3.8.7 Tuberculosis Surveillance Program

(a) Procedure Overview

(1) California Correctional Health Care Services (CCHCS) and the California Department of Corrections and Rehabilitation (CDCR) shall maintain guidelines for the assessment, screening, treatment, and containment of tuberculosis (TB) in the correctional setting. These guidelines shall be consistent with community standards and the recommendations of the American Thoracic Society (ATS) and the Centers for Disease Control and Prevention (CDC).

(2) As required by Penal Code Sections 7570 through 7576, this procedure ensures that all patients receive the required annual TB surveillance, testing, education, and medically necessary treatment consistent with the CCHCS Tuberculosis- Surveillance Care Guide, community standards, and the recommendations of the ATS and CDC.

(b) Responsibility

(1) Statewide

CDCR and CCHCS departmental leadership, at all levels of the organization, within the scope of their authority, 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 maintained.

(2) Regional

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

(3) Institutional

(A) The Chief Executive Officer (CEO) has overall responsibility for the 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:

1. Access to and utilization of equipment, supplies, health information systems, Patient Registries and other patient care tools, and evidence-based guidelines.
2. New Care Team members including other health care staff with a role in TB surveillance are adequately prepared to assume team roles and responsibilities in the TB Surveillance Program.
3. Competence of existing Care Team members including other health care staff with a role in TB surveillance.
4. Procedures, roles, and responsibilities are updated as new tools and technology become available.
5. Institutional leadership, in consultation with the CCHCS Public Health Branch (PHB), develops a Local Operating Procedure (LOP) to address the application of the TB Surveillance Program within their institution.
6. Ongoing review by the Public Health Nurse (PHN) of all patients housed at the institution to confirm that each patient is participating in the TB Surveillance Program.

(B) The CME is responsible for the overall medical management of patients and ensures resources are available to meet the needs of the population.

(C) The CNE is responsible for the oversight of daily operations, and management of the TB Surveillance Program, processes, and resources including personnel. The CNE shall ensure that the institution's PHN participates in all aspects of the TB Surveillance Program as described in the procedure below.

(D) The institutional PHN, in conjunction with the responsible local Health Officer and/or designee, shall act as the liaison between the institution and the CCHCS PHB for coordination of operational strategies, questions, and concerns.

(E) 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, patient registries, patient summaries, and other patient care and decision support tools to address or elevate issues as necessary.

(c) Procedure

(1) Reception Centers

(A) Upon arrival to a CDCR Reception Center (RC), patients shall be screened and tested for TB unless there is documentation of a negative Interferon-Gamma Release Assay (IGRA) test or negative Tuberculin Skin Test (TST) in the prior 30 calendar days, or documentation of latent tuberculosis.

1. All patients shall be screened for TB symptoms upon arrival at the RC as part of the RC initial health screening process using the Initial Health Screening PowerForm and the TB Screening/Evaluation Report PowerForm in the Electronic Health Record System (EHRS). The CDCR 7277, Initial Health Screening (All Institutions), and CDCR 7331, Tuberculin Screening/Evaluation Report, paper forms shall be used during EHRS downtime periods to document symptom screening and health record review.
   a. Licensed health care staff (PHN, Registered Nurse [RN], Licensed Vocational Nurse [LVN], Psychiatric Technician [PT], or the Medical Assistant [MA]) shall:
      1) Question the patient about signs and symptoms of disease and previous TB history.
      2) Listen actively.
      3) Prompt the patient for additional information, if necessary.
      4) Allow time for questions.
      5) Refer to an RN or health care clinician if the patient has any signs or symptoms consistent with active TB disease.
2. Symptomatic Patients
   Patients with signs or symptoms of TB, regardless of any past IGRA test or TST result, shall wear a surgical mask and shall be transported to the Triage and Treatment Area (TTA) for further evaluation of active TB disease. The workup shall include a medical evaluation and, if clinically indicated, a chest ray (CXR) and sputum smears and cultures for Acid-Fast Bacilli (AFB). The results of the TB symptom screening shall be recorded on the Initial Health Screening PowerForm in EHRS.
   Refer to the current CCHCS Care Guide: Tuberculosis-Surveillance for details.
3. Asymptomatic Patients
   a. Patients with a prior negative IGRA test, negative TST, or unknown or inadequate documentation of TB infection status shall have an IGRA test drawn at the RC.
   b. An IGRA test is not indicated for patients with documented:
      1) History of an IGRA test interpreted as positive.
      2) TST with millimeter (mm) reading interpreted as positive at any time in the past.
      3) TST < 5 mm in the past 30 calendar days; with a high-risk condition.
      4) TST < 10 mm in past 30 calendar days; without a high-risk condition.
   c. Refer to the current CCHCS Care Guide: Tuberculosis-Surveillance for definition of high-risk conditions.
4. Human Immunodeficiency Virus (HIV) Infected
   a. Asymptomatic patients known to be HIV infected shall also receive a CXR within 72 hours of arrival unless their records contain documentation of a normal or stable CXR within the preceding 30 calendar days.
   b. Any HIV infected patient with a CXR abnormality that cannot be documented as stable for 60 or more calendar days by previous records with the exception of an isolated calcified granuloma or apical pleural thickening, shall be isolated and evaluated by a clinician even if asymptomatic.

