MONTANA STATE PRISON
OPERATIONAL PROCEDURE

Procedure:	**MSP HS B-02.4 DISEASE PREVENTION – TB CONTROL PLAN**
Effective Date:	11/01/2010 Page 1 of 4
Revision Date(s):	10/01/2020; 06/30/2026
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I. PURPOSE

Ensure that transmission of tuberculosis (TB) infection does not occur or is minimized through surveillance and containment activities and provide appropriate care to infected inmates.

II. DEFINITIONS (see Glossary)

III. REQUIREMENTS

A. General Requirements

1. Montana State Prison will maintain a TB infection control plan.
2. The MSP Infection Control Committee is a designated team of staff responsible for the following TB infection control program throughout MSP:
   a. screening and surveillance, which includes identifying and reporting of active tuberculosis inmates who have recently converted from negative to positive screening tests;
   b. containment and management of persons who have active tuberculosis (who have recently converted from negative to positive screening tests) to prevent the transmission of tuberculosis;
   c. assessment through monitoring and evaluating surveillance and containment activities; and
   d. education to inmates regarding tuberculosis.
3. Screening and surveillance processes are aimed at identifying those inmates who have active TB or LTBI or are at high risk for future development of active TB.
   a. These inmates will be offered regimes to treat either active or latent disease and minimize the risk of transmission throughout MSP.
4. This procedure is subject to variance, based on:
   a. the Centers for Disease Control;
   b. the MT Department of Health and Human Services (DPHHS) *Guidelines for the Detection, Control, and Treatment of Tuberculosis*; and
   c. applicable Department of Corrections policies and procedures.
5. Any variance from this procedure:
   a. will be documented in the inmate's Electronic Health Record (EHR); and
   b. should include a narrative describing the nature of the variance and clinical, procedural, and administrative reasons for the variance.

B. Screening Methods

1. At initial intake screening, symptom assessment is designed to identify key signs and symptoms of previous or current TB:
   a. productive, prolonged cough;
   b. coughing up blood;
   c. weight loss;
   d. loss of appetite;
   e. fever;
   f. chills;
   g. night sweats;
   h. fatigue and/or malaise; and
   i. recent exposure to anyone with TB.
2. Inmates identified with the above symptoms should be placed in a surgical mask immediately and referred to a health care provider (HCP) for further evaluation as soon as possible.
   a. It should be noted that these symptoms are common with other medical conditions and do not constitute a diagnosis of tuberculosis.
   b. Additionally, the further evaluation should include the following diagnostic tests:
      1) IGRA Blood Test (QuantiFERON-TB Gold test)
      2) Chest X-Ray (PA/Lat);
      3) Blood Tests: CBC, C Reactive Protein (CRP), Complete Metabolic Panel (CMP), and HIV and Hepatitis C screening; and
      4) Induced Sputum Smears for Acid Fast Bacilli (AFB) and AFB Cultures.
3. Documentation will be made in the appropriate area of the EHR.
4. Upon clinical evaluation by an HCP, the inmate may:
   a. be placed on medication until confirmatory testing is complete; and
   b. remain in respiratory isolation until such time as determined to be non-infectious.
5. The HCP is encouraged to consult with the State Medical Director, DPHHS, and other local authorities to determine whether other diagnostic and treatment modalities are applicable.
6. IGRA Blood Testing is required by all incoming inmates with or without a documented positive Mantoux IPPD test or treatment for a documented positive IPPD, LTBI, or active TB infection.
   a. A history of BCG (Bacille Calmette-Guerin) vaccination is not a contraindication for receiving an IGRA Blood Test.
   b. Inmates reporting the above positive reactions or a necrotic or allergic reaction to an IPPD will be interviewed and evaluated by an HCP.
   c. Inmates refusing an IGRA Blood Test will likewise be interviewed by an HCP.
7. For all inmates with a positive IGRA Blood Test, a chest X-ray will be ordered. Once the chest X-ray is complete, the infection control nurse will:
   a. see the inmate to provide education on LTBI;
   b. offer 12-week (once a week dosing) and LTBI treatment; and
   c. complete the State Report for LTBI.
8. Annual screening will be performed on all inmates utilizing *MSP HS B.02.4 (A) Inmate Annual Tuberculosis Screening.*

C. Containment

1. The Health Care Provider (HCP) is responsible for full evaluation and treatment of inmates who either present with signs and symptoms of active TB infection or LTBI. As outlined in the above intake screening section, a thorough history (symptom assessment) along with diagnostic testing is performed. They include but are not limited to the tests outlined above.
   a. Consultation with the Department of Corrections Medical Director and Montana Department of Public Health and Human Services (DPHHS) Tuberculosis Program is recommended. In all **suspected** cases of active TB, the HCP will contact the Department Medical Director and DPHHS.

