarding blood draws and vital signs/physical exams for in-person assessments that are needed.
Performing monthly assessments on patients with TB infection.	***Unchanged from April 21st:*** • If bloodwork or physical assessments are needed, follow process in those sections. • All efforts should be made to perform in-person assessments monthly. However, if no bloodwork is needed, toxicity assessments can be done over the phone for select patients as determined by the healthcare team. In those cases, medications may be provided in **one-month** increments.

	○ Develop revised care plans with the treating physician prior to decreasing frequency of in-person assessments; re-assess monthly. ○ HCP should coordinate plan with the patient to call them at least monthly for toxicity assessments. ○ Instruct the patient to contact the PHR/LHD if any concerning symptoms of medication toxicity occur.
Performing initial, follow-up and end of treatment CXRs.	***Unchanged from March 20 and April 21st*** • Contact contracted radiology sites or sites where the PHR or LHD sends patients and identify if there are any changes to radiology services for COVID-19 response; relay any changes to the treating physician and patients. • Initial CXR is required, ideally prior to starting treatment for active disease or TB infection. • Decisions to delay follow-up CXRs can be made by the treating physician. ○ Clinician should document the rationale for deferring the CXR such as improvement in symptoms, bacteriology, and overall clinical course suggesting positive response to therapy. ○ If end of treatment CXR is deferred due to concerns about COVID-19, it must be completed once the Coronavirus crisis passes. • Clinicians should order a CXR whenever clinically indicated and deemed essential.
Performing sputum collection, natural or induced.	***Unchanged from March 20 and April 21st:*** • **Initial sputum specimen collection**: ○ Continue to observe first specimen *if patient can come in for a CV or if the observation can be safely done at a HV*; perform where possible: outside with PPE, inside the clinic with PPE, or in a sputum induction booth with a window between patient and observer. If outside, patient privacy should be maintained. ○ May be collected unobserved if CV is not possible; send canister to patient's home. ○ If a HV is necessary, staff should collect sputum outside maintaining a six feet distance from patient and following protocol for HV with appropriate PPE.

	• **Follow-up sputum collection**:
	  ○ Subsequent sputum collection may be performed by the patient alone. Canisters may be mailed to the patient with a laboratory slip already filled out and patient can place in the mail.
	  ○ **Do not collect more specimen than necessary.** For example, the DSHS Standing Delegation Orders (SDOs) recommend initial sputum collection x3, then every other week until three consecutive negative sputum smears. Do not collect weekly just to have more specimen, unless an extenuating circumstance is needed to get patient off isolation. Extra testing drains DSHS laboratory resources.
	• The treating physician may consider decreasing frequency of sputum collection. For example, after initial specimens, the two-week samples may be deferred with the next three samples collected monthly. Considerations include if patient has no high-risk contacts in the same airspace.

Performing TSTs, IGRAs and **any** blood draws.	***Unchanged from March 20 and April 21st:*** • Continue **bloodborne precautions along with PPE** as specified under CV/HV protocols (Attachment 1). • Decisions to defer TSTs or blood draws should be made on a case-by-case basis by the treating physician. • Follow CV/HV protocols when bloodwork is needed.
Performing physical assessments/examination (may/may not require hands on evaluation).	***Unchanged from March 20 and April 21st:*** • May defer hands-on physical examinations for individuals with pulmonary or pleural TB, unless specified by the treating physician or as clinically indicated. If an examination is indicated, practice hand hygiene before and after assessment and **use PPE** as necessary. • If patient is thought to have extrapulmonary TB, a physical examination may be required, especially if the medical record does not support a specific site of infection. This is commonly seen in lymphatic TB where examination of the cervical, supraclavicular, and axillary regions can be high yield. • Clean any equipment used (i.e. stethoscopes).

Performing vital signs, visual acuity examinations, weights, assessments using equipment (i.e. ECGs).	***Unchanged from March 20 and April 21st:*** • Follow CV/HV protocols for monthly toxicity assessments. • Clean equipment after each patient encounter, including any equipment the patient touches.
Conducting contact investigations (CI).	***Unchanged from March 20 and April 21st:*** • Visiting primary residences for CIs may be delayed more than three days if there is a justification for delay. Patients may be interviewed on the phone to elicit contacts initially. Any further delays should be done on a case-by-case basis considering safety of staff and patients, and resource allocation. • Prioritize CIs*** and perform testing based on prioritization of contacts: ○ **High priority CI**- sputum smear positive and or NAAT positive cases ▪ Prioritize contacts; evaluate and test **high** and **medium** risk contacts individually and not in a group setting. ▪ Evaluate and test **low** risk contacts if expansion is indicated by positivity rate. ○ **Medium priority CI**- sputum smear negative, culture positive cases; cavitation on CXR despite negative sputum smear results. ▪ Evaluate and test contacts individually and not in a group setting. ▪ Follow prioritization as specified in high. ○ **Low priority CI**- sputum smear negative, NAAT negative, non-cavitary. ▪ Conduct evaluation and testing of **high** risk contacts *if resources allow.* ***cdc.gov/mmwr/preview/mmwrhtml/rr5415a1.htm
Targeted Testing.	***Unchanged from April 21st:*** • May continue to defer. • Considerations to re-open or continue targeted testing: ○ When an epidemiologic assessment determines the selected facility is considered high risk for TB and targeted testing is a reasonable response to prevent a recurrence of TB disease transmission, **and** ○ When there is no longer a risk to staff and patients for exposure to COVID-19, as determined locally.

