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

# Correctional Tuberculosis Screening Plan Instructions

# TB-805-I

The Correctional Tuberculosis (TB) Screening Plan (Publication # TB-805) is designed for jails and community corrections facilities which meet Texas Health and Safety Code Chapter 89 criteria and fall under the purview of the Texas Department of State Health Services (DSHS) (Texas Health and Safety Code, Chapter 89, Subchapter A, Section 89.002 and Subchapter E, Section 89.101).

Texas Administrative Code, Rule §97.190 requires Chapter 89 facilities to submit the Correctional Tuberculosis Screening Plan and to obtain approval from DSHS prior to the adoption of jail standards (Texas Administrative Code, Title 25, Part 1, Chapter 97, Subchapter H, Rule §97.190).

## WHAT IS THE PURPOSE OF THIS FORM?

The purpose of the Correctional Tuberculosis Screening Plan is to provide a framework for the implementation and monitoring of legally required TB prevention and care standards for Chapter 89 correctional facilities.

TB is a deadly disease caused by *Mycobacterium tuberculosis* which is spread through the air from person to person. TB is more common in correctional facilities due to factors favorable to transmission. These factors include close living quarters, and poor air circulation, combined with a higher proportion of persons with medical conditions associated with increased risk of TB disease progression after infection (i.e. HIV).

Due to the public health risk TB in correctional facilities presents, counties, judicial districts, and private entities operating Chapter 89 facilities must adopt local standards for TB prevention and care. These standards must be compatible or at least as stringent as the standards set out in Texas Health and Safety Code Chapter 89 and Texas Administrative Code Chapter 97, Subchapter H.

## WHO MUST COMPLETE THIS FORM?

Jail or community corrections facilities meeting the following criteria must complete this form.

1) A capacity of 100 beds or more;
2) Houses inmates transferred from a county that has a jail with a capacity of at least 100 beds; **or**
3) Houses inmates transferred from another state (Texas Health and Safety Code, Chapter 89, Subchapter A, Section 89.002).

## WHEN TO COMPLETE THIS FORM?

Chapter 89 facilities must complete this form annually prior to the adoption of local jail standards.

The Plan expires 12 months after DSHS' approval date. To allow enough time for DSHS' review and approval before the plan expires, a new plan must be submitted 90 days before the expiration date.

## WHERE TO SEND THE FORM?

Plans must be completed, signed, and emailed to:

Texas Department of State Health Services Tuberculosis and Hansen's Disease Unit at: CongregateSettings@dshs.texas.gov

## DEFINITIONS

***Airborne infection isolation room (AIIR).*** Formerly, negative pressure isolation room, an AIIR is a single-occupancy patient-care room used to isolate persons with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs should provide negative pressure in the room (so that air flows under the door gap into the room); and an air flow rate of 6-12 air changes per hour (ACH) (6 ACH for existing structures, 12 ACH for new construction or renovation); and direct exhaust of air from the room to the outside of the building or recirculation of air through a high-efficiency particulate air (HEPA) filter before returning to circulation (MMWR 2005; 54 [RR-17]).

***Chapter 89 Facility:*** A jail or community corrections facility that meets the Texas Health and Safety Code Chapter 89 criteria that has:

1) A capacity of 100 beds or more;
2) Houses inmates transferred from a county that has a jail with a capacity of at least 100 beds; or
3) Houses inmates transferred from another state (Texas Health and Safety Code, Chapter 89, Section 89.002).

***Community Correction Facility:*** A facility established under *Texas Government Code Chapter 509* that is usually administered by a community supervision and corrections department and is established by a district judge or a vendor under contract for the purpose of treating persons placed on community supervision or participating in a drug court program. This type of facility provides services and programs to modify criminal behavior, deter criminal activity, protect the public, and restore victims of crime. It includes restitution centers, court residential treatment facilities, custody facilities or boot camps, facilities for offenders with a mental impairment, and intermediate sanction facilities.

***Facility:*** A jail, prison, or other detention area, including the buildings and site.

***Inmate:*** A person confined to an institution. For the purposes of this document, the term "inmate" is used to refer to any person in custody, including detainees and residents of community correction facility under court order.

***Interferon-Gamma Release Assays (IGRA):*** TB blood tests used to detect TB infection. Two IGRAs have been approved by the U.S. Food and

Drug Administration (FDA): QuantiFERON®-TB Gold In-Tube test (QFT-GIT) and T-SPOT®.TB test (T-Spot). They do not differentiate TB infection from TB disease. An IGRA test can be done instead of a Tuberculin Skin Test (TST).

