



## CDPH/CTCA Joint Guidelines

***Guidelines for Coordination of  
TB Prevention and Control by  
Local and State Health Departments and  
California Correctional  
Health Care Services  
2015***

These guidelines are intended to be used as an educational aid to help clinicians make informed decisions about patient care. The ultimate judgment regarding clinical management should be made by the health care provider in consultation with their patient, in light of clinical data presented by the patient and the diagnostic and treatment options available. Further, these guidelines are not intended to be regulatory and not intended to be used as the basis for any disciplinary action against the health care provider.

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## **Preface**

The following guidelines have been developed by the California Tuberculosis Controller's Association (CTCA) guidelines workgroup composed of members from local health departments, the California Department of Public Health (CDPH), Tuberculosis Control Branch (TBCB) and the California Correctional Health Care Services (CCHCS), Public Health Branch (PHB). These guidelines are endorsed by the California Department of Public Health, Tuberculosis Control Branch, the California Tuberculosis Controllers Association and the California Correctional Health Care Services, Public Health Branch.

The purpose of this guideline is to improve the continuity of care of state prison inmates with known or suspected tuberculosis (TB) during and after incarceration, and to ensure the prompt and thorough evaluation of their contacts in the community and in correctional facilities. This guideline defines the roles and responsibilities for carrying out the needed activities by prison and health jurisdiction staff at the local and state levels. Discretionary roles and actions are derived from references listed at the end of the document. The Chief Medical Executive (CME) and/or designee is responsible to oversee the clinical management and ensure the timely reporting of suspect and confirmed TB cases. The correctional facility public health nurse (PHN) as designated by their Chief Nurse Executive (CNE) and CME has primary responsibility for submission of the TB reporting forms, providing case management and managing contact investigations.

## **NOTES FOR THIS GUIDELINE**

THERE ARE IMPORTANT ACRONYMS USED TO IDENTIFY THOSE RESPONSIBLE FOR IMPLEMENTING SPECIFIC TASKS. PLEASE REFER TO PAGE 20-21, FOR THE DEFINITION AND INFORMATION FOR ALL OF THESE ACRONYMS.

GREY TEXT BOXES CONTAINING PARTIAL SECTIONS OF THE CALIFORNIA CODE OF REGULATIONS (CCR) OR THE HEALTH AND SAFETY CODE (HSC) ARE LOCATED PRIOR TO THE SECTIONS THAT THEY PERTAIN TO. REFER TO PAGE 22 FOR THE COMPLETE REFERENCE.

## SECTION 1: REPORTING

### California Code of Regulations (CCR) Title 17 Section 2500

#### TB Reporting to the Local Health Authority

(b) It shall be the duty of every health care provider knowing of or in attendance on a case or suspected case [of TB] to report to the local health officer for the jurisdiction where the patient resides by mailing, telephoning or electronically transmitting a report within (1) working day of identification of the case or suspected case. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from [TB] may make such a report to the local health officer for the jurisdiction where the patient resides.

(c) The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.

(d) Each report pursuant to (b) shall include all of the following if known:

(1) name of the disease or condition being reported, the date of onset, the date of diagnosis; the name, address, telephone number, occupation, race/ethnic group, Social Security number, sex, age, and date of birth for the case or suspected case; the date of death if death has occurred; and the name, address, and telephone number of the person making the report.

(2) The report shall [also] include information on the diagnostic status of the case or suspected case; bacteriologic, radiologic, and tuberculin skin test findings; information regarding the risk of transmission of the disease to other persons, and a list of the anti-tuberculosis medications administered to the patient.

(j) Health care providers shall report TB outbreaks immediately by telephone.

**Note:** Suspect TB cases include any person begun on multi-drug anti-tuberculosis (TB) therapy; or who has an acid fast bacilli (AFB) smear positive specimen; **or** clinical history or findings; **or** chest x-ray suggestive of tuberculosis (2). Refer to *CDPH/CTCA Joint Guidelines for Reporting Tuberculosis Suspects and Cases in California* for further examples of TB cases and suspect cases.

**I. The Chief Medical Executive (CME) of each prison will ensure that California Correctional Health Care Services (CCHCS) health care providers from their facility:**

A. Follow mandatory reporting requirements in CCR Title 17, Section 2500 to the Responsible Local Health Officer (RLHO)/Responsible Local Health Department (RLHD) (see above text box).

