CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

VOLUME 10: PUBLIC HEALTH AND INFECTION CONTROL	Effective Date: 06/2017
CHAPTER 3	Revision Date:
10.3.2 TUBERCULOSIS SURVEILLANCE PROGRAM PROCEDURE	Attachments: Yes ☒ No ☐

I. PROCEDURE OVERVIEW

The California Correctional Health Care Services (CCHCS) in conjunction with the Division of Health Care Services (DHCS) and the California Department of Corrections and Rehabilitation (CDCR) has adopted guidelines for the assessment, screening, treatment, and containment of Tuberculosis (TB) in the correctional setting. These guidelines are consistent with community standards and the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

As required by Penal Code Sections 7570 to 7576, CCHCS has developed the following procedure to ensure that all patients receive the required annual TB surveillance, testing, education and medically necessary treatment consistent with the CCHCS TB Surveillance Care Guide, community standards and the recommendations of the ATS and CDC.

II. DEFINITIONS

Category "S" Patients: Patients who were transferred into a CDCR institution from county/city jails for reasons such as riots or an earthquake.

Latent Tuberculosis Infection: A TB infection that has not developed into disease. Most TB infections do not progress to TB disease. However, persons with Latent Tuberculosis Infection (LTBI) are at risk of developing TB disease throughout their lifetime and are at higher risk of developing TB disease in the first two years after becoming infected. Patients with LTBI who are immunocompromised are at even higher risk of developing TB disease in the first two years after becoming infected.

Recent Tuberculosis Infection: A TB infection detected within the past two years. The new infection can be detected on entry to prison, during annual screening, or during a contact investigation.

TB High Risk: Patients with a recent TB infection (diagnosed with TB infection within the past two years) who are not currently on TB infection treatment or did not complete a full course of TB infection treatment.

TB Low Risk: Patients who are not infected with Mycobacterium Tuberculosis (MTB) and patients with TB infections who have completed a full course of TB infection treatment or a full course of treatment for TB disease. Patients currently on TB infection treatment are considered low risk if they are being case managed as described in this procedure.

TB Medium Risk: Patients with remote TB infections (diagnosed with TB infection greater than two years ago) who have not completed a full course of TB infection treatment.

Tuberculosis Disease: A disease caused by bacteria known as MTB. TB is a treatable infectious disease that usually affects the lungs and airway, but may also affect other parts of the body. People with TB disease of the lungs or airway may be infectious to others until they have

received their initial phase of treatment with TB medications. People with TB disease in other parts of the body are not infectious to others.

III. RESPONSIBILITIES

A. Statewide

CDCR, DHCS, and CCHCS departmental leadership, at all levels of the organization shall ensure administrative, custodial, and clinical systems are in place and appropriate tools, training, technical assistance, and levels of resources are available to ensure the TB Surveillance Program is successfully implemented and maintained.

B. Regional

Regional Health Care Executives are responsible for implementation of this procedure at the subset of institutions within an assigned region.

C. Institutional

1. The Chief Executive Officer (CEO) has overall responsibility for implementation and ongoing oversight of the TB Surveillance Program at the institution and patient panel level. The CEO delegates decision-making authority to the Chief Medical Executive (CME) and the Chief Nurse Executive (CNE) for daily operations of the TB Surveillance Program and ensures adequate resources are deployed to support the system including, but not limited to, the following:
   a. Ensuring access to and utilization of equipment, supplies, health information systems, patient registries and other patient care tools and evidence-based guidelines.
   b. Ensuring new Care Team members, including other health care staff with a role in TB surveillance, are adequately prepared to assume team roles and responsibilities concerning the TB Surveillance Program.
   c. Assessing competence of existing Care Team members, including other health care staff with a role in TB surveillance.
   d. Providing updated procedures, roles, and responsibilities as new tools and technology become available.
   e. Ensuring that institutional leadership, in consultation with the CCHCS Public Health Branch, develop a Local Operating Procedure (LOP) to address the local implementation of the TB Surveillance Program within their institution.
   f. Implementing a quarterly review of all patients housed at the institution to ensure that each patient is participating in the TB Surveillance Program.
2. The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.
3. The CNE is responsible for the overall daily operations, oversight, and management of the TB Surveillance Program, processes, and resources, including personnel. The CNE shall ensure that the institution's Public Health Nurse (PHN) participates in all aspects of the TB Surveillance Program as described in the procedure below.
4. The institutional PHN, in conjunction with the designated TB Control Program Provider, shall act as the liaison between the institution and the CCHCS Public Health Branch for coordination of implementation and operational strategies, questions and concerns.

