This document was approved by Dr. Mary Perrien, chief of the Division of Education and Treatment, on 12/28/08 (signature on file).

BOARD OF CORRECTION IDAPA RULE NUMBER 401

Medical Care

POLICY STATEMENT NUMBER 401

Hospitalization, Institutional Clinical Services, and Treatment

POLICY DOCUMENT NUMBER 401

Hospitalization, Institutional Clinical Services, and Treatment

DEFINITIONS

Standardized Definitions List

Contract Medical Provider: A private company under contract with the Department to provide comprehensive medical, dental, and/or mental health services to the incarcerated offender population. A contract medical provider may include private prison companies and other entities under contract with the Department to operate the Idaho Correctional Center (ICC) and other out-of-state facilities housing Department offenders.

Facility Health Authority: The contract medical provider employee who is primarily responsible for overseeing the delivery of medical services in an Idaho Department of Correction (IDOC) facility.

Facility Medical Director: The highest ranking physician in an Idaho Department of Correction (IDOC) facility.

Health Authority: The Department employee who is primarily responsible for overseeing or managing the Department's medical and mental health services. The health authority is commonly referred to as the health services director.

Medical Director: A physician either employed by the Idaho Department of Correction (IDOC) or contracted through privatized services (i.e., the physician in charge if medical services are privatized).

Qualified Health Professional: A physician, physician assistant, nurse practitioner, nurse, dentist, mental health professional or others who -- by virtue of their education, credentials, and experience -- are permitted by law (within the scope of their professional practice) to evaluate and care for patients.

Reception/Diagnostic Unit (RDU): Initial housing for newly committed offenders--except those under sentence of death--where orientation, screening, assessment, and classification occur.

Tuberculosis (TB): An infectious disease caused by bacterium that most commonly affects the lungs.

PURPOSE

The purpose of this standard operating procedure (SOP) is to establish procedures for a program to identify, counsel, evaluate, and treat offenders who have latent tuberculosis infection (LTB) and active tuberculosis (TB).

SCOPE

This SOP applies to all Idaho Department of Correction (IDOC) healthcare services staff, offenders, contract medical providers and subcontractors.

RESPONSIBILITY

Health Authority

The health authority is responsible for:

- Monitoring and overseeing all aspects of healthcare services, and
- The implementation and continued practice of the provisions provided in this SOP.

When healthcare services are privatized, he will also be responsible for:

- Reviewing and approving (prior to implementation) all applicable contract medical provider policy, procedure, and forms; and
- Monitoring the contract medical provider's performance, to include but not limited to reviewing processes, procedures, forms, and protocols employed by the contract medical provider to ensure compliance with all healthcare-related requirements provided in respective contractual agreements, this SOP, **and** in *National Commission on Correctional Health Care (NCCHC) standard P-B-01, Infection Control Program.* (See section 10 of this SOP.)

Contract Medical Provider

When healthcare services are privatized, the contract medical provider is responsible for:

- Implementing and practicing all provisions of this SOP, unless specifically exempted by written contractual agreements;
- Ensuring that all aspects of this SOP and NCCHS standard P-B-01 are addressed by applicable contract medical provider policy and procedure;
- Ensuring facility health authorities utilize all applicable contract medical provider policy, procedure, forms, and educational information to fulfill all healthcare-related requirements provided in this SOP, *NCCHC standard P-B-01*, **or** as indicated in their respective contractual agreement(s);

- Ensuring all applicable contract medical provider policy, procedure, and forms are submitted to the health authority for review and approval prior to implementation; and
- Administering tests for TB to both offenders and IDOC staff who work with offenders.

Note: Nothing in this SOP shall be construed to relieve the contract medical provider(s) of any obligation and/or responsibility stipulated in respective contractual agreements.

Facility Medical Director

The facility medical director and facility health authority (or designees) will be jointly responsible for reporting cases of TB.

Facility Health Authority

The facility health authority will be responsible for:

- Ensuring the presence of an adequate number of appropriately trained staff and materials are available to meet the requirements of this SOP, and
- Establishing and monitoring applicable contract medical provider policy and procedure to ensure that all elements of this SOP **and** *NCCHC standard P-B-01* are accomplished as required.