- B. Take action to respond to activities required of the RLHD/CDPH listed in section II Local Health Department below.
- C. Utilize the California Correctional Health Care Services (CCHCS) California Department of Corrections and Rehabilitation (CDCR) "Correctional Facility TB Patient Plan" (CFTP), mutually agreed upon local form, or the Confidential Morbidity Report (CMR), that is used to report suspected or confirmed cases of TB to RLHD. The CMR can be found on the CDPH/TBCB website: <http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx>. (18)
- D. Promptly request immediate consultation with the CCHCS PHB, the RLHO and the CDPH Tuberculosis Control Branch's Outbreak Duty Officer (510) 620-3000 for any cluster of TB cases or suspects diagnosed at the same institution within 90 days of each other.
- E. Also see Section 2: **Case Monitoring, Tracking, Oversight of Suspect and Confirmed Cases.**

**II. Responsible Local Health Department (RLHD) will:**

- A. Designate a correctional liaison/TB case manager for coordination, review, and support of TB activities involving current and former inmates of correctional facilities.
- B. Inform prison of reporting requirements (2), and supply needed forms (e.g., the TB specific CMR or RLHD reporting form) which can be found on the CDPH/TBCB website.
- C. Follow up on any instance of non or delayed reporting and request a corrective action plan from the Responsible Chief Medical Executive (RCME), or their designee, to prevent this from occurring in the future.
- D. Assist prison staff as needed in obtaining required/requested case information so that they can notify the assigned parole agent as required in California Health and Safety Code Section 121362 (see text box below).

## SECTION 2: CASE MONITORING, TRACKING, OVERSIGHT OF SUSPECT AND CONFIRMED CASES

### California Health and Safety Code (HSC) Sections 121361(a)(1) and 121362

#### TB Treatment Plan, Case Management and Continuity of Care

**121361 (a)(1)** A health facility, local detention facility, or state correctional institution shall not discharge, release, or transfer a person known to have active tuberculosis disease [or] a person who the medical staff of the facility or the penal institution has reasonable grounds to believe has active tuberculosis disease [until] notification and a written treatment plan pursuant to HSC Section 121362 has been received by the local health officer.

**121362.** Each health care provider who treats a person for active tuberculosis disease, each person in charge of a health facility, or each person in charge of a clinic providing outpatient treatment for active tuberculosis disease shall promptly report to the local health officer at the times that the health officer requires, but no less frequently than when there are reasonable grounds to believe that a person has active tuberculosis disease, and when a person ceases treatment for tuberculosis disease.

The initial disease notification report shall include an individual treatment plan, that includes the patient's name, address, date of birth, tuberculin skin test result or the results of any other test for tuberculosis infection recommended by the federal Centers for Disease Control and Prevention and licensed by the federal Food and Drug Administration, pertinent radiologic, microbiologic and pathologic reports, whether final or pending, and any other information required by the local health officer. Subsequent reports shall provide updated clinical status and laboratory results, assessment of treatment adherence, name of current care provider if the patient transfers care, and any other information required by the local health officer.

A facility discharge, release, or transfer report shall include all pertinent and updated information required by the local health officer not previously reported on any initial or subsequent report, and shall specifically include a verified patient address, the name of the medical provider who has specifically agreed to provide medical care, clinical information used to assess the current infectious state, and any other information required by the local health officer.

Each health care provider who treats a person with active tuberculosis disease, and each person in charge of a health facility or a clinic providing outpatient treatment for active tuberculosis disease, shall maintain written documentation of each patient's adherence to his or her individual treatment plan.

In the case of a parolee under the jurisdiction of the Department of Corrections and Rehabilitation, the local health officer shall notify the assigned parole agent, when known, or the regional parole administrator, when there are reasonable grounds to believe that the parolee has active tuberculosis disease and when the parolee ceases treatment for tuberculosis. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.

**California Health and Safety Code (HSC) Section 121361 (e)**

**Transfer, Release or Parole of Persons with TB**

(e)(1) Any discharge, release, or transfer may occur only after notification and a written treatment plan pursuant to Section 121362 has been received by the local health officer. When prior notification would jeopardize the person's health, the public safety, or the safety and security of the penal institution, the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer.

(2) When a person is released on parole from a state correctional institution, the notification and written treatment plan specified in this subdivision shall be provided to both the local health officer for the county in which the parolee intends to reside and the local health officer for the county in which the state correctional institution is located.

(3) CDCR shall inform the parole agent, and other parole officials as necessary regarding the need for evaluation and treatment. The parole agent and other parole officials shall coordinate with the local health officer (LHO) in supervising the person's compliance with medical evaluation or treatment, and shall notify the LHO if the person's parole is suspended as a result of having absconded from supervision.

**I. The Responsible Chief Medical Executive (RCME) will ensure that California Correctional Health Care Services (CCHCS) health care providers from their facility follow mandatory requirements in the Health and Safety Code (HSC) (see above text boxes) and:**

- A. Maintain written and or electronic documentation of the patient's adherence to the treatment plan, order directly observed therapy (DOT) for inmate TB cases and suspects (8,13) and provide the Responsible Local Health Department (RLHD) clinical updates.
- B. Provide current clinical information for their TB cases and suspects to the CCHCS, Public Health Branch (PHB) so that the CCHCS-PHB electronic data system is regularly updated to include the following minimal information for their class 3 and 5 inmates. (TST, chest radiograph, laboratory results, treatment, movement, etc.) This system must retain the TB case information for the inmates' entire duration of custody and for at least 5 years after their date of diagnosis.
- C. Contact the RLHD to assist with verifying prior TB treatment if the patient gives a history of TB treatment outside of the CDCR facility.
- D. Provide the needed information or access to the medical record to the requesting RLHD within 2 working days of the initial request.
- E. Report to the RLHD and to the Chief Medical Executive (CME) or their designee of

the receiving prison facility, when an inmate with known or suspected TB transfers to a different CDCR facility in or out of jurisdiction.