Personal Protective Equipment (PPE) Required for Infection Control Precautions.	***Unchanged from March 20 and April 21st:*** Infection control measures should be determined by the local or regional public health department. Refer to the Centers for Disease Control and Prevention (CDC): cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ **Airborne Precautions:** cdc.gov/infectioncontrol/pdf/airborne-precautions-sign-P.pdf • N95 respirator or higher **Droplet Precautions:** cdc.gov/infectioncontrol/pdf/droplet-precautions-sign-P.pdf • Surgical Mask • Face shield or eye shield **Contact Precautions:** cdc.gov/infectioncontrol/pdf/contact-precautions-sign-P.pdf • Disposable gown • Gloves **Standard Precautions:** cdc.gov/infectioncontrol/basics/standard-precautions.html • Used for all patients • Assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting • Based on a risk assessment and making use of common sense practices and personal protective equipment use that protect healthcare providers from infection and prevent the spread of infection from patient to patient

	Universal Precautions: osha.gov/SLTC/etools/hospital/hazards/univprec/univ.html • Universal precautions apply to blood and to other body fluids containing visible blood
Home Visits (HV) Protocol	***Modified from April 21st:*** • Refer to the CDC, specifically "Protections that Pertain to Field-Based Public Health Staff" located at: cdc.gov/coronavirus/2019-ncov/hcp/non-covid-19-client-interaction.html#protections-public-health-staff
Clinic Visits (CV) Protocol	***Modified from April 21st:*** • Refer to the CDC, specifically "Protective Measures That Pertain to Public Health Clinical Settings" located at: cdc.gov/coronavirus/2019-ncov/hcp/non-covid-19-client-interaction.html#protective-measures-public-health-settings

Attachment 1: Protocols to Minimize Staff and Patient Exposure to COVID-19

Home Visits (HV) Protocol

HVs during COVID-19 require additional precautions. Consider HV as an option if it is not possible for the patient to come into the clinic. If a HV occurs, all efforts should be made to meet outside, maintaining six feet distance, using PPE as necessary, and minimizing passing of pens, papers, or other potential fomites when possible. Limit patient signing of consents or other forms unless absolutely necessary (HAWLs, medication consents, etc. NOTE: Daily DOT logs **do not** have to be initialed by the patient during this time but should be signed each month by the patient). Leave pen with patient if they must sign if sanitizing pen is not possible after HV. ***Follow local PPE protocols during COVID-19.***

Prior to HV

1. Call patient/guardian and ask about any new symptoms that have changed from any TB symptoms they had at baseline (if first visit, this is the baseline). Use the questions below, unless otherwise directed by PHR/LHD COVID-19 questionnaire:
   1) Have you been exposed, that you know of, to COVID-19? This may include any travel in the past 14 days.
   2) Has anyone in the household been exposed to COVID-19 or is anyone in the household experiencing any of the symptoms (fever, shortness of breath, or cough) or is currently under Quarantine for COVID-19?
   3) Do you have a new/worsening cough?
   4) Do you have difficulty breathing or shortness of breath?
   5) Do have you fevers? What degree? _____F
   6) Do you have (*insert additional COVID–19 symptoms here as determined locally*)?

   Response to Answers 1-2

   If YES:
   - **Stop** and do not proceed with HV; contact treating physician and supervisor for individual plan of care

   If NO: Proceed to next questions.

   Response to Answers 3-6

   If YES:
   - **Stop** and do not proceed with HV; contact treating physician and supervisor for individualized plan of care (consider if this is an active TB case vs. LTBI vs. contact).
   - If proceeding with HV, follow any local protocols for COVID-19 disease screening or reporting and for recommendations on PPE prior to visit.

   If NO:
   - Use *at* minimum, standard precautions if health care worker can maintain six feet distance (if patient is still in TB airborne isolation, use an N95 or higher). Use *at* minimum, an N-95 or higher **anytime** sputum collection is required, as this is an aerosolizing procedure. Sputum collection should be done outside when possible.

2. If proceeding with HV, supervisor should view documentation of ***Self Observation Log*** (Attachment 3) to ensure staff member is able to make a HV.

