CORRECTIONAL TUBERCULOSIS SCREENING PLAN (TB-805)

INSTRUCTIONS
The Correctional Tuberculosis (TB) Screening Plan (TB-805) is required of all jails designated as Texas Health and Safety Chapter 89. **Refer to publication #TB-805-I for instructions on filling out this form.** Type in each box using the fillable electronic form. **All sections of the plan must be filled out completely and must be legible or the form will be returned.** Do not leave questions blank (type N/A if needed). The electronically signed original plan must be **emailed to your Local or Regional Health Department with a copy to the Texas Department of State Health Services (DSHS) Tuberculosis and Hansen's Disease Unit at CongregateSettings@dshs.texas.gov.**

A. CONTACT INFORMATION			
1. Facility Name			
2. Physical Address (*list additional sites in Section F*)	**City**	**State**	**Zip Code**
3. Mailing Address *(if different from physical)*	**City**	**State**	**Zip Code**
4. Jail Administrator's Name	**5. Title (Captain, Lieutenant, etc.)**	**6. Phone Number**	
7. Email Address	**8. Fax Number**		
9. Medical Director (MD, DO, NP, or PA-C)			
Name	**Credentials (MD, DO, NP, or PA-C)**		
National Provider Identifier (NPI)	**Email Address**		
Phone Number	**Address**		
City	**State**	**Zip Code**	
10. Is the contact person the same as the jail administrator? ______ YES ______ NO If NO, complete question 11 below.			

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

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

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 inmates booked into the facility in the previous calendar year:

8. Which category of inmate is the facility authorized to hold? ***(Select all that apply)***

_____ Federal (*Select all that apply*): ______ Immigration and Customs Enforcement ______ Bureau of Prisons ______ U.S. Marshals

_____ County

_____ Out-of-County *(Please list the counties that you have a contract, memorandum of agreement (MOA), or memorandum of understanding (MOU) with):*

____

____

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

____

____

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

______ YES ______ NO

Is the health care team contracted? If contracted, please indicate who employs the health care team in the space below and *attach a copy of the contract.*

______ YES ______ NO Contracted entity, if applicable: ____

Who is the health care team employed by?

______ County ______ Hospital

______ Private ______ Other (*please specify*): ____

10. Does the Medical Director, listed in A9, provide TB medical care services for inmates? If no, please provide the name of the treating physician and their National Provider Identifier (NPI). *Note: A TB medical provider must have a valid and current license to practice in Texas with one of the following credentials: MD, DO, NP, or PA-C.*

______ YES ______ NO

Provider name(s): ____

National Provider Identifier (NPI): ____

Does the facility maintain a contract with the TB medical provider? If contracted, please indicate the contracted entity in the space below and *attach a copy of the contract.*

______ YES ______ NO Contracted entity, if applicable: ____

Who is the medical provider employed by?

______ County ______ Hospital

______ Private ______ Other (*please specify*): ____

11. Number and credentials of health care staff at the facility (ex: RN—1, LVN—2, Jailers—3, etc.)

12. Number and credentials of staff trained on TB symptom screening (ex: RN—1, LVN—2, Jailers—3, etc.)

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13. List names and credentials of all staff the medical director or TB medical provider has authorized to administer, read, and interpret the TB skin test. ***(Attach a separate sheet if necessary).***

14. Types of TB tests performed at your facility ***(Select all that apply)***

______ QuantiFERON-TB Gold (QFT)

______ T-SPOT

______ Tuberculin Skin Test (TST)

15. If your facility uses a blood test (QFT and/or T-SPOT) to screen for TB, please answer the questions below. Please indicate N/A if your facility only uses TST to screen.

Please specify who provides the QFT and/or T-SPOT to your facility (e.g., Quest Diagnostics)?

____

In what instances is the blood test used (e.g., confirmatory testing, testing of refusals, etc.)?

____

____

16. Are chest x-rays performed at the facility?

______ YES ______ NO

Please provide the information of the chest x-ray provider:

Name (provider of x-rays): ______________________________

Phone Number: ____________________________________

Address: ____

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

______ YES ______ NO

Name (provider of x-rays): ______________________________

Phone Number: ____________________________________

Address: ____

Note: Routine chest x-rays are not required for asymptomatic persons who have negative TB skin test results. After the initial chest radiograph is taken, persons with positive tuberculin skin test reactions do not need repeat chest radiographs, unless symptoms develop that may be or are suspected to be due to tuberculosis disease.
http://statutes.capitol.texas.gov/Docs/HS/htm/HS.89.htm

18. In the event of a hurricane or other natural or man-made disaster, do you have a written evacuation plan on file?

______ YES ______ NO

Will you relocate? If YES, please specify the location you will relocate to.