5. The CNE and CME, or their designees, shall meet to review the Care Teams' performance, including the overall quality of TB Surveillance Program services provided and shall utilize Dashboards, the Master Registry, Patient Summary, and other patient care and decision support tools to address or elevate issues as necessary.

IV. PROCEDURE

A. Reception Centers

1. Upon arrival to CDCR, all patients shall be evaluated and tested for TB.
   a. All patients shall be immediately screened for TB symptoms upon arrival at the Reception Center (RC) as part of the RC Screening Process.
   b. Placement and reading of Tuberculin Skin Tests (TST) must be completed within 72 hours of arrival for all newly arriving patients at RCs.
   c. Patients with a documented history of a positive TST with documented history of completing a full course of treatment for LTBI shall be screened for TB disease symptoms. Patients with a documented history of a positive TST without documented history of completing a full course of treatment for latent TB infection shall be screened for TB disease symptoms and receive a baseline chest x-ray.
   d. Patients with a history of a positive TST that cannot be documented shall be tested.
   e. Unless medically contraindicated, treatment for LTBI shall be considered if previous treatment was incomplete or inadequate.
2. Patients who exhibit signs or symptoms of TB disease during the screening/evaluation process shall wear a surgical mask and be referred to the Triage and Treatment Area (TTA) to be evaluated for TB disease.
3. All evaluations and testing for TB shall be recorded on a CDCR 7331, Tuberculin Testing Order/Report, or 7331 Powerform.

B. Interfacility Transfers

1. All patients arriving at a CDCR institution shall be immediately evaluated and receive symptom screening for TB disease as part of the transfer screening process.
   a. This includes patients who are transferred between CDCR institutions, who return from Out to Court, who return from a higher level of care, or who are short stay (enroute/layover) patients with no known recent exposure to an active TB patient.
   b. All Category "S" patients shall be evaluated and screened for symptoms of TB disease in accordance with the new arrival screening processes contained in the Interfacility Transfer Process pursuant to Inmate Medical Services Policies and Procedures.
   c. Patients transferring to/from Department of State Hospitals facilities shall have a symptom screening for TB disease only.
2. Patients who exhibit signs or symptoms of TB disease during the screening/evaluation process shall wear a surgical mask and be referred to the TTA to be evaluated for TB disease.
3. The results of the TB symptom screening shall be recorded on a CDCR 7331 or 7331 Powerform.

C. Annual Screening

1. All patients housed in a CDCR facility shall receive a TB evaluation annually. The type of evaluation shall be based on the TB status of the patient. All patients, regardless of their TB status shall be screened for the signs and symptoms of TB disease unless they have had a symptom screening for TB disease within the past 30 calendar days under one of the processes outlined in sections A or B above.
2. The following processes shall be used for conducting annual TB evaluations. Each institution shall develop an LOP to implement the tasks below if necessitated by institutional or operational needs, e.g., physical plant, staffing or other factors such as oversight of Fire Camps, Modified Community Correctional Facilities or other facilities.
   a. On at least a monthly basis, the institution PHN or Registered Nurse (RN) designee shall review the Quality Management (QM) TB registry and determine which patients are "DUE" (or overdue) for their annual TB evaluation.
   b. The Nursing Supervisor assigned responsibility for each care team shall coordinate with the Care Team(s) to ensure that all patients who are due or overdue for an Annual (or periodic) TB Evaluation are scheduled for the appropriate screening (refer to Attachment A).
      1) A Licensed Vocational Nurse or Psychiatric Technician may screen patients who have no history of a TB infection, or who have completed treatment for TB infection (LTBI treatment). The evaluation consists of a symptom screen for TB disease.
      2) An RN or PHN shall evaluate patients with TB infections who have not been treated, patients currently on treatment for TB infection, patients currently on treatment for TB disease, and patients who have completed treatment for TB disease.
         a) Symptom screening and education tailored to the patient's TB status shall be provided.
            i. All patients shall be educated about TB infection and disease.
            ii. Patients with untreated TB infection shall be encouraged to initiate and complete treatment for TB infection and encouraged to seek medical attention if they develop symptoms of TB disease.
            iii. Patients on treatment for TB infection shall be encouraged to complete the course of treatment, advised about possible side effects of treatment and encouraged to seek medical attention if they develop symptoms of TB disease or possible side effects. Patients on treatment for TB disease shall be encouraged to complete the course of treatment, advised about possible side effects of treatment and encouraged to seek medical attention if they develop symptoms of TB disease or possible side effects.
            iv. Education provided shall be noted in the comments section of the CDCR 7331 or 7331 Powerform.
         b) If during the patient education session the patient agrees to begin treatment for TB infection (LTBI treatment), the RN shall report the patient's decision to the PHN on the same day it is made. The patient