- F. Notify their LHD upon receiving an inmate with known or suspected TB from another state prison or local jail.
- G. Have a plan in place to take corrective action when problems with case management occur.
- H. Ensure that inmates with known or suspected TB are not returned to the prison facility from a health care facility until the criteria stated in the current *CDPH/CTCA Joint Guidelines for the Assessment of TB Patient Infectiousness and Placement into High and Lower Risk Settings* are met. [Unless the prison provides respiratory (atmospheric) isolation meeting the minimum requirements contained in reference 15. Continuous monitoring of respiratory isolation rooms located in the prison is recommended.]
- I. Work proactively with community health facilities treating inmates with known or suspected active TB disease to ensure that they report and provide a treatment plan to the RLHD before such persons are transferred back to a state correctional facility.
- J. In addition to following mandatory requirements in HSC 121361(e) when an inmate TB case or suspect is scheduled to be transferred, released or discharged do the following:
  - 1. Obtain and verify locating information, name of medical provider who has agreed to provide care, and transmit this and any other information required by the local health officer to the RLHD.
  - 2. Obtain parole office and agent's name and phone number.
  - 3. Make an appointment for the patient's TB follow up with the local health department in the jurisdiction to which s/he is discharged.
  - 4. Arrange for DOT.
  - 5. Make compliance with TB treatment a condition of parole.
- K. Meet at least annually with LHD staff in their jurisdiction to review TB control activities and interactions.

## **II. Responsible Local Health Department (RLHD) will:**

- A. Initiate suspect or case files and maintain a registry for CDCR inmates that are Class 3 TB cases and TB 5 high suspects.



- B. Review the initial report to ensure required information is complete, and initial treatment regimen and management are appropriate. Should contact the provider within 3 working days to get additional information as needed on the reported TB suspect/case and use this opportunity to inform the provider who the RLHD case manager assigned will be and offer assistance if needed.
- C. Define with the Responsible State Prison (RSP), their Responsible Chief Medical Executives (RCME)s and their providers:
1. How the information for the Report of a Verified Case of TB (RVCT), initial and follow up 1 and 2, will be obtained. This includes all needed medical information, the patient interview outcome, and contact information. If this information is not provided in a timely manner by the RSP public health staff or CCHCS-PHB, then proceed with obtaining clearance to do an on-site record review and patient interview at the prison where the inmate is housed. Once all information is obtained from the prison, complete the RVCT. This electronic RVCT form can be found on the CDPH/TBCB website:  
<http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx> . (18)
  2. How to follow up with the prison for updated clinical status.
  3. How to follow up if information received indicates a problem, such as failure of sputum conversion to culture negative, or inappropriate treatment regimen.
- D. Review local medical records and contact other health departments when indicated, to attempt to verify history of TB treatment.
- E. Ensure that the index patient interview is conducted within the timeframes (listed in Section 3 below) of receipt of the initial report to:
1. Obtain RVCT information.
  2. Determine infectious period.
  3. Elicit community contacts and contacts in other facilities that were exposed during the index cases infectious period (see Section 3 below).
  4. Provide CCHCS staff with any needed TB patient education materials.
  5. Initiate discharge planning, including obtaining locating information should the inmate be released or paroled before completion of treatment (See **Case Monitoring, Tracking, Oversight of Suspect and Confirmed Cases**, Section 2 [K-N] ).
- F. Use information from the Correctional Facility TB Patient Plan (CFTP) that is sent to

the RLHD by fax to obtain the necessary information to complete the RVCT to comply with CCR Title 17 Section 2501, or:

1. Contact the prison medical staff by telephone or fax to request the additional needed information.
  2. If the prison medical staff is unable to respond in a timely fashion, request access to the prison medical record by contacting the CCHCS-PHB. They will either obtain the needed medical information or will assist the RLHD staff with getting access to the prison so that the medical record can be reviewed within two business days of the request.
  3. If additional assistance is needed, contact the CDPH, TB Control Branch Correctional Liaison and ask for assistance with obtaining the necessary information at (510) 620-3000.
- G. Obtain subsequent reports every one to three months (or more frequently if required) to ensure completion of treatment.
- H. Contact the physician (employed by CCHCS and/or contracted as working within CDCR) designated by the facility RCME directly if:
1. The subsequent report is not received or is incomplete.
  2. The patient's isolate is drug resistant.
  3. There is lack of improvement or worsening on chest x-ray, smear/culture, or clinical status of patient.
  4. The treatment plan is not in accordance with established standards. (5 ,6, 8, 9)
  5. The patient is non-adherent.
  6. Sputum conversion to culture negative is not documented within first three months.
  7. The patient is suspected to be infectious but is not isolated in an airborne infection isolation room (AIIR).
- I. Notify, prior to discharge, the local health officer of the destination jurisdiction if inmate is moving, transferring, or is hospitalized in another jurisdiction outside the RLHD (7). Complete the NTCA Interjurisdictional TB Notification (ITN) form for this purpose. This form can be found on the CDPH/TBCB website:  
<http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx>. (18)
- J. Assist the prison in discharge planning (except when prior notification would

jeopardize the person's health, the public safety, or the safety and security of the penal institution, then the notification and treatment plan shall be submitted within 24 hours of discharge, release, or transfer)(3) to ensure continuity of care if the inmate is being released or paroled:

1. Transmit the inmate's locating information to the appropriate receiving jurisdiction.
2. Transmit the parole office and agent's name and phone number to the appropriate receiving jurisdiction.
3. Ensure the inmate has an appointment for their TB follow up at the local health department in the jurisdiction to which s/he is discharged.
4. Prepare to issue a Health Officer's legal order for TB examination pursuant to HSC 121365 (a) upon the inmate's release, if indicated, and
5. Arrange for DOT in the appropriate jurisdiction.

**CCR Title 15, Div. 1, Chap. 1, Article 11, Section 1206.5 (a)**

**Local Detention Facility Responsibility**

(a) The responsible physician, in conjunction with the facility administrator and the county health officer, shall develop a written plan to address the identification, treatment, control and follow-up management of communicable diseases including, but not limited to, tuberculosis and other airborne diseases. The plan shall cover the intake screening procedures, identification of relevant symptoms, referral for a medical evaluation, treatment responsibilities during incarceration and coordination with public health officials for follow-up treatment in the community. The plan shall reflect the current local incidence of communicable diseases which threaten the health of inmates and staff.

- K. Work with the local sheriff and jail health authority to ensure that transfers from local jails to state prisons include medical information required under CCR Title 15, Div.1, Chap. 1, Article 11 Sections 1206 and 1206.5 and that transfers and releases of jail inmates with known or suspected TB occur in accordance with HSC Section 121361.
- L. The RLHO from the RLHD shall notify their local parole region to inform them that an inmate will parole that has active TB or when they cease treatment for TB. Situations where the local health officer may conclude that the parolee has ceased treatment include times when the parolee fails to keep an appointment, relocates without transferring care, or discontinues care.
- M. Oversee the care provided to inmates in community hospitals (6, 8, 9) and ensure

that community hospital physicians follow established CDPH/CTCA criteria (6) when releasing inmates with suspected or confirmed infectious TB from AFB isolation [as per Case Monitoring, Tracking, Oversight of Suspect and Confirmed Cases, Section 2 (G,H)]. **If the inmate is hospitalized in a different jurisdiction than the RSP, the LHO in that jurisdiction is responsible for overseeing the care and approving the discharge of the inmate.**

- N. Advise that the community hospital staff notify the LHO in that jurisdiction prior to transfers back to the correctional facility as provided in HSC Section 121361. That LHO should contact the RLHO to inform them about the transfer prior to it happening.
- O. Meet at least annually with correctional facility staff to review TB control activities and interactions.
- P. Assign a case manager to co-manage all TB cases and suspects with the RSP PHN.

### **SECTION 3: CONTACT IDENTIFICATION, EVALUATION AND FOLLOW-UP**

- I. **California Correctional Health Care Services, Public Health Branch (CCHCS-PHB) will provide the following to the Responsible Chief Medical Executive (RCME) of a prison where a culture-confirmed, rapid diagnostic test-confirmed, or high-suspect pulmonary, laryngeal or pleural TB case is identified:**
  - A. Clinical and case management consultation.
  - B. Assistance with collecting contact location and movement history during the infectious period to identify contacts with greater proximity and duration of exposure to the index case or suspect and to locate contacts during Phase I (first round) and Phase II (second round) TB testing/evaluation.
  - C. Assistance with gathering index case or suspect information, inmate and non-inmate contact information, contact investigation summaries, determining the overall inmate contact conversion rate for contact investigations in individual prisons or where exposure and/or contact movement during TB testing/evaluation involves multiple prisons.
  - D. Evaluation of the contact investigation to determine if it is complete or if it needs to be expanded.
- II. **The Responsible Chief Medical Executive (RCME) and PHN of the Responsible State Prison (RSP)**

- A. In consultation with the responsible local health department (RLHD) and the CCHCS-PHB, will initiate a contact investigation among inmates when an inmate/patient is being treated for confirmed active TB (TB 3) (see tables on pages 13-14).
- B. In consultation with the RLHD and the CCHCS-PHB will initiate a contact investigation if the inmate is considered a TB 5 high suspect due to presumed pulmonary, laryngeal, or pleural TB, and is started on multi-drug treatment and is found to have at least one of the following: (see table on pages 13-14)
1. Respiratory specimen that is AFB smear positive and either NAAT positive or NAAT not done and culture pending.
  2. Respiratory specimen that is AFB smear negative and NAAT positive and culture pending.
- C. Consult with the RLHD as needed if a patient is a TB 5 low and has not been started on TB medication for active TB disease, but does have all of the following:
1. Three (3) respiratory specimens that are all AFB smear negative, at least one specimen that is NAAT negative (and no other NAAT positive specimens), and *Mycobacterium tuberculosis* culture pending.
  2. No cavitory lesions on chest radiograph.
  3. No respiratory symptoms.
  4. Most recent HIV test in the past last 6 months is NEGATIVE