In addition, to the above responsibilities, the facility health authority and the facility medical director (or designee) will be jointly responsible for reporting cases of TB.

Qualified Health Professional

The qualified health professional will be responsible for:

- Providing sufficient explanation and information to the offender to allow the offender to understand the symptoms, screening process, and treatments available for TB; and
- Documenting all clinical contacts in the offender's healthcare record.

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GENERAL REQUIREMENTS

1. Transmission of Tuberculosis

Mycobacterium tuberculosis (M. Tuberculosis), the organism that causes TB, is transmitted through airborne respiratory droplets when an individual with active pulmonary TB coughs, sneezes, or speaks. The transmission of M. tuberculosis depends on the length of time and frequency of the exposure, the degree of contagiousness of the infected person, the environment and airflow in which the exposure occurred, and the intensity of the contact with the TB organism itself. Infection with M. tuberculosis usually requires prolonged contact with an infectious case in an enclosed space. This exposure usually results in LTBI. The majority of persons who become infected with LTBI never develop active TB.

2. Screening, Testing, and Treating Offenders for TB

The guidelines for screening, testing, counseling, evaluation and treatment in this SOP are based on the most recent information from the National Institute of Health (NIH), Centers for Disease Control and Prevention (CDC), and other nationally recognized science-based literature.

The Federal Bureau of Prisons clinical practice guideline is based on recommendations made by NIH and CDC, as well as current scientific research from a wide variety of sources, and is the standard adopted by the IDOC for the identification, evaluation, and treatment of LTBI and active TB.

Screening

Screening for TB in correctional facilities involves both ongoing surveillance for active TB disease and detection of LTBI. Early detection and isolation of inmates with suspected pulmonary TB is critical to preventing widespread TB transmission. Identification of LTBI provides an opportunity for providing treatment to prevent future development of TB disease.

TB Symptom Screening

All offenders received at the Reception/Diagnostic Unit (RDU) shall be systematically screened for TB symptoms by a qualified health professional.

Screening for LTBI

All offenders received at the Reception and Diagnostic Unit will be screened for LTBI. Risk factors for LTBI include the following:

- Intravenous drug abuse
- Chemotherapy
- Malnutrition
- Recent exposure to active TB

- Human immunodeficiency virus (HIV) infection
- Systemic steroid medication use.

Offenders will receive the two (2)-step Mantoux tuberculin skin test (TST) by intradermal injection of purified protein derivative (PPD) of killed tubercle bacilli, usually on the inner forearm. The forearm (or site) will be examined by a qualified health professional 48 to 72 hours later for a reaction.

The diameter of the induration is measured, disregarding erythema or bruising, as follows:

- An induration of **five (5) mm** in any imunocompromised patient is considered **positive**.
- An induration of **10 mm or more** in recent immigrants and persons participating in high-risk behaviors is considered **positive**.
- An induration of **15 mm or more** in an otherwise healthy individual is considered **positive**.

Note: Periodic repeat screenings will be accomplished based on incidence of TB **and** incidence of impaired immunity from other diseases.

Note: All offenders will receive mandatory annual PPD testing in their birth month. If previously positive, a questionnaire will be completed annually **and** a chest x-ray done every five (5) years.

Chest Radiograph Screening

The following categories of offenders should have a chest x-ray at intake (in addition to the intake TB symptom screen and a TST):

- All HIV positive offenders
- All offenders with a positive result on the TST.

Treatment of LTBI or Active TB

When privatized, treatment for LTBI or active TB will be under the direction of the contract medical provider.

Medication compliance is a major issue in the treatment of LTBI and active TB. When non-compliance occurs in an offender with either LTBI **or** active TB, the offender shall be placed in the appropriate type of restrictive housing (see SOP 319.02.01.001, *Restrictive Housing*) per their diagnosis or as clinically indicated because he poses a serious threat to the health of others.

3. Testing IDOC Employees for TB

The testing of all new IDOC employees who work with offenders (including contracted staff) is mandatory. The two (2)-step Mantoux TST shall be used (see section 2). TSTs should then be repeated annually for all IDOC employees who work with offenders.

