ICE HEALTH SERVICE CORPS **OPERATIONS MEMORANDUM**

OM 19-001
Effective Date: 21 February 2019

By Order of the Assistant Director:
Stewart D. Smith, DHSc, MPH STEWART D SMITH Digitally signed by STEWART D SMITH Date: 2019.03.18 09:40:28 -04'00'

TO: **IHSC Public Health Service (PHS) Commissioned Corps Officers, Civilian Federal Employees, and Contract Personnel**

SUBJECT: **Pediatric Tuberculosis Screening and Evaluation Guidance for Family Residential Centers**

1. **APPLICABILITY.** This Operations Memorandum (OM) is applicable to all U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) personnel (federal and contract staff), supporting health care operations in ICE family residential centers (FRC).

2. **PURPOSE.** The purpose of this OM is to provide clinical guidance to screen children (less than 18 years of age) for tuberculosis (TB) in IHSC-staffed FRCs pending release of revised Family Residential Standards (FRS).

3. **AUTHORITIES AND REFERENCES:**

   3-1. American Academy of Pediatrics: Redbook 2018.

   3-2. American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children.

   3-3. American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis.

   3-4. Centers for Disease Control and Prevention: Tuberculosis.

   3-5. Curry International Tuberculosis Center | Pediatric TB Resource Page.

   3-6. For adult residents, refer to Directive 05-11 Public Health Actions for Tuberculosis Care and 05-11 Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Facilities in the IHSC policy library.

4. PROCEDURE:

4-1. All new arriving children will receive screening for symptoms consistent with pulmonary TB, within 12 hours of intake and in accordance with Centers for Disease Control and Prevention (CDC) guidelines (www.cdc.gov/tb) and the most current American Academy of Pediatrics (AAP) Redbook.

4-1.1. For children who have been in continuous law enforcement custody, symptom screening, plus documented negative TB testing, within one year of arrival may be accepted for intake screening purposes and complete TB testing.

4-2. Further testing of children for TB will be done using the following screening recommendations; it is recommended that the same test is used consistently for a target age group with minimal exceptions.

4-2.1. All children with signs or symptoms suggestive of TB: promptly administer a test for TB infection [interferon gamma release assay (IGRA) preferred or TB skin test (TST)] and chest x-ray (CXR) with two views [anteroposterior (AP) or posteroanterior (PA) and lateral views].

4-2.2. All children accompanied by an adult identified with confirmed or suspected TB, or other known exposure to a person with TB disease: promptly administer a test for TB infection (IGRA preferred, or TST) and CXR with two views (AP or PA and lateral views).

4-2.3. Children who do not have signs and symptoms suggestive of TB and no known exposure to TB disease:

4-2.3.1. Under 2 years: no further testing unless required by state law;

4-2.3.2. Children 2–14 years of age: within 30 days of arrival, administer a test for TB infection (IGRA preferred, or TST). If a test for TB infection cannot be accomplished, then conduct screening using a CXR with two views [AP or PA and lateral views];

4-2.3.3. Children 15–17 years of age: administer a CXR (within 72 hours of arrival) with two views (AP or PA and lateral views). If a CXR cannot be accomplished promptly, then administer a test for TB infection (IGRA preferred or TST).

4-3. Post-Screening Evaluation.

4-3.1. Children with a positive IGRA or TST:

4-3.1.1. If the test for TB infection (IGRA or TST) is positive, administer a CXR with two views (AP or PA and lateral views].

4-3.1.2. Perform a directed physical examination for all children and adolescents with a positive IGRA, TST, or CXR to assess for pulmonary or extrapulmonary disease.

4-3.2. Children with symptoms consistent with pulmonary TB or abnormal CXR results:

4-3.2.1. Refer children who have any symptom suggestive of TB disease, or any resident with an abnormal CXR suggestive of pulmonary TB disease, to a medical provider for medical consultation. If a medical provider is not on duty at the time of identification, then admit the resident with suspected TB to an airborne infection isolation (AII) room if available on-site pending prompt evaluation;

4-3.2.2. If no AII room is available on-site, then refer the resident to the nearest tertiary care facility for isolation and evaluation in consultation with the Clinical Medical Authority or designee; and

4-3.2.3. Fit the child with a tight-fitting surgical mask (without an exhalation valve) when not in an AII room until a provider determines the child is noncontagious.

