



Correctional Tuberculosis Screening Plan (TB-805) Checklist

The checklist is a tool for first-line reviewers (local and regional TB programs) to perform quality assurance for correctional tuberculosis screening plans on commonly missed items. Please note the checklist is not comprehensive for all form questions and/or situations.

Ensure the screening plan is complete before submitting to Central Office. If you have any questions, please email cqiteam@dshs.texas.gov. Attach the completed checklist when submitting the screening plan and supporting documents for review and approval.

Facility Name: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Table with 6 columns: Question #, QA Question, Yes, No, N/A, Notes. Rows include A9, A11, Section A, B1, and B8.



Question #	QA Question	Yes	No	N/A	Notes
<b>B8</b>	If the facility selected "Out-of-County" or "Out-of-State," did they specify the counties and/or states?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B9</b>	Did the facility attach a copy of the <b>current</b> contract for the healthcare team?  <b>Note:</b> Current contracts are active through the approval period, i.e., 2025, or automatically renewed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B10</b>	Did the facility complete the remaining questions if the medical provider is the same as in question A9?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B10</b>	Did the facility attach a <b>current</b> contract for the medical provider?  <b>Note:</b> Current contracts are active through the approval period, i.e., 2025, or automatically renewed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B13</b>	If needed, was a separate sheet with the names <b>and</b> credentials attached?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B14</b>	Does the facility perform QFTs and/or T-SPOTs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B15</b>	Did the facility indicate N/A if the facility only uses the TST?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B15</b>	If IGRAs are used, did the facility list the entity providing the QFT/T-SPOT supplies?  <b>Note:</b> TB Programs cannot use DSHS-funded services (e.g., Quest) to provide IGRA testing for Chapter 89-designated facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	QA Question	Yes	No	N/A	Notes
<b>B15</b>	If the facility uses a TST and an IGRA, do the instances align with DSHS standards (i.e., no confirmatory testing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B16</b>	Did the facility provide information on the CXR provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B17</b>	If "NO" is selected, did the facility fill out ALL appropriate information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B18</b>	If the facility will relocate, was the location specified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B19</b>	If the TB infection control person is NOT the same as the contact person in Section A, was the appropriate information filled out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B20</b>	If the facility has AIIRs, did they indicate the number of AIIRs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B21</b>	If the facility has fewer than two AIIRs, did they specify where they will isolate inmates?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B21</b>	Did the facility attach a copy of the contract or agreement with the hospital/facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B22</b>	If "YES" is selected, did the facility provide information on who oversees inspection and maintenance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B22</b>	If "NO" is selected, did the facility indicate the reason for not routinely inspecting and maintaining AIIRs at the facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	QA Question	Yes	No	N/A	Notes
<b>B24</b>	Did the facility provide the current contact information for the individual(s) listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B26 and B27</b>	If the health department provides testing supplies, is it reflected accurately? Ensure the full spelling of the health department.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B26 and B27</b>	Did the facility provide both the full name and address of the supplying entity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B28</b>	Did the facility list an entity that is not the health department?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B28</b>	If the facility lists the health department as the supplier of TB medications, does the health department serve as the medical provider (refer to question B10)?  <b>Note:</b> The LHD/PHR may review medication orders but shall not supply medications directly to Chapter 89-designated facilities unless the LHD/PHR serves as the TB medical provider listed on the Correctional TB Screening Plan for that facility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B29</b>	Are the services checked consistent with what is provided by the local or regional TB Program? Ensure alignment with your TB program's services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Section B</b>	Is Section B complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1</b>	Did the facility include AM or PM for the facility shift hours if not using a 24-hour format?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	QA Question	Yes	No	N/A	Notes
<b>C3</b>	Did the facility note that TSTs are read within 48-72 hours of placement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C4</b>	If symptom screenings are conducted, did the facility specify when they are performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C4</b>	Did the facility attach a copy of the TB symptom screening form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C6</b>	If the facility does NOT offer treatment for TB infection, did the facility explain why?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C7</b>	If "On a designated month" is selected, did the facility list the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C7</b>	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C8</b>	Did the facility attach a copy of the continuity of care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C12</b>	Did the facility attach all applicable transfer forms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Section C</b>	Is Section C complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>D1</b>	If "Other" is selected, did the facility specify when initial screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Question #	QA Question	Yes	No	N/A	Notes
<b>D2</b>	If "On a designated month" is selected, did the facility specify the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>D2</b>	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Section D</b>	Is Section D complete (i.e., no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>E3</b>	If "Other" is selected, did the facility specify when initial screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>E4</b>	If "On a designated month" is selected, did the facility specify the month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>E4</b>	If "Other" is selected, did the facility specify when annual screenings occur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Section E</b>	Is Section E complete (no missing information)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>F1</b>	If the facility selected "YES," did they provide the appropriate information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Section G</b>	Did the facility check the correct submission type?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>END PAGE</b>	Did the jail administrator sign and date the plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Supporting Document	Yes	No	N/A	Notes
Current Health Care team provider contract (question B9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current Medical service provider contract (question B10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Staff and their credentials (question B13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Contract or agreement with hospital/facility (question B21)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TB symptom screening form (question C4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Continuity of Care Plan (question C8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Form(s) used to transfer inmate records (question C12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I am confirming I have thoroughly reviewed the screening plan for completion and accuracy and am submitting a complete and accurate plan for review and approval.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_