(B) Workup for Positive Tests

A patient with a positive IGRA test or TST shall have a workup as follows:

1. A CXR shall be completed to assess for radiographic evidence of active TB disease within 72 hours for patients with the following:
   a. New positive IGRA test result.
   b. TST 5-9 mm result, with high risk condition.
   c. TST ≥ 10 mm, with or without high risk condition.
2. Refer to the current CCHCS Care Guide: Tuberculosis-Surveillance for definition of high-risk conditions.
3. After TB disease is ruled out by a CXR and a physical assessment by a health care provider, treatment for latent TB infection should be considered.

(C) Evaluation for CXR Findings Consistent with Active TB Disease

1. If the patient has an abnormal CXR consistent with TB, or if the CXR is normal but the patient has symptoms consistent with TB, the patient should wear a surgical mask and be sent to the TTA to be evaluated for TB disease.
2. Treatment for latent TB infection should be delayed until TB disease has been ruled out.

3. Sputum specimens for AFB smear and culture shall be obtained even when the radiographic abnormalities appear stable (excluding isolated calcified granulomas and apical pleural thickening).
4. Treatment for latent TB infection shall not be initiated until three culture results are documented as negative for TB disease.

(D) Documented Prior Positive IGRA Test or Prior Positive TST
Patients with written documentation of a positive IGRA or TST with a written record of an mm read and a positive interpretation of ≥5 mm with risk factors or ≥10 mm without risk factors shall:
1. If unable to confirm prior treatment of latent TB infection, within 72 hours of arrival at an RC, have a CXR and further workup as clinically indicated to rule-out TB disease before being encouraged to accept latent TB infection treatment.
2. Have a repeat CXR, if the prior CXR is unavailable or was taken more than six months before entry or re-entry into CDCR.
3. Be encouraged to accept treatment for latent TB infection if there is no documentation of treatment or if previous treatment was incomplete or inadequate.

(E) Documented Prior TB Disease
Patients with a history of prior TB disease shall be evaluated by a health care provider, and shall have a baseline CXR.

(2) Interfacility Transfers

(A) Patients arriving at a CDCR institution shall receive TB symptom screening pursuant to Section (c)(1)(A)1.a above to evaluate for TB disease as part of the transfer screening process.
1. 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.
2. All Category "S" patients (patients who transfer into a California Department of Corrections and Rehabilitation institution from county/city jails for reasons such as riots or a natural disaster) shall be evaluated and screened for symptoms of TB disease.
3. Patients transferring to/from Department of State Hospitals facilities shall have a symptom screening for TB disease only.

(3) Annual and other Periodic Screening

(A) Patients housed in a CDCR facility shall receive an annual TB evaluation based on the TB status of the patient. In addition, a patient may receive periodic screenings based on the status of TB infection treatment.

(B) The following processes shall be used for conducting annual TB evaluations. Each institution shall develop an LOP to operationalize the tasks below if necessitated by institutional or operational needs (e.g., physical plant, staffing or other factors such as oversight of Fire Camps or Modified Community Correctional Facilities).
1. The PHN or RN shall review the Quality Management (QM) TB registry at least monthly and determine which patients are due or overdue for their annual TB evaluation.
2. The Nursing Supervisor shall coordinate with the Care Team(s) to ensure that all patients who are due or overdue for an annual or periodicTB evaluation are scheduled for the appropriate screening (refer to Appendix 1).
   a. An LVN, PT, or MA may screen patients who have no history of a TB infection or who have completed a full course of treatment for TB infection. The evaluation consists of a thorough TB symptom screen for TB disease pursuant to Section (c)(1)(A)1.a above.
   b. 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.
      1) TB symptom screening and education tailored to the patient's TB status shall be provided.
         a) All patients shall be educated about TB infection and disease.
         b) 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.
         c) Patients on treatment for TB infection shall be:
            i. Encouraged to complete the full course of treatment,
            ii. Advised about possible side effects of treatment, and

iii. Encouraged to seek medical attention if they develop symptoms of TB disease or possible side effects.

d) Patients on treatment for TB disease shall be:
   i. Encouraged to complete the course of treatment,
   ii. Advised about possible side effects of treatment, and
   iii. Encouraged to seek medical attention if they develop side effects.

e) Education provided shall be documented in the health record.

2) If during the patient education session the patient agrees to begin treatment for TB infection, the RN shall notify the PHN of the patient's decision on the same day the decision is made. A routine referral to the Primary Care Provider (PCP) for evaluation and treatment of latentTB infection shall be made by the RN. The PHN shall monitor the patient's care to ensure the referral and evaluation by the Care Team PCP occurs within fourteen calendar days.

c. 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.

d. The results of the TB screening shall be documented on the Initial Health Screening PowerForm and in the health record.