# Initiating a Contact Investigation In California State Prisons

Adapted from the CDPH/CTCA "Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis"

## Timeframes for initial follow-up of persons exposed to tuberculosis

TB Classification	Index Case Characteristics	Decision to initiate a contact investigation	Minimal recommendation for beginning of the likely period of infectiousness	Business days from listing of a contact to initial encounter	Business days from initial encounter to complete medical evaluation *
<b>TB 3</b> <b>Culture-confirmed pulmonary, laryngeal or pleural TB from a respiratory specimen (sputum, or bronchial fluid or identified lung tissue biopsy)</b>	<b>1. Inmate patient with at least one of the following:</b>  a. Positive AFB smear on a respiratory specimen, or NAAT positive b. Cavitory CXR or c. TB Symptoms	<p style="text-align: center;"><b><u>Always</u></b></p> <p style="text-align: center;"><b>Consult with your local health department</b></p>	<p><b>3 months prior</b> to symptom onset or first positive findings (e.g. abnormal chest radiograph) consistent with TB disease, whichever is longer</p>	<p><b>High priority contact</b> <i>3-5 days</i></p> <p><b>Medium priority contact</b> <i>14 days</i></p>	<p><b>High priority contact</b> <i>5 days</i></p> <p><b>Medium priority contact</b> <i>10 days</i></p>
	<b>2. Inmate patient with all of the following:</b>  a. Negative AFB smears <b>and</b> b. No cavitory lesions on CXR <b>and</b> c. NO TB symptoms	<p style="text-align: center;"><b><u>Always</u></b></p> <p style="text-align: center;"><b>Consult with your local health department</b></p>	<p><b>4 weeks prior</b> to date of diagnosis as a confirmed case</p>	<p><b>High priority contact</b> <i>7 days</i></p> <p><b>Medium priority contact</b> <i>14 days</i></p>	<p><b>High priority contact</b> <i>10 days</i></p> <p><b>Medium priority contact</b> <i>10 days</i></p>

\*Comments on prioritizing high priority contacts:

- Symptomatic contacts need immediate referral and evaluation, regardless of type of contact or index case characteristics
- High priority contacts at highest risk for progression from TB infection to disease or increased severity of TB disease should be evaluated as quickly as possible

# Initiating a Contact Investigation In California State Prisons

Adapted from the "CDPH/CTCA Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis"

## Timeframes for initial follow-up of persons exposed to tuberculosis

TB Classification	Index Case Characteristics	Decision to initiate a contact investigation	Minimal recommendation for beginning of the likely period of infectiousness	Business days from listing of a contact to initial encounter	Business days from initial encounter to complete medical evaluation*
				High priority contact <i>3-5 days</i> Medium priority contact <i>14 days</i>	High priority contact <i>5 days</i> Medium priority contact <i>10 days</i>
<b>TB 5</b> High suspicion (culture pending) for Pulmonary, laryngeal, Or pleural TB, <u>started on presumptive treatment for active TB disease</u>	<b>1. Inmate patient with at least <u>one</u> of the following:</b>  a. Positive AFB smear on a respiratory specimen <b>and</b> NAAT positive or NAAT not done. <b>or</b> b. 3 negative AFB smears and 1 NAAT positive on a respiratory specimen.	<b><u>Always</u></b>  <b>Consult with your local health department</b>	<b>3 months prior</b> to symptom onset or first positive findings (e.g. abnormal chest radiograph) consistent with TB disease, whichever is longer		
<b>TB 5</b> High suspicion (culture pending) for pulmonary, laryngeal, or pleural TB and <u>started on presumptive treatment for active TB disease</u>	<b>2. Inmate patient with <u>all</u> of the following:</b>  a. <b>Three</b> negative AFB smears <b>and</b> b. 1 NAAT negative on a respiratory specimen c. No cavities on CXR and d. No respiratory signs or symptoms	<b>Consult with local health department to determine if a contact investigation is recommended</b>	<b>4 weeks prior</b> to date of presumptive diagnosis as a TB case	<b>High priority contact</b> <i>7 days</i>  <b>Medium priority contact</b> <i>14 days</i>	<b>High priority contact</b> <i>10 days</i>  <b>Medium priority contact</b> <i>10 days</i>
<b>TB 5</b> Low suspicion (culture pending) for pulmonary, laryngeal, or pleural TB, <u>not started on presumptive treatment for active TB disease</u>	<b>3. Inmate patient must have <u>all</u> of the following:</b>  a. 3 negative AFB smears <b>and</b> b. 1 negative NAAT <b>and</b> c. No cavities on CXR <b>and</b> d. Most recent HIV test is negative, and was taken in the past 6 months <b>and</b> e. No respiratory signs or symptoms	<b>A contact investigation is not indicated, If respiratory specimens are subsequently culture positive for MTB, follow guidelines for TB 3</b>			
<b>TB 3 or 5</b> extrapulmonary	No pulmonary or laryngeal or pleural involvement	Not indicated	Not applicable	Not applicable	