shall be referred by the RN to the Care Team Primary Care Provider (PCP) within seven calendar days for evaluation and initiation of treatment for TB infection (LTBI treatment). The PHN shall monitor the patient's care to ensure the referral and evaluation by the Care Team PCP occurs within seven calendar days.

3) Patients who exhibit signs or symptoms of TB disease during the screening/evaluation process shall wear a surgical mask and be referred to the TTA to be evaluated by a provider for TB disease.
4) The results of the TB screening shall be recorded on a CDCR 7331 or 7331 Powerform.

D. Monitoring and Sustainability

1. Institution leadership shall designate a standing committee reporting to the local QM Committee for oversight of the TB Surveillance Program activities.
2. The CEO and institution leadership team shall establish an ongoing monitoring program to periodically assess the quality of the TB Surveillance Program and adherence to this procedure including, but not limited to:
   a. Ensuring that each care team discusses surveillance program activities in the Population Management working sessions on a regular basis, i.e., at least monthly.
   b. Accuracy and efficacy of patient case management and appointment strategies.
   c. Compliance rates with required screening intervals based on patient TB risk levels.
   d. Documentation of TB Surveillance activities and necessary follow-up.
   e. Quality and documentation of patient education.
   f. Inclusion of other team members/disciplines to manage patient care and compliance.
   g. Information flow relative to required screening, referrals, and follow-up visits.
   h. Adverse events linked to TB Surveillance Program processes described in this procedure.
   i. Barriers.

E. Training and Decision Support

The CEO and institution leadership team shall establish an orientation and training program to ensure that all staff serving as members of a Care Team or supporting Care Team functions including other health care staff with a role in TB surveillance, fully understand their roles and responsibilities prior to assuming their duties. Elements of the program shall include, but are not limited to, review of:

1. Proper conduct of a TB Symptoms Review, referral requirements, and completion of the CDCR 7331 or 7331 Powerform.
2. Expectations in this procedure.
3. National health care industry advances pertinent to the TB Surveillance Program.
4. New information systems or technology that may increase the efficiency or effectiveness of the TB Surveillance Program.
5. Updates in clinical practice, including new or revised CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.
6. Training needs.

V. ATTACHMENT

- Attachment A: TB Screening and Evaluation Matrix

VI. REFERENCES

- California Penal Code, Chapter 8, Article 1, Title 8.7, Sections 3000-3456 and 7570-7576
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79805
- Centers for Disease Control and Prevention, Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm, July 7, 2006
- American Thoracic Society, https://www.cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf
- California Correctional Health Care Services, CCHCS Care Guide: Tuberculosis – Surveillance, December 2016
- Inmate Medical Services Policies and Procedures, Volume 4, Chapter 3.2, Health Care Transfer Procedure
- Inmate Medical Services Policies and Procedures, Volume 4, Chapter 2.2, Reception Health Care Procedure

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Attachment A

TB Screening and Evaluation Matrix

Cohort	TB Risk	Screening Type	Screening Location	Screening Frequency	Staff
Not infected	Low risk	Sign & symptom review	Yards or preventive care clinic	Yearly	LVN, PT
Infected, Completed LTBI treatment	Low risk	Sign & symptom review	Yards or preventive care clinic	Yearly	LVN, PT
Completed treatment for active TB	Low risk	Sign & symptom review Medical record review	Clinic	Yearly	RN or PHN
On LTBI or TB treatment	Low risk – if case managed	Case Management: -Sign & symptom review, -TB/LTBI education, -TB/LTBI medication administration, -Patient assessment, -PHN notified at beginning of treatment	Clinic	Depends on treatment regimen	PHN or RN
Remote infection (> 2 years), Not treated	Medium risk	Sign & symptom review, TB/LTBI education	Clinic	Yearly	RN or PHN
Recently infected (≤ 2 years), Not treated	High risk	Case Management: -Sign & symptom review, -TB/LTBI education, -PHN notified at beginning of treatment	Clinic	Q. month	PHN or RN
		CXR every 6 months x 24 months	Clinic	Q. 6 month x 24 months	