(4) Monitoring and Sustainability

(A) Institution leadership shall designate a standing committee that reports to the local QM Committee for oversight of the TB Surveillance Program activities.

(B) The CEO and institution leadership team shall maintain an ongoing monitoring program to periodically assess the quality of the TB Surveillance Program and adherence to this procedure including, but not limited to:

1. Ensuring that each Care Team discusses surveillance program activities in the Population Management Working Sessions at least monthly.
2. Verifying accuracy and efficacy of patient case management and appointment strategies.
3. Monitoring compliance rates with required screening intervals based on patient TB risk levels.
4. Ensuring documentation of TB Surveillance activities and necessary follow-up.
5. Monitoring quality and documentation of patient education.
6. Ensuring inclusion of other team members/disciplines to manage patient care and compliance.
7. Reviewing information flow relative to required screening, referrals, and follow-up visits.
8. Monitoring adverse events linked to TB Surveillance Program processes described in this procedure.
9. Identifying and addressing barriers.

(5) Training and Decision Support

The CEO and institution leadership team shall maintain 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. Requirements of the training program shall include, but are not limited to:

(A) Adhering to expectations in this procedure.

(B) Monitoring national health care industry advances pertinent to the TB Surveillance Program.

(C) Following new information systems or technology that may increase the efficiency or effectiveness of the TB Surveillance Program.

(D) Monitoring updates in clinical practice, including new or revised CCHCS guidelines, standing orders, nursing protocols, industry best practices, and findings in clinical literature.

(E) Identifying and addressing additional training needs.

(F) Specifying clinical training including, but is not limited to:

1. Training RNs, LVNs, PTs, and MAs to be competent in:
   a. Performing a TB symptom screen of patients and documenting in the Health Record.
   b. Locating IGRA blood test results in EHRS. Patients with a positive IGRA blood test shall have Latent Tuberculosis Infection (LTBI) listed on the Problem List in EHRS. Upon completion of LTBI treatment "Resolved" shall be documented next to LTBI on the Problem List in EHRS.
   c. Administering and measuring TSTs for patients in accordance with the CCHCS Tuberculosis-Surveillance Care Guide and documenting the results in the health record.
   d. Administering medication to patients on treatment for TB disease or TB infection.

2. Training RNs and PHNs to also be competent in:
   a. Ensuring that patients are screened yearly in accordance with the CCHCS Tuberculosis- Surveillance Care Guide.
   b. Reviewing the health record and accurately documenting previous TB testing and TB diagnoses.
   c. Educating patients regarding the importance of:
      1) LTBI treatment for TB infection.
      2) Treatment for TB disease.

Appendices

- Appendix 1: TB Screening and Evaluation Matrix

References

- California Health and Safety Code, Division 105, Part 5, Chapter 1, Sections 121361-121375
- California Penal Code, Part 3, Title 8.7, Examination of Inmates and Wards for Tuberculosis, Sections 7570-7576
- California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Sections 2500-2505
- California Code of Regulations, Title 22, Division 5, Chapter 12, Article 5, Section 79805, Inmate-Patient Health Record Content
- Centers for Disease Control and Prevention, Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC (July 7, 2006): https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm
- Centers for Disease Control and Prevention, Tuberculosis Fact Sheets, Tuberculin Skin Testing: https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
  Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis: https://www.cdc.gov/tb/publications/guidelines/pdf/clin-infect-dis.-2016-nahid-cid_ciw376.pdf
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.8, Reception Center
- Health Care Department Operations Manual, Chapter 3, Article 1, Section 3.1.9, Health Care Transfer
- CCHCS Care Guide: Tuberculosis-Surveillance
- CCHCS Care Guide: Tuberculosis Diagnosis and Isolation
- CCHCS Care Guide: Tuberculosis Disease
- CCHCS Care Guide: TB Infection Management
- CCHCS Care Guide: TB Contact Investigation

Revision History

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Appendix 1

TB Screening and Evaluation Matrix

Cohort	TB Risk	Screening Type	Screening Location	Screening Frequency	Staff
Not infected	Low risk	Signs and symptoms review	Yard clinic or preventive care clinic	Yearly	LVN PT or MA
Infected, Completed LTBI treatment	Low risk	Signs and symptoms review	Yard clinic or preventive care clinic	Yearly	LVN PT or MA
Completed treatment for active TB	Low risk	Signs and symptoms review Health record review	Clinic	Yearly	RN or PHN
On LTBI or TB treatment	Low risk – if case managed	Case Management:-Signs and symptoms 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	Signs and symptoms review TB/LTBI education	Clinic	Yearly	RN or PHN
Recently infected (≤ 2 years) Not treated	High risk	Case Management: -Signs and symptoms review -TB/LTBI education -PHN notified at beginning of treatment	Clinic	Every month	RN or PHN
		CXR	Clinic	Every 6 months x 24 months	

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