4-3.2.4. Children with suspected TB disease (extrapulmonary or pulmonary) should be referred to or managed in conjunction with a specialist with expertise in childhood TB;

4-3.2.5. A pediatric TB expert should be involved in the treatment of TB in children and in the management of infants, young children, and immunocompromised children who are known to

have been exposed to someone with infectious TB disease;

4-3.2.6. For more information about TB disease or risks for TB-drug toxicity, see *American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis,* and the *AAP Red Book*.

4-3.2.7. A medical provider should seek expert medical consultation as needed through TB Centers of Excellence.

4-4. For children with confirmed and suspected active TB, designated medical staff will:

4-4.1. Report all children to local and/or state health departments within one working day of meeting reporting criteria and in accordance with established guidelines and applicable laws. Identify the children as being in ICE custody and provide their alien numbers [A-numbers];

4-4.2. Promptly report any movement of TB patients, including hospitalizations, FRC transfers, releases, or removals/deportations to the local and/or state health department and the CDC CureTB Program.

4-4.3. Promptly notify local or state health departments and CureTB of release or removal with the intended destination address, including apartment numbers and telephone numbers.

4-4.3.1. Reporting must include names, aliases, date of birth, A-number, TB status, available diagnostic and lab results, treatment status (including drugs and dosages), treatment start date, a summary case report, and a point of contact and telephone number for follow up.

4-5. When treatment is indicated, multi-drug, anti-TB therapy will be administered using directly observed therapy in accordance with *American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis,* and the *AAP Red Book*.

4-6. Children receiving anti-TB therapy should be provided with a 15-day supply of medications and appropriate education when transferred, discharged, or deported, in an effort to prevent interruptions in treatment until care is continued in another location.

4-7. Treatment for latent TB infection (LBTI) should not be initiated unless active TB disease is ruled out or a pediatric TB expert advises staff to initiate LTBI treatment for a child with known exposure to contagious TB.

4-8. Annual TB testing should be implemented in accordance with CDC guidelines. The annual TB screening method should be appropriately selected with consideration given to the initial screening method conducted or documented. Routine annual CXRs are not required or recommended. Evaluate all children in continuous law enforcement custody for symptoms consistent with TB within one year of the previously documented TB evaluation. In HIV positive children, health staff should perform a TST or an IGRA annually to exclude recent TB infection.

4-9. For TB reporting, the Compliance Officer (CO), or designee if the facility does not have a CO, must oversee case reporting information in the TB Case Management (TB-CM) template in the electronic health record (eHR). Health staff should refer to the 05-06-G-03, Infectious Disease Public Health Actions Guide: Surveillance and Reporting, and the IHSC eCW User Guide: TB Case Management, for detailed guidance on reporting of presumptive and verified confirmed tuberculosis using the TB-CM template in eCW.

5. HISTORICAL NOTES. This OM supplements FRS on those elements of Directive 05-11: Public Health Actions for Tuberculosis Care, and 05-11, Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics involving pediatric TB screening.

6. APPLICABLE STANDARDS

6-1. Family Residential Standards (FRS):

Part 4: Care; 4.3: Medical Care.; 2. Communicable Disease and Infection Control; b. Additional Requirements Regarding Tuberculosis.

7. **NO PRIVATE RIGHT STATEMENT:** This OM is an internal statement of IHSC. It is not intended to, and does not create, any rights, privileges, or benefits, substantive or procedural, enforceable against the United States, its departments, agencies, or other entities; its officers or employees; or any other person.

8. **RECORDKEEPING:** All documentation should be completed in the electronic health record and retained as required for IHSC Alien Health Records.