______ YES ______ NO Location: ____

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19. Is the TB infection control person the same as the contact person listed in Section A?

______ YES ______ NO

If NO, provide the name and job title of the person responsible for your facility's TB infection control measures. This person may be responsible for generating and submitting monthly reports, maintaining supplies, and making necessary referrals.

Name: ____ Title: _________________________________

Email Address: _______________________________________ Phone Number: _________________________

20. Does your facility have airborne infection isolation rooms (AIIRs)? If YES, indicate the number of AIIRS.

______ YES ______ NO Number of individual rooms: ____________________________

21. If your facility has fewer than two (2) AIIRs, where will an inmate with symptoms suggestive of TB be isolated? Please attach a copy of the contract or agreement with the hospital/facility.

______ N/A Hospital/facility name: ____

22. Are AIIRs routinely inspected and maintained? If YES, who oversees inspection and maintenance?

______ YES ______ NO ______ N/A If NO, please indicate the reason: ____

Name: ________________________________ Title: _________________________ Phone Number: ____________________

23. Which of the following actions does your facility take in the event a suspected or confirmed TB case is identified? Please see the screening algorithm for incarcerated individuals for reference. Please check all that apply.

______ Immediately isolate the individual in an AIIR or send them to the hospital for isolation

______ Report to the local or regional health department within one working day

______ Perform chest x-ray within 72 hours

______ Order a Nucleic Acid Amplification Test (NAAT) (i.e., rapid PCR)

______ Order acid-fast bacilli (AFB) testing on sputum smear/culture within 72 hours

______ Provide treatment for TB

______ Ensure thorough medical evaluation

______ Conduct a Contact Investigation (CI)

______ Provide surgical mask to the inmate and ensure staff/personnel wear N-95 or equivalent

______ Perform TST for symptomatic inmates

______ Other (*Specify*): _________________________________

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24. Provide name, mailing address, and phone number of local or regional health department (who your facility reports to) and the name of the contact person(s). You may list up to two individuals.

Health department name:

____

Name: ____

Title: ____

Phone Number: ___________________________________

Email Address: ___________________________________

Address: ____

Name: ____

Title: ____

Phone Number: ___________________________________

Email Address: ___________________________________

Address: ____

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25. What is the name and title of the person at your facility who informs the local or regional health department about TB suspects and/or cases in custody? You may list up to two individuals.

Name: ____

Title: ____

Phone Number: ___________________________________

Email Address: ___________________________________

Name: ____

Title: ____

Phone Number: ___________________________________

Email Address: ___________________________________

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

______ Pharmacy (*Specify name and address*)

____

____

______ Health Department (*Specify full name and address*)

____

____

______ Other (*Specify name and address*)

____

____

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

______ Pharmacy (*Specify name and address*)

____

____

______ Health Department (*Specify full name and address*)

____

____

______ Other (*Specify name and address*)

____

____

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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*): ____

C. INMATE SCREENING

1. On which days and shifts are TSTs administered, or Interferon Gamma Release Assays (IGRAs) drawn? *Select all that apply.*

______ Monday ______ Tuesday ______ Wednesday ______ Thursday ______ Friday ______ Saturday ______ Sunday

Facility shift hours when tests are done: from _________ to _________

2. How soon after incarceration are inmates given a TST or IGRA?

Within ______ hours *or* ______ days

3. How long after placing a TST is it read? *Please indicate a range.*

Within ______ to ______ hours

4. Are symptom screenings conducted? ***If YES, attach a copy of your facility's TB symptom screening form.***

______ YES ______ NO If YES, when are symptom screenings conducted? ____

5. For inmates with <u>newly positive</u> IGRA/TST results, when are chest x-rays done? *Select all that apply.*

______ Within 24 hours ______ Within 4-7 days

______ Within 48 hours ______ Other (*Please specify below):*

______ Within 72 hours _________________________

6. Does your facility offer treatment for TB infection?

______ YES ______ NO

If NO, please explain the circumstances why.