- D. Will ensure that the index case or suspect is interviewed using the CCHCS CI toolkit. (To obtain this toolkit contact the CCHCS PHB (916) 691-9901 or the CDPH, TBCB Correctional Liaison 510-620-3000).
1. Within 3 business days of identification by correctional medical staff, if the case is currently located within the correctional facility; or,
  2. Within 5 business days of identification, in coordination with the RLHD if the case is currently located in a community hospital; or
  3. Within 7 business days of identification, in coordination with the RLHD if the case is currently located in an out-of-jurisdiction hospital.
- E. Will ensure within 3 business days of interviewing the index case or suspect that:
1. The interview will be summarized in writing using the CCHCS CI Toolkit mentioned previously and will include:
    - a. The index case or suspect's symptom history.
    - b. The index case or suspect's housing and movement history, and activities within CDCR and in the community or other detention facility while infectious.
- F. Will ensure that within 2 business days of completing the interview, documentation and summary, in consultation with the RLHD and the CCHCS-PHB that the:

**NOTE: This process should include recommendations and assistance from the prison custody administrators including the warden and others who can use electronic data systems to identify those actually exposed. Use the CCHCS CI toolkit, Inmate Contact Roster and populate it with as much personal and medical information on each of the known inmate contacts prior to the planned screening activities.**

1. The infectious period will be determined.
2. The high-priority contact groups/cohorts (including HIV-infected, medical high-risk, close contacts, and housing contacts) that were exposed to the TB case during the identified infectious period are identified per the CTCA/CDPH Contact Investigation Guidelines. (14)
  - a. Develop a strategy with assistance from the CCHCS-PHB and the RLHD for the identification, prioritization, and testing/evaluation of inmate and non-inmate contacts within the prison and for those inmates that have transferred to other prisons and non- inmate contacts who work or volunteer in the prison



but reside in the community,

- b. Create a list of inmate contacts (use the CCHCS CI Toolkit, Contact Roster mentioned previously),
- c. Create a list of non-inmate or employee contacts (consult the CCHCS-PHB for the blank roster and current procedures for follow up of non-inmate contacts).

G. Will ensure that once the inmate contact list is created, that the inmate contacts:

1. Still residing in the responsible state prison (RSP):
  - a. Begin their TB screening and evaluation process within 5 business days of identification and are fully evaluated in a timely fashion. Use the CCHCS CI Tool Kit and contact roster mentioned previously to document evaluation information.
2. Residing in another CDCR facility and have been confirmed by that facility's PHN that they are the exposed persons.
  - a. These contacts will begin their TB screening within 5 days of the notification and be fully evaluated in a timely fashion,
  - b. Evaluation data for these inmate contacts is gathered by the PHN in the current facility and shared in a timely fashion with the CCHCS-PHB,
3. That have been paroled, on probation or released to the community.

**NOTE: If the inmate's parole/probation information and address in the community is not easily obtained, seek assistance from the CDPH, TBCB Correctional Liaison at (510) 620-3000.**

- a. If the contact is residing in the county where the exposure occurred, the RLHD will attempt to locate them within 5 business days of the notification regarding their exposure and will arrange for their evaluation in a timely fashion. Once fully evaluated, the RLHD will share results with the CCHCS-PHB and the RSP.
- b. If the contact resides outside of the county where the exposure occurred, within 5 business days of obtaining locating information, the RLHD should begin the notification process to the receiving LHD using the NTCA Interjurisdictional TB Referral form (ITN) that can be found on the CDPH, TBCB website.

<http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx>.

- c. Once the contact has been fully evaluated, the information should be provided back to the RLHD who will share it with the CCHCS-PHB and the RSP.

**NOTE: When a contact is initiated for follow-up in the community anywhere outside of the RLHD, the NTCA Interjurisdictional TB Referral form (ITN) should be used; the following must be written on the form:**

- i. The index case's clinical characteristics.
  - ii. If known, the contact's complete name and DOB, medical risk factors, last known exposure to the index case, proximity and duration of exposure, address, work information and other important information.
4. Parole region and parole officer will be identified by the RSP PHN and will be notified of the contact's need for evaluation, (as required in the California Penal Code Section 7570).
- H. Will ensure that the CCHCS-PHB will take the lead on identifying which employees, contractors, volunteers and visitors need to be evaluated because they were exposed to an infectious case of TB.
1. These non-inmate contacts will be put onto a non-inmate contact roster within 10 business days after completing the patient interview.

**NOTE: The Warden and other employers of the prison where the index case was incarcerated when diagnosed and any other prison(s) where exposure occurred will follow current internal procedures for evaluating these contacts. However, if some contacts choose to be evaluated by their LHD or alternate provider, their evaluation information must be shared with the CCHCS-PHB and entered onto the non-inmate contact roster.**

2. CCHCS-PHB will consult and work closely with the RLHD as needed to ensure that these non-inmate contacts are notified and completely evaluated within a timely fashion.
- I. Within 20 business days of completing Phase I (round 1) and Phase II (round 2) testing and evaluation of inmate and non-inmate contacts, a summary of the contact investigation will be compiled by the CCHCS-PHB and shared with the RSP and the RLHD.
1. If applicable, incorporate the contact investigation summary form(s) from other prison(s) where exposure occurred.
  2. Include the results from as many of the non-inmate contacts (employees, contractors, volunteers and visitors) as possible.