***Jail:*** A confinement facility intended for adults usually administered by a local law enforcement agency or a vendor under contract which holds persons who have been charged but not convicted of a crime and persons committed after adjudication, typically for sentences of one (1) year or less and could be also called a county jail. It may hold inmates in the custody of another correctional institution pending transfer to a state or federal prison.

***TB Infection:*** TB infection is determined by a positive result from an FDA-approved Interferon-Gamma Release Assay (IGRA) test such as T-Spot TB or QuantiFERON - TB GOLD In-Tube Test or a tuberculin skin test, and a normal chest radiograph with no presenting symptoms of TB disease. A person who is infected with *TB* does not have TB disease and cannot spread TB infection to others. They do not feel sick and do not have any symptoms.

***Purview:*** The scope of authority, competence, and responsibility granted to DSHS by state law.

***Tuberculin Skin Test (TST):*** A common type of test for TB infection. It is also known as Mantoux test or Mendel-Mantoux test, tuberculin sensitivity test, or purified protein derivative (PPD) test. The TST involves injecting a very small amount of a substance called tuberculin PPD under the top layer of the skin. After 48-72 hours, the test site will be examined for evidence of swelling, an immune response for persons exposed to TB.

## INSTRUCTIONS

Follow these instructions carefully to expedite your plan's approval and avoid rejections. If you need assistance filling out this plan, email the DSHS Tuberculosis and Hansen's Disease Unit at: CongregateSettings@dshs.texas.gov.

- ☐ The form must be filled out and signed.
- ☐ All sections of the plan must be filled out completely.
- ☐ Do not leave questions blank, type N/A if needed.
- ☐ Attach a separate sheet with additional information if necessary, specify the section and question number (e.g. B13)
- ☐ Attach all applicable supporting documentation requested:
    - ☐ Medical service provider contract (question B9)
    - ☐ TB portion of the facility's infection control plan (question B19)
    - ☐ Facility's TB symptom screening form (question C4)
    - ☐ Facility's continuity of care policy (question C8)
    - ☐ Forms used to transfer inmate records (question C11)

| Section A. Contact Information | | |
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| A1 | Facility Name | Enter the name of the facility that the TB screening plan is being completed for. Do not use abbreviations or acronyms. Do not include the name of the company serving as the facility operator. |
| A2 | Physical Address | Provide the physical location of the facility. Do not provide a P.O. Box. |
| A3 | Mailing Address | Enter the mailing address *only if different* from the physical address in A2 above. Otherwise, enter N/A. |
| A4 | Jail Administrator's Name | Enter the full name of the facility's current jail administrator. |
| A5 | Title | Enter the rank or title of the jail administrator, e.g., Warden, Captain, Chief Deputy, etc. |
| A6 | Phone Number | Enter the telephone number for the jail administrator, including the area code and, if applicable, extension number. |
| A7 | Email Address | Enter the email address for the jail administrator. |
| A8 | Fax Number | Enter the fax number for the jail administrator, including the area code. |
| A9 | Medical Director | Enter the contact information for the medical director. This should include full name, medical credential (e.g., MD, DO) telephone number, and physical address. Information must be complete. If the individual indicated does not have adequate medical credential, the plan will be returned. |
| A10 | Is the contact person the same as the jail administrator? | Mark "YES" if the contact person is the same as the jail administrator and "NO" if the contact person is different from the jail administrator. |
| A11 | Contact person if different from jail administrator | If the contact person is different than the jail administrator, enter the name, telephone number, email address, and full honorific or title of the contact person. |

| Section B. Facility Information | | |
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| B1 | Facility operated by: | Select either "County" if operated by the county or "Private" if the facility is privately owned or contracted with a private company. **Note:** "Other" may include a city correctional facility like a Law Enforcement Center (LEC). |
| B2 | Name of operating agency/company: | Enter the name of the agency/company that is responsible for the daily operations of the jail as indicated in question B1. |
| B3 | Is this facility regulated by Texas Commission on Jail Standards (TCJS)? If NO, who is the regulatory body? | A correctional facility is regulated by a state or federal body. If your institution is not regulated by TCJS, please check the "Other" box and provide the name of the institution. Do not use abbreviations or acronyms. |
| B4 | Total number of employees: | Enter the total number of employees at the facility at the time the plan was prepared. This is the number of employees that are required to be tested for employment purposes. |
| B5 | Facility bed capacity: | Enter the maximum number of inmates for which you have been approved as stated by the Texas Commission on Jail Standards (TCJS) or other regulatory body. This is also known as the number of beds in the facility. Bed capacity must match the TCJS records, if applicable. Visit https://www.tcjs.state.tx.us/population-reports/ and select County Jail Population. |
| B6 | Current population: | Enter the number of inmates housed at the facility at the time of completing the plan. |
| B7 | Total number of inmate admissions in the past calendar year: | Enter the total number of inmate admissions during the past calendar year. |