____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

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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 written continuity of care plan for inmates diagnosed or suspected with TB scheduled for release into the community or transferred? ***If YES, please attach a copy of the plan.***

______ YES ______ NO

9. Who maintains inmate screening records?

Name: ____

Title: ____

Phone Number: _________________________________

Email Address: _________________________________

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

Name: ____

Title: ____

Phone Number: _________________________________

Email Address: _________________________________

11. Who is responsible for notifying the local or regional health department when an inmate with TB infection or suspected/confirmed TB disease is transferred or released?

Name: ____ Title: ____

Phone Number: _________________________________ Email Address: _________________________________

Note: All inmates shall be evaluated for TB infection and disease. All treatment must be documented. A record of treatment (TB-400A and TB-400B) must be completed and submitted to the local or regional health department TB program located in the county of the facility. Form TB-400A, TB-400B, and other forms are available at dshs.texas.gov/disease/tb/forms.shtm.

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

______ Texas Uniform Health Status Update

______ Prisoner in Transit Medical Summary Form (USM-553)

______ Other (*Please specify*): ________________________________

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D. EMPLOYEE SCREENING

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

3. Are employee screenings performed onsite or through referral?

______ Onsite at facility ______ Referral (*Please specify):* ____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

4. If an employee has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The employee must provide a physician certification indicating "no active disease" before returning to work.

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

5. Who is responsible for keeping employee certification records?

Name: ___________________________________ Title: ___________________________ Phone Number: ______________________

E. VOLUNTEER SCREENING

1. Do volunteers provide services in your facility?

______ YES ______ NO (**If marking NO, please skip the rest of the section.)**

2. Do volunteers in this facility work more than 30 hours a month? Note: According to TAC §97.173, "All volunteers who share the same air space with inmates on a regular basis (more than 30 hours per month) shall be screened prior to becoming a volunteer and at least annually thereafter according to this section unless the volunteer is exempt as described in clauses (ii), (iii), or (iv) of this subparagraph."

______ YES ______ NO **(If marking NO, please skip the rest of the section.)**

3. Does your facility perform initial volunteer screenings? ______ YES ______ NO ______ N/A **If YES, when do initial screenings take place?** ______ Prior to becoming a volunteer ______ Within 7 days of starting ______ Other (*Please specify):* ____________________________	**4. Does your facility perform annual volunteer screenings?** ______ YES ______ NO ______ N/A **If YES, when do annual screenings take place?** ______ 12 months from date of hire ______ On a designated month (Please specify): _____________ ______ Other (*Please specify):* ___________________________

5. Are volunteer screenings performed onsite or through referral?

______ N/A ______ Onsite at facility ______ Referral (*Please specify):* ____

Note: According to Figure: 25 TAC §97.175(a), a chest x-ray shall always be done within 72 hours of a positive TB skin test reading. A chest x-ray and sputum smear and culture shall always be done within 72 hours of identification of symptoms of TB.

6. If a volunteer has a positive reaction (10 mm or greater), a chest x-ray and medical evaluation must be done. Chest x-rays must be done immediately if TB symptoms are present or within three (3) days of a positive Interferon Gamma Release Assay (IGRA) or skin test if the person is asymptomatic. The volunteer must provide a physician certification indicating "no active disease" before returning to work.

______ N/A **How many days are allowed for the volunteer to submit this certification?** ______ days

7. Who is responsible for keeping volunteer certification records?

______ N/A

Name: __________________________________ Title: ___________________________ Phone Number: ______________________

F. ADDITIONAL SITES (Refer to Section A2)

1. Does your facility have additional sites? If YES, enter the names and locations of additional sites. Use the "ADD" button at the bottom for additional facilities.

______ YES ______ NO

2. Facility Name

3. Physical Address	**City**	**State**	**Zip Code**

4. Mailing Address *(if different from physical)*	**City**	**State**	**Zip Code**

5. Jail Administrator's Name	**6. Title**	**7. Phone Number**

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8. Email Address	**9. Fax Number**
10. Contact Person *(if different from jail administrator)* You may list up to two contact persons. We recommend that at least one person listed is the nurse supervisor or person responsible for overseeing TB screening and reporting.	
Name:	**Title:**
Phone Number:	**Email Address:**
Name:	**Title:**
Phone Number:	**Email Address:**

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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 may be electronically signed using Adobe Sign and may be locked after being 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

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