3. Within 30 business days after completing Phase II testing and evaluation of inmate and non-inmate contacts, the CCHCS-PHB and the RSP will submit the final summary report of the contact investigation to their RLHD.
- J. In consultation with the RLHD and CCHCS-PHB, based on the summarized results of evaluations of inmate and non-inmate contacts, will expand the contact investigation if indicated.
- K. CCHCS-PHB will take the lead and attempt to flag and monitor the records of exposed inmate contacts who left CDCR prior to being identified and/or evaluated, and who may still need evaluation in the event that they are re-incarcerated within CDCR.

**III. The Responsible Local Health Officer (RLHO) and/or designee of the Responsible LHD (RLHD) where the index case or suspect was incarcerated when diagnosed will:**

A. Communicate as needed and will:

1. Provide initial, ongoing, and as needed, consultation and assistance to the prison facility health care providers and the CCHCS-PHB conducting the contact investigation.
2. Notify the jurisdiction where the index case is now located, (because they are hospitalized in the community outside of the jurisdiction where the prison is located) to ensure that they are aware of this patient and their diagnosis.
3. Assist with continuity of care between the CCHCS-PHB, the RSP and the hospital, including obtaining medical records, labs, treatment information etc. from the hospital as needed.

B. Provide direct assistance when requested by the RCME and/or designee with:

1. Determining if the index case or suspect needs to be re-interviewed using the time frames previously outlined in this document.
2. Determining if the contact investigation needs to be expanded.
3. Compiling and summarizing the evaluation results of all contacts.
4. Determining if transmission or an outbreak has occurred based on the identification of additional cases.
5. Sending interjurisdictional referrals for contacts as they are identified.

## Implementation

Local health officers, TB Controllers, California Department of Public Health (CDPH), health care providers working in the California Department of Corrections and Rehabilitation (CDCR) institutions and California Corrections Health Care Services (CCHCS) Public Health Branch (PHB) staff will establish procedures and coordinate efforts to ensure respective responsibilities delineated in these guidelines are implemented and continued. Each will have a plan in place to take corrective action when problems are identified with implementing these guidelines.

CDPH will provide technical assistance in working with local health departments (LHDs) toward implementation and continuation of these guidelines. Because many of the issues and actions addressed in these guidelines have regional or statewide implications, and may be beyond the scope or capacity of individual LHDs (e.g., out of county contact investigations, transfers, releases), this assistance may include CDPH staff to liaison with LHDs and correctional facilities. CDPH will also work with regional collaboratives to implement these guidelines. When problems cannot be resolved at the local level, the local health department (LHD) will bring the issue to CDPH which will evaluate the problem, and if necessary, resolve it with the CCHCS-PHB.

CCHCS-PHB will provide assistance to institutions to implement these guidelines and will work with the individual facility Chief Medical Executive (CME) to bring about resolution at the local level. When problems cannot be resolved at the local level, CCHCS-PHB may bring the issue to CDPH TBCB for resolution.

CCHCS-PHB will designate a contact person to receive requests from LHDs/CDPH for patient's medical records, and will provide the needed information or access to the medical record within 5 business days of the request.

**Note:** No set of guidelines can cover all individual oversight situations which can and will arise. Thus, when questions on individual situations not covered by these guidelines arise, consult with your local TB Controller or the California Department of Public Health, TB Control Branch, for consultation and further information.

**THE FOLLOWING ARE IMPORTANT ACRONYMS and INFORMATION USED THROUGHOUT THIS DOCUMENT.**

California Correctional Health Care Services (CCHCS): At the time that these guidelines were revised, (August 2015), CCHCS is the organization formed under federal court receivership to address the medical needs of state prison inmates. All employees working in the state prisons in California in a medical related capacity (e.g. physicians, nurses and therapists) and at the CCHCS Public Health Branch work for California Correctional Health Care Services (CCHCS).

California Correctional Health Care Services - Public Health Branch: (CCHCS-PHB): is the Branch within CCHCS that houses physicians, nurses, epidemiologists and support staff that provide public health related technical and medical support for all state prisons in California.

California Department of Corrections and Rehabilitation (CDCR): The government agency overseeing operation of California state prisons and parole.

California Department of Public Health (CDPH): Refers to the state Tuberculosis Control Branch (TBCB) in the Division of Communicable Disease Control in the Center for Infectious Diseases.

Chief Medical Executive (CME): Is the designated clinician that oversees the treatment, case management and contact investigation at a state prison. *This will only be used if there are inmate contacts that are NOT incarcerated at the RSP.*

Correctional Facility TB Patient Plan (CFTP): The form used by CCHCS/CDCR to collect and share TB suspect and case medical information. To obtain this form Contact the CCHCS-PHB at (916) 691-9805.