When performing a HV:

- Enter home, taking in the minimum necessary supplies; avoid touching anything upon entry.
- Use hand sanitizer and offer to patient (do not hand them the bottle).
- Put on PPE as specified by PHR/LHD protocols.
- When HV is complete, remove gloves appropriately if worn (inside-out).
- Remove and discard PPE as specified by PHR/LHD protocols.
- Leave home.
- Use hand sanitizer.
- Wipe down any surfaces that may have touched something in the home.
    - Consider placing folders, papers, and pens in a zip-lock baggie that may be wiped down before and after visit.
- Reminder: wash hands regularly, do NOT touch face, mouth, nose.

Clinic Visit (CV) Protocol

CVs are preferred during the COVID-19 outbreak. When CVs occur, all efforts should be made to meet the patient prior to entering the clinic, maintaining six feet distance, using PPE and minimizing any passing of pens, papers, or other potential fomites when possible. Before and after the CV, the clinic room and any equipment used should be cleaned and/or sanitized. ***Follow local PPE protocols during COVID-19.***

Prior to CV

1. Call patient/guardian to ask about any new symptoms that have changed from any TB symptoms they had at baseline (if first visit, this is the baseline). Use the questions below unless otherwise directed by PHR/LHD COVID-19 questionnaire:
    1) Have you been exposed, that you know of, to COVID-19? This may include any travel in the past 14 days.
    2) Has anyone in the household been exposed to COVID-19 or is anyone in the household experiencing any symptoms (fever, shortness of breath, or cough) or currently under Quarantine for COVID-19?
    3) Do you have a new/worsening cough?
    4) Do you have difficulty breathing or shortness of breath?
    5) Do have you a fever? What degree? _____F
    6) Do you have (*insert additional COVID–19 symptoms here as determined locally*)?

Response to Answers 1-2

If YES:

- **Stop** and do not proceed with CV; contact treating physician and supervisor for individual plan of care.

If NO: Proceed to next section.

Response to Answers 3-6
If YES:

- **Stop** and do not proceed with CV; contact treating physician and supervisor for individualized plan of care (consider if this is an active TB case vs. LTBI vs. contact).
- If proceeding with CV, follow any local protocols for COVID-19 disease screening or reporting and for recommendations on PPE prior to visit.

If NO:

- Use *at minimum*, standard precautions if health care worker can maintain six feet distance (if patient is still in TB airborne isolation, use an N95 or higher). Use *at minimum*, an N-95 or higher anytime sputum collection is required, as this is an aerosolizing procedure. Sputum collection should be done outside or in sputum induction booths when possible.

2. If proceeding with a CV, the supervisor should view documentation on the ***Self Observation Log*** (Attachment 3) to ensure the staff member is able to work in clinic.

When arranging a CV:

- Coordinate with patient **prior** to entering clinic. Meet at the entrance of the clinic and escort to clinic room to avoid waiting.
- Ensure those accompanying patients are screened per local protocols.
- Perform visit with PPE as determined by the PHR/LHD.
- Wipe down any surfaces that may have been touched during visit.
- Reminder: wash hands regularly, do NOT touch face, mouth, nose.

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Attachment 2: COVID-19 Screening Logs for Patients Prior to TB Home or Clinic Visit

Patient Name:	**DOB:**
Telephone:	
Call patient/guardian to ask about any new symptoms that have changed from any TB symptoms they had at baseline (if first visit, this is the baseline). **Call prior to each scheduled visit.**	

Signs/Symptom Screen: (Y) = Yes (N) = No To be completed prior to each visit

MONTH/YEAR:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
1. Have you been exposed, that you know of, to COVID-19? This may include recent travel* (Y/N)																
2. Has anyone in the household been exposed to COVID-19, is currently under Quarantine for COVID-19, or is experiencing cough, shortness of breath or fever**? (Y/N)																
3. Do you have a new/worsening cough? (Y/N)																
4. Do you have difficulty breathing or shortness of breath? (Y/N)																
5. Do have you a fever**? (Y/N) What degree? _____F																
6. Do you have any additional symptoms (insert here)?																
Employee Initials																
Interpreter Initials																

	17	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
1. Have you been exposed, that you know of, to COVID-19? This may include recent travel* (Y/N)															
2. Has anyone in the household been exposed to COVID-19, is currently under Quarantine for COVID-19, or is experiencing cough, shortness of breath or fever**? (Y/N)															
3. Do you have a new/worsening cough? (Y/N)															
4. Do you have difficulty breathing or shortness of breath? (Y/N)															
5. Do have you a fever**? (Y/N) What degree? _____F															
6. Do you have any additional symptoms (insert here)?															
Employee Initials															
Interpreter Initials															

* cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html

**Fever is either measured temperature ≥100.0°F or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0°F) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue).