b. If an active case is confirmed at MSP, a *Tuberculosis Information Exchange for Active Cases* report form, which is provided to MSP by the State TB Program Office each calendar quarter, will be completed and submitted to the State TB Program Office for active case tracking and follow-up purposes.
c. A treatment regime will be developed on a case-by-case basis in consultation with the Medical Director and State TB Program Coordinator to ensure full compliance with:
   1) accepted standards of medical practice and state; and
   2) federal medical guidelines for the prevention and treatment of tuberculosis.
d. If an inmate is to be released from MSP prior to completing treatment or preventive therapy, the State TB Program Office must be notified as far in advance as possible to ensure continued adherence with therapy.
   1) This may include transferring to an appropriate medical facility where respiratory isolation can be maintained until the risk of minimal infectivity can be determined.
e. Before release or transfer of an inmate on direct observed therapy for treatment of TB disease:
   1) provisions will be made for the local health department or receiving facility to oversee continued adherence and to ensure the timely completion of therapy; and
   2) notification will also be given to the State TB Program manager to ensure coordination of TB care for the inmate upon release, with as much advance notice as possible.

2. Respiratory isolation will be guided by *DOC 4.5.11 Infection Disease Prevention and Control*.
   a. Appropriate personal protective devices will be used until the inmate is considered non-infectious.
   b. In general, inmates who have or who are suspected of having active pulmonary or laryngeal TB should be considered infectious if they are coughing, undergoing cough-inducing or aerosol-generating processes, or their sputum smears contain AFB, and they are not receiving therapy, have just started therapy, or have a poor clinical or bacteriological response to therapy.
   c. Inmates who have suspected or confirmed pulmonary or laryngeal TB disease will be immediately placed in TB isolation in the Infirmary.
      1) If the negative pressure room or rooms in the Infirmary are non-functional, upon consultation with the Department Medical Director the inmate will be transferred to an outside medical facility with a negative pressure room.
      2) The inmate must remain isolated until infectiousness is ruled out.
   d. LTBI undergoing prophylactic treatment are not considered infectious and do not require isolation.
   e. Inmates suspected of having active pulmonary or laryngeal TB will be referred for offsite care and may be placed in a negative pressure isolation room.
   f. An inmate may be released from respiratory isolation when they are considered non-infectious, according to the following criteria:
      1) they have received adequate therapy for 2 to 3 weeks;
      2) they have a favorable clinical response to therapy;
      3) they have three consecutive negative sputum smear results from sputum collected on different days; and
      4) other diagnostic modalities show minimal risk for infectivity, especially when in consultation with the Department Medical Director and State TB Program Coordinator.

3. Continuity of Care in the treatment of inmates with active but not infectious TB and prophylaxis of LTBI is ensured through cooperative efforts of the MSP medical staff.
   a. Once inmates are considered non-infectious:
      1) they may be required to continue medical treatment after they are released from the Infirmary; and
      2) those inmates who do not demonstrate active disease but have a positive IGRA Blood Test (for example, LTBI), will be offered 12 week (once a week dosing) treatment per Medical Director standing orders.
         a) Inmates will be placed on a 3 month hold in to ensure completion of treatment.

b) In the event the inmate refuses to take the medication, education on importance of the medication will be provided and it will be documented in the inmate's EHR.

b. Treatment will be continued on an outpatient basis.
   1) Mandatory attendance by inmates at directly observed therapy for all outpatient TB treatment is required.
   2) Nursing staff will report to the Infection Control Nurse and/or HCP any failure of the inmate to take TB medication as prescribed.
   3) The Infection Control Nurse and/or HCP will see the inmate as soon as possible to counsel the inmate on the importance of completing the prescribed regime.
   4) Failure on the part of the inmate to continue treatment will be discussed with the Department Medical Director to determine if further action is required.
   5) Inmates for whom TB preventive therapy is recommended but who refuse or are unable to complete a recommended course of therapy will be counseled to seek prompt medical attention if signs or symptoms suggestive of TB develop.
      a) Screening for symptoms of tuberculosis will be completed and recorded annually.
      b) Routine periodic chest radiographs will not be done in the absence of symptoms.
      c) Chest radiographs will be taken if symptoms develop, especially a persistent cough.
   6) Education will be provided to the inmate, since many anti-tubercular drugs have significant side effects including peripheral neuropathy and hepatotoxicity.
   7) Any sign of deterioration of the inmate's condition warrants full evaluation to see if an active TB infection has developed.

D. Continuous Quality Improvement

1. Health care staff involved in annual testing will complete *MSP HS B.02.4 (A) Inmate Annual Tuberculosis Screening*.
2. The purposes of the forms will be to monitor for TB within the facility and to improve the process of TB surveillance.
3. The forms will then be turned into the Infection Control Nurse (inmates) or personnel (employees), along with the names of inmates and employees who did not compete the applicable annual TB form.

IV. CLOSING

Questions about this procedure should be directed to the Medical Health Services Manager.

V. FORM

A. *MSP HS B.02.4 (A) Inmate Annual Tuberculosis Screening*