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

Correctional Tuberculosis Screening Plan (TB-805) Checklist A

The checklist is a tool for **first-line reviewers (local and regional TB programs)** to perform quality assurance for correctional tuberculosis screening plans on commonly missed items. Please note the checklist is **not** comprehensive for all form questions and/or situations.

Ensure the screening plan is complete before submitting to the Assessment, Compliance, and Evaluation (ACE) team. If you have any questions, please email aceteam@dshs.texas.gov. Attach the completed checklist when submitting the screening plan and supporting documents for review and approval.

Facility Name: _____ **Date Reviewed:** _____

Question #	QA Question	Yes	No	N/A	Notes
A9	Does the medical director have one of the following credentials: MD, DO, NP, or PA-C?	☐	☐	☐	
A11	If the point of contact is not the same as the jail administrator (refer to question A10), did the facility provide at least one point of contact?	☐	☐	☐	
Section A	Is Section A complete (i.e., no missing information)?	☐	☐	☐	
B1	If the facility selected "Other (Specify)," did they specify by whom the facility is operated by?	☐	☐	☐	
B8	If the facility selected "Federal," did they select at least one facility type (ICE, BOP, USMS)?	☐	☐	☐	

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Question #	QA Question	Yes	No	N/A	Notes
B8	If the facility selected "Out-of-County" or "Out-of-State," did they specify the counties and/or states?	☐	☐	☐	
B9B	Did the facility attach a copy of the **current** contract for the healthcare team? **Note**: Current contracts are active through the approval period, i.e., 2027, or automatically renewed.	☐	☐	☐	
B10	Did the facility complete the remaining questions if the medical provider is the same as in question A9?	☐	☐	☐	
B10B	Did the facility attach a **current** contract for the medical provider? **Note**: Current contracts are active through the approval period, i.e., 2027, or automatically renewed.	☐	☐	☐	
B13	If needed, was a separate sheet with the names **and** credentials attached?	☐	☐	☐	
B14	Does the facility perform QFTs and/or T-SPOTs?	☐	☐	☐	
B15	Did the facility indicate N/A if the facility only uses the TST?	☐	☐	☐	
B15	If IGRAs are used, did the facility list the entity providing the QFT/T-SPOT supplies? **Note**: TB Programs cannot use DSHS-funded services (e.g., Quest) to provide IGRA testing for Chapter 89-designated facilities.	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
B15	If the facility uses a TST and an IGRA, do the instances align with DSHS standards (i.e., no confirmatory testing)?	☐	☐	☐	
B16	Did the facility provide information on the chest x-ray provider?	☐	☐	☐	
B17	If "NO" is selected, did the facility fill out ALL appropriate information?	☐	☐	☐	
B18	If the facility will relocate, was the location specified?	☐	☐	☐	
B19	Is the information for the person responsible for the facility's TB infection control measures completed?	☐	☐	☐	
B20	If the facility has AIIRs, did they indicate the number of AIIRs?	☐	☐	☐	
B21	If the facility has fewer than two AIIRs, did they specify where they will isolate inmates?	☐	☐	☐	
B21	Did the facility attach a copy of the contract or agreement with the hospital/facility?	☐	☐	☐	
B22	If "YES" is selected, did the facility provide information on who oversees inspection and maintenance of the AIIRs?	☐	☐	☐	
B22	If "NO" is selected, did the facility indicate the reason for not routinely inspecting and maintaining AIIRs at the facility?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
B23	If applicable, was a date provided for the last AIIR(s) inspection?	☐	☐	☐	
B25	Did the facility provide the current contact information for the individual(s) listed?	☐	☐	☐	
B27 and B28	If the health department provides testing supplies, is it reflected accurately? Ensure the full spelling of the health department.	☐	☐	☐	
B27 and B28	Did the facility provide both the full name and address of the supplying entity?	☐	☐	☐	
B27 and B28	Did the facility list instances when the secondary supplier would be needed?	☐	☐	☐	
B29	If the facility lists the health department as the supplier of TB medications, does the health department serve as the medical provider (refer to question B10)? **Note:** The LHD/PHR may review medication orders but shall not supply medications directly to Chapter 89-designated facilities unless the LHD/PHR serves as the TB medical provider listed on the Correctional TB Screening Plan for that facility.	☐	☐	☐	
B30	Are the services checked consistent with what is provided by the local or regional TB Program? Ensure alignment with your TB program's services.	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
Section B	Is Section B complete (i.e., no missing information)?	☐	☐	☐	
C1	Did the facility include AM or PM for the facility shift hours if not using a 24-hour format?	☐	☐	☐	
C3	Did the facility note that TSTs are read within 48-72 hours of placement?	☐	☐	☐	
C4	If symptom screenings are conducted, did the facility specify when they are performed?	☐	☐	☐	
C4	Did the facility attach a copy of the TB symptom screening form?	☐	☐	☐	
C7	If "On a designated month" is selected, did the facility list the month?	☐	☐	☐	
C7	If "Other" is selected, did the facility specify when annual screenings occur?	☐	☐	☐	
C8	Did the facility attach a copy of the continuity of care plan?	☐	☐	☐	
C12	Did the facility attach all applicable transfer forms?	☐	☐	☐	
Section C	Is Section C complete (i.e., no missing information)?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
D1	If "Other" is selected, did the facility specify when initial screenings occur?	☐	☐	☐	
D2	If "On a designated month" is selected, did the facility specify the month?	☐	☐	☐	
D2	If "Other" is selected, did the facility specify when annual screenings occur?	☐	☐	☐	
Section D	Is Section D complete (i.e., no missing information)?	☐	☐	☐	
E2	If "NO" is selected, did the facility skip the rest of the section?	☐	☐	☐	
E3	If "Other" is selected, did the facility specify when initial screenings occur?	☐	☐	☐	
E4	If "On a designated month" is selected, did the facility specify the month?	☐	☐	☐	
E4	If "Other" is selected, did the facility specify when annual screenings occur?	☐	☐	☐	
Section E	Is Section E complete (no missing information)?	☐	☐	☐	

Question #	QA Question	Yes	No	N/A	Notes
F1	If the facility selected "YES," did they provide the appropriate information?	☐	☐	☐	
F1	If the facility selected "NO", did the facility skip the rest of the section?	☐	☐	☐	
Section G	Did the facility check the correct submission type?	☐	☐	☐	
END PAGE	Did the jail administrator sign and date the plan?	☐	☐	☐	

Supporting Document	Yes	No	N/A	Notes
Current healthcare team provider contract (question B9)	☐	☐	☐	
Current medical service provider contract (question B10)	☐	☐	☐	
Staff and their credentials (question B13)	☐	☐	☐	
Contract or agreement with hospital/facility (question B21)	☐	☐	☐	

TB symptom screening form (question C4)	☐	☐	☐	
Continuity of care plan (question C8)	☐	☐	☐	
Form(s) used to transfer inmate records (question C12)	☐	☐	☐	

I am confirming I have thoroughly reviewed the screening plan for completion and accuracy and am submitting a complete and accurate plan for review and approval.

Name: _____ **Date:** _____

Signature: _____