| Section B. Facility Information | | |
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| B8 | Which category of inmate is your facility authorized to hold? | Enter the type of federal inmates that you have a contract to house, i.e., Immigration and Customs Enforcement (ICE), Bureau of Prisons (BOP), or U.S. Marshals (USM). Enter the names of the states and counties with which you have a contract to house their inmates. **Note:** Inmates picked up on warrants should not be included in this section. |
| B9 | 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. | Mark "YES" if the facility maintains a health care team and "NO" if the facility does not. If contracted, please indicate in the additional text box who employs the health care team and attach a copy of the contract. **Note:** A health care team refers to, at minimum, a LVN or RN, and a part-time or full-time physician. |
| B10 | Who is the service provider that provides medical care for inmates and oversees the health care team? *Please specify.* | Enter the name of the medical provider and select the type of facility where the medical provider is based. |
| B11 | Number and credentials of health care staff at the facility | Enter the number of health care staff at the facility by type of credentials, e.g., RN–1, LVN–2, etc. |
| B12 | Number and credentials of staff trained on TB symptom screening | Enter the number and credentials of all staff trained to screen inmates for TB symptoms, e.g., RN-1, LVN-2. |
| B13 | List the names and credentials of all staff the medical director has authorized to administer, read, and interpret the TB skin tests | Enter the names and credentials of all staff that the medical director has authorized to place the TB skin test, read the test 48-72 hours after placing the test, and interpret the result as either positive or negative based on the millimeter reading. Attach a separate sheet if necessary. |
| B14 | Types of TB tests performed at your facility | Mark the types of TB tests performed at your facility. Select all that apply. Available TB tests include the two TB blood or Interferon-Gamma Release Assays (IGRA) tests, also known as QuantiFERON-TB Gold (QFT) and T-Spot, and the tuberculin skin test (TST). |
| B15 | Are chest x-rays done at the facility? | Answer "YES" or "NO" by checking the relevant box to indicate if chest x-rays are done at your facility. Enter the name of the chest x-rays provider, the provider's telephone number, and the physical address where the chest x-ray will be done. |
| B16 | Are chest x-rays interpreted by the same x-ray facility listed above? If NO, provide the information below. | Answer "YES" or "NO" by checking the relevant box to indicate if chest x-rays are interpreted by the same x-ray facility listed in B15. If "NO", enter the name, telephone number, and physical address of the person or organization that will interpret the chest x-rays. |
| B17 | In the event of a hurricane or other natural or man-made disaster, do you have a written evacuation plan on file? Will you relocate? If YES, please specify the location you will relocate to. | Answer "YES" or "NO" by checking the relevant box to indicate if your facility has an evacuation plan. Answer "YES" or "NO" by checking the relevant box to indicate if you will relocate in the event of a disaster. If "YES," enter the name of the location where inmates will be relocated to. |