Local Health Department (LHD): Differs from the RLHD because it refers to the health department located in the jurisdiction where the inmate is housed while hospitalized or is transferred to or from. *This acronym is only used if the county differs from the one where the inmate was incarcerated when diagnosed.*

Local Health Jurisdiction (LHJ): Jurisdiction/county/city where the patient or contact is residing.

Local Health Officer (LHO): Differs from the RLHO because this health officer is assigned to the health department that is responsible for the jurisdiction where the inmate is hospitalized or transfers to or from. *This acronym is only used if the county differs from the one where he/she was incarcerated when diagnosed.*

Public Health Nurse (PHN): Is in most cases the staff person responsible for overall case management of a TB case and its related contact investigation both inside the prison and in the health department

Responsible Chief Medical Executive (RCME): Is the designated clinician that oversees the treatment, case management and contact investigation at the “Responsible State Prison” (RSP).

Responsible Local Health Department (RLHD): Refers to the health department located in the same jurisdiction as the “Responsible State Prison”.

Responsible Local Health Officer (RLHO): Refers to the health officer representing the RLHD.

Responsible State Prison (RSP): Refers to the state prison facility where the suspect or index case was incarcerated when initially diagnosed. This includes privately-run Community Correctional Facilities (CCF).

## References

1. California Code of Regulations, Title 15, Section 1206 and Title 17, Sections 2500, 2501, 2502, and 2505.
2. CDPH California Department of Public Health (CDPH) /California Tuberculosis Controllers Association (CTCA) Joint Guidelines for Reporting Tuberculosis Suspects and Cases in California, 2011.
3. California Health & Safety Code. Sections 121361, 121362, 121363,121364,121365, and 121375.
4. CCHCS Correctional Facility Tuberculosis (TB) Patient Plan, CCHCS form # 7539
5. American Thoracic Society/ Centers for Disease Control and Prevention (CDC)/ Infectious Diseases Society of America: Treatment of Tuberculosis, 2002.
6. CDPH/CTCA Joint Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Low Risk Settings, 2009.
7. CDPH/CTCA Interjurisdictional Continuity of Care of Care Statement, 2011.
8. CTCA/CDHS Joint Guidelines Treatment of Active Tuberculosis Disease, 2003.
9. American Thoracic Society: Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection, 1999.
10. California Department of Corrections and Rehabilitation, Tuberculosis Control Guidelines, 2005.
11. CDPH/CTCA Joint Guidelines for Oversight of Tuberculosis Care Provided Outside the Local Health Department, 2011.
12. CDC. Essential Components of a Tuberculosis Prevention and Control Program: recommendations of the Advisory Committee for Elimination of Tuberculosis. MMWR 1995; 44 (No. RR-11):6.
13. CDC. Prevention and Control of Tuberculosis in Correctional and Detention Facilities, Recommendations from the CDC. MMWR, 2006, Vol.55, No. RR-09.
14. CDPH/CTCA Joint Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, 2011.
15. California Code of Regulations Title 8, Section 5199, Aerosol Transmissible Diseases. *The employer shall provide all safeguards required by this section, including provision of*

*personal protective equipment, respirators, training, and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during the employee's working hours.*

16. National TB Controllers Association website: [www.tbcontrollers.org](http://www.tbcontrollers.org)
17. California Penal Code, Sections 6006, 7570-7576
18. CDPH – TB Control Branch website:  
<http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx>
19. Southeastern National TB Center, TB in Corrections Toolkit. Website:  
<https://sntc.medicine.ufl.edu/corrections.aspx#.VCMI Aef40p9>



## Appendix A

### Notification Process for Prison Inmates with Suspected or Confirmed Tuberculosis who are Being Transferred, Discharged/Released or Paroled

Transfer/ Discharge/ Release/ From (Sending)	To (Receiving)	Sending Facility or Their Designee Must Notify the Following:				Parole Region and Parole Agent
		Responsible Chief Medical Executive (RCME)	Chief Medical Executive (CME)	Responsible Local Health officer (RLHO)	Local Health Officer (LHO)	
<b>Health Facility</b> ◆	Health facility regardless of jurisdiction			X*	X	
	State prison prior to hospitalization	X		X		
	State prison other than the one prior to hospitalization	X		X*	X	
	Release or parole			X*	X	X
<b>State Prison</b> ◆	State prison regardless of jurisdiction	X**	X	X*	X	
	Health facility regardless of jurisdiction			X*	X	
	Release or Parole			X*	X	X

◆ **Health and Safety Code 121361 has mandated reporting requirements which are not listed here**

Responsible Chief Medical Executive (**RCME**) is from the sending state prison

Chief Medical Executive (**CME**) is located in the receiving state prison

Responsible Local Health Officer (**RLHO**) is from the sending jurisdiction

Local Health Officer (**LHO**) is located in the receiving jurisdiction

X\*- **RLHO** contacts the **LHO** in the receiving jurisdiction

X\*\*- **RCME** contacts the **CME** in the receiving prison

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