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
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 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 FOC, COITeam@dshs.texas.gov, FOC, 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

<table>
<thead>
<tr>
<th>A. CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Facility Name</td>
</tr>
<tr>
<td>2. Physical Address</td>
</tr>
<tr>
<td>3. Mailing Address</td>
</tr>
<tr>
<td>4. Jail Administrator’s Name</td>
</tr>
<tr>
<td>5. Title</td>
</tr>
<tr>
<td>6. Phone Number</td>
</tr>
<tr>
<td>7. Email Address</td>
</tr>
<tr>
<td>8. Fax Number</td>
</tr>
<tr>
<td>9. Medical Director (MD, DO, NP, or PA-C)</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>Email Address</td>
</tr>
<tr>
<td>Phone Number</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>

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

Credential must be MD, DO, NP, or PA-C
NEW! Up to two contact persons can be listed.

<table>
<thead>
<tr>
<th>11. Contact Person (if different from jail administrator)</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Title:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Email Address:</td>
</tr>
<tr>
<td>Name:</td>
<td>Title:</td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Email Address:</td>
</tr>
</tbody>
</table>
Section B. Facility Information
Section B. Facility Information

### 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:**

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**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. Marshalls

- 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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Facility should check all applicable federal inmates that they house.
Ensure that medical contracts are current until 12/31/24 or automatically renewed and attached to the screening plan.
Sample Contracts

Automatic Renewal

Expires Mid-Year

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.

<table>
<thead>
<tr>
<th>Contract Period: October 1, 2022, through September 30, 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base annualized fee: $221,335.92 ($18,444.66 per month)</td>
</tr>
<tr>
<td>Per diem greater than 130 inmates: $1.57</td>
</tr>
<tr>
<td>Annual outside cost pool limit: $40,000.00 (includes 100% pool refund provision)</td>
</tr>
</tbody>
</table>
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
Section B. Facility Information (continued)

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.
### Section B. Facility Information (continued)

<table>
<thead>
<tr>
<th>24.</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Department Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Name and Title:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Name and Title:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>25.</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
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<tr>
<td><strong>Name:</strong></td>
<td></td>
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<tr>
<td><strong>Title:</strong></td>
<td></td>
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<tr>
<td><strong>Phone Number:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
<td></td>
</tr>
</tbody>
</table>

NEW! List up to two individuals

<table>
<thead>
<tr>
<th>26.</th>
<th>Who supplies purified protein derivatives (PPD) for inmate TB testing at your facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>____</td>
<td>Pharmacy (Specify name and address)</td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>Health Department (Specify full name and address)</td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>Other (Specify name and address)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>27.</th>
<th>Who supplies syringes for inmate TB testing at your facility?</th>
</tr>
</thead>
<tbody>
<tr>
<td>____</td>
<td>Pharmacy (Specify name and address)</td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>Health Department (Specify full name and address)</td>
</tr>
<tr>
<td>____</td>
<td></td>
</tr>
<tr>
<td>____</td>
<td>Other (Specify name and address)</td>
</tr>
</tbody>
</table>
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
- [ ] Education and/or Training
- [ ] TB Testing at Intake
- [ ] Contact Investigation
- [ ] TB Annual Screenings
- [ ] TB Medication
- [ ] Other (Specify): 

Ensure that the services checked are in alignment with the services provided by the TB program.
Section C. Inmate Screening
**Section C. Inmate Screening**

<table>
<thead>
<tr>
<th>C. INMATE SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On which days and shifts are TSTs administered, or Interferon Gamma Release Assays (IGRAs) drawn? Select all that apply:</td>
</tr>
<tr>
<td>Monday</td>
</tr>
<tr>
<td>Facility shift hours when tests are done: from ___ to ___</td>
</tr>
<tr>
<td>2. How soon after incarceration are inmates given a TST or IGRA?</td>
</tr>
<tr>
<td>Within ___ hours or ___ days</td>
</tr>
<tr>
<td>Within ___ to ___ hours</td>
</tr>
<tr>
<td>3. How long after placing a TST is it read? Please indicate range.</td>
</tr>
<tr>
<td>4. Are symptom screenings conducted? If YES, attach a copy of your facility's TB symptom screening form.</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>If YES, when are symptom screenings conducted?</td>
</tr>
<tr>
<td>5. For inmates with newly positive IGRA/TST results, when are chest x-rays done? Select all that apply:</td>
</tr>
<tr>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Within 72 hours</td>
</tr>
</tbody>
</table>

**Notes:** According to Figure 23 TAC 597.170(e), 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.
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?
   - YES ___ NO ___
   - If YES, please attach a copy of the plan.

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 infections 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: __________________

NEW!

Ensure that the continuity of care plan is attached, when applicable.
Section D. Employee Screening
## Section D. Employee Screening

### 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 592.175(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.

5. **How many days are allowed for the employee to submit this certification?** ______ days

6. **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.
Section F. Additional Sites
Section F. Additional Sites

<table>
<thead>
<tr>
<th>F. ADDITIONAL SITES (Refer to Section A2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your facility have additional sites? If YES, enter the names and locations of additional sites. Use the &quot;ADD&quot; button at the bottom for additional facilities:</td>
</tr>
<tr>
<td>____ YES ____ NO</td>
</tr>
<tr>
<td>2. Facility Name</td>
</tr>
<tr>
<td>3. Physical Address</td>
</tr>
<tr>
<td>4. Mailing Address (if different from physical)</td>
</tr>
<tr>
<td>5. Jail Administrator’s Name</td>
</tr>
<tr>
<td>8. Email Address</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Names:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

Add information on additional sites
Section G. Plan Submission and Acknowledgement
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.
<table>
<thead>
<tr>
<th>Name</th>
<th>Credentials (MD, DO, NP, or PA-C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June Smith</td>
<td>LVN</td>
</tr>
</tbody>
</table>

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 1

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

Street address is not provided
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):
Did not specify whom the health care team is contracted by.

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

- [X] 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.

- [X] Yes
- [ ] No

Contracted entity, if applicable:

Who is the health care team employed by?

- [ ] County
- [ ] Hospital

- [X] Private
- [ ] Other (please specify):
Check your Understanding: Question 4

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:
### D. EMPLOYEE SCREENING

1. **Does your facility perform initial employee screenings?**
   - [ ] YES
   - [x] NO

   **If YES, when do initial screenings take place?**
   - [ ] Prior to employment
   - [x] 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):
• 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