| Section B. Facility Information | | |
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| B18 | Is the TB infection control person the same as the contact person listed in Section A? | Answer "YES" or "NO" by checking the relevant box to indicate if the TB infection control person is the same as the contact person listed in Section A11. If "NO", enter the name, job title, email address, and telephone number of the person who oversees TB control in the facility. |
| B19 | Does your facility have an infection control plan (ICP)? | Answer "YES" or "NO" by checking the relevant box. If "YES", attach a copy of the TB portion of the infection control plan. |
| B20 | Does your facility have airborne infection isolation rooms (AIIRs)? If YES, indicate the number of AIIRS. | Answer "YES" or "NO" by checking the relevant box to indicate if you have airborne infection isolation rooms (AIIR), also known as negative air pressure rooms, in your facility. If "YES", indicate the number of individual rooms. **Note:** Refer to the definition of AIIR in this document. **Segregation or separation rooms without appropriate environmental controls are NOT AIIRs.** |
| B21 | If your facility has fewer than two (2) AIIRs, where will an inmate with symptoms suggestive of TB be isolated? | Enter the name of the hospital/facility where you will transfer your inmates that need respiratory isolation if your facility has fewer than two AIIRs. |
| B22 | Are AIIRs routinely inspected and maintained? If YES, who is in charge of inspection and maintenance? | Answer "YES", "NO", or "N/A" by checking the relevant box. Provide the name, title, and phone number of the individual responsible for inspection and maintenance. **Note:** Procedures for routine inspection and maintenance of AIIRs should be implemented. This is essential to ensure that staff will be alerted if the controls fail and will protect staff and inmates from airborne infectious diseases. |
| B23 | Provide name, mailing address, and telephone number of the local or regional health department (who your facility sends reports to) and the name of their contact person. | Enter the name, address, and contact information for the local or regional health department that your facility sends monthly correctional TB reports to. **Note**: Ensure this information is current. If needed, contact the health department to verify this information. |
| B24 | 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? | Enter the name, title, and telephone number of the person who is responsible for contacting the local or regional health department about TB cases and suspects in your facility. |
| B25 | What TB services, if any, does your local or regional health department provide to your facility? | Enter the services provided by the local or regional health department. If "Other" is checked, specify the type of service provided. Select all services that apply. |
| B26 | Who supplies your purified protein derivatives (PPDs) for inmate TB testing at your facility? | Select the type of agency that provides your PPDs. Enter the name and address of the agency or organization that provides the testing material to your facility. If "Other" is selected, please specify. Do not use acronyms. |
| B27 | Who supplies your syringes for inmate TB testing at your facility? | Select the type of agency that provides your syringes. Enter the name and address of the agency or organization that provides the testing material to your facility. If "Other" is selected, please specify. Do not use acronyms. |

| Section C. Inmate Screening | | |
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| C1 | On which days and shifts are TSTs or Interferon Gamma Release Assays (IGRAs) administered? | Enter the days of the week and the hours of the shifts when this service is provided. |
| C2 | How soon after incarceration are inmates given a TST or IGRA? | Indicate within how many hours or days of incarceration that a TST or IGRA was administered. **Per Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter H:** Inmates must be tested on or before the seventh day of incarceration and at least annually thereafter. Correctional facilities may elect to perform chest x-rays on inmates on intake instead of a skin test screening program; however, the use of chest x-ray screening method on intake must be followed by testing for TB infection within 14 days. |
| C3 | How long after placing a TST is it read? | Indicate within how many hours skin tests are read after they are placed. **Per Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter H:** Skin tests should be read within 48 to 72 hours after placed. |
| C4 | Are symptom screenings conducted? | Answer "YES" or "NO" by checking the relevant box. If "YES", enter when you screen your inmates for TB symptoms. Attach a copy of the form your facility uses for symptom screening. |
| C5 | For inmates with newly positive IGRA/TST results, when are chest x-rays done? | Indicate in what time frame chest x-rays are done. **Note:** Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive IGRA or TST if the person is asymptomatic. |
| C6 | Do you offer treatment for TB infection (also known as latent TB infection)? If NO, please explain why. | Indicate whether you offer treatment for TB infection. If "NO", please explain why. **Note:** Refer to the definition of TB infection in this document. All correctional facility staff and inmates should be considered for treatment if infected. Decisions to initiate treatment for TB infection should be based on the person's risk for progressing to TB disease, and the likelihood of continuing and completing treatment if released from the facility before the treatment regimen is completed. |
| C7 | When do annual screenings of long-term inmates take place? | Indicate at what intervals you screen your long-term inmates for TB. If on a designated month, specify which month. If other, please specify. |
| C8 | Do you have a continuity of care policy for inmates diagnosed with TB and scheduled for release into the community? | Answer "YES" or "NO" by checking the relevant box. If "YES," attach a copy of the policy. **Per Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter H:** A correctional facility regardless of size that houses adult or youth inmates must assure continuity of care for those inmates receiving treatment for tuberculosis who are being released or transferred to another correctional facility. A facility must contact the department prior to the inmate being released or transferred, if possible. If that is not possible, the facility must make the contact immediately upon the inmate's release from custody or transfer to another correctional facility. |
| C9 | Who maintains inmate screening records? | Enter the name, title, and telephone number of the person who is responsible for maintaining the inmate screening records at the facilities. |

| Section C. Inmate Screening | | |
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| C10 | Who is responsible for sending transfer records to Texas Department of Criminal Justice (TDCJ) or other correctional facilities on inmates with TB? | Enter the name, title, and telephone number of the person who is responsible for ensuring the records of transferred inmates are sent to TDCJ or other correctional facilities. |
| C11 | Which form(s) are used to transfer inmate records? Check all that apply. | Enter the forms used in transferring the records of inmates and attach a copy to the complete screening plan. Check all that apply. |