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Preparing for the Visit

Response to Answers **1-2**

If YES: Stop and do not proceed with visit; contact treating physician and supervisor for individual plan of care.

If NO: Proceed to next section.

Response to Answers **3-6**

If YES: Stop and do not proceed with visit; contact treating physician and supervisor for individualized plan of care (consider if this is an active TB case vs. LTBI vs. contact).

- If proceeding with visit, follow any local protocols for COVID-19 disease screening or reporting and for recommendations on PPE prior to visit.

If NO:

- Prepare for the visit by coordinating with patient prior to visit; instruct them on any changes to expect.
- Use *at minimum* standard precautions if health care worker can maintain six feet distance (if patient is still in TB airborne isolation, use an N95 or equivalent). Use *at minimum* an N-95 or equivalent anytime sputum is collected, as it is an aerosolizing procedure; preferably collect outside or in sputum induction booths if possible.
- Follow process on DOT visits to include maintaining six feet distance, using *at minimum* universal precautions for handing over of medications, and do not have patient sign DOT log.
- Follow local protocols on PPE prior to visit**. Practice frequent hand hygiene;** don't touch nose, eyes, mouth.

Date	Notes/Comments on Responses
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Signature(s) of staff **Date**

COVID-19 Screening Logs for Patients Prior to TB Home or Clinic Visit, continued from previous page

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Attachment 3: COVID-19 Self-Observation Log for TB Staff

Name:	**Program:**	**Telephone:**

Take your temperature (oral or temporal) ***as frequently as recommended by Local/Regional Medical Director***. Temperatures should be taken before brushing teeth and prior to drinking hot/cold liquids. Document temperature and signs and symptoms listed below. If you have a sign or symptom, mark "+" on the day and report to your supervisor. Each column represents the day at the top of the column (for example, information for the 13th of the month is marked in the column with the "13" at the top). Print and sign your name at the bottom and turn in to supervisor at the end of the month. **Frequency (supervisor check all that apply):** ☐ Morning (A.M.) ☐ Noon (P.M.) ☐ Evening (Eve)

Signs/Symptom Screen: + = Yes -- = No * If temperature is greater than 100.4ºF, notify your supervisor

	MONTH/YEAR:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
A.M.	Temperature (oral or temporal), ºF*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
P.M.	Temperature (oral or temporal), ºF*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																
Eve.	Temperature (oral or temporal), ºF*																
	Cough (+/-)																
	Subjective fever (feeling flush) (+/-)																
	Shortness of breath (+/-)																
	Fatigue (+/-)																
	Other:																

	MONTH/YEAR:	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
A.M.	Temperature (oral or temporal), ºF*															
	Cough (+/-)															
	Subjective fever (feeling flush) (+/-)															
	Shortness of breath (+/-)															
	Fatigue (+/-)															
	Other:															
P.M.	Temperature (oral or temporal), ºF*															
	Cough (+/-)															
	Subjective fever (feeling flush) (+/-)															
	Shortness of breath (+/-)															
	Fatigue (+/-)															
	Other:															
Eve.	Temperature (oral or temporal), ºF*															
	Cough (+/-)															
	Subjective fever (feeling flush) (+/-)															
	Shortness of breath (+/-)															
	Fatigue (+/-)															
	Other:															

Signature of staff **Signature of Supervisor** **Date**

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Attachment 4: Prioritization of TB Program Activities

Activities that must CONTINUE

- Evaluation of high priority suspects (class V).
- Evaluation of new TB cases (class III).
- Management of TB cases and suspects on therapy.
- Evaluation of patients with TB infection based on Texas TB Work Plan prioritization recommendations.
- Management of patients on treatment for TB infection, with modifications as outlined in this document (i.e. may limit in-person monthly examinations where possible).
- Medication administration to patients on treatment for TB disease, contacts to cases with TB infection (including window prophylaxis), and others with TB infection- when given by direct observation, follow HV/CV protocols as determined locally.
- Contact investigations prioritized as high or medium; limit large group testing where possible so that social distancing can be maintained.
- In-person assessments for patients with TB infection who need monthly laboratory specimen collected.
- Reporting of new cases, suspects, and contacts to DSHS Central Office.
- Submission of the Annual Progress Report.
- Evaluation of EDN referrals (although timeline for evaluation may be extended where resources are limited).
- Investigation of large TB clusters (10 cases or more).

Activities that may continue AS RESOURCES ALLOW

- Low Priority CIs.
- In-person assessments for patients with TB infection who do not require monthly specimen collection.
- Cluster investigations with fewer than 10 cases.
- Completing Incident Reports on CIs and sending into DSHS Central Office.

Activities that may be PLACED ON HOLD UNTIL RESOURCES ALLOW

- Targeted testing.
- Collecting monthly jail reports.
- Collecting annual jail plans.
- Cohort review.