The contract medical provider will be responsible for administering the TSTs to both offenders and IDOC staff.

4. Reporting Suspected or Active TB

The facility health authority and/or facility medical director shall:

- Ensure that the health authority is immediately notified of any suspected or active cases of TB, and
- Ensure all suspected or diagnosed cases of TB are reported to the Department of Health and Welfare so that they may assist in the proper management of the case and in the evaluation of contacts.

Note: In accordance with the *Health Insurance Portability & Accountability Act (HIPAA) of 1996* (Public Law 104-191), an IDOC offender has a right to understand and control how his health information is used. Therefore, the IDOC considers an offender's medical file and data to be confidential and shall not become the topic of conversation other than for professional purposes among healthcare services staff. Under no circumstances shall the contents of an offender's medical file be discussed with **or** disclosed to any other offender.

5. Transport of Offenders with Active TB

- Normal security precautions shall be utilized.
- The offender as well as security staff shall be provided with a special facemask to prevent the transmission of airborne droplets, which may occur due to the offender coughing, sneezing, etc.

6. Medical Isolation of TB Patients

When an offender has been diagnosed **or** when sufficient suspicion is present that indicates the possibility of TB, the offender shall be isolated in unit infirmaries **or** local hospitals. All healthcare services and security staff having contact with the isolated offender shall be fitted with a special facemask to prevent the transmission of airborne droplets, which may occur during contact.

Respiratory Isolation

Infected offenders shall be placed in respiratory isolation rooms until they are no longer infectious. The standard to prove that an offender is no longer infected shall be demonstrated by three (3) consecutive Acid-fast Bacillus tests showing a negative result **or** sufficient antibiotic therapy decreasing the risk of transmission.

Note: Respiratory isolation rooms should be under negative pressure so that all air currents come into the room (i.e., air should be ventilated to the outside of the building, not re-circulated).

Ultraviolet (UV) Lighting

The installation of UV lights in respiratory isolation rooms should be used only as **a supplement to good ventilation** (see the note box above). Cough inducing procedures (such as sputum, bronchoscopy, and the administration of aerosolized pentamidine) can place healthcare services staff and other offenders that are nearby at special risk of acquiring TB. It is very important to carry out such procedures in respiratory isolation rooms with negative pressure, relative to adjacent rooms and hallways. If installed, proper precaution and maintenance of the UV lights is essential.

7. Food Service for Medically Isolated TB Patients

All food will be prepared by facility food service staff and brought to the medical facility in disposable containers. Disposable utensils shall also be delivered.

8. Laundry Control for Medically Isolated TB Patients

All linen used for medically isolated TB patients shall be placed in water-soluble bags and laundered separately.

9. Educating Offenders and IDOC Employees on Containing TB

Educating both offenders and staff **and** openly addressing their questions and concerns is vital to efforts to contain TB. Education shall be a joint effort of healthcare services staff, facility heads, division chiefs, and the Idaho Peace Officer Standards and Training (POST) academy, and can be conducted in conjunction with the annual Acquired Immune Deficiency Syndrome (AIDS) update.

Offenders should receive education on TB and other communicable diseases during the intake process. (See SOP 401.06.03.032, *Receiving Screening*, for additional information.)

10. Compliance

Compliance with this SOP and all related Department-approved protocols will be monitored by the health authority (or designee) by using various sources to include: this SOP, clinical practice guidelines, routine reports, program reviews, and record reviews.

The health authority (or designee) must conduct two (2) audits a year (or more frequently as desired based on prior audit results). The audits must consist of monitoring applicable contract medical provider and IDOC policy and procedures, applicable NCCHC standards, and the review of a minimum of 15 individual records.

REFERENCES

Centers for Disease Control and Prevention, *Treatment of Tuberculosis* (MMWR June 20, 2003/52[RR11];1-77)

Federal Bureau of Prisons, *Management of Tuberculosis* (2007)

National Commission on Correctional Health Care (NCCHC), Standard P-B-01, *Infection Control Program*

Public Law 104-191, *Health Insurance Portability & Accountability Act (HIPAA) of 1996*

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