| Section D. Employee Screening | | |
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| D1 | Does your facility perform initial employee screenings? If YES, when do initial screenings take place? | Answer "YES" or "NO" by checking the relevant box. If YES, enter when initial employee screenings are done at your facility. **Per Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter H:** Employees who share the same air with inmates must be screened at time of employment and at least annually thereafter. |
| D2 | Does your facility perform annual employee screenings? If YES, when do annual screenings take place? | Answer "YES" or "NO" by checking the relevant box. If YES, enter when annual employee screenings take place at your facility. |
| D3 | Are employee screenings performed onsite or through referral? | Answer "Onsite" or "Referral" by checking the relevant box. If "Referral" is selected, please specify. Enter the name of the agency or organization that provides the testing. Do not use acronyms. |
| D4 | If an employee has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. 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? | Enter the number of days allowed by the facility for employees to produce a physician certificate. **Note:** Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive IGRA or TST if the person is asymptomatic. |
| D5 | Who is responsible for keeping employee certification records? | Enter the name, title, and telephone number of the person responsible for keeping these records. |

| Section E. Volunteer Screening | | |
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| E1 | Do volunteers provide services in your facility? | Answer "YES" or "NO" by checking the relevant box. |
| E2 | Do volunteers in this facility work more than 30 hours a month? | If volunteers provide services in this facility, indicate if they work more than 30 hours a month by checking the relevant box. |

| Section E. Volunteer Screening | | |
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| E3 | Does your facility perform initial volunteer screenings? If YES, when do initial screenings take place? | Answer "YES" or "NO" by checking the relevant box. If YES, enter when initial volunteer screenings are done at your facility. **Per Texas Administrative Code Title 25, Part 1, Chapter 97, Subchapter H:** 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. |
| E4 | Does your facility perform annual volunteer screenings? If YES, when do annual screenings take place? | Answer "YES" or "NO" by checking the relevant box. If YES, enter when annual volunteer screenings take place at your facility. |
| E5 | Are volunteer screenings performed onsite or through referral? | Answer "Onsite" or "Referral" by checking the relevant box. If "Referral" is selected, please specify. Enter the name of the agency or organization that provides the testing. Do not use acronyms. |
| E6 | If a volunteer has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. The volunteer must provide a physician certification indicating "no active disease" before returning to volunteer work. How many days are allowed for the volunteer to submit this certification? | Enter the number of days allowed by the facility for volunteers to produce a physician certificate. **Note:** 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. |
| E7 | Who is responsible for keeping volunteer certification records? | Enter the name, title, and telephone of the person responsible for monitoring the volunteer screening process. |

| Section F. Additional Sites | | |
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| F1 | Does your facility have additional sites? | Answer "YES" or "NO" by checking the relevant box. If "YES," enter the name and location of any additional facilities under the same operating agency using the "ADD" button for additional pages. |

| Section G. Plan Submission and Acknowledgement | | |
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| | Submission Type | Indicate if you are submitting an annual plan or an amended plan by checking the appropriate box. An annual plan submission must be filled out in full and include ALL applicable supporting documentation. An amended plan submission must reflect any administrative or operational changes in your facility that negate information provided on the annual plan. Amended plans include only supporting documentation which have changed since your annual plan submission. |
| | Plan Signature | This section is to be signed and dated by the jail administrator. |

| Section H. Approval | | |
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| | Email Submission | Email the completed, signed, and dated plan to CongregateSettings@dshs.texas.gov. |
| | DSHS Office Use Only | Do not write in this section. It is for DSHS use only. |

## REFERENCES


Texas Tuberculosis Code, Health and Safety Code, Chapter 13, Subchapter B
statutes.legis.state.tx.us/Docs/HS/htm/HS.13.htm

Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81
statutes.legis.state.tx.us/Docs/HS/htm/HS.81.htm

Screening and Treatment for Tuberculosis in Jails and Other Correctional Facilities, Health and Safety Code, Chapter 89
statutes.legis.state.tx.us/Docs/HS/htm/HS.89.htm

Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter A, Control of Communicable Diseases
texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=_97&sch=A&rl=Y

Texas Administrative Code TAC, Title 25, Part 1, Chapter 97, Subchapter H, Tuberculosis Screening for Jails and Other Correctional Facilities
texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=97&sch=H&rl=Y

Texas Tuberculosis Standards for Correctional and Detention Facilities. Texas Department of State Health Services.
https://dshs.texas.gov/IDCU/disease/tb/policies/TBCorrectionalStandards.pdf

Texas Department of State Health Service - Tuberculosis (TB) website.
dshs.texas.gov/disease/tb/